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Creating Successful Rehabilitation Partnerships Between Health Professionals and Employers

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Successful rehabilitation outcomes rest on the quality of the links among multiple stakeholders. However, the literature has increasingly recognised the challenges in creating effective partnerships between stakeholders such as external health professionals, employers and injured workers. This study presents findings from an industry-directed project aimed at investigating the links between external health professionals and the employer in relation to return-to-work rehabilitation. Semistructured interviews were conducted with general practitioners (GPs), psychologists, and organisation-based rehabilitation personnel. Findings indicated several major points of consideration to facilitate health professional and employer partnerships, including educating stakeholders about organisational rehabilitation services and key contact personnel within the organisation, establishing standard communication protocols, understanding organisational culture and providing explicit organisational support for the rehabilitation process. To ensure appropriate and timely outcomes for injured workers, the current findings highlight the proactive and educative role that employers must assume when acting in partnership for rehabilitation.

Successful return to work is largely determined by the quality of the interactions among the stakeholders involved (Friesen, Yassi, & Cooper, 2001). Indeed, effective collaboration between external health professionals and employers can mitigate the negative impact of work-related disability (Franche, Baril, Shaw, Nicholas, & Loisel, 2005; Friesen, Yassi, & Cooper, 2001; Kenny, Kable, Kroon, Quinn, & Edwards, 1999; Krause, Frank, Dasinger, Sullivan, & Sinclair, 2001). Although the literature consistently identifies the importance of communication

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and collaboration among external health professionals and employers, the nature of this partnership is unclear and requires further exploration. The current study aimed to examine the rehabilitation partnership between external health professionals and organisation-based rehabilitation personnel with a view to determining factors that may optimise the quality of the interaction. Specifically, the study aimed to identify the challenges to communication and collaboration between external health professionals (general practitioners [GPs] and psychologists) and employer-based rehabilitation providers within a major public sector organisation, the Queensland Police Service (QPS). For QPS, their review of collaborative partnerships represented an important step in improving outcomes for injured workers.

Kenny (1995) confirmed the importance of viewing 'relationships in context' in rehabilitation (p. 55). In this sense, she considers that the focus of rehabilitation must extend beyond the focus of the individual and reflect the dynamic relationship that exists between the injured worker, other stakeholders and the system. Franche and Krause (2002) similarly recognised that although the injured worker remains the principal change agent in the rehabilitation process, the behaviours and responses of other stakeholders can determine the outcomes of rehabilitation.

External health professionals, such as GPs and psychologists, are primary liaison professionals involved in the development and implementation of the injured worker's rehabilitation plan. GPs in particular are often considered to be the 'gateway' of care and are expected to direct the rehabilitation process to a large extent, referring to other health professionals only as needed. These external health professionals maintain central involvement across various stages of injury management and return to work, though their primary role is to support injured workers in their return to a level of functioning comparable to their preinjury status. The influence of health professionals on the rehabilitation experience is substantial. Indeed, better health outcomes and greater satisfaction among injured workers have been found to be a direct result of the positive influence of the treating health professional (Beach & Watt, 2003; Beaumont, 2003; Rasmussen & Anderson, 2005). It has been suggested that the greatest impact of treating health professionals is during the acute stage of treatment (i.e., first 30 days of disability), thus placing even greater importance on establishing effective partnerships early on in the rehabilitation process (Dasinger, Krause, Thompson, Brand, & Rudolph, 2001).

However, researchers have confirmed the struggles faced by both external health professionals and employers when forging partnerships in the rehabilitation process (Habeck & Szymanski, 1999; Kenny et al., 1999). These challenges include difficulties in establishing contact and gaining access to information (i.e., for both employers and health professionals), limited knowledge of injured workers' job and suitable duties, and lack of involvement at crucial times in the rehabilitation process (Beach & Watt, 2003; Krause et al., 2001). Poor collaboration among multiple stakeholders contributes to the tensions and mismatch that have been found to characterise some rehabilitation processes (Muenchberger, 2006). It is not surprising then that some key external health professionals, such as GPs and psychologists/case managers report a need for greater awareness, understanding, and resources (i.e., training opportunities, time to implement new skills, personnel) when attempting to establish rehabilitation services.

The present study aimed to investigate and describe the nature of rehabilitation partnerships between external health professionals and organisations, in particular the QPS. The specific objectives were to determine (a) the awareness of QPS rehabilitation services among external health professionals, (b) the experiences of external health professionals in relation to the return-to-work process, and (c) the perceptions of QPS rehabilitation coordinators about their existing links with external providers.

