Return to work after acquired brain injury
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Chapter 5:
Early Vocational Rehabilitation after acquired brain injury: a structured and interdisciplinary approach

Abstract

The Early Vocational Rehabilitation (EVR) protocol is a process guideline to facilitate the interdisciplinary rehabilitation team to systematically focus on return to work during an early stage of (inpatient or outpatient) rehabilitation of people with acquired brain injury (ABI). The development was expert based. The EVR protocol consists of four stages and cooperation among all relevant partners from inside or outside the rehabilitation institute is important for maximally adapting the EVR treatment to the individual (work) situation of the person with ABI. The aim of this paper is to give a description of the EVR protocol and its development in order to make it available for implementation in rehabilitation institutes to strengthen the appearance of the rehabilitation institutes as relevant partners and supporters during the process of (sustaining) return to work of people with ABI.
1. Introduction

Returning to work after acquired brain injury (ABI) is not always obvious. From previous research, it is known that only 40% of the people are able to return to paid work within two years after acquiring brain injury.\(^1\) There is evidence that supports the benefits of specialist vocational rehabilitation after ABI.\(^2\) Different approaches of vocational rehabilitation are available.\(^2\) An interdisciplinary approach in which specific vocational rehabilitation elements are integrated within the standard rehabilitation program is the Early Vocational Rehabilitation (EVR).\(^3,4\) The EVR protocol is integrated in the inpatient or outpatient rehabilitation process in a structured manner, and it ensures that attention is paid to return to work (RTW) from the first day of the rehabilitation process. EVR facilitates an interdisciplinary team approach on the RTW process, which is thought to be beneficial for the person who acquired brain injury. Abilities of the person with ABI are explored and discussed with actors from inside and outside the rehabilitation center. The aim of the current study is to give a description of the EVR protocol and its development in order to make it available for implementation in rehabilitation institutes to strengthen their appearance as relevant partners and supporters during the process of sustaining return to work of persons with ABI. To increase the readability of the study and to avoid confusion we decided to use the word ‘patient’ when mentioning a person with ABI. This is in line with the Dutch situation in which people are called patient when they are admitted for rehabilitation, without having the intention to provide a negative image of people with ABI.

2. Development of the EVR protocol

The development of the EVR protocol was expert based. The first structured version was developed in 2008 by experts of a center of expertise for long-term care, based on the experiences with vocational rehabilitation of people with ABI of eight rehabilitation institutes in the Netherlands and Belgium that participated in a project in order to increase the number of persons that returned to work after ABI or multiple sclerosis between 2003 and 2006. In 2009 the EVR protocol was implemented as a pilot program in the ABI unit of Heliomare Rehabilitation Center, a Dutch center that was not involved in the development of the EVR protocol until then. Before implementing the EVR protocol it was adapted in cooperation with the professionals of this rehabilitation center, making it usable in this center.

From 2010 to 2011, a project was undertaken in which the EVR protocol was revised based on the experiences acquired after the pilot program’s implementation. Recommendations for implementation were included in the description of the protocol as well. Subsequently, the revised version of the protocol was discussed with
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representatives of nine other Dutch rehabilitation centers, patient organizations, and other relevant partners, such as occupational physicians, social insurance physicians, and employers, in order to make it suitable for implementation elsewhere. Based on this discussion, some adaptations were made concerning the description of the implementation recommendations. No significant adaptations were made concerning the steps of the protocol itself. Finally, the discussion resulted in the publication of a textbook in which a description of EVR is given in Dutch. The textbook consisted of a general overview of EVR, a detailed overview of the steps of the EVR protocol (including a description of the available forms and brochures), the implementation conditions, points of interest concerning the communication between the actors involved in the EVR process, and an overview of Dutch RTW legislations and vocational rehabilitation tools.

3. Actors involved in the EVR process

Actors from inside and outside the rehabilitation institute are involved in the EVR process. The cooperation between the actors should guarantee that the support of the person with ABI is continued smoothly after rehabilitation has ended.

