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Comète France: a French Network for Early Vocational Reintegration after Severe Disease or Injury

Summary

Many vocational training and reintegration programs exist in Europa. In this short paper we present Comète France, a French reintegration network that has been developed in addition to current public administrative systems. Comète France is a private association funded and supervised by public institutions: Ministry of Health and two Offices for employment of disabled persons. The program relies on four main concepts: early intervention during rehabilitation of inpatients or outpatients; global, systemic and ICF-directed approach; multi, interdisciplinary approach; tailored programs. The network comprises 450 part-time employed professionals in 43 teams implemented in 56 French public or private rehabilitation settings. The process is structured in four phases: identification and assessment; drawing a reintegration plan; implementation; follow-up. As a whole, more than ten thousand cases are assessed and/or treated by Comète France every year. As for outcome, among 1746 participants, 83% completed the program: 68,5% were regularly employed at the end of the year, 9,5% undertook vocational retraining and 5% resumed studies. For other 12% the program was delayed and probably most of them would find a job on the following year. Data on dropouts on 2020 and two case studies illustrate the functioning.

Keywords:

vocational reintegration, vocational rehabilitation, return to work, Comète France, ICF

Introduction

Working is one of the most important human activity. Vocational situation is a major component of wellbeing and satisfaction with life in adults, and vocationally disabled subjects have significantly lower levels of life satisfaction as compared with paired non-disabled subjects[1]. They are less employed, they have more hard, more low-skilled and more precarious jobs than non-disabled ones, with lower pay and poor promotion. Vocational reintegration is a factor of recover self-esteem, financial independence, participation (in the sense of the ICF) and quality of life after severe disease or injury. But finding a job or returning to work is not easy: 42,2%

[1] I. B. Bränholm, M. Eklund, K. Fugl-Meyer, A. Fugl-Meyer, *On work and life satisfaction*. J Rehabil Sciences 1991; 4-2:29-34

of disabled persons are in employment, as compared with 64,5% of non-disabled[2]. Thus, vocational reintegration stands as the logical and ultimate step of the rehabilitation process in adults[3], and vocational training and/or programs to help disabled persons to return to work after rehabilitation developed everywhere in Europa (see 4 for review)[4].

The current French model of vocational rehabilitation has been described elsewhere[5]. It relies largely on public facilities and services. But many doctors and members of rehabilitation teams were concerned by the chronic weaknesses of the system: too slow, too late, too administrative. There was a gap between medical rehabilitation and vocational reintegration. In 1992 Dr Busnel decided with some colleagues to undertake a private alternative and created Comète France, a network for early and global vocational reintegration of patients hospitalized for rehabilitation after a severe disease or injury. In this brief note we present Comète France philosophy and concepts, organization and functioning.

Comète France philosophy and concepts

Among the other, previous French systems for helping disabled adults to returning to work, Comète France takes its specificity from its philosophy and values. Our program relies on four main concepts: early intervention; global, systemic and ICF-directed approach; multi, interdisciplinary approach; tailored programs.

Early intervention is a very specific dimension of Comète France. The advantages of initiating vocational reintegration soon after severe disease or injury have been evidenced in the literature[6,7] and emphasized in the document: Recommendations for Best Practice: Early Reintegration Process in Physical Medicine and Rehabilitation published in 2011 by the French Higher Health Authority in association with Comète France and scientific societies (see full description in 8)[8]. Vocational reinte-

[2] 2 OECD. *Sickness, disability and work: breaking the barriers—a synthesis of findings across OECD countries*. Paris: OECD Publishing 2010

[3] C. Gutenbrunner, A. Ward, M. A. Chamberlain. *White book on physical and rehabilitation medicine in Europa*. J Rehabil Med 2007; S45

[4] M. A. Chamberlain, V. Fialka Moser, K. Schüldt Ekholm et al. *Vocational rehabilitation: an educational review*. J Rehabil Med 2009; 41: 856–869

[5] J. M. André, C. Le Chapelain, J. Paysant. *The French model of vocational rehabilitation. Existing legal plans of action for reimbursement for the deficiency. Plans of action enabling preparation for job retention*. In: C. Gobelet, F. Franchignoni eds. Vocational rehabilitation, Paris: Springer-Verlag 2006: 283–308

[6] A. Westman, S. Linton, T. Theorell et al. *Quality of life and maintenance of improvements after early multimodal rehabilitation: a 5-year follow-up study*. Disabil Rehabil 2006; 28(7):437-446

