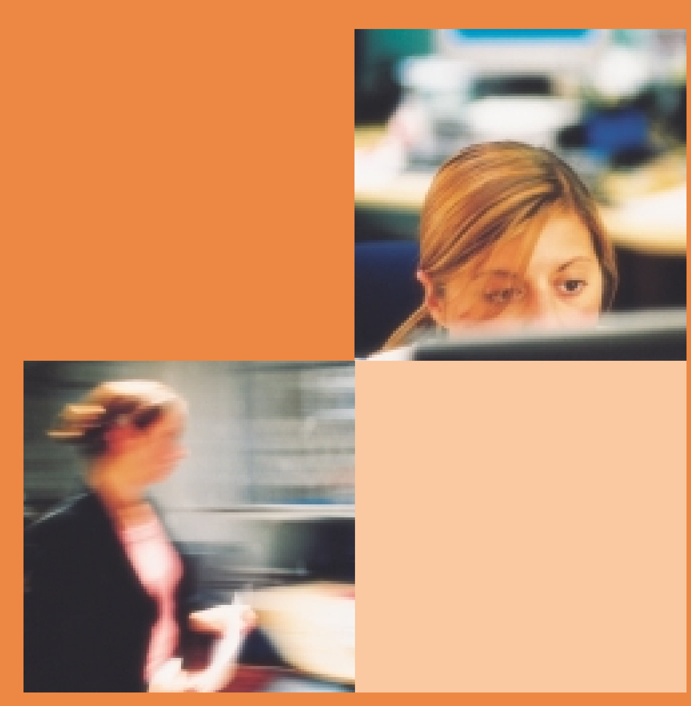
Establishing A Framework For Vocational Rehabilitation

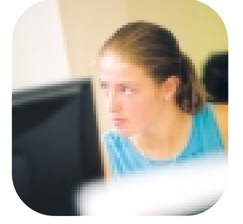


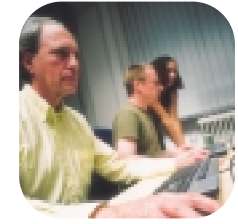
Ingeus Ltd is pleased to offer the following contribution as a response to the consultation paper on developing a Framework for Vocational Rehabilitation, published by Andrew Smith, the Secretary of State for Work and Pensions in May 2004. We have sought to answer the questions posed by the consultation exercise through the use of our experience of delivering services to people on both active and inactive benefits. We do this in the UK through our New Deal, Employment Zone and New Deal for Disabled People programmes. Our approach to vocational rehabilitation has been developed through synthesising knowledge and experience from both the UK and Australia, where we have our origins in injury management.[1] We hope that through contributing to the debate we will both continue to challenge and enhance our methodology, and promote the development of a more integrated, holistic service to all those who are socially excluded by worklessness.

Specifically we suggest the following:

- A barrier-led approach is counter productive. Working with individuals to achieve their goals provides a more effective solution-orientated focus. Health is just one of a number of issues which need to be addressed during the transition to employment;
- A concurrent, holistic approach is more efficient than a sequential process in which interventions occur in isolation. GPs, other health and employment services need to be effectively integrated in order to ensure the greatest benefit for the client;
- 'Incapacity' can fluctuate and transform – structures need to be responsive both strategically and in the delivery of services;
- An assessment of need should draw together medical and labour market expertise. Ongoing assessment, however informal, ensures that clients' needs continue to be met;
- Activity is central to our approach. Employment-related in focus, activity needs to occur alongside, and be integrated with, rehabilitation provision;
- Employers and GPs should be engaged throughout this process;
- The financial consequences of a vocational rehabilitation approach require a review of the current contracting processes – both in terms of size and length. A detailed cost-benefit analysis should involve the assessment of not only the expense of maintaining the current population on benefits, but also the associated financial, social, emotional and opportunity costs.

1 These services are delivered through Inergise, part of the Ingeus Group. More information about the Group is included at the end of this paper.





Defining Vocational Rehabilitation

Question1: Does the description of vocational rehabilitation correspond to your understanding and/or practice of vocational rehabilitation?

The description of vocational rehabilitation used in the consultation paper corresponds in broad terms to common usage throughout the UK. However, we suggest it is helpful to draw a further distinction between vocational and occupational rehabilitation.