Method

This study was part of a larger project investigating rehabilitation services within the police service. For the current study, only those results pertaining to the partnership between the external health provider and employer are presented. A detailed description of all stakeholder experiences, including that of the injured workers is presented elsewhere (see Kendall, Muenchberger, & Murphy, 2005). A qualitative methodology was employed where semistructured interviews were conducted and analysed using thematic analysis (Lincoln & Guba, 1985). In accordance with qualitative validation procedures, an expert panel comprising three independent researchers all with a tertiary qualifications in rehabilitation and injury management, independently checked themes against primary data. In order to contain the scope of the study, data collection was focused on the region from Brisbane city to the Gold Coast, Queensland.

Participants

Two participant samples were selected to represent key external provider groups, namely, GPs ($n = 14$) and psychologists ($n = 27$). The majority of GPs (70%) reported 'extensive' experience in treating injured workers and engaging in the rehabilitation process. Psychologists reported a mean of 15 years professional experience either in general psychology settings or a rehabilitation context ($SD = 10.19$), ranging from 3.5 years to 38 years.

A sample of QPS internal rehabilitation personnel was also selected. To ensure representativeness across the QPS, participants who responded to the request to be interviewed were categorised according to whether they were based in a rural, regional or metropolitan area. Participants were then randomly selected from each of the three categories. An attempt was also made to ensure that the final sample represented differing levels of experience in the role, gender and tenure with the QPS, although this was more difficult to achieve. The final sample of QPS rehabilitation personnel consisted of rehabilitation coordinators (RCs; $n = 12$), human services officers (HSOs; $n = 5$), other occupational health and safety personnel including health and safety coordinators (HSCs; $n = 3$) and workplace health and safety officers (WH&SOs; $n = 4$). Within the QPS, RCs are primarily responsible for the return-to-work process for individual workers, but are not qualified health professionals. HSOs are behavioural science professionals or psychologists who often form part of the rehabilitation team. HSCs are responsible for managing health and safety and rehabilitation within their respective regions/commands. HSCs also ensure that there are sufficient trained and accredited RCs within their police region/command. They oversee the rehabilitation process and respond to compensation queries. WH&SOs

have prescribed duties under the *Workplace Health and Safety Act*. Within QPS, their duties encompass investigation of incidents/accidents, hazard reporting and some workplace inspections with limited involvement in the rehabilitation process. WH&SOs and RCs often volunteer for these rehabilitation roles (in addition to their normal police service duties) and are provided with limited time to carry out this extra role.

Materials and Procedure

Participating psychologists were randomly contacted by telephone following a systematic search of the Yellow Pages® directory for the area. Initial screening was undertaken to exclude psychologists who had reported no experience with return to work, rehabilitation and/or injured QPS members. GPs were contacted via written invitation distributed through their local division. Rehabilitation personnel within the organisation were individually recruited through purposive mail out distributed by the QPS. Each participant underwent a semistructured telephone interview, or completed a written survey equivalent if they were unable to complete a telephone interview. All participants completed a written consent form, and confidentiality was assured.

The interview protocol included questions pertaining to several key aspects of the rehabilitation process including the experiences of external providers with QPS, the role of the external provider from the perspective of QPS, current benefits and pitfalls associated with rehabilitation and strategies for improving current rehabilitation services.

Results

Qualitative investigation of the interviews with external providers (GPs and psychologists), and QPS rehabilitation personnel (i.e., RCs, HSOs, WH&SOs and HSCs) highlighted three key factors that were thought to promote successful rehabilitation partnerships. These factors included (1) awareness among external providers of rehabilitation programs offered by the employer and understanding of the respective roles within the rehabilitation process, (2) accurate and detailed information transfer between all stakeholders, including the need for standardised reporting processes, and (3) organisational support for rehabilitation and an accommodating cultural environment within the organisation. Each of these issues will be discussed in the following sections.

Awareness of Internal Rehabilitation Services

The QPS has a rehabilitation policy that details the responsibilities for QPS rehabilitation personnel. The extent to which external health professionals were aware of the QPS rehabilitation process and rehabilitation roles was variable. Overall, many psychologists (60%) and few GPs (25%) were aware that rehabilitation services are offered by QPS. Despite all GPs receiving rehabilitation forms from the employer, only a small percentage of GPs and psychologists (30%) had ever completed the required documentation according to employer protocols. The majority of GPs (92%) felt hampered by an inability to contact specific

rehabilitation personnel at the organisation, 'we [GPs] don't know who to contact — usually a superior officer'. Psychologists as a group were comparatively more aware of a rehabilitation contact person (45%) within the QPS organisation.

