

The knowledge, skills, and behaviours required by supervisors to facilitate a return to work after a mental disorder or musculoskeletal injury

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Executive Summary

The aim of this project was to develop an evidence base for an intervention targeted to line supervisors who provide support and assistance to workers temporarily disabled by a mental health condition (MHC) or musculoskeletal disorder (MSD), specifically:

- To identify the competencies, defined as knowledge, skills, and behaviours, needed by supervisors to support the process of returning to work for injured and ill workers who have sustained a MHC or MSD
- To investigate differences between competencies needed to support workers returning from a MHC or a MSD
- To explore supervisors' views of the necessity, the format and the content of a training program for supervisors who support workers who have sustained a MHC or a MSD to return to work

The project comprised two phases. The first phase consisted of a series of focus groups attended by supervisors from five Australian industry sectors with high rates of compensation claims for mental health or musculoskeletal disorders: transport, health and community services, manufacturing, education, and public administration. Supervisors were asked to describe the challenges they face in the course of assisting staff to return to work; strategies they have found helpful or not helpful in this process; qualities they believe are important for supervisors who support returning workers to possess; advice they would give to a new supervisor regarding support of return to work; and their ideas about the optimal delivery method and content of a return to work training program for supervisors.

A multi-stage analysis of responses from focus group participants to these questions generated a final set of 94 competencies, of which 84 were generic, 8 applied to mental health conditions, and 2 pertained to musculoskeletal

disorders. These competencies were organised into 11 clusters and incorporated into an online survey.

In the second phase of the project, the survey was administered to a large sample of rehabilitation professionals throughout Australia. Participants rated the importance of each competency to a supervisor's effectiveness in support of a worker returning from a period of disability due to a MHC or a MSD on a 1 to 5 scale. The analysis of results included calculation of the average rating for each competency, identification of the 10 highest and lowest-rated competencies, and calculation of the overall average rating for each cluster of competencies.

Findings

This project has identified a framework of 11 competency clusters for supervisors to facilitate RTW for employees with a MHC or MSD. The research has demonstrated widespread agreement among supervisors and rehabilitation professionals that a comprehensive program to train supervisors in competencies needed to support disabled workers returning to work would be worthwhile. By optimising return to work processes, such programs in other countries have yielded cost savings and a decrease in compensation claims. Similar outcomes could be expected in Australia from a program based on the self-identified training needs of Australian supervisors elucidated in this research.

Supervisors cited more differences than similarities in comparing support needs between workers returning after a mental health condition and those who sustained musculoskeletal injuries. They also viewed mental health conditions as more challenging and desired more knowledge in this area. The preponderance of necessary competencies were applicable to either condition, hence, we advocate for a single generic training program but with more attention given to mental health conditions than musculoskeletal disorders.

Most supervisors favoured a face-to-face format for a training program with periodic refresher sessions and augmented by printed or online resources.

While personal characteristics or behaviours of the supervisor such as honesty, fairness and respect were recognised as important to the supervisor's effectiveness, this research showed they were not sufficient. A wide range of competencies in the domains of knowledge and skills were also identified as very important or essential for supporting and assisting return to work generally and for MHC and MSDs specifically. In addition, the research showed that supervisors need organisational support to carry out their return-to-work responsibilities and achieve a successful outcome.

Key implications

- Employers should explicitly recognise the supervisor's role in return to work, and organisational policies should clearly delineate the supervisor's obligations and role boundaries.
- A comprehensive, face-to-face return-to-work training program that includes competencies from all domains – knowledge, skills, and behaviours – should be provided to supervisors in high-claims industries early in their tenure, and periodic update sessions offered.
- Given the high costs of work-related mental health conditions, supervisors' perception of greater difficulty in providing support for workers with mental health conditions, and supervisors' expressed needs for more knowledge and skills in this area, mental health-specific competencies should receive commensurate attention in the training program.
- Face-to-face training for supervisors should be supplemented with access to information through a return-to-work website or other online resources, fact sheets, and by maintaining the currency of policies and procedures.
- Support mechanisms and resource staff, such as in-house or external rehabilitation professionals, should be clearly identified and easily accessible to supervisors for informational needs as well as support for themselves. Smaller organisations without in-house rehabilitation staff could work with insurers to provide this expertise for their supervisors.

- The importance of contact among supervisor, rehabilitation professionals, and injured worker during the recovery and return to work phases cannot be overemphasised. The supervisor's knowledge of the job and job demands is essential for planning the return to work and he or she should be involved at all stages of the process.

The knowledge, skills and behaviours required by supervisors to facilitate a return to work after a mental disorder or musculoskeletal injury

Background

Return to work* (RTW) to usual pre-injury duties, or to modified duties, is considered essential to the disability prevention process [1]. Resuming duties results in less time off work for the worker, lower compensation premium rates and less disruption to productivity for the employer, and improved management of compensation costs for insurers [2]. The observed decline in return to work rates between 2005-06 and 2008-09 in Australia was a disturbing trend [3]. As of mid-2011, this rate stood at 86%, having nearly returned to the 2005-06 peak of 87% [4], but clearly room for improvement remains.

Although there are many stakeholders in the RTW process, the supervisor is recognised as having a pivotal role [5-8]. In a recent review of workers' compensation systems in Australia, injured workers nominated someone from the workplace as providing the most help with their RTW (17%) second only to their general practitioner (22%) [4].

In most jurisdictions, the employer's role is to ensure rehabilitation is provided, that a RTW plan is developed, implemented, and monitored, and that there are duties suitable to ensure a successful RTW. The person at the workplace who assists with the RTW may vary by organisation, but 33% of injured workers nominated their immediate supervisor as the most helpful compared with occupational health and safety (OHS) officers (9%), human resource (HR) staff (4%) or RTW coordinators (3%) [4]. The role of the line supervisor has been previously explored, in which both workers and supervisors indicated that line managers provide modified work, interpret policies, assist with access to

* A list of abbreviations and definitions is in the Glossary, Appendix 1.

resources, monitor a worker's health and function, facilitate communication among stakeholders, and communicate positive messages of concern and support, while having intimate knowledge of the jobs available [5, 6, 9, 10]. Immediate supervisors are important as the conduit among upper management, the health care provider, co-workers, and the injured worker. Whether these key personnel actually have the knowledge and skills to undertake these roles is unknown.

Attributes required by supervisors to ensure a successful RTW include knowledge, a relationship of trust with the worker, support, and a participative management style [6, 8, 11]. However, supervisors frequently experience role conflict between their production responsibilities and the demands of the modified work program [6, 12]. Some do not have a good understanding of musculoskeletal disorders or the ergonomic principles underlying the selection of appropriate duties or how to modify duties to meet medical restrictions [12]. These problems may result in the supervisor either not adhering to restrictions set by the medical certificate or preferring the worker to be fully recovered before RTW. The optimal method for supporting supervisors during the RTW of injured/ill employees has not been explored.