The terminology of our Australian company, Inergise, provides us with the following definitions:

> **Occupational rehabilitation** is the restoration of injured, ill and disabled workers to the fullest physical, psychological, social, vocational and economic functioning of which they are capable, consistent with pre-injury status. It is a managed process aimed at maintaining injured or ill workers in, or returning them to, suitable employment.[2] Key to the distinction between occupational and vocational rehabilitation is that the person accessing the former is usually still in employment. This includes those people on Statutory Sick Pay (SSP).
>
> Occupational rehabilitation is a central component of the Australian approach to working with people with ill health, injuries and disabilities. There are systemic differences between the UK and Australia; some of these are highlighted in our response to the Pathways to Work Green Paper. Occupational rehabilitation in the UK may occur as part of an insurance package, be organised directly by the employer, or may be delivered by a local programme, of which the Job Retention and Rehabilitation Pilot (JRRP) is an example. However, more often than not, occupational rehabilitation in this form does not currently occur in the UK.

2 Inergise work to a 'hierarchy of goals', from which a suitable rehabilitation objective is identified, following a holistic assessment. The 'hierarchy of goals' reads: • Return to pre-injury job, same employer, full pre-injury hours • Return to pre-injury job, same employer, reduced hours • Return to alternate job, same employer, full pre-injury hours • Return to alternate job, same employer, reduced hours • Return to an alternate job with a new employer • A non-vocational outcome

Vocational rehabilitation is focused on supporting people who are out of work to return to the labour market. It is targeted at those people who are no longer eligible for SSP and therefore likely to be on an Incapacity Benefit. As a result, vocational rehabilitation is likely to consist of a more complex programme necessitating a wider variety of interventions, potentially over a more extended period of time. In common with occupational rehabilitation, there is a requirement for a multi-disciplinary team, combining both medical and employment expertise. In Australia the Inergise teams include occupational therapists, psychologists, rehabilitation counsellors and physiotherapists working closely in conjunction with the treating doctor. A rehabilitation co-ordinator orchestrates the process according to a negotiated rehabilitation plan.

This paper focuses on vocational rehabilitation as described above, and is based on our experience with workless populations living on a variety of benefits in the UK. We will also draw on the expertise and practice of our operations in Australia as appropriate.

Barriers to work

Question2: Have you come across health or disability related barriers to work? Please describe the health or disability related barriers you have come across and to whom they were applicable (e.g. employer or person with a disability)

As a major private sector provider of welfare-to-work services in both the UK and Australia, we work with clients with multiple barriers between them and the achievement of sustainable employment. It is our experience that those clients who are furthest from the labour market, also suffer extreme social exclusion. This is manifested in a number of ways, including psychosocial behaviours. One of the consequences of social exclusion is that, as the label implies, people are less likely to voluntarily access services which could provide support. The ramifications of this are discussed as part of our longer term objectives.

Health and disability related barriers are common amongst the client groups with which we work. However, it is not possible in many cases to disaggregate cause from consequence, or the start of one barrier from the end of another. As we identify in the next section, clients' needs must be met holistically. In fact, unless support is integrated and addresses the full breadth of need, it is unlikely that sustainable solutions will be achieved.

> We work with clients with multiple barriers between them and the achievement of sustainable employment

The health issues and range of disabilities clients face can either be explicit or hidden. They are explicit on NDDP for example, where all clients claim an Incapacity Benefit, or on New Deal when 'Person with Disability' (PWD) markers are in place. However, a number of those on our New Deal and Employment Zone programmes have histories of ill health and, in particular, of mental ill health, but these details are not always recorded or volunteered by the client.

Use of language is important – many people with health issues do not consider themselves to be disabled and do not want to be labelled in such a way. Subsequently it is difficult to assess accurately the proportion of people on mainstream programmes with such issues, although a number of studies have undertaken research in order to do so.

For instance, the National Centre for Social Research (NatCen) suggests that 25% of all participants on mainstream New Deals have a physical impairment or long-term health problem. Their qualitative study also suggests that one in ten participants has a mental health condition.[3] The Institute of Employment Research has identified individuals with a disability as the fastest growing group participating in New Deal 25+. It is estimated that within this age range (25 to retirement), the number of participants with a disability or health condition has increased to one in three. These proportions concur with our estimates based on operational experience. DWP statistics from the Employment Zones (EZs) show that one in five EZ starters have a declared disability. The same set of statistics[4] also shows that you are 25% less likely to move successfully into work from the EZ if you have a disability. Nationally, EZ clients with a PWD marker have a less than one in three chance of moving into work, whilst those without have slightly less than a one in two opportunity of making the same transition.