GPs considered that it was the employer's responsibility to initiate contact with the external health professional to introduce the injured worker. GPs highlighted the importance of providing detailed information at the initial point of contact. For instance, GPs wanted more specific information about the injury and/or job, beyond what could be offered in the usual cover note provided by the employer. One GP suggested 'a letter of introduction was sent, however, there was no detailed information [pertaining to the injured worker's job or injury] — additional requests for detailed reports is frustrating and time consuming'. GPs were of the view that the level of experience, and quality of training for RCs potentially compromised the rehabilitation process. However, GPs commented on their own time constraints and workload that prevented sufficient contact with the employer.

For externally based psychologists, establishing and maintaining contact with rehabilitation staff within the organisation presented similar challenges. Despite almost half the psychologists being aware of QPS rehabilitation services and having knowledge of who to contact, the majority reported being unable to access the RC, HSO or HSC when required, and similar to GPs, felt they would have benefited from more detailed information from QPS regarding a respective case. Although psychologists appeared more willing than GPs to initiate contact with the employer, the availability of the QPS rehabilitation personnel to discuss a rehabilitation case was dictated by their hectic work schedules.

QPS rehabilitation personnel reported that GPs were able to provide valuable diagnostic information and guidance about rehabilitation and return-to-work strategies. Specifically, HSCs considered GPs to be a pivotal point of referral in that they provided a medical coordinating role and were a primary source of trust and refuge for the injured worker. They perceived GPs to be directive in the rehabilitation process, in that they 'take over' the case management role. However, RCs noted how this directive role could sometimes be counter-productive to collaborative partnerships. Although they believed that GPs should be 'facilitators of return to work' and a 'liaison point', RCs felt that GPs could be seen to be obstructive to the rehabilitation process by being 'unavailable', 'protective and rigid about the information they release (due to GP-patient confidentiality)', 'disinterested in return-to-work process' or 'failing to take their responsibility further'. RCs recognised the importance of establishing a trusting collaboration with external providers; however, they found it difficult to establish rapport with GPs. They believed that the rehabilitation outcome could be partially determined by 'how you treat the GP'.

Locum GP appointments and shift changes were also thought to compromise communication between GPs and QPS rehabilitation personnel. As a result of this difficulty in accessing the GP, the return-to-work plan sometimes bypassed the GP and was sent directly to other specialists as needed (e.g., psychiatrists). However, RCs described how important it was for the GP to endorse the plan if it was to be successful.

HSCs and RCs believed that the psychologists' role was critical to diagnosis and specialist information to improve understanding of the injured worker's condition. Psychologists were described as being solution focused, with proven capacity to provide early intervention strategies and assistance in return-to-work planning. A notable difference emerged, however, between psychologists and GPs in the degree to which they were seen to provide support and encouragement to clients.

According to QPS staff, the least positive aspects relating to psychologists were the processes that were necessary to engage them. The time taken to access psychology services was considered to be too slow, 'taking up to 18 months to progress a client'. It was also reported that psychological treatment was sometimes influenced by the psychologists' perceptions of the organisation. HSCs suggested that it was hard to 'win them [psychologists] over' if psychologists held negative views of the organisation. According to QPS staff, timely and positive outcomes for the injured worker largely depended on the employer's ability to familiarise external providers about organisational rehabilitation services.

Information Exchange: Detailed and Standardised Processes

Ensuring adequately detailed information exchange with relevant stakeholders was considered a key factor in facilitating collaborative partnerships between external providers and the employer. Establishing standard protocols to communicate this material was also found to be important. However, information shared between health professionals and the QPS appeared highly variable, as were the methods used to communicate this information.

Psychologists and GPs stressed the importance of information that was specific to the individual worker and contained a necessary and detailed rehabilitation focus. They believed it was important for rehabilitation staff (i.e., HSOs, RCs) to have an in-depth knowledge of the rehabilitation process, because 'if the RC doesn't understand some things [about rehabilitation], it can hinder or destroy the process and prevent return-to-work'. One GP acknowledged the need for GPs to familiarise themselves with the injury process and liaise with colleagues to fully appreciate the actual work-related condition and needs of the worker.

