Rebirth of vocational rehabilitation in the UK 1999-2009

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Abstract

This paper reviews the developing collaborative working between UK government departments, charities representing disadvantaged individuals and health/employment professionals in the UK between 1999-2009.

The Vocational Rehabilitation Association (VRA) defined Vocational Rehabilitation (VR) as *'a process, which enables persons with functional, psychological, developmental, cognitive and emotional impairments or health conditions to overcome barriers to accessing, maintaining or returning to employment or other useful occupation'*.

Although VR is often defined in terms of 'job retention', it embraces the additional roles of preparing individuals for work – either because they were disadvantaged during childhood/adolescence (e.g. with cerebral palsy), or because they have lost their previous job after injury or illness. Job retention is the general term for the processes that enable an employee to remain at work with their same employer. The nature of the tasks and responsibilities of the work may be the same, modified or totally changed after illness or injury.

In 2000, the British Society of Rehabilitation Medicine (BSRM) reported a new consensus within the UK. Firstly Government wished to convert 'benefit recipients' into 'tax payers' as it realised that the increasing numbers of those receiving incapacity benefits (peaking at nearly 2.7 million people in 2003) was unsustainable. Secondly those with disabilities wanted to work, given the necessary support; and finally rehabilitation professionals encouraged those with disabilities to work if possible as they felt that maximising individual's independence improved health and wellbeing.

The BSRM report drew together most of the strands that complicate the health/work interface. They embraced health and safety at work (including occupational health), 'the importance of good employer/employee relations, primary care including the vital sickness certification and the appropriate health/rehabilitation resources needed to facilitate a return to work combined with an increasing combination of government incentives and appreciation of the need to avoid disincentives.

Successful strategies to facilitate working for disadvantaged individuals take two facets that together encompass VR. Simply they can be described as 'top down' and 'bottom-up'.

Top-down approaches reflect government policy and its implementation via employment services. In the UK they are provided through the Department for Work and Pensions (DWP) and until this current administration, the Department of Health (DH) played no part. The difficulties for governments have been reviewed by the Organisation for Economic Co-operation and Development which outlined strategies used by member states to 'meet the potentially conflicting goals of empowering those

with disabilities to participate optimally in society, particularly to engage in gainful employment, whilst ensuring that those unable to work have income security'. What was clear was the need for 'joined up' working within different branches of government.

Bottom up approaches are those used by individual professions to assist their clients/patients and reflect approaches needed in clinical practice. The responsibility of individual health professionals to support their patients at work has been neglected in the UK since the 1980s with loss of many services which supported VR. However the situation changed in 2008 with the publication of the 'Healthcare Professionals Consensus Statement' which was agreed and signed up by 37 professional bodies including the General Medical Council (GMC), British Medical Association (BMA) and 14 royal colleges. Led by Professor Dame Carol Black (who was appointed National Director for Health and Work crossing both the DWP and DH), this statement was strongly supported by those professional bodies most related – including the BRSM, Faculty and Society of Occupational Medicine and the VRA: -

"We, the undersigned, will work with government, other healthcare workers, the voluntary sector, employers and trades unions, to promote and develop ways of supporting individuals to achieve the socio-economic and health benefits of work.

This pledge includes a commitment to continue to educate the healthcare community, employers and people of working age about the benefits that work can provide; and, as appropriate, to do all we can to help people enter, stay in or return to work.

Health professionals are relearning to perform an occupational history and to understand the patient's conception of their work difficulties. Although sometimes relating purely to their underlying physical or emotional impairments, often there are complex interactions which may include the relationships between employee and supervisor/manager as well as co-workers, who may or may not be willing to assist their colleague(s).

An important principle is to spot impending health issues before sickness absence becomes an issue. The concept of work instability – 'a state in which the consequences of a mismatch between an individual's functional abilities and the demands of his or her job can threaten continuing employment if not resolved' – evolved in Leeds and is important for job retention.