[7] I. Z. Schultz, J. Crook, J. Berkowitz et al. *A prospective study of effectiveness of early intervention with high-risk back injured workers. A pilot study*. J Occup Rehabil 2008; 18: 140-151

[8] Haute Autorité de Santé. Démarche précoce d'insertion socio-professionnelle en établissements de soins de suite et de réadaptation spécialisés relevant du champ de compétences de la médecine physique et de réadaptation. https://www.has-sante.fr/jcmms/recommandations-de-bonne-pratique (2011). Access 08/08/2021

gration is in adults a priority as important as medical cares and rehabilitation, and should be thought of and undertaken as soon as possible, during the rehabilitation phase for inpatients or outpatients as well. We are aware that later interventions implemented at the work-place have been shown to impact positively employment outcomes[9] but an important weakness of these interventions is the usually long time between discharge of rehabilitation and beginning of vocational reintegration. An empty time, with inactivity, boredom, anxiety regarding the Future often shared by proxies, and when carrying out prior job tasks seems to be problematical, having only vague ideas of working again, when, and how? And then returning to work might be perceived as "a second trauma". So, implementing vocational reintegration programs during medical rehabilitation may help the disabled worker to avoid the psychological and social gaps between rehabilitation and return to work.

Secondly, Comète France develops a global, comprehensive and systemic approach according to the International Classification of Functioning ICF[10]. The ICF is a useful tool to understand human functioning and to make assessment in view of job placement or vocational rehabilitation[11]. Although most of reintegration systems are mainly centered on medical sequelae and physical abilities faced with job requirements, the ICF reminds us of the importance of taking into account personal and environmental factors as well as impairments and activity limitations. Age, gender, psychological status and mood, professional experience, waits and wishes are among the ICF personal factors the most important to consider. Environmental factors may be facilitators or barriers. The context of work-place and job needs plays a major role. Physical barriers like stairs or other obstacles preventing access to the work-place, transportations, driving and parking a car are the most obvious and easy to assess. The ICF stresses also the role of administrative systems, social laws, insurance and compensation process, and within the Attitudes component, human factors and relationships. Colleagues and managers' opinions and representations of handicap play a major role in return to work. Family members feelings and representations are also to be strongly considered, for they influence largely the disabled worker behavior, wishes and waits. Many partners and parents are for instance anxious with the idea of their relative learning a new, unknown job.

Third, drawing such reintegration plans requires a multi, interdisciplinary approach. We try to promote and coordinate in the team all competencies involved in the way to reintegration: medical, physical, occupational, psychological, technical and social professionals, and outside the walls, actors from social services and the World of work.

[9] M. van Vilsteren, S. H. van Oostrom, H. C. W. de Vet et al. *Workplace interventions to prevent work disability in workers on sick leave*. Cochrane Database Syst Rev 2015; 10:CD006955

[10] World Health Organization & The World banks. *World report on disability*. Geneva: World Health Organization 2011

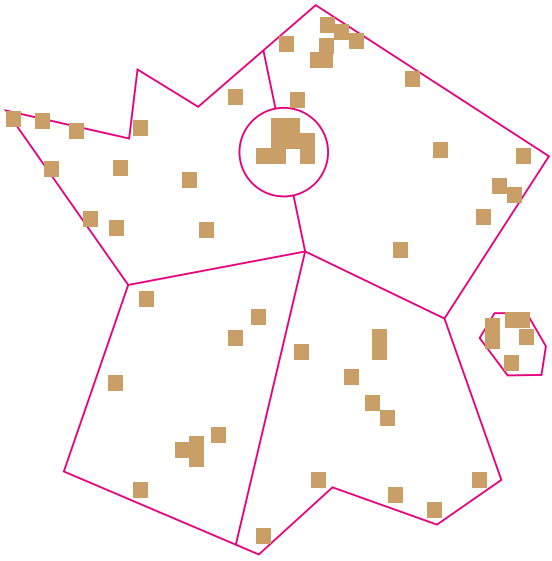
[11] D. B. Homa. *Using the International Classification of Functioning, Disability and Health (ICF) in job placement*. Work 2007; 29: 277–286. 99

Building tailored projects is the last concept that drives our functioning. As the disabled worker is unique, standardized or too administrative approaches in which the person would stay passive do not fit with, the plan should be tailored from the person's ICF personal factors, wishes and waits, so that he/she can engage actively in.