3.1. Actors from inside the rehabilitation institute

All relevant disciplines of the interdisciplinary rehabilitation team are involved in the EVR process, such as rehabilitation physicians, occupational therapists, physical therapists, cognitive trainers, (neuro)psychologists, speech therapists, social workers, and vocational rehabilitation specialists. By integrating the monodisciplinary observations and ABI expertise into the RTW process, a common viewpoint is generated. The whole EVR process is coordinated by the EVR specialist. The EVR specialist is a member on the rehabilitation team and has knowledge about ABI and about the rules and legislations concerning sick leave and RTW. The EVR specialist takes care of the completion of the stages of EVR and of the communication and the transfer of information between the different actors during the entire EVR process. Although the coordination of the EVR process is transferred to the EVR specialist, the rehabilitation physician remains responsible for the rehabilitation process, including the EVR process. During the first stage of the process, the rehabilitation physician decides whether it is medically justified to begin the EVR process. Throughout the process, the rehabilitation physician monitors the medical situation of the patient, which is linked to his or her ability to return to work and with the continuation of the EVR protocol. If required, the rehabilitation physician can also be consulted about the medical situation of the patient by the occupational physician or by other physicians involved in the RTW process of the individual, during or after finalizing the EVR process.
3.2. Actors from outside the rehabilitation institute

In the Netherlands, a strict distinction between the systems of health care insurances and social security insurances exists. As a result, it is not possible to finance the entire vocational rehabilitation process from one source. Health care related costs, including the stay in a rehabilitation institute, are covered by an obliged health insurance (www.wetten.overheid.nl/BWBR0018450). The social security insurances are linked to the working position. People who are working for an employer are automatically insured against unemployment, illness, and occupational disability. The employer and employee are responsible for the RTW process during the first two years of sick leave (http://wetten.overheid.nl/BWBR0013063). During these two years the employer is responsible for the costs of wage-replacement (at least 70% of the employee’s wage) and for providing (temporary) modified work within the own company or elsewhere in order to facilitate the RTW process. After two years, the contributions of the employer and employee on the RTW process are assessed by an insurance physician and it is assessed whether the employee qualifies for a governmental disability pension. An employee cannot be dismissed because of sick leave during the first two years of sick leave. The employer and employee can be supported by either an occupational physician or a certified vocational reintegration company. To maximize the RTW possibilities of the person with ABI and because of the responsibility of the employer, at least the employer and the occupational physician are asked to cooperate as early in the EVR process as possible. This involvement can be positive for all actors. On the one hand, the employer and the occupational physician receive actual and specific information about the abilities and pitfalls concerning the employee’s RTW process. In addition, the employer and the occupational physician receive advise about the continuation of the RTW process. On the other hand, the employer and the occupational physician are able to inform the rehabilitation team about the employee’s job and the work situation. Incorporating this information is attempted during the EVR process, in addition to adapting the process maximally to the individual situation which is thought to be beneficial for the person with ABI. Therefore, starting the vocational rehabilitation process during standard rehabilitation and in cooperation with the employer and the occupational physician is thought to be helpful to use the first two years of sick leave as efficiently as possible.

4. The EVR process

The EVR protocol consists of four different stages: 1) orientation of the rehabilitation team towards the patient’s work; 2) investigating the gap between the patient’s abilities and work; 3) work training; and 4) finalizing EVR. The stages follow each other over time (Figure 1) and will be described here. Every stage is explained by the description of three cases of which the EVR process over time is presented.
4.1. Stage 1: Orientation of the rehabilitation team towards the patient’s work

