Health and work: Literature Review

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Most documents mentioned in this review can be found on the shared drive organised by date, author and title.

Overview

Evidence for effective return to work interventions is limited; pilots often do not pay adequate attention to evaluation. Successful randomised controlled trials were few, and were often only focussed on very specific situations, such as IPS for severe mental health difficulties. There were a number of key characteristics which consistently emerged from successful interventions:

1. **Close engagement with (potential) employers:**
   - There was greater success helping employees to return to work when services engaged with employers early on. This allowed adjusted duties and phased returns to be negotiated, as well as for clinicians to better understand the work required.
   - IPS, an intervention for severe mental health conditions with clear evidential support, involves engagement with employers in advance of placement, and support for both the employer and the employee once placement has begun.
   - The lack of supportive employers was thought to reduce the success of condition management programmes in improving outcomes.
2. **Engagement by all services with both health and employment considerations:**
   - Simple interventions; such as requiring GPs to think more about planning for return to work (the 'fit note'), or training JCP staff on health and health service pathways, have been helpful in encouraging positive employment outcomes.
   - Co-location of clinical and employment teams is helpful in improving engagement between teams, such as in IPS or the DWPs condition management programmes. OECD would like to see a pilot of IPS for mild/moderate conditions.
3. **An integrated or coordinated package of services *(This seems to be the main focus of on-going pilots).***
   - It is important to specifically address the primary health condition.
   - Psychological treatments are key to the vocational rehabilitation of cancer services, despite not being the primary diagnosis.
   - Multidisciplinary teams seem to help to address complex needs effectively.
   - Training occupational therapists in CBT helped Dutch patients on sick leave for adjustment disorders.
   - Case management that helps make effective use of existing services is also helpful**.**
4. **Quick and early access to services:**
   - Some of the more successful interventions (e.g. Abasolo 2005) began very shortly after individuals took sick leave. Others, such as 'Fit to Work' pilots in the UK, have proven successful with those already in employment. Allowing people to self-refer to Physiotherapy in the UK similarly reduced time off sick.

- This principle is of less relevance for the long term unemployed. However, delays in service access seem to have frustrated progress in the UKs commission management programmes, and in the IPS in IAPT studies.

Secondary Themes worthy of investigation:

5. **Education:**
   - Education of professionals and employers and patients about conditions and condition management improves integration of services, and increases the extent to which employers feel able to support employees with long term conditions, and to which employees feel able to ask for support. The JCPs in the IPS in IAPT pilots sometimes had problems identifying appropriate clients.
   - The role of vocational education might does not seem to be considered in any of the studies. For severe mental health, IPS is successful through adopting a **place-then-train approach, rather than a train-then-place**. It is not clear what in what circumstances this is the best approach. The OECD feels more focus on education is warranted.
6. **On-going support:**
   - The provision of on-going support in employment is a key feature of IPS, and lack of on-going support was a problem with the UK Condition management programmes. Similarly, patients had difficulty in the
7. **Voluntary participation:**
   - There was a general sense that it was felt that such interventions should be voluntary, although this does not seem to have been examined carefully. Condition Management Programmes were accessed through Jobcentre Plus, it is important to note that not all patients realised these were voluntary.

Health and Work – the current situation

There have been a series of reviews suggesting the importance of Work to Health, and highlighting the poor employment rates for people with mental health conditions. These also begin to suggest what can be done to improve the situation. Some of these reports are briefly detailed below.

Background

Is work good for your health and wellbeing?; Waddell G and Burton AK (DWP) 2006
A review of literature suggests work is good for health and wellbeing. However, there seem to be caveats, especially around severe mental health and stress, where there is less evidence.
Working for a healthier tomorrow; Black C. (DWP) 2008
Workplace ill health costs £100bn p.a. GPs feel ill equipped to do anything other than sign the sick off work, but working can be good for health. Suggest a 'fit note', focussing on what an employee can do. Mental health has not been improving, whereas other things have. There is still stigma and discrimination attached to mental health, so people allow it to get really bad before doing anything about it. Occupational health – currently outside of NHS, needs to be brought in. GPs need to be educated on the importance of work. - There should be a business led consultancy service on health and well-being. Understand how this improves productivity. Occupational health currently excludes smaller organisations. - Establish a fit for work service, referred to by GPs, which connects with the rest of the system, picks up people after they've been a few weeks off work and helps them work out a way to stay in the work place (e.g. returning with reduced duties)
Health at work - an independent review of sickness absence; Black C. & Frost D. (DWP) 2011
The fit note should be further developed with the introduction of an independent assessment service. The taxation regime should be changed to encourage employer engagement. A Job-Brokering service should be established and help people on long term SSP t before they enter ESA.
Mental Health and Integration; Economist Intelligence Unit 2015
Ranks European countries in terms of how they integrate people with mental health conditions into society. UK Performs very well, 2nd after Germany, although there are still problems. Addressing employment and integrating social and health care are seen as very important for tackling mental health.