Organization and functioning

Comète France is a private association funded and supervised by 3 public institutions: Ministry of Health, Office for employment of disabled persons AGEFIPH and Office for employment of public service officers. Our network comprises 43 teams implemented in 56 French public or private rehabilitation settings (Figure 1). Most of our 450 professionals are part-time employed, for at least an equivalent of 2,7 full-time employment by team. But most of teams include more professionals. They are PMR specialists, neuropsychologists, work psychologists, occupational therapists, social workers, physiotherapists, ergonomists, integration advisors and secretaries. We pay greatest attention to conviviality, shared values and pleasure to work together, with two national meetings of continuing education conferences and spending good, recreational times every year.

Figure 1. Comète France team implementations



56 private or public rehabilitation settings. 11 in the North-Western region: Bois-Guillaume (Rouen), Brest and Roscoff, Granville, Lannion, La Membrolle-sur-Choizille, Le Mans, Nantes, Ploemeur, Rennes, St Nazaire, 9 in the South-Western region: Albi, Bagnères-de-Bigorre, Bordeaux, Niort, Limoges and Noth, Toulouse (3 sites), 8 in Paris area: Bobigny, Bouffémont,

Chatillon, Coubert, Garches, Paris (3 sites), 14 in the North-Eastern region: Beauvais, Berck, Charleville-Mézières, Dijon, Fouquières (Lens) and Arras, Héricourt, Lille (3 sites), Mulhouse (2 sites), Nancy, Strasbourg, 11 in the South-Eastern region: Clermont-Ferrand, Hyères, Lyon (2 sites), Marseille, Montpellier, Perpignan, St-Etienne, St-Vallier and Valence, Vallauris, 5 in the Reunion Island, in Indian Ocean. The total number exceeds 56, as some teams are organized as multi-sites.
Source: Comète annual internal activity report

Our reintegration process is structured in four phases.

Phase 1. Identification and assessment

Comète is well-known from most of colleagues working in acute care or rehabilitation units, as our teams are settled inside their own hospitals or rehab centres, or in another one in the neighbourhood. So, it is easy for them to identify which patients will benefit from Comète, in the time they are still hospitalized. Thereafter Comète actions and process are explained to the person, and when he/she agrees with, a comprehensive assessment is undertaken. All the ICF dimensions involved in vocational reintegration are addressed. Personal factors and a complete medical history, including any previous injuries, dates and nature of surgical interventions and treatments are first collected by a PMR specialist. Then impairments in body functions and structures are assessed depending on the nature of the pathology. Pain, musculoskeletal system and joints impairments, motricity systems and neurological functioning are assessed by physiotherapists, who may have access to high-technology investigations like walk or balance analysis performed by colleagues. Cognition and language are assessed by neuropsychologists and speech therapists. Psychological status: anxiety, mood, fears, coping strategies and feelings are assessed by a psychologist, aside the work of the Work psychologist. ICF activity limitations: independence in daily living, walking, climbing stairs, lifting, using public transports and, depending on the case, using tools, computers or complex machines are assessed by occupational therapists. A special stress is put within Comète teams on driving a car, with a full assessment including on-road tests evaluated simultaneously by an occupational therapist and a driving instructor. Social workers provide information about participation restrictions in personal life, leisure, social, financial and administrative status and about environmental factors, including economic and insurance factors and conditions of the local labor market. Family members are met and listened to. Of course, the employment status is especially documented by social workers, work psychologists and integration advisors: qualification, experience, previous jobs, environmental factors of the last job, physical constraints, attitudes and support from colleagues and boss. As the assessment phase lasts long enough, all the team members have many opportunities to discuss deeply with the person and exchange their views, so they can give a documented opinion during the final

synthesis: who is really the person, what are his/her strengths and weakness regarding his/her previous job and the requirements of the World of work, what he/she still can do, as much as, and even more than what he/she can do no more, and above all what he/she wishes and waits.

Phase 2. Drawing a reintegration plan

The idea is to confront 3 dimensions:

- what the person wishes and wants to do,
- what he/she can do (work capacity),
- what is realistic to do in context of the present labour market conditions and job offers,

in view of drawing a first global orientation among whether returning to the previous job, or the previous work with facilities or part-time, or learning a completely new, or dropping the project. This, while taking into account the back-to-work predictors, that is analysing the agreement between clinical, social and vocational assessments and back-to-work predictors, and the fact that returning to a previous job, even with facilities, is always easier than learning a new one.