The first stage starts on the first day of the inpatient or outpatient rehabilitation process. During the first contact between the rehabilitation physician and the patient with ABI (with his or her relatives), the rehabilitation physician asks the patient whether he or she was involved in work before acquiring brain injury. If the patient was working, the rehabilitation physician asks the patient about his or her ideas concerning RTW and the willingness of the patient to be accompanied by the professionals of the rehabilitation center during the vocational rehabilitation process. Based on the information gathered during the first contact, the rehabilitation physician assesses whether the patient is expected to be able (cognitively and physically) to be treated according to the EVR protocol and whether the patient is able to provide informed consent (if necessary, with the help of a relative). If applicable, the EVR specialist is asked by the rehabilitation physician to take over the coordination of the EVR process. The EVR specialist starts to investigate the work
situation, as well as the patients' questions concerning return to work, in detail by asking questions about it to the patient and his or her relatives during a meeting. During this meeting, the EVR specialist also asks for permission to contact the employer and the occupational physician.

In box 1 John, Pete, and Susan are introduced. All three acquired brain injury but their RTW processes differed. In box 1 their stories concerning stage 1 of the EVR protocol are presented.

**Box 1: Case descriptions of stage 1**

**John**
John was 52 years old when he was admitted to inpatient rehabilitation because of a cerebrovascular accident. He experienced a number of cognitive consequences such as visual inattention, leading to lack of awareness of the left side of his body and of his surroundings. In addition, he experienced problems in processing information, paying attention, planning, and performing dual tasks. During the first contact, the rehabilitation physician asked John and his wife about John's work situation. John said that he was working as the manager of one of the largest and most often visited shops of a shoe company in the Netherlands. He explained that he wanted to return to his work as soon as possible.

**Pete**
Pete was 32 years old when he was admitted to inpatient rehabilitation. He acquired brain injury after a fall from a scaffolding during his work as a carpenter. Main consequences of his ABI were a lack of insight into his impaired functioning as result of the ABI, a decreased level of orientation of location and time, and impairments of attention, memory, learning abilities, and planning. In addition, minor disabilities in hand and leg coordination existed. During the first contact with the rehabilitation physician Pete stated that he did not understand why he was admitted to rehabilitation and that he wanted to return to his home and his work as soon as possible.

**Susan**
Susan was 43 years old when she acquired a non-traumatic ABI caused by a subarachnoid haemorrhage. The consequences of her ABI were not very notable at first sight, as a result of which she was sent home by the neurologist without being admitted to rehabilitation after her stay in the hospital. At home Susan encountered problems in combining the care of her children and household, and returning to her fulltime job at the same time. Susan was admitted to outpatient rehabilitation eight months after acquiring brain injury. As part of the rehabilitation a neuropsychological assessment was performed, which showed minor impairments in attention, memory, and the performance of dual tasks. Moreover, she experienced complaints of post stroke fatigue.

The rehabilitation physician decided to start EVR for John, Pete, and Susan. The EVR specialist was asked to take over the coordination of the EVR processes.
4.2. Stage 2: Investigating the gap between the patients' abilities and work