These figures highlight a central tension in this debate. The current benefits system assumes that you are either actively seeking work, or incapacited from so-doing. Experience suggests that in actuality there is a continuum for many clients that this stark distinction does not recognise. Clients move in and out of 'incapacity', and indeed from one type of 'incapacity' to another. A meaningful response to these clients' needs must reflect this.

Recognising Individual Need

Central to our delivery in all sites is the approach of our specialist and generalist advisors. Their focus is on the needs of each individual on their caseload, supporting and empowering them to progress towards work. The level of difficulty clients with health and disability issues face in returning to work varies widely - some manage the transition with comparative ease, for others the journey is long, difficult and may extend beyond the duration of current provision. Those who are identified as being the most disadvantaged are often those with the most multiple and individualised barriers. People with disabilities and health issues are a heterogeneous group with varying levels of skills, qualifications and experience.[5] It is exactly because of this heterogeneity that it is dangerous to produce a neat set of barriers with accompanying solutions. Indeed, for a number of clients, health issues themselves may not be the key reason they are finding it hard to re-enter the workplace.

Over 40% of those on Incapacity Benefits do not cite health as an obstacle to work. Indeed almost as many of those who say health is a barrier identify a lack of local job opportunities as key to their lack of success.[6] Research undertaken with people living with HIV who joined a return to work programme indicates that clients felt that poor job-search skills and a lack of understanding of the labour market were their biggest barriers; tellingly, this was swiftly followed by a fear of losing benefits. It is interesting that insofar as they were concerned about the barrier presented by their health, the primary issue was stigma, particularly around disclosure.[7]

Health may well be one of a number of issues which need to be addressed during the job-search and return to work process. We would stress, however, that we perceive this process to be concurrent and integrated rather than sequential. The service a client receives should facilitate integration between different aspects of their lives and the different agencies with which they come into contact, rather than provide job broking services in isolation from other interventions.

3 New Deal for Long-Term Unemployed People: Findings from a Qualitative Study (2000), Molloy & Ritchie, Employment Service, Research & Development Report ESR60
4 These cover the period from April 2000 (programme start) to March 2004
5 Whilst research has shown that those with higher qualifications find it easier to return to the workplace, we are not aware of any studies that compare re-entry to jobs held previously.
6 Pathways to Work Green Paper
7 Routes into Work: An Evaluation (2003), Griffith & Gordon, Centre for Economic & Social Inclusion

We suggest that success comes from working with each client as an individual, rather than matching pre-selected solutions to identified problems. It is however possible to theme the barriers clients face. For this response we have identified three key categories:

- Employers' Perceptions;
- Clients' Perceptions;
- Structural Barriers.

Employers' Perceptions

Employers have a number of concerns about appointing staff who have been out of the labour market for some time. These typically centre on out-of-date skills, reliability (read unreliability), understanding (or lack of) the business culture and the (in)ability to integrate into a team. These concerns are exacerbated by the potential impact such skills deficits will have on the existing workforce. When clients have multiple barriers, these concerns escalate.

Ill health or disability is just one area of concern. Employers have similar levels of nervousness about employing people who are older (or young and inexperienced), those with criminal records, those with an uneven work history and those with no UK experience, for example. Those clients who combine ill health with a number of other barriers become even more difficult for employers to perceive as someone who will be an effective employee.

Stigma can be a barrier for both client and employer. If the client has an illness that has stigma attached to it, they may be unwilling to discuss the reasons for their employment gaps with potential employers. This can create problems at the start of the process as it may raise questions in the interviewer's mind. Similarly employers may have concerns about introducing staff with stigmatised illnesses into the workplace, unsure of how colleagues will react. This can often be true for clients with mental health issues. Not only are mental illnesses poorly understood, but the perception can be that they will recur in the near future. The side effects of some medications exacerbate the stigma that can be associated with an illness – by stabilising their condition clients can be left with side effects such as facial tics, drowsiness, or a lack of concentration, none of which improve the chances of job success. HIV charities offering return to work support to their clients are aware that one of the biggest issues is that of disclosure, deciding at what stage, if indeed at all, it is appropriate for clients to identify themselves as living with HIV.