Factors that are known to negatively influence return-to-work have been identified in the literature[12]. Among ICF personal factors are older age, gender, health status, ethnicity, low social status, poor educational attainment, extended sick leave and expectation concerning likelihood of return to work. Health-related job discrimination is unfortunately another personal factor that impacts negatively return to work. A survey conducted in 2017 showed us that 36% of our participants said to be, or to have been, faced with job discrimination. Common forms were non-accurate job tasks in regard to handicap (37%), accessibility (35%) and transports (26%), resulting in loss of chance in job finding (32%) and promotion (26%) and exclusion process (23%)[13]. Others are external influences, which are categorized in the ICF environmental factors and may be barriers or facilitators: social welfare and work insurance laws, rehabilitation effectiveness, economic factors and labor market conditions.

All competencies are mobilized and concrete actions are undertaken: learning achievements are verified, task positions and job needs are specified, appropriate facilities are designed. Professional skills are concretely checked, in real-life situations, in context of the work-place.

This will allow for drawing vocational guidance for returning to work when it seems possible, or planning vocational retraining or resuming studies as early as possible after hospitalization discharge when returning does not seem realistic.

[12] C. Gobelet, F. Luthi, A. T. Al-Khodairy et al. *Vocational rehabilitation: a multidisciplinary intervention*. Disabil Rehabil 2007; 29: 1405–1410

[13] J. M. Mazaux, M. Busnel, A. Picard A et al. *Health and handicap-related job discrimination as viewed by professionals*. SOFMER congress, Nancy, 22.10.2017

Phase 3. Implementation

Once a decision is taken and a plan designed, accepted by the person and validated by all partners and professionals, procedures and actions required by the plan are undertaken. The idea is to help the person to reach the employability level despite impairments and activity limitations. The roles of the main actors that would make successful a vocational reintegration plan have been identified[14] and our interventions are targeted on these actors. With regard to the disabled worker's own role, the team encourages the person to imagine at work although he/she is still hospitalized, and to get in touch with his/her previous society or boss, and discuss which parts of the job could still be done. Appropriate facilities are eventually provided. With regard to participation and environmental factors, the local social and professional contexts are clarified, job vacancies are sought, helpful partners are identified, for instance vocational rehabilitation programs, touched and involved in the process. Employers and line managers are met and explained the situation. In context of the Covid-epidemy, the question of working at place or by tele-working is a key-question (see further, case study). Administrative, insurance and financial documents are set up. All along the process, the plan is periodically addressed, its feasibility and accuracy are verified. Table 1 shows the average duration of these three Phases.

Table 1. Average duration of Comète reintegration phases. Percentages of participants

	Less 1 month	1 to 3 months	3 to 6 months	6 to 12 months
Phase 1	41%	18%	15%	26%
Phase 2	12%	15%	20%	53%
Phase 3	12%	18%	25%	45%

Source: Comète annual internal activity report

Phase 4. Follow-up

Comète professionals stay in touch with the person two years along after his/her reintegration.

Participants

As a whole, more than ten thousand cases are assessed and/or treated by Comète France every year. With regard to demographic features, half of our participants are over 45 of age. They are mostly men (57%) with low to medium educational level (59% basic qualifications: school certificate or FPI, or no diploma). Forty-three per-

[14] M. A. Chamberlain, V. Fialka Moser, K. Schüldt Ekholm et al. *Vocational rehabilitation: an educational review*. J Rehabil Med 2009; 41: 856–869

cent of them suffer from neurological impairments, mostly stroke, or brain or spinal cord injury. Twenty-six per cent suffer from neck or chronic low back pain, 24% from other orthopaedic or traumatic impairments. Eight per cent are amputees persons, burnt or suffer from cardiac problems. According to the Higher Health Authority Recommendation, patients with psychiatric diseases do not usually participate in our program. Whatever the impairments, we observe that we are always faced with complex family/social situations.

Results

The following data are only indicative as no comparison group has been designed. Roughly, on 2020, Comète support stopped at the end of Phase 1in 39% of participants, at the end of Phase 2 in 69% and during or at the end of Phase 3 in 17%. Table 2 shows the reasons why.