Only two studies have addressed the needs of supervisors in RTW through a training program. Linton [13] administered a 1-day educational program to 47 Swedish railroad supervisors that resulted in changes in behaviour, attitudes, and knowledge of musculoskeletal pain, but did not evaluate the impact on duration and cost of sickness absence. In contrast, a training program delivered to supervisors in a food processing and a clothing company in the United States [14] resulted in a significant reduction in new workers' compensation claims of 47% and active lost-time claims of 18%. In addition, there was a reduction of 25% in indemnity costs of new claims in the first six-month period followed by a 75% decrease in the subsequent 12 months [15]. The key feature of this

training program was that it was based on the self-identified needs of the supervisors. The training was face-to-face and of short duration, over a total of 4 hours, yet resulted in cost savings in the short and long term. However, this program cannot be readily implemented in the Australian context due to differences in the industrial relations, compensation and health systems that may impact on the needs of supervisors to assist in the RTW process. Other concerns are the focus on musculoskeletal injuries and reliance on face-to-face training delivered by experts. The qualifications and skills required by the trainers were not detailed in the studies by Linton [13] or Shaw et al. [14] but the requirement for skilled trainers may be a major obstacle to the widespread implementation of any training. It is possible that an on-line training module using novel, interactive educational tools may be well accepted by supervisors in industry, but this has not yet been explored in the Australian setting or internationally.

In addition to managing workers with musculoskeletal injuries, there is an urgent need to up-skill supervisors in managing workers with work-related mental disorders due to their widespread occurrence in the working population [16]. The associated cost of workers' compensation claims for stress-related mental disorders in Australia is estimated at more than \$200 million per year [17]. More recently, Comcare, Australia's federal work health and safety regulator, announced a 54% increase in mental stress claims since 2006-07, as a proportion of total accepted claims [18]. While there are moves internationally to identify the competencies supervisors need for primary prevention of stress at work [17], there has been limited research conducted to identify the competencies required for secondary intervention in psychological conditions.

In summary, the needs of supervisors to promote a successful and sustainable RTW for employees with mental disorders or musculoskeletal injuries require comprehensive investigation to ensure that any training program developed is pertinent to supervisors' self-identified needs and appropriate for the Australian

context. Our study aimed to evaluate supervisors' RTW training needs, not only in terms of educational content, but also with respect to the most acceptable method for delivery.

Research questions

The aim of this project was to answer the following three research questions:

1. What knowledge, skills, and personal characteristics (hereafter referred to as behaviours) do supervisors believe are necessary to facilitate a successful and sustainable RTW for employees who have sustained a compensable mental health condition (MHC) or musculoskeletal disorder (MSD)?
2. How do the knowledge, skills, and behaviours required by supervisors to support employees returning to work differ for a MHC or a MSD?
3. What method(s) for delivery of RTW training would supervisors prefer?

Discussion and Implications for Industry/Employers

Discussion

To answer the research questions, we conducted a mixed-method research project in two phases. We first conducted focus groups with 29 supervisors from five industries with known high incidence of mental health conditions and musculoskeletal disorders - one each in the education, public administration, health care, manufacturing, and transport sectors varying from small (85 employees) to large (5000+ employees) organisation size. Four of the focus groups were conducted in Queensland and one in Victoria, despite several attempts to increase representation from Victoria. However, one of the focus groups conducted in Queensland was with a national organisation. Three of the organisations participating in the focus groups were insured with WorkCover Queensland, one with WorkSafe Victoria, and one was self-insured. Thus the needs of supervisors identified through the focus groups are most likely representative of those within large and small organisations, from the different jurisdictions in Australia, and from different compensation systems.

Readers of this report will note that several of the implications below are concerned with process issues that were revealed during the wide-ranging discussions in the focus groups but that are more appropriately addressed by employers. They are included here not to draw attention away from the competencies that are the main outcome of the research, but rather to offer employers some timely suggestions for changes that can be readily implemented with minimal cost and have the potential for immediate impact.

Focus group discussions resulted in a list of 94 competencies supervisors identified as necessary to effectively manage RTW of injured staff. Eighty-four of these competencies were generic to supporting a worker with either a MHC or MSD with an additional eight and two unique to assisting a worker with a MHC and MSD, respectively. The 94 competencies were distributed across the domains of knowledge, skills, and behaviours, suggesting that a combination of these attributes is required. Eleven clusters of conceptually related competencies were created and converted into an online survey targeted at OHS staff, RTW coordinators, and HR officers familiar with the RTW process. A total of 344 survey participants rated the importance of each of the competencies that emerged from the focus groups on a 5-point scale from 'not important' (scored as 1) to 'essential' (scored as 5). The key findings from both phases are discussed below and linked to the implications beginning on page 17.

Supervisors in the focus groups were in agreement that providing support for and assisting with RTW was one of their work responsibilities. In some cases, however, management expectations of their involvement were not well articulated to them, and they expressed uncertainty about the limits of their role in RTW. They functioned best when organisational policies, procedures, and processes were clear and easily accessible, including the supervisor's role, resources available to the supervisor, how to link the worker with resources,

and how to integrate various aspects of the RTW process into a coherent, practical, and individualised plan (Implications 1 and 2).

Those supervisors who had dedicated in-house RTW or OHS staff available valued highly the support provided by these specialists. This support is most likely to be found in large organisations, but supervisors are not always aware of these resources (Implication 3).

A recent report on the health benefits of work included RTW training for supervisors among its recommendations [19, p. 20]. A number of supervisors in the focus groups expressed their belief that a training program would be worthwhile. They discussed various formats and potential useful activities for inclusion in such a program. Comments from a few supervisors reflected a belief that training for RTW support was unnecessary for those with ‘the right skills’, and indeed some of the competencies with survey scores in the top ten were personal attributes such as being fair, being respectful, and knowing how to communicate sensitive or unwelcome information, which may be difficult to teach. While these necessary skills and behaviours may be inherent in some people, recent evidence suggests that even empathy can be taught [20]. Survey results from managers, HR officers, OHS practitioners and rehabilitation staff showed nearly unanimous (93.1%) agreement that supervisors need additional training to manage the RTW of injured staff (Implication 4).

Supervisors in the focus groups cited a number of challenges (see Box 1, page 23) they encountered when supporting returning workers, many of which surfaced in more than one focus group. The competencies resulting from these challenges tended to receive high ratings as assessed in the survey. This suggests supervisors will benefit from a RTW training program that highlights conflict management strategies, communication skills, maintenance of and respect for confidentiality and privacy, knowledge of the legal obligations of the role, and an appreciation of the impact of the condition on the worker’s ability to

do the job. However, the research showed that these would not be sufficient. The fact that 96% of the competencies were rated either 'very important' or 'essential' by survey participants calls for a comprehensive training program. In addition to the generic competencies applicable to either condition, the specialised information and skills necessary to support RTW following a MHC or a MSD should receive due attention in the program (Implication 5).

There was consensus among the supervisors that support for a worker returning from a MHC was more complicated and demanding than for a worker with a MSD. Supervisors readily listed several important differences they perceived between the two types of conditions (see Box 2, p. 25). They expressed both their sense that workers with MHCs need specific attention and their own need to know and understand more about MHCs. Eight specialised competencies relating to MHCs emerged from the focus groups, one of which was among the top ten highest-rated competencies by survey respondents (Implication 6).