It is clear that employers need to be involved in the development and delivery of vocational rehabilitation. If it is to be successful it needs to meet their needs and expectations. It is also essential that injury management services provided to clients have a clear vocational focus. These are issues which will be developed in this paper.

Clients' Perceptions

Clients' concerns about returning to work have a number of different causes. These determine the type of service required in order to re-engage with the labour market. As always there are inherent dangers with producing categories - challenging these barriers in silos will not result in sustainable change. It can be useful to divide the issues clients face into four groups: physical, practical, psychological and social.

Physical barriers can be very real; they can also be exacerbated by ignorance of different labour market opportunities, fear of leaving a comfort zone and lack of access to injury management specialists. Vocational rehabilitation is central to ensuring that the medical support provided has an employment focus. The relationship between the client's GP and other service providers is essential. Too many of our clients arrive believing that they will never work again, because they are physically unable to do the work they used to. There is very little joined up working between organisations delivering health and those delivering employment services. This leaves the client vulnerable and ultimately disempowered.

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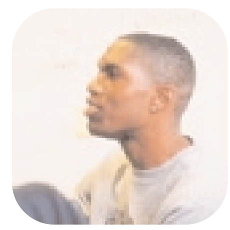
Many of the practical difficulties faced by clients on New Deal and Employment Zones can be addressed through advisor support, access to resources such as the WorkDirections Job Station[8], and discretionary funds. Clients claiming Incapacity Benefits are not always aware of the resources that are available to them through Jobcentre Plus, and may have concerns about the consequences for their benefits should they access them. Support is also available through the New Deal for Disabled People, although access is heavily reliant on proactive self-referral, and there are few firm links with GPs. Early results from the DWP evaluation also suggest that many clients are not aware they have a choice of job broker.

The psychological impact of spending a period of time on an Incapacity Benefit has been well-documented. It is surprising to us that only half of those on health-related benefits are said to describe themselves as lacking self-esteem[9]. The loss of motivation is a primary argument for mandating some form of intervention – regular 'new possibility' interviews for example. We regularly work with clients who worry that they are not worth the attention, and would be extremely unlikely to volunteer for a programme. It can be difficult for those people who feel much of their identity is tied to previous employment to cope with a transition to worklessness. However, once they have established a relationship with their advisor, and perhaps benefited from cognitive behaviour therapy provided by a specialist advisor, the change in their self-esteem, presentation and employability can be dramatic.

8 Supported access to jobsearch and job application resources
9 Pathways to Work Green Paper



We do not seek to suggest that everyone on Incapacity Benefits should be compelled to participate in a full programme. However, we do challenge the current default of inaction, and propose instead periodic interventions, with some exceptions. It should be possible to draw up these exceptions in consultation with GPs and the disability lobby.

It is our experience that in order for vocational rehabilitation interventions to work effectively, the client needs to be both active and willing. This necessitates that any psychological barriers and emotional concerns are identified and worked through from the earliest possible stage. It is essential that psychological issues are dealt with both sensitively and professionally.

Loss of self-esteem can be exacerbated by the labelling that occurs within society, and within the welfare system itself. Many people with health issues do not consider themselves to be disabled and so do not perceive programmes such as NDDP to be directed at them. The Pathways to Work Green Paper identifies that the title 'Incapacity Benefit' is itself unhelpful[10] and this paper notes that the changeable nature of ill health is not accounted for by the current system.

Family and peer networks are important factors in determining whether a return to work will be successful. Research into social capital continues to demonstrate that those who are surrounded by workers - in their families, in their friendship groups, and in their communities, are more likely to work, and more likely to transition easily between jobs.[11] It can be the case that for some individuals there is little familial support for a return to work, or alternatively, as we have experienced in Birmingham, as one family member successfully starts work, siblings and parents join the programme so that they too can benefit. It is important that the advisor has an understanding of the clients' social context and how this will contribute to their search for work.