In the field of spinal pain, obstacles to employment have been described using a flag system with blue and black flags suggesting workplace obstacles whilst yellow and orange flags suggest personal or psychological issues. Health professionals need to be able to elucidate the nature of the difficulties in (re)employment, place them in an appropriate health context, and refer on to appropriate VR or occupational health providers. The critical issue for health professional to remember is that most individuals with even severe health problems can contribute to society via work given adequate rehabilitation and support. It is therefore critical that health professionals do not close the door on future employment prospects through unprepared remarks. Advice to remain in contact with an employer and not to make precipitate judgments about future employability is crucial.

Job preparation for young adults is essentially part of the transitional process and needs to be part of a carefully co-ordinated approach to adult life. Whilst optimising education is often the key to employment for those with physical limitations, other important considerations include the attainment of independent living (with or without the need for personal assistance) and exposure to appropriate vocational opportunities and role models.

It can thus be seen that effective VR involves not only the understanding by health professionals of the importance and relevance of the education-health-work interface, but that resolving these issues requires a collaborative approach between the government agencies noted above, the health professionals, the individual involved and their (potential) employer (including the important relationships between employee, supervisor and co-workers).

The final partner in the VR process may be the voluntary of charitable sector. For example, the concept of 'Disability Leave' was developed in the 1990s by the Royal National Institute for the Blind. Sometimes there are effective collaborations between health professionals and those groups that represent 'patients'. Thus the Arthritis and Musculoskeletal Alliance (ARMA) has adopted 'standards' for the management of a whole range of musculoskeletal conditions that require health professionals to support their patients in their working lives.

The need for the development of a professional base for VR in the UK was recognised by the development of the National Vocational Rehabilitation Association in the UK in 1992. This has now developed into an association with nearly 300 members, from a wide variety of professional and other backgrounds, and is now known as the VRA. It has developed its scope and standards of practice that should drive up standards within the UK.

Co-ordination of these education, employment, health and social roles may be complex and thus the role of case manager has developed in the UK rather later than in many countries. The Case Management Association of the UK has developed since 2001 and now has a wide multiprofessional membership. The need for case management is observed most keenly after accidents when the roles of the legal profession and insurance companies add additional complications in adjusting to accidents or injuries.

Although it is seen as good practice for employers to keep in touch with employees whenever there is an episode of sickness absence, employees should also remain in touch with their employers. When the worker has been open with their employer in relation to their health condition(s), then the Disability Discrimination Act (DDA) applies and the employer is required to make 'reasonable adjustments' to their work. These include adaptations to premises, internal transfer to fill an existing vacancy, altering hours at work, providing training, providing specialist equipment or modifying existing equipment. Thus those assisting disadvantaged individuals to find, retain or regain work have to understand the 'top-down' approaches as well as the collaborative needs of 'bottom-up' VR.

For those who have lost their jobs and wish to re-enter the job market, assessment will wish to establish the patient's educational background, transferable skills, hobbies that might generate a wage and the potential of working from home. Many will need help in updating their CV and advice on training opportunities (e.g. in information technology skills). There are many companies that provide assistance of this kind and employment officials from the government's JobcentrePlus are able to give advice.

Although many professional people from a variety of backgrounds (often health) give assistance to disadvantaged individuals, the UK has now come to realise that VR is a highly sophisticated series of processes that requires close interdepartmental collaboration within government, and close working relationships between health and employment professionals, clients/patients and their employers.

The UK is rapidly redeveloping its vocational rehabilitation facilities through a combination of government initiatives and the development of professional practice.

References

British Society of Rehabilitation Medicine. *Vocational Rehabilitation - the way forward: Report of a Working Party (Chair Frank AO).* London: British Society of Rehabilitation Medicine, 2000

Vocational Rehabilitation Association. *Vocational rehabilitation standards of practice.* Vocational Rehabilitation Association: Glasgow, 2007

Dame Carol Black. *Working for a healthier tomorrow.* London: TSO, 2008