Several supervisors mentioned the emotional burden they feel from supporting staff RTW. It is possible that rehabilitation/RTW specialists are not cognizant of this challenge given the relatively low ratings in the survey for competencies relating to supervisors' access to support for themselves. Thus, it is desirable that rehabilitation/RTW specialists be made aware of this and other challenges faced by supervisors and understand that they can be a useful resource (Implications 7 and 8).

Evidence suggests that people in managerial roles may be more likely to experience burnout [21]. When the returning worker has high needs there is in addition a potential for emotional dissonance, where the supervisor may be 'required to express emotions that are not genuinely felt in the particular situation' [22, p. 245], which is also associated with burnout [22]. To decrease the risk of burnout it is important to include content relating to accessing help

and support for themselves in training for supervisors. Likewise, functional knowledge about the conditions was among the lowest-rated competencies, yet most supervisors felt this was important (“*The more you understand it, the better you can be*”). These discrepancies suggest that survey respondents, the majority of whom were workplace health and safety or human resources staff, may have a different understanding of supervisors’ needs and challenges faced in management of RTW. Supervisors’ comments revealed a need for a broad range of competencies across each of the domains of knowledge, skills, and behaviours (Implication 9).

In large organisations, because of their complexity, there is a risk that the supervisor could be overlooked and excluded from the RTW process. Supervisors in the focus groups voiced the importance of maintaining contact with the worker during the recovery period and keeping up-to-date with the worker’s progress toward RTW. As the personnel most thoroughly acquainted with the returning worker’s job and demands thereof, supervisors are and should be active contributors to the RTW plan. Hence, the communication between supervisor and in-house rehabilitation staff must be two-way with each party providing their own unique expertise to the benefit of the returning worker (Implication 10).

Supervisors in one group commented that a checklist would be helpful to remind them of the steps and actions they need to take at various points in the process, especially when the worker is about to return. Such a checklist might be particularly useful in organisations where the supervisors rarely have the opportunity to support returning workers because the incidence of work-related illness and injury is low (Implication 11).

The scope of this research was to explore the needs of supervisors for supporting injured workers following a work-related MHC or MSD. During the focus groups, many supervisors commented that the skills and behaviours were

similar, and often they had difficulty in separating those needed to support a staff member with work-related and non-work-related injury/illness. Given the consistent empirical evidence that a supervisor's behaviours are strongly associated with employee health, we believe that any training to enhance knowledge, skills and behaviours can be applied to supporting staff with non-work-related injuries and illnesses (Implication 12).

We found evidence that support from rehabilitation experts was limited or unavailable to supervisors in small to medium-sized businesses. This indicates a need for innovative solutions that will promote supervisors' access to expert and timely support regardless of organisation size. Strategies to assist with provision of such support to smaller businesses could be adopted by insurers and may have the added benefit of enhancing interorganisational relationships. Possible options include offering an advisory service to link these organisations with rehabilitation providers who can assist supervisors in the RTW role. On-site support could be augmented with telephone coaching and/or a website with fact sheets and links to additional resources.

Implications for Industry/Employers

On the basis of the findings from this project, we offer the following implications for organisations wishing to develop or offer RTW training programs for supervisors.

1. Organisational policy should clearly state that support of staff RTW after injury or illness is one of the supervisor's roles. Linking this to performance criteria within the OHS umbrella would signal its importance. Companies might consider bestowing special recognition on the supervisor when an injured or ill worker successfully completes the RTW process.
2. Organisational policies, procedures, and processes relating to RTW should be made known to supervisors at induction, easily accessible (e.g. on the

company intranet) when needed, suited to the enterprise, and periodically reviewed and updated.

3. Staff dedicated to worker health and safety are a crucial resource and should be known by all employees. A placard with contact details for resource people could be located at the supervisor's workstation for easy access when needed, and the organisation's intranet should have these individuals' details prominently displayed.

4. Supervisors want and need training to enhance their ability to support staff who are returning to work. On appointment or on promotion to a supervisory position, supervisors should be trained in the key aspects of supporting staff returning to work after injury or illness using a face-to-face format. Periodic updates should be provided as part of best practice. Consideration could be given to providing web-based resources to augment the in-person training.

5. The preponderance of generic competencies (84 of 94) suggests that a generic training program will assist supervisors in supporting staff with a MHC or MSD. In other words, a single comprehensive training program, rather than two separate programs, is recommended.

6. The greater number of competencies specific to supporting staff with a MHC compared to a MSD suggests that ample time for a wide-ranging exploration of common mental health diagnoses and management should be allotted in any supervisor training program.

7. Rehabilitation and RTW specialists who work in large organisations or are employed by insurers must be made aware of the challenges faced by supervisors in carrying out their RTW support responsibilities.

8. Rehabilitation and RTW specialists (either in-house, contracted or insurer based) are ideally placed to support supervisors at each stage of the injury process from initial absence from work through to full return. An example of how this support could be implemented is for the specialist to initiate contact with the supervisor responsible and include them in all discussions about duties, job restrictions and modifications to limit the negative impact on productivity and workload of others.

9. A RTW training program for supervisors should include competencies in all domains of knowledge, skills, and behaviours identified in this research. Competencies related to supervisors' own needs for support and functional knowledge should be integral to the training program.

10. Prior to a worker's return, the site's rehabilitation/OHS/HR staff should meet with the supervisor to review the RTW plan and explain how the supervisor should/should not interact with the worker, how to trouble-shoot problems, what to do if the RTW does not proceed as planned, and what steps to take or resources to offer if a problem arises outside of regular working hours.

11. A checklist could be used for the rehabilitation specialist and supervisor to ensure all relevant activities are completed. In addition, supervisors may find it useful to identify the behaviours necessary at each step of the RTW process [23], and as a reflective tool for self-evaluation of effectiveness in the RTW process.

12. Given the consistent empirical evidence that a supervisor's behaviours are strongly associated with employee health, we believe that any training to enhance knowledge, skills and behaviours for facilitating return to work can be applied to supporting staff with non-work-related injuries and illnesses.

Conclusions

Supervisors believe they have an important role to play in supporting staff RTW after MHC or MSD but the extent of this role is not always articulated to them by their employing organisations. They want and need support to undertake this aspect of their job. This support can be provided by in-house rehabilitation, OHS, or HR staff in larger organisations but is often unavailable in small to medium-sized organisations.

Competencies needed for support of staff for RTW after a MHC or a MSD extend beyond personal attributes. The focus groups suggested that supervisors are likely to benefit from additional training to develop competencies needed to support the RTW process, and the overwhelming majority of those surveyed believe this additional training is needed. The study has elucidated eleven groups of competencies in the areas of knowledge, skills, and behaviours considered by people with expertise in the field to be very important or essential for inclusion in a supervisor training program.

While the majority of competencies were generic for support of a worker with either a MHC or a MSD, participants identified 8 and 2 unique competencies, respectively. The identified differences between supporting a staff member with a MHC or a MSD suggest that training should devote more attention to the former. It appears that interjurisdictional differences are minimal. With this in mind we conclude that training based on the identified competencies could be applicable to both types of conditions and in any Australian jurisdiction or compensation system.