Structural Barriers

The current system has endemic barriers. As has been noted, health and employment have hitherto been regarded as separate entities, with very little crossover between departments at either strategic or delivery level. This results in medical interventions that are rarely integrated with employment approaches, and vice versa. WorkDirections' NDDP operations in Birmingham offer clients a holistic and integrated service providing access to on-site physiotherapist, psychologist and cognitive behaviour therapist support, in addition to the team of advisors working to identify suitable career paths and job opportunities. This approach is, however, both expensive at the front end of delivery (though not in terms of sustainable outcomes) and unique on this scale. The funding provided for most NDDPs means they can offer little other than supported jobsearch, and the size of the contracts means many providers are not able to invest in such an infrastructure. This failure to integrate sufficient medical and employment support must be a key contributing factor to the low employment outcomes associated with NDDP

10 WorkDirections have suggested Additional Support Allowances (ASA) as a more appropriate title, and one which has a thematic resonance with JobSeekers Allowance (JSA)

11 See for example, Putnam, R Bowling Alone (2000); Hall 'Social Capital in Britain' in British Journal of Political Science (1999: 29(3)); The Henley Centre The Responsibility Gap (2004)

nationally. Indeed, they are significantly lower than pilots working with similar client groups that have closely aligned medical and employment provision – of which the Salford Back Programme[12] and Rehab UK[13] (working with clients with severe brain injuries) are good examples. This lack of integration has been regularly identified, and is prominent in the critiques of vocational rehabilitation made by medical experts.[14]

These issues are compounded by the contracting arrangements made to deliver services. The NDDP delivered by WorkDirections in Birmingham is a comparatively large contract (up to 2,700 people), yet we would argue it is still too small. Indeed, even when the full potential caseloads of all Job Brokers in the area are combined, fewer than 10% of the population on Incapacity Benefits in that city could potentially receive support. The length of contracts (two years in this example) also discourages investment in infrastructure, as capital costs have to be off-set against a short timeframe. It is possible for WorkDirections to invest in a holistic service because the programme can share delivery space with the Employment Zone, which we also deliver in Birmingham. It would not be financially viable to deliver an integrated service, such as the one we are proposing, unless this was the case. In order to deliver the services that research demonstrates the majority of these clients require in order to return to work, contractors need to be provided with a critical mass of clients, and a length of contract which encourages investment.

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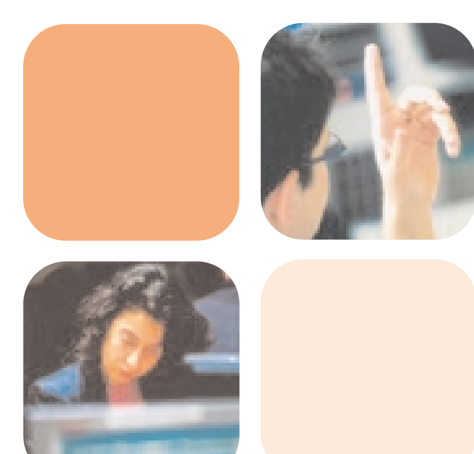
The benefits' structure helps to create psychological barriers for the clients. The distinction between Incapacity Benefit and JobSeekers Allowance is all too clear - there is no middle ground, people are either 'incapacitated' or they are well and able to work. Incapacity Benefit was not originally conceived as a continuum and is not used as such - recipients have no sense of being on a journey back to health and work. The lack of a transition phase means the move from 'incapacity' to 'job readiness' is not phased, and generally has little, if any, accompanying support. It also does not acknowledge that people move in and out of, and indeed between, different types of incapacity.

Some structural barriers are based on incorrect perceptions. For example, there is a lack of knowledge about the 52-week linking rule. Many clients on Incapacity Benefits are concerned about losing their (sometimes significant) entitlements should their forays into the world of work be unsuccessful. This fear acts as a deterrent to clients at every stage of the jobsearch process. There is opportunity to improve significantly the linking system, by guaranteeing that those leaving Incapacity Benefits can return to it at the same rate. This would have negligible financial ramifications (claimants are currently on IB for an average of eight years, and their most likely destination is retirement) but could provide a potentially significant motivational impact.

12 From Back Pain to Work (2002), Watson, Salford Royal Hospitals Trust & Jobcentre Plus
13 www.rehabuk.org
14 See British Society of Rehabilitation Medicine Working Party Report (2003); 'The decline of Rehabilitation Services and its Impact on Disability Benefits' in Journal of the Royal Society of Medicine (95); 'Vocational Rehabilitation' in Journal of the Royal Society of Medicine (96); 'Vocational Rehabilitation' in BMJ (323)



Approaches

Question 3: From your experiences of vocational rehabilitation which approaches work best and which work less well and for whom?