Long term health related unemployment

Fulfilling Potential? ESA and the fate of the Work-Related Activity Group; Hale C. (MIND) 2014

WRAG performs very poorly for ESA clients. 5% in employment, much less than targets. Because no specialist support, just sanctions and standard employment stuff (CV polishing, interview techniques,…)

Mental Health and Work: United Kingdom; OECD 2013

The UK performs generally well worldwide. Good understanding that health and work are importantly related. However, there are problems.

Work Programme performance is worst for MH patients (2.6%) Outcomes based payments and low performance of the Work Programme has led to providers:
- Disinvesting - too few case workers
- Prioritising the easy wins - people who are helped by easy, standard services such as CV writing etc.
- Lack of work search conditionality for ESA claimants.

Work Programme Should:
- Categorise clients based on complex needs, rather than merely by type of benefit claimed -> this could lead to parking.
- Make use of post placement incentives to improve follow up support.
- Contract in specific support for customers with health conditions (e.g. CMPs)
- Provide further access to education as well as

Query - should IPS be offered through employment services for those with mild to moderate problems?

Other aspects of the system:
- Sanctions go to far, and are used slightly more often with mental health claimants.
- Work Capability Assessments take inadequate account of mental health concerns.
- JCP Advisors should be more aware of spotting the vulnerable, and be more prepared to raise health issues in interviews.

Promoting Contribution: Boosting Employment Opportunity for All; Cooke G. et al (IPPR) 2015

Bringing ESR claimants into the work programme does not help them much. The contractors do not have much incentive to get involved in the integrated support needed to get people back to work. Highlights individual placement support as an effective approach in mental health trusts. Need to reduce inflow, assess support needed to work, strengthen participation obligations, pursue 'supported employment' strategies, and improve incentive to hire

Evidence Note - relationship between employment and health; DH 2015

General picture, work is good for you. Higher income levels associated with a reduction in mental health problems. Examined three areas:

A. Relationship between employment and Health: Generally well evidenced (eg. Unemployed men have 78% higher risk of death). Unemployment associated with poor mental health outcomes.

B. Moving off benefits - generally leads to subjective improvements in health

C. Moving between benefit levels - general picture of income related health outcomes. Some problems as income reduces.

Sickness absence

Health and Employment Outcomes: Data Exploration; Policy Lab 2015

About going off work into long term sickness benefits - aims to identify patterns of experience critical around that time.

- Once they are off work as long term sick/disabled, people tend to remain off work.
- Long term sick: risk affected by age, marriage, salary and education
- Arthritis, Marriage more important, mental wellbeing les
- Depression, Demographic factors much less important, but gender is
- Suggests five segments based on age and pay.

Helping people not in Employment into work

General

There are a number of on-going and planned pilots aimed at helping people into work. In the UK, many of these are focussed on claimants of Incapacity Benefit or ESA, although there are also some more general programmes. Interventions focus on **integrating services, training JCP staff, and training patients to manage their conditions.**

Pilot/Policy Evaluations			
Provider-led Pathways: experiences and views of Condition Management Programmes, Nice & Davidson (for DWP) 2010 *(see also Warrener 2009)*			
UK	Incapacity Benefit claimants on Provider led Pathways to work Programmes	Condition management programmes offered as part of provider led pathways to work programmes. Varied, often one on one or group sessions (around 4-12,…) led by clinical professionals. Psychological therapies (CBT) or advice on pain management techniques might be provided.	There were significant difficulties in recruiting appropriate and empathetic staff. Shared office space, the provision of regular appointments and on-going support were seen as important factors in increasing effectiveness. Suggests that it was in general successful in initiating and enhancing progress towards work, and improving wellbeing. Participants didn't feel ready for work yet, and it was clear that other barriers to work remained (e.g. supportive employers). Participants often did not understand that the scheme was voluntary.
Planned/Ongoing Pilots			
Delivering health interventions through Jobcentre Plus' Social Justice Coaches, D Cope et al, 2014 - unpublished			
Essex	Users of JCP	Training offered to JCP staff to be aware of health and referral pathways.	A number of customers have stopped smoking and/or started to exercise. Free off-peak swimming has been set up. Customers with low self-esteem have been identified and referred to courses.