Results

Focus groups: Competencies

Focus groups were held between August and October 2012 with a total of 29 supervisors in companies representing each of the five target industry sectors, i.e. manufacturing, transport, education, health and community services, and public administration. The five organisations included one medium-sized business (i.e. 20-199 employees) [24] from the health and community services sector and four large businesses (i.e. more than 200 employees) [24]: a manufacturing plant (200-999 employees), a national transport company, an education facility, and a public administration organisation (all 5000+ employees). One of the five organisations came under the Victorian workers' compensation jurisdiction; the rest fell under Queensland's jurisdiction, of which one was self-insured.

The majority (66%) of focus group participants were women. Most (83%) had recent experience supervising staff with MSDs (i.e. in the month prior to the focus group). Fewer than half (13 participants, 44%) had supervised staff with MHCs and fewer still (7 participants, 24%) had recent experience doing so. About one-third of participants had attended formal RTW training, such as a three-day Rehabilitation Return to Work Coordinator training program. Table 1 summarises focus group participants' characteristics.

Table 1. Selected demographic and employment characteristics of the 29 supervisors who participated in focus groups

Characteristic	Number (%)	Average	Range
Age (years)		46	29-59
Gender			
<i>Female</i>	19 (66)		
<i>Male</i>	10 (34)		
Years with current employer		10.8	0.7-33
Years in current role		4.5	0.5-12.8
Team size		65	4-500
Number of staff for whom supervisor has direct responsibility		40	1-350
Estimated number of staff supervised through RTW process over supervisor's career		44	1-300
Experience supervising staff with MSDs	24 (83)		
Experience supervising staff with MHCs	13 (45)		
Formal RTW training	9 (31)		

RTW: Return to Work
MSD: musculoskeletal disorder
MHC: mental health condition

In the focus groups, supervisors raised and discussed challenges they encounter as they support staff to RTW (Box 1). Challenges were apparent for supervisors in every industry sector, even for those who had a good support structure in the workplace.

Box 1. Challenges reported by supervisors when supporting staff RTW

Finding suitable duties when the nature of the work doesn't readily present them

Interpreting the medical certificate

Managing the emotional burden of the RTW

Dealing with own concern about the worker's risk of self-harm

Setting boundaries in the relationship with the injured worker

Finding support or having to cope without it when in-house support is limited or unavailable

Fostering safe and sustainable RTW when the worker is either too eager or reluctant to return

Attending to other aspects of own work while managing RTW

Balancing needs of the worker with needs of the organisation (e.g. for productivity)

Managing RTW in difficult economic circumstances

Problem-solving ergonomic adaptations (for MSDs)

Communicating effectively and sensitively with the worker – not wanting the worker to feel harassed or pressured (for MHCs)

Trusting the worker's judgment of what s/he can do

Getting the work done when the returning worker calls in sick at short notice (i.e. is unreliable)

Understanding the insurance processes

Managing conflict

Being honest in communication, especially around job security

Delivering information the injured worker doesn't want to hear

Participants expressed a high degree of commitment to and acceptance of the supervisor's role in supporting RTW. **

- *...but for me with people I've helped the recognition has been I felt good because I know I've helped them.* (Public administration)
- *Yeah, I think they need...this is [a] supervisors[role] no matter where they work, they need to have an understanding of the rehab and the return to work process.* (Manufacturing)
- *We do have a vested interest in making sure that it's successful because if it's not successful, it's going to impact on the output of the whole unit.* (Education)

**Text in italics is direct quotes from supervisors in the focus groups. Each quote is followed by the name in parentheses of the industry in which the quoted supervisor worked.

Some supervisors raised concerns that though their role in RTW was seen as important, they did not receive adequate support to fulfill it.

- *The first time you go through it, you actually feel like you're at the end of a line off the back of a ship somewhere, just bobbing up and down in the ocean, just waiting for something to throw you... (Education)*
- *Maybe what we need as an organisation is having a coordinating person with a medical background with our documentation, with that medical documentation and then coming and visiting us and making sure that that person is outfitted in such a manner that they can carry on with their disability and improvements. I think that's where we need someone that's in the middle, that's taking on the role of coordinating and assisting. (Education)*

Participants cited strong values and enabling behaviours of empathy, acceptance and openness as requirements of the role.

- *Even if you've not experienced [a disability], being able to try and understand what that must be like. (Education)*
- *Empathy. Yeah, I was going to say empathy. You've got to be empathetic. (Public administration)*

The group discussion elicited competencies relevant to RTW policies, procedures and processes at both organisational and system levels. These included a concern about the worker's privacy and an awareness of the legal aspects of RTW.

- *[Employer] is very good at having appropriate policy frameworks including for this area, at least for physical injury. So I think you can know your obligations, responsibilities, all that sort of stuff. It is of necessity a kind of general template but pretty detailed just the same. (Education)*
- *you have to actually ask the question well, how much do you want the staff to know, you don't assume anything. (Public administration)*
- *...you have to know what your legal obligations are. (Health & community services)*
- *I know now but I didn't when it first happened. So yeah, just the - what happens when somebody goes off on WorkCover, what does the certificate of incapacity mean? So all the processes. How long is - when do the payments, broadly when do the payments drop and all that sort of stuff? (Public administration)*

Clarity regarding the boundaries of the supervisor's role in RTW was frequently lacking.

- *It's also understanding the supervisor's role in the return to work process so you're not over stepping or under stepping the mark...* (Transport)
- *I mean we can do as much as we can but we aren't mental health practitioners. We're not people who are appropriately trained in that and we possibly need more training in how to deal with that.* (Education)
- *I've had some issues with what should fit with HR and what should fit with me.* (Public administration)

It was clear that understanding and support of the injured or ill worker were priorities.

- *Because of the staff support role that we have anyway, we know our [workers] quite well and we do get to understand their personality...* (Health & community services)
- *And to be supportive and accepting in a very visible way so that you model that behaviour to their colleagues. So everybody knows that they have full support of their manager because one day it could be them as well.* (Education)

Several comments concerned the style, content and frequency of communication and the need for well-developed communication and interpersonal skills.

- *...communication skills, simple things like remaining – having eye contact with someone when you[re] speaking to them, making sure that that person feels valued and feels important when you're talking to them about their injuries, so no being distracted by your phone, or making the time for them.* (Transport)
- *And I think that sort of thing has really helped just in general, knowing how to approach certain people, listening skills.* (Health & community services)

The supervisors mentioned the importance of maintaining contact with the injured or ill worker.

- *I think that's what's worked well in my instance that there is that daily contact. It could be two minutes, it could be 10 minutes but it's just to touch base to say how is it going? I saw that you looked in a bit of pain yesterday. What's going on?* (Education)
- *I think what worked well is keeping in very regular contact with them and just ringing them up at the end of the day, "How'd your day go?" and then they know that we're interested, that we're supportive...* (Health & community services)

Communication with the treating practitioners was challenging for many supervisors. In particular, some felt that medical practitioners frequently did not understand the demands of the returning worker's job.