As has been identified, 40% of clients claiming an Incapacity Benefit do not perceive their health issues to be the primary barrier to returning to work.[15] This raises two important questions: how do we assess what the needs of clients are; and how do we meet the challenge for those clients who require a vocational rehabilitation approach? Our experience of vocational rehabilitation in the UK is necessarily limited by the fragmented services that are currently available. We are, however, able to comment on the approaches we have to working with people with health issues who are claiming Jobseekers Allowance (JSA) through our New Deal and Employment Zone delivery, in addition to our experience of working with people on Incapacity Benefits on our New Deal for Disabled People (NDDP) in Birmingham. These include interventions by skilled employment consultants, occupational psychologists, cognitive behaviour therapists, and in Birmingham, physiotherapists and psychologists. It should be noted that the NDDP is a new programme for us; we have been delivering services from our New Street site since April 2004.

We are in the process of undertaking a year-long action research project which will operate alongside our NDDP programme. We will use the results of our research to inform the development of NDDP Birmingham as well as our work with clients with health issues on mainstream programmes. We will be happy to share our findings more widely in order to continue the debate and extend our understanding of which approaches work best for clients.

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Our experience in Australia also provides an interesting comparison in terms of an approach to occupational rehabilitation. Of particular interest is the case management approach, the need for this in the UK has been identified by Dr Mike Floyd as widely recognised. He also highlights a lack of clarity about how this can be achieved in UK vocational rehabilitation approaches.[16] This is echoed in the British Society of

15 Pathways to Work Green Paper
16 See paper prepared for IPPR seminar, 2002

Rehabilitation Medicine report, which identifies Australian experience as a compelling argument to develop the concept more widely in the UK.[17] In both papers, case management is presented as a method of better co-ordinating the delivery of health and employment focused services.

We have identified four key areas in which determining the right approach is essential:

- Programme structure;
- Assessment of need;
- Activity and transition;
- Managing the return to work and sustainability.

Programme Structure

A holistic approach is essential for sustainable results. The integration of a number of services and the delivery of them concurrently facilitates effective management of the return to work process. Barriers individuals face have to be approached in the context of their broader life and employment goals. The current lack of service integration has been discussed. The benefits of providing a holistic and integrated service have only been shown to date through small condition-specific pilots. We aim to provide an individual-specific response. We deliver services through a combination of one-to-one and group work, accessing highly specialised support as required. Our goal is holistic professionalism.

Assessment of need

Research undertaken in Australia demonstrated that only 30% of workers required formal occupational rehabilitation in order to return to work.[18] Whilst there are significant client and systemic differences, this is a useful reminder that not all benefit claimants will require the same level of support. It is essential that an initial assessment of need is undertaken in order that tailored support can be provided. This should not be a 'one-off'; ongoing assessment, however informal, needs to occur in order to ensure that clients' needs continue to be met and to account for the fluctuating nature of much incapacity. We do not register clients onto our NDDP programme until we have completed a 'Back to Work Plan' in partnership with them. This can be done in a single appointment with some clients; others take longer. There is no benefit to the client in registering them for a programme for which they are not yet ready. This initial process is integral to our approach; undertaking a professional assessment takes time, and perhaps requires the involvement of a physiological or psychological professional, but ensures that we are able to deliver a service that is tailored to meet the needs and timescales of the individual. We are also aware that the National Centre for Social Research (NatCen) are designing an assessment tool to help determine the level of support required by individuals as part of their evaluation of the Pathways to Work pilots, and we look forward to further detail.

Activity and transition

Activity is central to our approach. As discussed earlier, we believe that much of the loss of self-esteem that accompanies long periods on benefits can be halted and counteracted through engagement in programmes. The transition clients need to make, both mentally

17 Vocational Rehabilitation: The Way Forward, (2nd Edition: 2003) Working Party Report, British Society of Rehabilitation Medicine
18 'Vocational Rehabilitation' in BMJ (323)