After obtaining the permission of the patient, the EVR specialist contacts the occupational physician and the employer. If necessary, ABI and its possible consequences for work are explained to the employer and the occupational physician. During the conversation with the occupational physician and the employer, the EVR protocol and the way in which the rehabilitation team is able to support the person with ABI during the process of return to work are also explained. The EVR specialist visits the employer to get an impression of the workplace of the person with ABI. With help of the employer and during discussion with the occupational physician, an overview of the job requirements of the patient is made by asking them to give an indication of the relevance (scored as very relevant, relevant, a little relevant, or not relevant) of a list of possible activities and skills of the job of the patient. The list of activities and skills is divided into the categories personal functioning, social functioning, adjusting to physical environment, dynamic movements, static movements, and working hours and transportation. After completing the overview of the job requirements, the professionals on the rehabilitation team assesses whether the patient is able to fulfill the job requirements at that time, based on their professional expertise and their knowledge about the current abilities of the patient. The results of the investigation of the rehabilitation team are recorded in a so-called personal profile and scored as normal, slightly impaired, impaired, or strongly impaired. The overviews of the job requirements and the personal profile consist of the same categories, facilitating comparison between both overviews. The categories are based on the Functional Ability List that is used by insurance physicians in the Netherlands. By comparing the job requirements and the abilities of the person as registered in the personal profile, an overview of the possibilities and pitfalls of the RTW process of the patient is provided. Based on this overview, it can be decided whether training on specific (work) skills is necessary and whether it is possible to decrease the gap between the job requirements and abilities of the patient by training or not. If training is necessary and the gap between the job requirements and the individual's abilities is not too large, goals for vocational rehabilitation are established by the rehabilitation team in cooperation with the employer and the occupational physician. Job carving, or searching for another job or another way of spending the day can be other options if the gap between the job requirements and the abilities of the person is too great to overcome by natural recovery, training, or introducing helping aids. In that case, the vocational rehabilitation specialist first discusses the opportunities to return into another job within the own workplace or to adapt the job based on the abilities of the employee with the person with ABI, employer, and occupational physician. If there are no opportunities, the possibilities of another job or ways of spending the day are explored.

As can be seen in box 2 John was not able to return to his own job. Another job was found in agreement with the employer and the occupational physician. Also Pete was not able to return to his own job. However, it was decided to start work training in order to try
to increase the insight of Pete into his impairments and to investigate if it is possible for Pete to perform certain parts of his own or another job.

**Box 2: Case descriptions of stage 2**

Each professional on the rehabilitation team evaluated the job requirements and the abilities of John, Pete, and Susan based on the knowledge and experiences of his or her own profession.

**John**

While discussing the results of this evaluation, it became evident that there was a major gap between the job requirements and John’s abilities. It was therefore concluded that return to John’s own job was not realistic, at least not within an acceptable length of time. Working as a manager in one of the most popular shops in the Netherlands did not seem feasible due to John’s decreased processing speed, and diminished ability to plan and perform dual tasks. John, the occupational physician, and the employer agreed on this. It was therefore decided to investigate the possibilities of an alternative job within the same company. An administrative job in the main office was suggested by the occupational physician. John agreed to this suggestion.

**Pete**

In Pete’s case it was concluded that returning to his own job was potentially dangerous for Pete and his colleagues. His lack of insight into his impairments could lead to life-threatening situations. For example if Pete decides to climb on the scaffolding, while the coordination abilities of his legs are impaired. However, Pete really wanted to return to his work and did not understand nor accept that he was not allowed to do so. Therefore, it was decided to start work training in order to try to increase Pete’s insight into his impairments and to train certain working skills to investigate if Pete would be able to perform parts of his own or another job.

**Susan**

A minor gap existed between the job requirements and Susan’s abilities. The professionals on the rehabilitation team expected that Susan would be able to return to her own job if a balance between her private life and working life was established.

**4.3. Stage 3: Work training**

After setting goals for vocational rehabilitation, training is the instrument to attain these goals. Purpose of the training is to train working skills, not to test them. A decision about the content and the character of the training (physical, cognitive, or both) is made based on the individual goals for vocational rehabilitation and in discussion with the employer and the occupational physician as much as possible. Initially, the training takes place within the rehabilitation center. Because the training preferably starts a few weeks after
acquiring brain injury, most people are not able to return to the workplace immediately. The center provides a safe environment in which the person with ABI can gain some confidence before returning to his or her own workplace. In addition, because the training is part of the regular rehabilitation, it is possible to combine the work training with regular rehabilitation when it is given at about the same location. To be able to train the patient also in traveling to the workplace, it is decided to locate the work training in a building of the rehabilitation center other than the building in which standard rehabilitation is located. The patients are divided into small groups for the training. The training has an interdisciplinary character, and it is provided by an occupational therapist, a cognitive trainer, and a vocational trainer. During the first few weeks of the training, basic skills are covered: skills that are necessary during daily living (such as concentrating, planning, and organizing) but that take on special meaning when focusing on the individual’s return to work. During work training, work is highlighted as the purpose to realize the training, making it clearly meaningful for the patient and society. This motivation of the client to work can also be used during therapies other than work training, to set goals that are related to work. Conversely, successful strategies for compensation that are learned during standard rehabilitation treatment are applied during work training. After the patient has successfully attained the basic skills, training specifically focused on the work of the individual begins. During the training, work samples are used: simulated work situations that are defined in cooperation with the employer and the occupational physician. By discussing the content of the work samples with the employer and the occupational physician, it is attempted to simulate the individual’s work tasks as much as possible. As a result, a smooth transition from training on the rehabilitation center to training on the workplace is stimulated. If the patient is expected to be ready to return to the workplace, training in the workplace itself begins. During the interdisciplinary team meetings the results of the work training are discussed. If necessary, the goals for vocational rehabilitation can be adjusted.