- *I'm just in the process of putting together a booklet at the moment, an information booklet if you like, because if you're trying to tell a doctor what a [job title] does...doctors don't have a lot of idea from what they've seen on TV and the perception of shows that they've seen to know, this is reality of what this person has to do. (Public administration)*
- *I could also say that my recollection of the interaction with the doctor was that the doctor didn't really have insight into the full scope of interaction that a [worker] has with their patient... (Health & community services)*

There was an acute awareness of the need to access knowledge and support for themselves in the RTW process.

- *It's very hard because the situation just happens or emerges and I think really support more than training, really. Someone coordinating, assisting you, I think would be more appropriate than training because it's the unknown. You just don't know until you come across it. (Education)*
- *I think it's also about knowing where the supervisor can get their support from, so they're playing a supportive role to an injured person but through that it can be quite a new process that can be some quite significant things that they're needing to overcome or impact. (Transport)*
- *So I think maybe if we'd had a briefing about what to look for. So this is the plan, but as supervisors these are the things that you also need to be thinking about day-to-day with this person. (Education)*

In this regard, several supervisors described the emotional burden of supporting and managing a staff member to RTW.

- *You get to a space where you yourself don't want to come to work because you don't want to face that. You yourself have had enough and you ring up your manager on the weekend and say I just can't do this anymore. I've had that feeling. (Education)*
- *And I think that that when you're having a meeting with somebody for 2 hours after that you leave that and you're emotionally exhausted, it is quite a draining thing to assist a person who has such high support needs. (Transport)*

This was especially problematic where there was concern about the personal safety of the worker with an injury or mental health condition.

- *And in his particular case, going back some years, there was an issue of self-harm. So we know that, so there's history there. You couldn't live with yourself if you didn't go and the worst happened. (Education)*

Creating a suitable duties program for the returning worker, then monitoring and when necessary trouble-shooting it was a significant and multifaceted responsibility. Supervisors were confident in their knowledge of the job and valued support from in-house rehabilitation staff. They expressed frustration with medical restrictions that were inconsistent with what their experience suggested and with workers who were over-eager to resume normal work and hence resistant to safer alternatives. They recognised the importance of diligent observation of the worker.

- *...you need to have knowledge of your work area and what jobs require what. (Manufacturing)*
- *But...if you're told Doctor's saying this, they're [injured worker] saying this, you've had some sort of training, someone says this and you go well that's not what I know. (Manufacturing)*
- *I suppose the other thing is knowing our organisation well enough as well to know what the alternative is for each individual, knowing where there is space for them to work and where we can fit them in...And that's our job to know and to do and we're doing that sort of thing all the time. (Health & community services)*
- *...being able to meet with them early and getting their buy in and their treating practitioners buy in to place them somewhere else within the organisation can be quite challenging for us... (Transport)*
- *But everyone's an individual as well so like you got to rely on the doctor and you got rely on the restrictions that have been given and then if it's not working, you go back and see them. (Manufacturing)*
- *So I think having a supportive workers compensation team that I was able to lean on in terms of being subject matter experts in that area 'cause I was very new to this...assisted me with getting some good outcomes. (Transport)*
- *We make sure that we sort of say to the people that are on alternative duties...if somebody happens to tell them to do something, they need to let them know that they're on alternative duties and they can't. So, you know, they're aware that they're on alternative duties and they're not just saying no to you or anything like that. (Manufacturing)*

- *And when you try and slow somebody down that's used to working like flat out and you know, he just couldn't cope that he couldn't do everything that he used to do and didn't like being on alternative duties. So he was a constant that you had to watch all the time. (Manufacturing)*
- *I don't know how you obtain the skill but it's a power of observation. You've got to - it's okay when you're busy banging out whatever reports you're banging out and the staff are doing what they're supposed to be doing, but you've got to have your other eye sort of watching them. (Public administration)*
- *So recognise that there's [a] problem early and try and address it either with the person or with the team, because things can get out of hand quite quickly. Yeah, so I suppose trying to put in place some sort of management strategy fairly early really. (Health & community services)*

Supervisors were also mindful of the effect on co-workers or members of the injured or ill worker's team, and on the organisation as a whole.

- *I think it's really important to communicate what you can to the rest of the workforce. (Public administration)*
- *It was a person who had an injury in the workplace and was absent for quite a period of time. There was also the issue of supporting her team through the process as well because it was occurring in front of them. (Education)*
- *...We have some high numbers in our area and while these people aren't able to do all the tasks that they would normally do, it means all these other people are picking up what they have to. So you have to be mindful that we're not going to be hurting those people as well, and it can be quite hard...it's quite hard sometimes. (Manufacturing)*
- *If [worker] can't do any of them then I need to look at [alternative] area for you because [I] need to think about the impact it has on other staff. (Public administration)*
- *Competing workloads particularly in our role, we've got a really prescriptive rosters that we're trying to work around, not only with our [team] but also within our department. So I think time in the really initial stages to be able to meet with your [worker], consult with our workers compensation team for support and case conference with doctors is very challenging for us, working around the rest of our role. (Transport)*
- *I think we're all suffering tight budgets and we're always looking for efficiency. I know that I'm putting a lot more pressure on managing sick, managing return to work and that sort of stuff. So we're all going to be more and more accountable. (Public administration)*

- *...it's more about trying to see whether or not the person can [get] back to full-time...workload management with a long term view of there is light at the end of the tunnel. (Education)*

Differences and similarities when supporting a worker with a MHC or MSD

Supervisors recognised several differences in the provision of support to a worker returning from a MHC compared to a MSD (see Box 2, page 30).

Competencies specific to MSDs were focused on ergonomic modifications but the possibility of secondary mental health problems also arose.

- *I think dealing with someone who's coming back from an injury which is repetitive strain...ensuring that that space is appropriately set up and that she had everything she needed to make sure she was doing all the right things in terms of sitting and how she was sitting. (Education)*
- *Sometimes the injury can lead to the person having mental health issues too. (Public administration)*

They viewed support for MHC-affected workers as more challenging due to factors such as stigma, the invisibility of the condition to other staff who may resent having to work harder or longer, the unpredictable nature of recovery, and what constitutes suitable alternative duties.

- *So it's not just that you're managing that particular staff member who's affected but the other people around them who they have to interact with, often very closely, who are not accepting and are hostile to that condition. They wouldn't be hostile to a broken leg because you can see it, you can touch it and all that sort of stuff. (Education)*
- *...you need to almost be over the top cautious in how you say to them, 'cause I mean you don't know what's going to trigger them or set them off or send them backwards. (Manufacturing)*

In particular, they cited inadequate knowledge and understanding of MHCs and how they affect work.

- *So I think we really should have some more, you know, compulsory almost awareness, some sort of training on what makes people tick, call it what you like. (Public administration)*

The similarities cited included a need to individualise the process and to avoid aggravating factors or circumstances when devising alternative duties.