Table 2. Comète program dropouts. Percentages of participants

Included	Too early	Wanted to go on by themselves	Other partners more relevant	Gave up or unrealistic project
Phase 1 N=6750	7%	12%	7%	13%
Phase 2 N=4800	20%	13%	24%	12%
Phase 3 N=1750	12%			5%

Source: Comète annual internal activity report

For some patients it was too early, mainly for medical reasons, and sometimes the program was opened again later for them. For some others alternative reintegration partners were touched, as more relevant, generally because these participants could benefit from more local or pathology-specific reintegration systems (e.g. head injured patients). The last ones wanted to go on by themselves, or unfortunately their project was unrealistic.

As for outcome, 1746 participants entered Phase 3:

- 83% completed the program. Among them, 68,5 % were regularly employed at the end of the year: 52,3% returned to the same job, 9,4% returned to the same company on another work-place or task, 5,7% in a new company and 1,2% created a new society. Among others, 9,5% undertook vocational retraining to learn a completely new job, and 5% resumed studies.
- for 12% Phase 3 went on, but was delayed; probably most of these participants would find a job on the following year.

– 5,3 gave up.

On follow-up around 80% of the completers were still employed one and two years after the end of the program.

Case studies

Case 1

Mr V, 39 years old, suffered 20 years ago a spinal cord injury with T7 AIS A paraplegia associated with head injury. He is now hospitalized in a rehabilitation unit for shoulder pain assessment. As he was a cosmetic packaging employee, the PMR specialist suspects a link between his job and the shoulder pain and gets in touch with the local Comète team. Indeed, a rotator cuff pathology may be related to living with a paraplegia and transferring all day long during 20 years, but any other contributing factor should be sought and removed to help the person in independent living. Comète Phase 1. The ergonomic assessment confirms that installation on packing line is very harmful for shoulder functioning. However, Mr V wishes to come back at this work-place as soon as possible. Phase 2. Simple work-place arrangements are drawn up, as a wheeling chair with optional lifting device would prevent from excessive elevation of the shoulders (Figure 2).

Figure 2. Case study 1

Figure 2.1 Mr V on his wheelchair before arrangement

Figure 2.2 Mr V after arrangement, with a lifting device on his wheelchair

Source: pictures by Dr Anne-Claire d'Apolito, personal documents

But Mr V is strongly reluctant to this device. So many view exchanges are necessary to convince him to accept: returning as soon and as long as possible on this job requires primarily to save his shoulders; perhaps a visit on the work-place with such a device would be helpful? A concertation takes place between Mr V, the Comète team, the occupational physician and the employer, and through their cooperation, a visit is organized. The visit demonstrates the feasibility of the project with some further arrangements. Mr V is so convinced of the lifting device benefit on his pain that he asks for keeping this wheeling chair while waiting for getting his own! Phase

3. Administrative documents and funding requests are set up by the team. Mr V is supported until he gets his own wheelchair and device. Commentary. Would not the PMR specialist have thought of a link between Mr V's job and his shoulder pain, Mr V would have suffered a long sickness absence, or would have continued working a short time before stopping definitively for rotator cuff rupture. This situation has been an opportunity for fruitful exchanges with occupational physicians and to raise awareness among them on the long-term consequences of paraplegia, and on the importance of ergonomic work-places for these persons.

Case 2

Ms B, 52 years old, is treated in a Day hospital for multiple sclerosis, and complains from a severe fatigue, which makes her professional activity more and more difficult. And working is so important for her. She is referred to the local Comète team for advice. Comète phase 1. Comète professionals notice that she is holding on in the same time her job and her rehabilitation, or spends her rehabilitation sessions during vacation days. The following multidisciplinary exchanges help Ms B becoming aware that fatigue worsens her cognition and work capacity, and increases the risk of falling down. The conclusion is that she must draw a new personal and vocational life project taking her fatigue into account. Phase 2. Tele-working might be a solution, provided that the work-place would prevent from the occurrence of any musculoskeletal impairment. Ms B agrees with, and the occupational health office of her company is called and agreed. Then our ergonomist visits Ms B's home and proposes some arrangement to reorganize home disposition. Some devices: ergonomic seat, foot-rest, double screen and PC support are tried at home to check the project. Phase 3. Funding requests are undertaken to get the material. One half of expenses is covered by the French Office for employment of disabled persons AGEFIPH, the other by the employer. Commentary. So tele-working with facility allowed Ms B to keep her job without too much pain and fatigue. And this was most welcome, as the Covid epidemy occurred just after, and Ms B was already accustomed to full-time tele-working, whereas so many disabled workers have been forced by the Covid to move quickly to tele-working without any support and nobody to check that their work conditions at home were appropriate.