As presented in box 3, John, Pete, and Susan started their work training at the rehabilitation center. Susan for example, learned to apply the cognitive strategies that she had learned during regular rehabilitation to the performance of her work tasks. After that training she was able to start working at her own workplace.

4.4. Stage 4: Finalizing EVR
EVR ends if the standard rehabilitation process is stopped, if the person with ABI has returned (fully or partly) to his or her former job or an alternative job, or if return to work turned out not to be a realistic option at the time. When finalizing EVR, a report called a ‘vocational rehabilitation perspective’ is provided by the EVR specialist. The content of this report is based on the input of the professionals on the rehabilitation team. The vocational rehabilitation perspective includes an overview of the steps taken during EVR
and of the most important factors to which attention should be paid during continuation of the RTW process, as experienced by the professionals on the rehabilitation team. Based on these experiences, advice is given about the continuation of the process of return to work, including possible resources that can be used in this process. The vocational rehabilitation perspective is discussed with and transferred to the patient, employer, and occupational physician. Together, they must decide how the vocational rehabilitation process will continue, with or without external support. For most persons with ABI

**Box 3: Case descriptions of stage 3**

**John**  
To give working in the administrative job a chance to succeed, John had to learn to work with the computer system that was used in the office. The employer provided a copy of the system for John to work with during the training. Work training started at the rehabilitation center. After a few weeks, John was able to continue training at the main office of the company for which he was working. John started to train at the office for two hours per week. At the office, John was able to practically apply the skills that he had learned during the work training. In addition to the training at the workplace, John continued training for two hours per week at the rehabilitation center. During this training, he discussed the problems he encountered when working at the workplace. As a result, the training was focused on these problems specifically. During the training, there was contact on a regular basis among the EVR specialist, trainers from the work training, the employer, and the occupational physician. In this way, all of the relevant partners were informed about John’s progress. In addition, goals set for the work training or the training on the workplace itself could be easily adapted if necessary.

**Pete**  
Carpenters’ working skills were trained with Pete during work training. First, he trained some basic cognitive skills like calculating and planning, after which he started to build simple constructions. Pete believed that he would be able to return to his work immediately. Therefore, it was decided to train skills at his own workplace a few times in order to improve Pete’s insight into his impairments. To prevent potential dangerous situations, Pete was supported by a colleague and a professional on the rehabilitation team.

**Susan**  
During the work training Susan learned to apply the strategies she learned during rehabilitation to her work tasks. In addition, she learned to estimate the amount of work she was able to handle. Because the consequences of ABI are not very obvious, her employer, colleagues, and occupational physician were informed about the consequences of ABI in order to avoid that Susan would be asked to do more than she could handle. After a few training sessions in the rehabilitation center, Susan started working at her workplace again. She was encouraged to apply the learned strategies at the workplace.
ongoing support on the workplace is necessary and therefore advised. However, due to the strict distinction between the systems of health care insurances and social security insurances in the Netherlands it is not possible to finance the entire vocational rehabilitation process from one source. So although the professionals on the rehabilitation team are willing to continue their support to the person with ABI on the job, they are not allowed to do so by the health insurances. Continuing support from the rehabilitation center can only be purchased if financed by the employer or by social security insurances after financing from the health care insurances must end. Instead, external support can for example be delivered by a job coach who is able to provide long-term support to both the person with ABI and the employer.