In addition to injury-specific information, all participants reported a need for greater cognisance of QPS operations and job demands. Both HSCs and RCs reported that GPs were generally unaware of the various job descriptions of operational police officers or the rehabilitation systems within the QPS. RCs highlighted the need to provide the GP with an 'outline of the role [as rehabilitation personnel]', and associated duties in the rehabilitation process. RCs and HSCs were concerned that without detailed job descriptions for injured workers, GPs were likely to generalise the role of the police officer, presuming that police officers were all engaged in stereotypical operational roles. Consequently, it was believed by HSCs and RCs that GPs tended to automatically 'label' police officers as 'traumatised' and hence provide them with approval for extended sickness absence. GPs themselves reported a lack of information about suitable work duties for injured police officers, and noted the challenges created by limited contact between the employer and GP regarding rehabilitation progress.

Methods of reporting between external providers and the organisation were inconsistent, with a variety of procedures being utilised. The potential for untimely receipt of relevant information was heightened by a lack of standardised communication methods, inconsistent awareness and use of required administrative forms, as well as ad hoc reporting. For instance, psychologists frequently utilised a variety of communication methods, including written information, facsimile and telephone, all with varying response effect, whereas GPs were more likely to communicate via facsimile than any other method. Although external health professionals indicated their preferred communication methods, these were not usually clarified with QPS rehabilitation provider. As a result, receipt of information was characterised by delays and further requests for information. Providing feedback to GPs and psychologists, either in the form of written progress reports or round table case meetings was mentioned by both GPs and QPS rehabilitation providers as a potentially useful communication strategy in rehabilitation planning. GPs considered the provision of feedback was the responsibility of the employer and the insurance body.

Organisational Support for Rehabilitation

Positive collaborations must be embedded within a culture that supports the importance of rehabilitation, health and general wellbeing for injured workers. Psychologists confirmed the importance of transparent organisational support for the worker postinjury, and noted that if the culture supported this model, their collaboration with the organisation was simplified. Indeed, some psychologists asserted that psychological injuries (i.e., stress, depression, anxiety and post-traumatic stress) can be exacerbated by a lack of support once the worker returned to the workplace.

The issue of confidentiality and concerns about misrepresentation underpinned the nature of assistance sought and received by injured workers. Almost all psychologists interviewed stated that the injured worker was intent on receiving external assistance and support through the therapeutic relationship, rather than rely on workmates as the support person, or divulge information regarding a psychological injury to their superior for internal referral. Nearly half the psychologist group raised confidentiality as a major contributing factor to workers' reluctance to seek assistance. For instance, some clients frequently cancelled counselling appointments and others travelled interstate for treatment of psychological injury, in order to avoid divulging their injury to colleagues.

Practice philosophies between external providers and employer based rehabilitation providers appeared to be different. For instance, GPs confirmed that a major problem was the 'workplace expectation differing with the medical prognosis'. Although early intervention is considered a necessary rehabilitation strategy, some GPs reported that workers returned to work *too* early and in haste. GPs concluded that time off work attracted criticism from co-workers, and 'the [injured worker] was reluctant for the GP to contact anyone [other health professionals such as physiotherapy]'. HSOs and HSCs reported that GPs appeared to favour the views of injured workers, where they perceived the GP to be overly protective in some instances and tended to 'err on the side of caution' when treating an injured worker.

RCs reiterated that GPs did not often understand the ‘culture of the Service’, and were more likely to ‘act against [the organisation]’ than work collaboratively.

Discussion

There is considerable research confirming the need to establish effective collaborations between key stakeholders in the rehabilitation process. Given the pivotal role of external health professionals within the rehabilitation process, the partnership between these groups and the employer deserves particular attention. The current study aimed to provide a clearer understanding of the nature of the rehabilitation partnership between GPs and psychologists and the QPS. Although the study specifically pertains to the police service, some general conclusions can be made and applied in other organisational contexts. The research highlighted several key issues that organisations might consider in order to facilitate positive rehabilitation partnerships, namely familiarising external providers about organisational rehabilitation services and programs, ensuring timely and detailed information exchange to relevant stakeholders using their preferred medium, and employer validation of the rehabilitation process, thereby lifting the status of rehabilitation within the organisation.

Collaboration remains an essential component of any effective rehabilitation process, and a pre-requisite to return-to-work planning. Overall, the results indicated a willingness among all stakeholders to work collaboratively. Although the current study confirmed the importance of collaborations between employers and external health professionals, results highlighted that such partnerships were not often optimised. For instance, QPS rehabilitation personnel indicated the need for their employer to offer external health professional’s education and guidelines about available organisational rehabilitation services and the various rehabilitation personnel roles within the QPS.