Engaging Vulnerable and Deprived Groups, Ipswich 2014			
Ipswich	Hard to reach customers, particularly with Mental Health difficulties	Training Jobcentre Plus, Housing and Work Programme providers to understand the relationship of employment and housing with health. Help them to deliver health messages, and establish communication and referral pathways with health and mental health services.	
DWP Pilots, 2014			
England	JSA claimants not on work programme	JOBS II programme offered, consisting of workshops to improve resilience of job-seekers	Trial programme run in Thames Valley, Gloucestershire and the West of England
Yorkshire	JSA claimants not on work programme	Third party provision of telephone psychological and wellbeing support	
Working Capital, Central London Forward			
UK	ESA claimants who have left the work programme after two years.	A case worker to be provided to help ESA claimants leaving the work programme	
Working Well, Manchester 2015			
Manchester	People in ESA WRAG for two years	Key worker is to support people back into work.	Has been going for about one year and there have not as yet been a great number of job-starts (26 based on 448 referrals), although experience of the programme is generally positive.

Mental Health

The only substantial controlled trials for helping patients with long term conditions to find work were focussed on those with **severe mental health conditions**. These focus around the provision of Individual Placement Support. This focusses on specialised employment professionals **embedded in and co-located with clinical teams**, who **liaise with employers** in accordance with client preferences. It focusses on getting people into work early and providing unlimited on-going support, rather than training people in advance. There has been little work to demonstrate its suitability for patients with milder conditions.

Trials			
Vocational Rehabilitation for people with severe mental illness, Crowther et al 2001			
Worldwide	People with severe mental illness	Compares Pre-Vocational Training with Supported Employment (which involves getting people into work quickly and then supporting them) for patients with severe mental illness, as an approach to helping people back to work.	Five randomised trials (484 people) shows that people are significantly more likely to be in employment after supported employment than pre-vocational training. Pre-vocational training was no more effective than standard care. IPS was generally effective. After 12 months: 34% employed in Supported Employment compared with 12% in Pre-vocational Training.
Individual Placement and Support in Europe: The EQOLISE trial; TOM BURNS et al for the EQOLISE group, International Review of Psychiatry, December 2008; 20(6): 498–502			
Cross - European	Unemployed individuals with long term psychotic illness with major role dysfunction	RCTs at 6 Sites across Europe: London (UK), Ulm-Guenzburg (Germany), Rimini (Italy), Zurich (Switzerland), Groningen (the Netherlands) and Sofia (Bulgaria). A sample of 312 individuals with psychotic illness was randomly allocated to either IPS or vocational services (50 per site).	54.5% returned to work with IPS compared to 27.6% for vocational services. IPS patients also kept their jobs longer and were less likely to be rehospitalized. Ulm and Groningen showed no significant difference between approaches, but London did. Five factors were considered to explain differences, (local unemployment rates, GDP per capita growth rate, percentage of GDP spent on health, long-term unemployment rate and the existence or otherwise of a 'benefit trap'). Only local unemployment rates were significantly associated with variation in IPS effectiveness.