Box 2. Differences and similarities in supporting RTW after a MHC or a MSD

Differences	Similarities
<p>MHC: A sense that more empathy is needed to support the worker</p> <p>MHC: The worker is more difficult to manage, and requires a more intensive, 'caseworker' approach</p> <p>MHC: The supervisor (and possibly the worker) has less understanding of the impact of the condition on work</p> <p>MHC: Typically, there is less visibility of the condition so the reason for accommodation is not as obvious</p> <p>MHC: More time is needed for recovery</p> <p>MHC: The worker is often unpredictable, and the absences and limitations are of a more subtle nature</p> <p>MHC: There is greater stigma for the worker, hence the privacy issues are more complex</p> <p>MHC: The supervisor feels greater uncertainty about how much to trust worker's decision-making and judgment</p> <p>MSD: RTW is related more to motivation than to the condition</p>	<p>The needs depend on the individual, not the condition</p> <p>There is a problem of co-workers' acceptance of the need for accommodation when the condition is invisible (whether it is a MHC or MSD)</p> <p>It is important to avoid placing the worker in situations where the condition could be aggravated</p>

Training needs of supervisors

There were disagreements in some groups about a key question of the study, i.e. whether supervisors even needed training in some areas required for supporting staff to RTW. Some participants felt strongly that the important thing for the supervisor was to know the job, the workload, and the organisation, and the rest could be learnt 'by experience' and that supporting staff to RTW successfully was simply about 'Having the right people with the right skills to manage it well'.

- *...it's all people management, isn't it? Same skills. (Public administration)*

Others felt that important skills could be learnt and that training would be worthwhile.

- *...when a supervisor commences, it should be provided, this sort of training whether it be mental health and return to work and all of the above, should be provided to any leader, across the organisation in any role as part of their induction. (Transport)*
- *And you can help I think, the leaders...to develop those communication skills... they definitely can be taught and developed with our leaders. (Transport)*
- *It's good to have some support but I think if you're formally trained or centrally trained first and then as a back-up you've got that phone number... or I'll just check that handout after I've had the training. (Public administration)*

Most focus group participants who offered opinions on training methods preferred a face-to-face format. They saw an advantage in being able to learn from others' experiences, and having the time protected from normal work concerns.

- *...the face to face in the discussions and people talking about examples of cases that they've managed is where a lot of the knowledge comes from (Transport)*
- *You learn things, you learn things face to face, you learn things in groups. (Manufacturing)*

- *...you need to be away from your environment, you need to come somewhere like this so you can focus on and not have to worry about your Blackberry and your other pressures. (Public administration)*

However, the Education group disagreed, supporting alternatives such as online training modules or fact sheets.

- *it has to fit what's going on and so therefore it's tailored to whatever the injury is because all the injuries are different. And it's tailored to how we deal with that specific case.*
- *It needs to be delivered at the time, when it's most needed. It's [ir]relevant if it's delivered outside of that.*

The Manufacturing group, on the other hand, expressed doubt over whether an online course would be effective given their work context.

- *Plus the other thing is too many distractions. You start doing something and then five minutes in you'll go it's time for a break down, we need to go because there is an issue here.*
- *It's not so much having the time to go onto the computer; it's getting the chance to use the computers.*

In addition there was support for periodic refresher training, help lines, and written information such as fact sheets or a handbook, though some felt fact sheets would fail to address the uniqueness of a particular RTW situation.

- *We need refresher training as well. I suppose I did my return to work [training] maybe three years ago now and I know that we've had new supervisors come on board that haven't actually done return to work. So it just leaves the supervisors that have done the course, dealing with most of the kinds – so we sort of need that regular training... (Transport)*
- *But there should be refresher training as well because policies change all the time, but we're just expected to pick them up and learn them. But yeah, I think quality time every one or two years. (Public administration)*
- *I think if you're formally trained or centrally trained first and then as a backup you've got that phone number... or I'll just check that handout after I've had the training. (Public administration)*
- *(Discussing fact sheets) 'Cause it's just black and white, there's nothing outside of what you're writing. (Manufacturing)*

Survey

A total of 349 individuals responded to the online survey developed from the focus group proceedings. Five responses were excluded from analysis as four did not meet inclusion criteria and one answered 'N/A' to all of the competencies. The average age of participants was 45.8 years; almost 70% were female, who interestingly were significantly younger on average than the male respondents (44.3 vs. 49.1, $p = .002$). They had an average of 9.2 years of experience supporting employees' RTW, and about 76% had formal training in RTW. Table 2 summarises survey respondents' characteristics.

Table 2. Selected demographic and employment characteristics of survey respondents

Characteristic		
Average age, years		45.8
Range 23-68 years		
Average RTW experience, years		9.2
Range 0-35 years		
		Number (%)
Gender		
Female		157 (68.9)
Male		71 (31.1)
Industry sector		
Accommodation and food services		7 (3.0)
Administrative and support services		7 (3.0)
Agriculture, forestry and fishing		3 (1.3)
Arts and recreation services		9 (3.9)
Construction		15 (6.5)
Education and training		10 (4.3)
Electricity, gas, water		2 (0.9)
Financial and insurance services		7 (3.0)
Health care and social assistance		39 (16.8)
Information, media, telecom		2 (0.9)
Manufacturing		22 (9.5)
Mining		17 (7.3)
Public administration and safety		47 (20.3)
Rental, hiring, and real estate services		2 (0.9)
Retail trade		8 (3.4)
Transport, postal, and warehousing		33 (14.2)
Wholesale trade		2 (0.9)

Workers' compensation system

<i>WorkSafe Victoria</i>	48	(21.7)
<i>Self-insured Victoria</i>	17	(7.6)
<i>TAC Victoria</i>	6	(2.7)
<i>Comcare</i>	3	(3.2)
<i>WorkCover Queensland</i>	159	(71.9)
<i>Self-insured Queensland</i>	24	(10.8)
<i>NSW</i>	15	(6.8)
<i>SA</i>	11	(5.8)
<i>WA</i>	15	(6.8)
<i>NT</i>	12	(5.4)
<i>ACT</i>	10	(4.5)
<i>TAS</i>	10	(4.5)
Size of organization		
<i>1-19 employees</i>	3	(1.3)
<i>20-199 employees</i>	28	(12.1)
<i>200-999 employees</i>	60	(25.9)
<i>1000-4999 employees</i>	62	(26.7)
<i>5000 or more employees</i>	79	(34.0)
Role in organization		
<i>OHS role</i>	55	(24.1)
<i>Rehab/injury management officer</i>	53	(23.2)
<i>HR officer/manager</i>	42	(18.4)
<i>External rehab provider</i>	36	(15.8)
<i>Supervisor/manager/team leader</i>	21	(9.2)
<i>OHS + rehab and/or RTW role</i>	8	(3.5)
<i>RRTW coordinator</i>	8	(3.5)
<i>In-house rehab provider</i>	3	(1.3)
Experience managing MHC/MSD RTW	205	(89.9)
Formal training in RTW	173	(75.9)

Not all survey respondents answered all questions

RTW: Return to Work

MSD: Musculoskeletal disorder

MHC: Mental health condition

As derived from analysis of focus group data, the survey contained 94 competencies, which were organised into nine clusters of conceptually related generic competencies and an additional two clusters of unique competencies for assisting a worker with a MHC (8 competencies) and MSD (2 competencies). We observed a decline in the response rate from the first cluster (344 responses) to the last one (250 responses). Of the 94 competencies in the survey, we found that 90 were rated 4 or 5 ('very important' or 'essential') by at

least 50% of respondents, reflecting a very high degree of consensus. Of these, seven were rated 'essential' by 50% or more respondents (Box 3). These essential competencies ranged across the domains of knowledge, skills, and behaviours.