For John, Pete, and Susan a vocational rehabilitation perspective was discussed with the employer and the occupational physician (Box 4). The outcome of the EVR process was different for all three persons: Susan was able to return to her work after adaptation of her working hours, John returned to another job, and Pete was not able to return to work but started training at an activity center.

**Box 4: Case descriptions of stage 4**

**John**

During the work training, it became evident that being involved in work was possible for John as long as his capacities were considered. Because John becomes tired more easily than before acquiring brain injury, more moments of rest are necessary during the day. In addition, performing visual tasks is more difficult and exhausting for him than performing verbal tasks, due to his visual inattention. All of this advice was recorded in the vocational rehabilitation perspective and discussed by the EVR specialist with John, the employer, and the occupational physician. Because of their own involvement and experiences during the EVR process, they agreed with the vocational rehabilitation perspective and the advice given by the professionals on the rehabilitation team. On the advice of the rehabilitation team, it was decided to allow John to be supported by a job coach. As a result, John is able to work a few hours per week, supported by the job coach and guided by his occupational physician.

**Pete**

As was expected, the work training showed that return to work was not possible for Pete, at least not within an acceptable range of time. In the vocational rehabilitation perspective it was advised to continue work training in an activity center specialized in construction work. In the hope that Pete would be able to perform certain working tasks by repeating working skills during that training. As result of the work training and the training on his workplace, Pete finally realized that returning to his own job would not be as easy as he had expected. Also the employer and occupational physician realised this and were relieved that the work training had prevented dangerous situations on the workplace.
Box 4 (continued)

Susan
Susan was able to perform the same work as before ABI as long as she worked in a structured way. Working in a quiet workplace without all of her colleagues surrounding her, helped her to concentrate on her own working tasks. In order to keep balance between her private and working life, the professionals on the rehabilitation team advised her to reduce the number of working hours. Susan, the employer, and the occupational physician agreed with this advise. In addition, they adapted the working times so she did not have to drive her car in a traffic jam which was exhausting for her. Susan was allowed to start working at 9.30 am and to go home at 16.00 pm. Because traveling and working cost less energy, Susan was able to keep working and take good care of her children and her household.

5. Forms and brochures of EVR

For each step forms have been developed to structure the working of the rehabilitation team. An overview of the forms is provided in table 1. To inform the patient and his/her relatives, the employer, the occupational physician, and other relevant partners about ABI and its possible consequences on RTW, a brochure has been developed. In addition a brochure is developed to provide information about the EVR process.

6. Implementation conditions

It is important that some conditions are fulfilled in order to facilitate the implementation process. First, the staff of the rehabilitation institute has to be ‘work-minded’. In addition, the professionals on the rehabilitation team have to be willing to integrate the EVR protocol into their existing routines and to perform the activities they are expected to perform (like completing the personal profile). An EVR specialist has to be appointed to guarantee coordination of the EVR process. Whether one EVR specialist for all patients or different EVR specialists for different patients is appointed is up to the staff of the rehabilitation institute, as long as the EVR specialist has sufficient knowledge about the rules and legislations concerning sick leave and RTW, and is able to stay in close contact with the professionals on the interdisciplinary rehabilitation team. Finally, an efficient communication structure has to exist. Not only for the contact between the EVR specialist and the members on the rehabilitation team but also between the EVR specialist and the patient, employer, occupational physician, and other relevant partners. Due to the disabling consequences of ABI, ongoing support for RTW and for maintaining a job is necessary. Cooperation with and a transfer of information to the relevant partners that will provide this support after EVR has ended, is important therefore.
**Table 1: Overview of the EVR forms**