An Evaluation of the 'IPS in IAPT' Psychological Wellbeing and Work Feasibility Pilot, Steadman & Thomas 2015			
Four sites in England.	People in ESA WRAG with a prognosis of 12-17 months who have a mental health problem	Integrated Placement and Support was provided in conjunction with IAPT in four pilot sites. Made available through referral by JCPs.	413 referrals led to a take up of 240. There was difficulty in providing IPS and IAPT in parallel because IAPT referral takes a while. Some participants wished only for IPS, which it may be appropriate to offer. There were 15 jobs offered during the six month pilot, and general improvement in measurements of health and well-being.
An update on randomized controlled trials of evidence-based supported employment. Bond, Gary R.; Drake, Robert E.; Becker, Deborah R. Psychiatric Rehabilitation Journal, Vol 31(4), 2008, 280-290.			
International	Individuals with Severe Mental Illness	IPS works integrating clinical and employment support to help individuals gain competitive employment: "jobs paying at least minimum wage in integrated community settings (i.e., employing nondisabled workers) and are jobs that anyone could hold"	Review of 11 international RCTs. In all 11 studies, the competitive employment rate was significantly higher for the IPS condition than for controls. Averaging the rates across studies, the competitive employment rate was 61% (Median = 64%) for IPS compared to 23% (Median = 27%) for controls. The average difference in percentage employed between supported employment and controls was 38%, ranging from 20% to 55%. The individual study effect sizes ranged from .56 to 1.23. The overall unweighted effect size was .83.

Specific Rehabilitation

There are several on-going trials relating to rehabilitation for specific conditions. Work by MacMillan on cancer suggests that psychological interventions, employer engagement and helping patients navigate existing services was key to ensuring effective treatment.

Pilot/Policy Evaluations			
Thinking Positively about work: Delivering work support and vocational rehabilitation for people with cancer; Eva 2012 (Macmillan, DH, UCL)			
UK	People with cancer seeking support with work	Differing vocational support offers were made for cancer patients across seven pilot sites. 2 Sites focussed on case management, 2 integrated with existing Condition Management Programmes, others offered specialist vocational rehabilitation etc. Three levels of support were offered depending on complexity of condition. Vocational rehabilitation was appropriate for those with complex needs.	597 Cancer Patients across seven pilot sites, 38% of people had improved employment status after the intervention. - Embedding work support into the patient pathway was key, as was having the support of clinicians and senior management (it was only in sites where this happened that the services continued). Health workers should bring up work early in an appropriate way and help patients think about the benefits of returning. - Psychological interventions were integral. - Engagement with Employers - Help patients to move between existing services. Average cost per patient of £840
Trials - Planned			
A multidisciplinary intervention to facilitate return to work in cancer patients Groenveld IF et al, 2012			
Amsterdam, Holland	18- 60 years, employed and on sick leave	The intervention comprises three counselling sessions with an oncological occupational physician and a 12-week moderate-to high intensity physical exercise programme, starting at the onset of chemotherapy.	Evaluation to consider: - Number of counselling and exercise sessions executed - Number of topics discussed per counselling session - Number of exercises performed per exercise session - Number of written materials provided by the OOP The percentage of the participants who attended all three counselling sessions and all 24 exercise sessions will be calculated

FRESH, University of Nottingham 2015			
Nottingham, then 3 UK trusts	Working Age People with new Traumatic Brain Injuries TBIs	FRESH (Facilitating Return to work through early specialist Health-based interventions): Offer early specialist traumatic brain injury vocational rehabilitation (ESTVR). The intervention, targeted at preventing job loss, will be delivered 'one-to-one' by an occupational therapist, supported by a TBI case manager with an average of 10 sessions over 12 months	Aim to develop a treatment manual, training package and mentoring model, test delivery feasibility, measure effects across three new NHS sites in an RCT using 102 patients. Main study currently being set up. Pilot: compared outcomes for ESTVR. More people return to work within 12 months, cost only £75 more.
Recommendations			
Ready to work: Meeting the Employment and Career aspirations of People with Multiple Sclerosis			
UK	People with Multiple Sclerosis	Highlights the importance of specialist health professionals for navigating patients through the various services available. The need for support / training to help with negotiating workplace changes - health professionals should begin such discussions. There should be general education around MS. More research needs to be done.	

Sick Leave reduction and preventing future benefit claims

General

There was a greater amount of evidence associated with interventions focussed around reducing sickness absence and people entering benefits. Effective interventions involved **engaging with employers** to help manage early and phased returns to work, and facilitate adjustments in the working environment.