Box 3. Competencies rated 'essential' by 50% or more of survey respondents

Managing and respecting privacy issues and medical and other confidential information received (71.5%)

Managing privacy issues in terms of disclosure, e.g. with co-workers (57.6%)

Knowing what and how much the injured worker can and can't do and how the injury impacts on the demands of the job (54.9%)

Knowing the tasks and workload of the injured worker's job (54.6%)

Being honest (52.6%)

Knowing their legal obligations as a supervisor (52.2%)

Being able to deliver sensitive information, including information the injured worker doesn't want to hear (50.6%)

Subsequent to analysis of respondents' scores for individual competencies, we developed a list of the ten competencies scoring highest and lowest on average. All competencies with average ratings in the top ten received at least 47% 'essential' ratings. These corresponded to the 90th and 10th percentiles of the rating distribution, respectively and are shown in Tables 3a and 3b.

Table 3a. Competencies achieving the 10 highest average ratings among 94 competencies assessed, as rated by survey respondents

Competency	Average rating
Managing and respecting privacy issues and medical and other confidential information received	4.62
Knowing the tasks and workload of the worker's job	4.42
Knowing what and how much the injured worker can and can't do and how the injury impacts on the demands of the job	4.39
Managing privacy issues in terms of disclosure, e.g. with co-workers (mental health conditions)	4.38
Being honest	4.36
Being able to manage conflict	4.33
Being able to deliver sensitive information, including information the injured worker doesn't want to hear	4.33
Being fair and just	4.32
Communicating in a respectful and appropriate way	4.32
Knowing their legal obligations as supervisors	4.32

Table 3b. Competencies achieving the 10 lowest average ratings among 94 competencies assessed, as rated by survey respondents

Competency	Average rating
Knowing the right questions to ask, including specific ones about the impact of the condition	3.53
Working hand in hand with the injured worker and treating medical practitioner	3.53
Having awareness and understanding of common mental health conditions	3.45
Assessing what the person can and can't do (e.g. the supervisor themselves assessing suitable duties when the condition isn't visible or the restrictions aren't clear or the doctor's view is conflicting with their own observations)	3.43
Handling doubts and concerns about treating doctor's certifications and his or her understanding of the RTW process and job demands	3.40
Engaging treating doctors in the RTW plan and process and getting their support for the RTW plan	3.25
Having functional knowledge about the condition and where to find it (e.g. time for recovery, impact on work, and researching it if necessary; includes knowing the medical diagnosis and what the problem is and interpreting the medical certificate in relation to work restrictions)	3.24
Accessing external professional expertise, e.g. treating medical practitioner, psychologist, rehabilitation provider, or obtaining an independent medical exam	3.08
Liaising with doctors or specialists	3.03
Having counseling-type knowledge	2.81

We also examined the average rating for each cluster of competencies. The highest-rated clusters included competencies relating to personal attributes of the supervisor, knowledge of RTW processes, and understanding and supporting the affected worker. The two lowest-rated clusters contained competencies involving liaison with other stakeholders such as treating

practitioners, and supervisors' access to support and knowledge for themselves. These cluster averages are shown in Table 4.

Table 4. Average rating of items within each competency cluster

Competency cluster	Average rating	Number who answered items in cluster
Enabling behaviours or personal attributes	4.22	344
Knowing return-to-work systems, processes, procedures	4.18	337
Communicating effectively with the injured worker	4.06	320
Managing the impact of the RTW on teams and co-workers	4.05	271
MSD-specific competencies	4.00	257
Developing, establishing, and monitoring the RTW program	3.92	284
Managing impact of RTW programs on organisational effectiveness	3.87	259
MHC-specific competencies	3.82	250
Understanding and giving support to the injured worker	3.74	326
Accessing knowledge and support for themselves	3.69	303
Liaising with key stakeholders (other than the injured worker)	3.30	314

Differences in ratings between participants from Victoria and Queensland for the ten highest- and lowest-rated competencies were not significant with one exception. Victorian participants rated the competency 'Communicating in a respectful and appropriate way' significantly higher ($p = .005$) than did those from Queensland. This result must be interpreted with caution as the two groups were discordant in size (Victoria $n = 40$, Queensland $n = 164$), but

suggest that a generic training program should meet supervisors' needs regardless of location.

Eighteen survey respondents indicated they had participated in one of the focus groups. Fifteen of the 18 (83.3%) agreed that the points raised in the focus group had been, for the most part, represented by the competencies assessed in the survey. A final question asked participants to indicate the degree to which they agreed with the statement 'Supervisors need additional training to manage the RTW of injured staff.' The responses 'somewhat agree' and 'strongly agree' were selected by 93.1% of participants; of these, 78% answered 'strongly agree'.

Method

Research framework, design, and participants

The research framework was underpinned by the concept of competency-based training as described by Marrelli et al. [25]. They proposed that a competency 'may be comprised of knowledge, a single skill or ability, a personal characteristic, or a cluster of two or more of these attributes' [25, p. 534]. The goal of the current research was to produce a competency model, defined as a set of competencies 'required for effective performance in a specific job' [25, p. 537], in this case supervisors' support of RTW for employees returning to work after sustaining a MHC or a MSD. The research was planned as a mixed-methods design using focus groups with supervisors followed by a survey of management representatives. This design allowed for two different types of data collection methods to inform the final competency model, as recommended by Marrelli et al. [25]. Organisations in the manufacturing, transport, education, health and community services, and public administration industry sectors across two jurisdictions were invited to participate due to these industries' identified highest incidence of claims for MSDs and MHCs [17, 26] within Victoria and Queensland. Ethics clearance was obtained from The University of Queensland Behavioural and Social Sciences Ethical Review Committee (see Appendix 2).

Recruitment

Participants for both phases of the project were recruited using purposive sampling to ensure the transferability of results to supervisors throughout Australia. Recruitment notices were placed on the [Return to Work Matters](#) website and in industry newsletters and further disseminated via a snowball technique through the researchers' networks. Supervisors, defined as those who directly oversee the RTW of injured staff and supervise a minimum of three staff, with experience managing employees with compensable MSDs or MHCs were invited to participate. Organisational gatekeepers, such as workplace HR

officers, OHS representatives, or RTW coordinators, agreed to invite supervisors from their organisations to participate in a focus group and collaborated with the researchers to organise a suitable time and on-site venue for the focus groups.

Participants recruited for the survey included supervisors, HR officers, OHS practitioners, and rehabilitation staff at the workplace. It was essential to collect data about competency requirements both from those functioning in the job and from others familiar with the job requirements, as the former may report that their work requires more impressive-sounding competencies than those that are in fact needed [25]. This strategy, known as *triangulation*, enhances the objectivity, reliability and credibility of the data obtained. Similar multi-method, multi-perspective approaches have been successfully employed previously to develop competencies required by supervisors [27] and RTW coordinators [28] for work disability prevention.