Concluding remarks

For 30 years now Comète France has been working successfully at vocational reintegration and return to work of thousands of disabled workers in France. This provides evidence that a private system, involving highly motivated professionals and engaging ICF-directed and person-tailored programs early in the course of rehabilitation is viable and useful. Implementing our programs during rehabilitation facilitates the relationships with medical colleagues and helps to draw on Phase 1

a complete medical history and full physical assessment. It helps also the disabled worker at imagining working again at a time where medical issues still occupy the front of the scene. Return to work is for him/her a concrete Future. Also, the ICF helps us to go beyond present impairments and activity limitations on Phase 1 and Phase 2. The relevant ICF codes are useful to analyse the agreement between clinical data and return to work predictors[15]. Sections d7 or d 720 reminds us of the importance and complexity of human relationships at work, and sections e 330 and e 410 outlines the role played by employers, colleagues and family members' attitudes; and health-related job discrimination is one of these factors. In the present context, facing the difficulties raised by the Covid epidemy is our priority, in terms of assessing the capacity of tele-working or developing facilities for transports and work-places. We think we have also to improve our local collaborations with other, public reintegration systems and relationships with actors in the World of work and employers, while respecting medical confidentiality. We think also that European exchanges may and should be developed. Beyond politicians' hesitations and system diversity and complexity, to what extent may professionals like us contribute to a better harmonisation in vocational reintegration in Europa?

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References

André J. M., Le Chapelain C., Paysant J. *The French model of vocational rehabilitation. Existing legal plans of action for reimbursement for the deficiency. Plans of action enabling preparation for job retention.* In: C. Gobelet, F. Franchignoni eds. Vocational rehabilitation, Paris: Springer-Verlag 2006: 283–308

Bränholm I. B., Eklund M., Fugl-Meyer K., Fugl-Meyer A. *On work and life satisfaction.* J Rehabil Sciences 1991;4-2:29-34

Chamberlain M. A., Fialka Moser V., Schüldt Ekholm K. et al. *Vocational rehabilitation: an educational review.* J Rehabil Med 2009; 41: 856–869

Gobelet C., Luthi F., Al-Khodairy A. T. et al. *Vocational rehabilitation: a multidisciplinary intervention.* Disabil Rehabil 2007; 29: 1405–1410

Gutenbrunner C., Ward A., Chamberlain M. A. *White book on physical and rehabilitation medicine in Europa.* J Rehabil Med 2007; S45

Haute Autorité de Santé. Démarche précoce d'insertion socio-professionnelle en établissements de soins de suite et de réadaptation spécialisés relevant du champ de compétences de la médecine physique et de réadaptation. https://www.has-sante.fr/jcmms/recommandations-de-bonne-pratique (2011). Access 08/08/2021

Homa D. B. *Using the International Classification of Functioning, Disability and*

[15] M. A. Chamberlain, V. Fialka Moser, K. Schüldt Ekholm et al. *Vocational rehabilitation: an educational review*. J Rehabil Med 2009; 41: 856–869

Health (ICF) in job placement. Work 2007; 29: 277–286. 99

Mazaux J. M., Busnel M., Picard A et al. *Health and handicap-related job discrimination as viewed by professionals*. SOFMER congress, Nancy, 22.10.2017

OECD. *Sickness, disability and work: breaking the barriers—a synthesis of findings across OECD countries*. Paris: OECD Publishing 2010

Schultz I. Z., Crook J., Berkowitz J. et al. *A prospective study of effectiveness of early intervention with high-risk back injured workers. A pilot study*. J Occup Rehabil 2008; 18: 140-151

van Vilsteren M., van Oostrom S. H., de Vet H. C. W. et al. *Workplace interventions to prevent work disability in workers on sick leave*. Cochrane Database Syst Rev 2015;10:CD006955

Westman A., Linton S., Theorell T. et al. *Quality of life and maintenance of improvements after early multimodal rehabilitation: a 5-year follow-up study*. Disabil Rehabil 2006; 28(7):437-446

World Health Organization & The World banks. *World report on disability*. Geneva: World Health Organization 2011