<table>
<thead>
<tr>
<th>Stage 1: Orientation of the rehabilitation team towards the patient's work</th>
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<tr>
<td>Form 1: Intake of the rehabilitation physician</td>
<td>Contains questions about patients’ working situation before ABI, education level, and goals concerning work. The decision whether it is medically justified to begin the EVR process is recorded.</td>
</tr>
<tr>
<td>Form 2: Intake of the EVR specialist</td>
<td>Contains detailed questions about patients’ working situation before ABI, the employer and the occupational physician, and goals concerning work.</td>
</tr>
<tr>
<td>Form 3: Permission exchange of information</td>
<td>Permission to exchange information concerning EVR between the rehabilitation team and the employer, occupational physician, or other relevant partners can be given by signing by the person with ABI.</td>
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<tr>
<th>Stage 2: Investigating the gap between the patient's abilities and work</th>
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<tbody>
<tr>
<td>Form 4: Job requirements</td>
<td>Contains a list of possible job requirements. The relevance of these job requirements for the patients’ job can be scored.</td>
</tr>
<tr>
<td>Form 5: Feedback visit of the workplace</td>
<td>Feedback about the visit of the workplace can be given by the EVR specialist to the rehabilitation team.</td>
</tr>
<tr>
<td>Form 6: Personal profile</td>
<td>Contains the same items as form 4. Patients’ ability to fulfill the relevant job requirements can be scored.</td>
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<tr>
<th>Stage 3: Work training</th>
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<tr>
<td>No special forms are developed but form 6 can be repeated to investigate patients’ improvements</td>
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<th>Stage 4: Finalizing EVR</th>
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<tr>
<td>Form 7: Vocational rehabilitation perspective</td>
<td>An overview of the steps taken during EVR and of the most important factors to which attention should be paid during continuation of the RTW process, as experienced by the professionals on the rehabilitation team, can be given. Advice about the continuation of the process of return to work, and the availability of possible resources can be recorded.</td>
</tr>
<tr>
<td>Form 8: Feedback transfer of vocational rehabilitation perspective</td>
<td>Contains items that can be completed to give feedback to the members on the rehabilitation team about the transfer of the vocational rehabilitation perspective to the person with ABI, employer, and occupational physician.</td>
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</table>
7. Clinical implications

The EVR protocol aims to facilitate an interdisciplinary team approach on RTW, which is thought to be beneficial for patients with ABI. Different studies are now undertaken to provide insight into the feasibility and the effectiveness of EVR. Given the demonstrated effects of early rehabilitation training⁷, it can be expected that EVR facilitates an improved, more effective and/or more rapid return to work due to the efficient use of the first two years of sick leave during which the person with ABI has to try to return to work in cooperation with the employer according to Dutch legislation. The EVR protocol is suitable for implementation in Dutch rehabilitation institutes now. Although rules and legislations can be different in other countries, the benefits of an early, interdisciplinary approach of vocational rehabilitation apply equal for persons in other countries. However, before implementation elsewhere, it is recommended to perform a context analysis for each new context.⁸ Depending on the specific context of the country or the rehabilitation institute, the optimal strategy should be chosen to implement the EVR protocol and to allow it to become part of the existing routines.⁸ For example, if there are no employers or occupational physicians usually involved during the RTW process, it is recommended that other relevant partners are contacted (such as the general practitioner) while cooperation with these partners is essential during EVR. The cooperation makes it possible to adapt the EVR process to the individual situation maximally and to ensure that the process can be continued after discharge from rehabilitation. It is expected that, as a result, unnecessary losses of time, stays at home and, possibly, frustration can be avoided.

The textbook in which a description of the EVR protocol is provided⁹ can be downloaded from www.heliomare.nl/AGR (only available in Dutch). From this website, it is also possible to download a video in which the EVR process is demonstrated (also in Dutch).

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References