Focus groups

Five focus groups with 5-7 supervisors each were held, four in Queensland and one in Victoria. Each session lasted for 1-1.5 hours. The focus groups were held on-site for each organisation and were facilitated by the principal investigator, who is experienced in focus group research methodology. All participants received a participant information sheet and signed a consent form (Appendix 3).

An interview guide with specific trigger questions and prompts was developed through discussion among the researchers. This guide was pilot-tested with three independent supervisors and revised based on their feedback. The interview guide may be found in Appendix 4.

Prior to commencement of each focus group session, demographic data were collected from the participants including age, gender, years employed by the

current employer, years in their current role with this or another employer, and number of staff for whom they have direct and indirect management responsibility. In addition, there were questions on the number of staff they had supervised who had been on RTW plans for MSD or MHC, the recency of these experiences, and any training the participants had received in providing RTW support.

In the focus groups, participants were asked to identify the challenges they had faced in assisting injured or ill employees' RTW; what worked well and not so well; what they would tell a new staff member about assisting with RTW in terms of what they need to know or be aware of; and possible differences in supervising staff with a MSD or MHC. Finally, the supervisors were asked to describe the support and training (type and duration) they would need to assist a worker to RTW. The stimulus questions were designed to elicit from the supervisors their perceptions of the knowledge, skills, and behaviours required to assist a worker, without imposing a competency framework on their thinking. A rolling interview schedule was used, that is, the questions were modified and rearranged slightly over the course of the focus groups to ensure the required information was elicited [29].

During the focus group phase of the project, the facilitator documented her reflections about the groups in a journal. She recorded her impressions after each session. These included notes about conversation flow and participation and nodding heads in agreement, which are not captured in an audio transcript. For example, in one group, the supervisors were quite senior in their respective departments and one person dominated the conversation. In another group, staff tried to be 'politically correct' and carefully worded their comments. In a third group, the members obviously trusted each other as they openly disagreed with each other in a respectful way and were comfortable doing this. Keeping a journal in this manner enhances the dependability and credibility of the results [30].

Each group's discussion was audio-recorded and transcribed verbatim by an independent transcription service provider into computer-readable text files. The principal investigator checked the accuracy of the transcription from recording to text.

One researcher independently coded the transcripts before discussing the codes and categories with an independent experienced qualitative researcher to ensure accurate and unbiased analysis. A commercially available software package, [Dedoose](#) [31], was used to organise the coded data. Responses were coded according to the question asked and the type of competency: competencies for assisting workers with both MSDs and MHCs, with MSDs only, or with MHCs only.

The coding approach followed the method suggested by Braun and Clarke [32]. Data were coded for as many competencies and as many times as relevant and extracts were coded as “inclusively” [32, p. 89] as possible by including some of the context of the data. As also recommended by Braun and Clarke [32], responses that appeared different to the emerging themes were still coded and included and any reflections or opinions of the coder about such responses were documented in the memos facility provided in Dedoose. Memos were also used to document any personal responses by the coder about other aspects of the data.

Initial coding identified 478 competencies across the three main questions. Two researchers reduced these to 115 items with 89 generic competencies and 26 unique items for competencies for supervising staff with MSDs or MHCs (5 and 21 respectively) by removing duplicates and combining conceptually similar statements. This process was aided by considering initially which competencies were identified across three or more focus groups and which had the highest code application counts across the three questions of interest. Participants'

statements concerning perceived differences or similarities between supervising staff with MSDs and MHCs as well as training needs in RTW support, preferred training format, and when and how often the training should occur were also coded.

A process of affinity mapping was used to create clusters of the competencies identified by the focus group participants. This technique is an inductive, bottom-up process [33] and was conducted by a team of three project researchers and the independent qualitative researcher referred to above who is also a subject matter expert. The team synthesised and labelled the 115 competencies into conceptually related groups without using predetermined categories [33]. Each competency, with a brief definition or explanation, was printed on large pieces of paper; the pieces of paper were divided into four equal piles then randomly allocated one pile to each team member. The team member reviewed the allocated pile independently, after which the mapping process was carried out. This process involved each researcher in turn reading aloud a competency and then placing it on a whiteboard with similar items. From this process 10 competency groupings emerged. Each grouping was placed on larger pieces of paper and each member of the team took two or three of these groupings to attempt to confirm their relationship with each other and organise and name the grouping. The result was nine groupings of 90 competencies.

Survey

Following the mapping process, some competencies were refined and combined. Competencies nominated by ≥ 3 focus groups were included in the survey using the participants' own words. Less frequently reported competencies were considered for inclusion based on their perceived importance/relevance to the role of supervisors. In considering the question of differences and similarities for support of a worker returning from a MHC versus

a MSD, the greater number of differences as opposed to similarities led to the decision to allocate these unique competencies to their own distinct groupings.

The result was a draft survey of 94 generic items, 20 items unique to MHCs, and 2 items unique to MSDs. This draft list was emailed to the rest of the research team for comment. Team members felt the language was clear and appropriate but there was some duplication and overlap, so the items were further reorganised to form a pilot survey of 84 generic items plus 8 items unique to managing staff with MHCs and 2 items unique to managing staff with MSDs. The link to this pilot survey was sent to five colleagues with management experience in supervising RTW. The feedback from these responses indicated the survey was acceptable and complete.

The final version of the survey, consisting of the 94 competency statements generated from focus group data and affinity mapping as described above, was distributed using SurveyMonkey, an online survey tool. The survey items were prefaced by instructions that read: 'Following are the competencies identified by supervisors as important to assist a worker return to work following a MSD or MHC. Please rate the level of importance of each competency on a five-point scale (1 = not important; 2 = somewhat important, 3 = important, 4 = very important, and 5 = essential). Two reminders were sent to enhance response rate. Personal and organisational demographic data, in addition to position in the workplace and years in that position, industry sector and compensation system were requested from each survey participant. Respondents were also asked to rate how strongly they agreed with the following statement: 'Supervisors need additional training to manage the RTW of injured staff'. The full survey may be found in Appendix 5.

To establish the credibility of the competencies extracted from the focus group sessions, the survey was sent via the onsite liaison to each focus group member to complete. The focus group members were directed to specific

questions to determine if the competencies generated by their group were satisfactorily represented in the survey. This procedure, an example of *member checking*, enhances the credibility and objectivity of the results [30].

Descriptive analysis was undertaken to determine the average scores for each competency statement and the average score for all items within each affinity group or cluster, using Stata/IC version 12.1 [34]. The response of 'not applicable' originally had a numeric value of 0 assigned to it. There were nine competencies for which 10 or more respondents selected 'not applicable' as well as eight competencies for which fewer than 10 chose that response. The researchers believed these respondents were making a strong statement that supervisors have no need for those specific competencies, hence took the decision to recode all '0' responses to '1' ('not important').

After the initial analysis to determine the average rating for each competency was completed, response options 'very important' and 'essential' were collapsed and the frequency of this combination of ratings and of 'essential' for each item was calculated. To determine whether there were differences in ratings between jurisdictions, we used independent-sample t-tests to compare the average rating for each of the ten highest and lowest rated competencies according to the state compensation schemes in which respondents functioned. Sample size was insufficient to compare ratings among industries, and due to the small number of TAC participants, we were unable to analyse them as a subsample.

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