Trials			
Intervention Characteristics that facilitate return to work after sickness absence: A Systematic Literature Review, Hoefsmit et al. 2012			
International	Those on sickness absence	Divides interventions by characteristics. Compares the outcomes of different studies with respect to the characteristics of intervention.	Reviews around 20 trials internationally. Concludes that the most effective interventions are interventions for physical conditions that conform with a pre-set plan.
Pilot/Policy Evaluations			
Effectiveness of return-to-work interventions for disabled people: a systematic review of government initiatives focused on changing the behaviour of employers, Clayton et al 2011			
International	People off sick	Rapid review of policies in OECD Countries. Considered: - Anti Discrimination legislation - Workplace Adjustments - Wage Subsidies - Engaging employers with return to work process	Wage subsidies are sometimes effective. Workplace adjustments and engaging employers tend to be more so. Such interventions suffer from low awareness and take up.
Evaluation of the Statement of Fitness to Work: qualitative research with employers and employees, Lalani et al. 2012			
UK	Those on short term sickness absence (~<1 wk)	The 'fit note' enabled Doctors to sign of employees as 'May be fit for work' as well as fit or unfit.	54 employers and 87 employees were interviewed. Employees and Employers felt that this enabled discussions about adaptions to take place, sometimes enabling earlier return. Particularly successful are phased returns to work.

Telephonic support to facilitate return to work: what works, how, and when? DWP 2013			
UK	People starting sick leave	Telephone support (assessment, triage, case management, advice) provided early to new people on sick leave.	General reduction on sick leave. Cost/benefit: about £1.50-£3.00 for every £1 spent. Successful when: 1. Focussed on return to work. 2. Demedicalised problem solving early on. 3. Integrates line managers into the process 4. Involves an early referral
Evaluation of the Fit for Work service Pilots: First Year Report; Hillage J. et al (DWP) 2012			
UK	People on or at risk of sick leave	Personalised case-management support offered to clients through a variety of models on 11 pilot sites.	Only 40% of expected takeup - this is mostly by those already in work rather than those who are off sick, wanting help staying in work. But generally positive experience. 200 stakeholder interviews. Telephone survey of 300 clients. Suggests most effective when involved early access to assessment and then to treatment, and facilitated employee/employer communication.
The Effects of the Swedish Rehabilitation Guarantee on Health and Sickness Absence; Swedish Social Insurance Inspectorate, 2014 (detailed reports in swedish only)			
Sweden	People with health conditions.	CBT was offered for patients with mental health problems, Multimodal Rehabilitation for physical health.	CBT reduced sickness absence and the number of medical prescriptions for patients who were not on sickness absence when the programme started. For patients on sickness absence, only the number of prescriptions was reduced. MMR increased sickness absence. Cost-benefit analyses show that CBT treatment is not profitable using a one-year follow-up period. However, using a two-year follow-up period, the treatment becomes profitable. The MMR treatment is very expensive and not profitable using any length of the follow-up period.

Mental Health

There is some limited evidence that early access to psychological therapies is the most effective way of helping people with mental health conditions remain in employment. In particular, the provision of Employment Advice in addition to IAPT in England has had ambiguous results.

Trials			
Reducing long term sickness absence by an activating intervention in adjustment disorders: a cluster randomised controlled design; van der Klink, 2003			
Netherlands	Patients who were ill for >2weeks with an adjustment disorder for the first time according to DSMIV criteria in a Postal and Telephone company in the Netherlands.	The intervention comprised a graded activity approach and was based on a three stage model, resembling stress inoculation training, a highly effective form of cognitive behavioural treatment. Randomly selected occupational Physicians were given training, and the patient had to undergo four or five 90 minute sessions in the first six weeks.	A prospective, cluster randomised controlled trial was carried out with 192 patients on first sickness leave for an adjustment disorder. Symptom intensity, sickness duration, and return to work rates were measured at 3 months and 12 months. Analyses were performed on an intention to treat basis. At 3 months, significantly more patients in the intervention group had returned partially or fully to work to work (97%, 78% fully) compared with the control group. (86%, 63% fully)
Pilot/Policy Evaluations			
IAPT three year report, DWP 2012			
England	People with depression and anxiety disorders	Improved Access to Psychological Therapies – in particular offering access to NICE recommended services to a broader range of people than before.	45,000 people have entered the workforce through benefits through IAPT. 45% of participants recover.

Evaluation of Employment Advisers in the Improving Access to Psychological Therapies programme, Hogarth et. al., DWP, 2013			
United Kingdom, various	IAPT patients in employment or on sick leave.	Employment advisors were offered as part of IAPT services across 13 sites over two years, generally co-located or integrated as much as possible. They were aimed at those already in employment.	People did seem to get back to work, however, rates were on a par with ordinary IAPT services. There is, however, prima facie evidence which suggests that those who saw an EA were relatively more disadvantaged at the outset than the group who did not do, and that EA support had largely redressed that disadvantage. Employment outcomes for EA clients were on a par with other IAPT clients. Where there was colocation, it helped to increase the number of referrals and helped keep the remainder of the IAPT service job focussed. There were significant difficulties due to the long IAPT referral times.