External health professionals also mentioned the importance of RCs possessing a sound understanding of the inherent complexities of the rehabilitation process and an understanding of medical terminology and boundaries of care that would likely enhance the RC and HSC role. GPs similarly expressed a desire for a greater understanding of the rehabilitation continuum, and the organisational initiatives in place to support the return-to-work process. In accordance with previous research (Wyman, 1999), all external health professionals expressed a preference for more detailed information about the nature of the injury and injured worker’s background (i.e., nature of injury, type of job, date and severity of injury) as well as more comprehensive descriptions about suitable duties.

Both QPS rehabilitation personnel and external health professionals acknowledged the need for timely access to rehabilitation services, but discordant views were evident regarding the referral process for psychological injuries. Although the majority of GPs reported regular referral to specialist services for treatment of psychological injury as required, HSCs speculated that GPs were overly focused on medical concerns to the exclusion of psychosocial issues, and accordingly, did not actively promote a referral to a specialist source to address psychological needs. This finding corresponds with the traditional training models for medical practitioners, where GPs, informed by the medical model of service delivery,

focus primarily on functional limitations and job restrictions (Pransky, Shaw, Franche, & Clarke, 2004). HSCs offered that GPs provided the injured worker with a medical certificate for a prolonged period, up to 3 months in some cases, in order to avoid dealing with a psychological injury. GPs themselves were more likely to provide a sickness certificate where there was a perceived lack of suitable duties for the injured worker to return to. Previous research by Kenny (1996) highlights the difficulties faced by GPs when attempting to manage psychological complexities in the rehabilitation process. Kenny found that determining an appropriate course of action was even more challenging for GPs when there was an overlay of drug and alcohol abuse and the influence of dependent personality characteristics. This difference of opinion further highlighted the need to promote regular liaison between stakeholders and understanding of organisational rehabilitation programs.

The organisation has the greatest potential to provide a coordinated system of communication between key stakeholders in the injury management process. Previous research has emphasised the critical role of employers in facilitating successful return-to-work (Kearns, 1997; Friesen et al., 2001; Gard & Larsson, 2003; Williams & Westmorland, 202). Research by Habeck, Scully, Vantol and Hunt (1998) highlighted the influence of several employer strategies in effectively managing work disability, including demonstrated organisational commitment (e.g., explicit support of high level management), accountability, and timely responses. In their review of workplace disability management, Williams and Westmorland (2002) further suggested that employers needed to foster an organisational culture that explicitly validated the experiences and perceptions of injured workers.

However, the current findings highlight some of the challenges in achieving in achieving proactive cooperation in the presence of an established organisational culture. For instance, HSCs confirmed that the process by which external health professionals were engaged with injured workers, particularly following a psychological injury, presented a significant organisational challenge due to long held concerns over confidentiality and mistrust. In this instance, early access to treatment for a work-related psychological injury depended on the injured worker having lodged a claim, and consequently consenting to employer investigation about the injury. As a result, issues such as confidentiality, mistrust and legal constraints contributed to the injured worker's reticence to access timely and professional assistance. These findings highlight that internal rehabilitation systems, including treatment access requirements and reporting mechanisms, should reflect the intended rehabilitation strategy in order to ensure credibility and 'buy-in' from other stakeholders.

The quality of the collaboration between health professionals and organisational rehabilitation personnel seemed highly dependent on the efficiencies surrounding the initial point of contact and the working relationship established from this point onwards. However, additional challenges to collaborative partnerships included resource limitations, increasing workloads and role expansion, particularly for GPs. Although GPs were considered central to the rehabilitation process, their actual role was not often indicative of this. Competing clinical and administrative demands, lack of contact with the employer early on and the need for a greater understanding of the rehabilitation process limited GPs ability to

focus on return-to-work strategies and devise appropriate workplace recommendations. Edlund and Dahlgren (2002) similarly reported that for GPs, lack of time, competing demands and limited rehabilitation knowledge hindered meaningful rehabilitation planning with injured workers.

With regard to the skills needed to progress rehabilitation processes, all parties recognised the need for specialist and standardised training for organisation-based rehabilitation personnel, and appropriate time allocation by the organisation to allow them to foster relationships and deliver rehabilitation services. The findings from the current study are limited to the perceptions of a sample of health professionals and a single employer, and do not extend to the experiences of injured workers. Nevertheless, the study provides useful data from which to develop employer strategies to enhance partnerships with external health professionals and potentially maximise injured worker outcomes.

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