Musculoskeletal

For patients with Musculoskeletal conditions, there is limited evidence that multidisciplinary treatments are effective. Effective interventions involved **early assessment and treatment**, as well as a focus on return to work. The UK self-referral pilots suggests that this is facilitated by allowing patients to access treatments directly, rather than through a GP. The Spanish trial emphasised **education** about a patient's condition and **planning** for return to work.

Trials			
A randomized controlled component analysis of a behavioural medicine rehabilitation program for chronic spinal pain, Jensen et al (Pain 91 (2001) 65-78)			
Sweden	People with Chronic back pain sick 1-6 months	Physiotherapy or CBT offered, or both. Both interventions part time but >10hrs per week. Individuals had training sessions on psychological and physical aspects of work.	No significant differences in total absence from work. Some differences in retirement dates for female participants only for PT and CBT groups.

A Health System Program To Reduce Work Disability Related to Musculoskeletal Disorders Abasolo et al, 2005			
Madrid, Spain	Working age population with onset of temporary MSD episode	Once a person had an episode of MSD they were referred (usually within 5 days) to see a RA specialist. This first session was 45 minutes long and included assessment and education (self-management; prescription schedule and discussion around RTW plan). Selection of patients (a few exclusion criteria based on underlying cause of condition) and randomisation occurred in year 1- both groups were almost of equal size.	Randomised controlled trial focused on 3 health districts for 2 years. Measured Number of episodes, Duration of episodes and number of days taken to return to work. This two-year trial with over 13,000 MSD patients resulted in a 50% reduction in permanent work disability (i.e. people leaving work completely) and a 39% reduction in temporary work disability (i.e. people having sick days from work as a result of their condition). Patient satisfaction with this intervention was high. ROI- An analysis of the cost-effectiveness of the intervention in relation to the reduction in temporary work disability showed that for every $1 of expenditure, $15 was saved in productivity benefits.
Pilot/Policy Evaluations			
Preventing Chronic Disability from Low Back Pain - the Renaissance Project; Irish Dept. of Social and Family Affairs, 2004			
Ireland	New claimants of disability benefit for low back pain	Claimants were invited to be assessed 4 to 6 weeks form date of their first disability claim. 600 Attended. Claimants who were deemed to be fit to work were asked to leave the benefit. They were able to appeal, but many chose not to.	Many claimants returned to work of their own accord pre intervention. 600 who remained were assessed early. A high proportion (64%) was found to be still capable of work, and this reduced the descent into long term disability.

A low-key social insurance reform—effects of multidisciplinary outpatient treatment for back pain patients in Norway, Aakvik et al, Journal of Health Economics 22 (2003) 747–762			
Norway	Norway	New and higher outpatient tariff for Multi-disciplinary treatment of patients with back pain.	656 patients studied. Multidisciplinary treatment increased chances of being in work after 9 months by 6 percentage points (significant). A lack of medical personnel has been the bottleneck to implementation in Norway
Self-referral pilots to musculoskeletal physiotherapy and the implications for improving access to other AHP services; DH 2008			
England	People experiencing sick-leave due to MSKs	Patients with musculoskeletal (MSK) problems or injury from 20 participating GP practices (total population 160,000) were able to self-refer to physiotherapy in addition to existing referral mechanisms. At no time were patients who self-referred given preferential treatment in terms of waiting times. Data was collected for 2835 patients.	Apparently no increase in demand - average days absent from work was 4.1 rather than 6.5 or 7 for GP referred or suggested. Much lower proportion absent from work for one month. Not clear what effected this. There were significant changes as to how MSKs were treated in the sites at the same time.

Other

Pilot/Policy Evaluations			
Return to work with chronic pain: employers' and employees' views, Wainwright et al 2013			
UK	People experiencing chronic pain	The 'fit note' enabled Doctors to sign of employees as 'May be fit for work' as well as fit or unfit.	The fit note was valued by employers and employees. However, trust was a very important component of successful return to work.