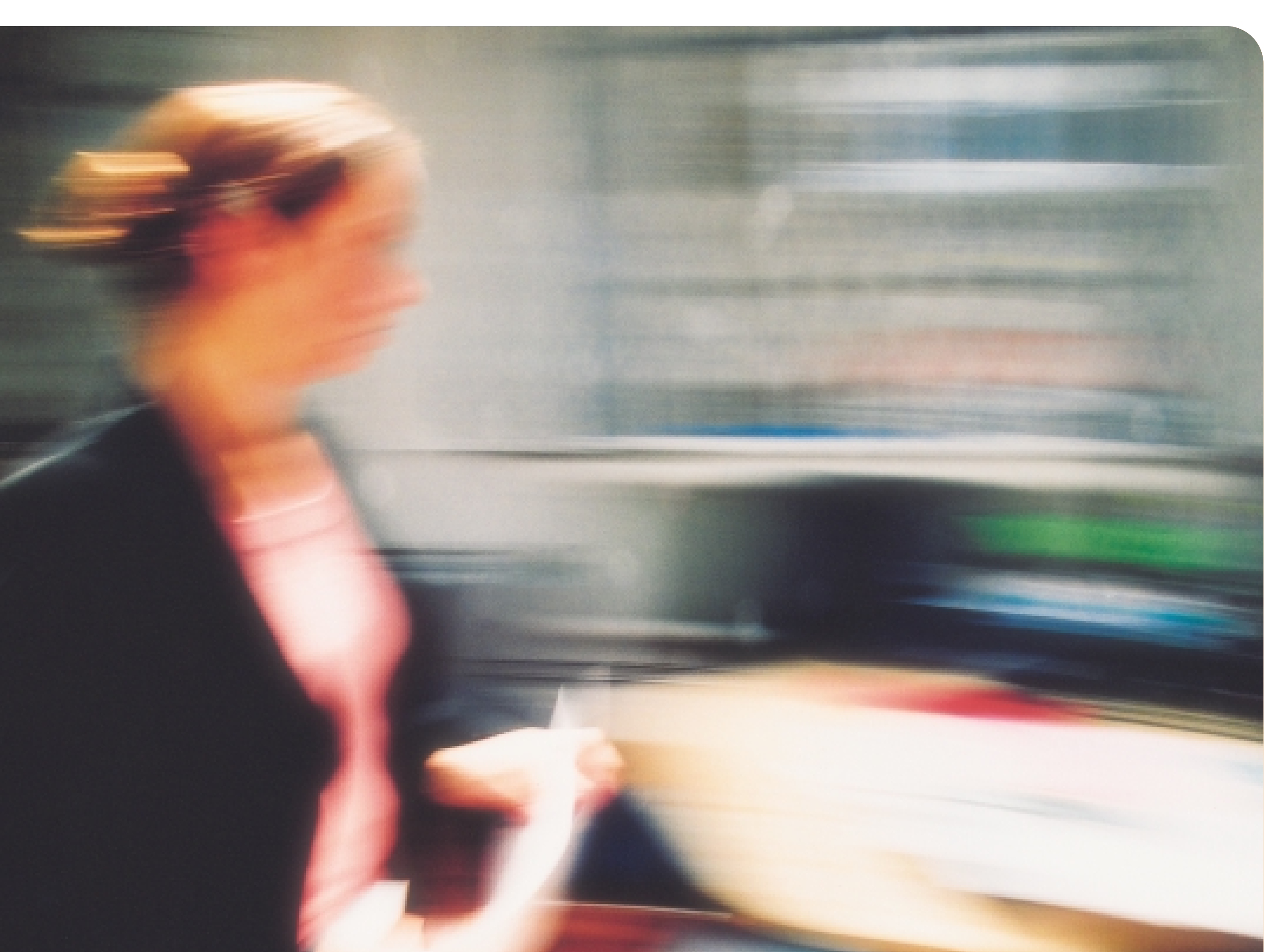
and physically, needs to be supported. It is important that goals are set in partnership with the client, rather than imposed on them. Some clients will manage the transition with relative ease; for others the process will be longer, and the provision needs to reflect this.

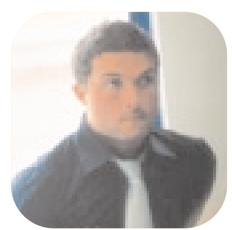
Some people who have been out of the workforce, and claiming inactive benefits for a significant period of time need a period of transition. This should lead into employment-related activity during which there is a gradual increase of support and services. This provides a space for people's fears about returning to work to be identified, and steps to enable the client to move forward to be developed. This requires the provision of practical information, emotional support and goal setting/action planning. This needs to occur in tandem with rehabilitation provision.

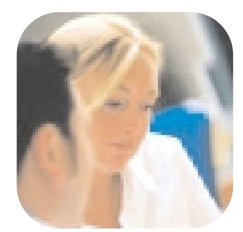
Managing the return to work and sustainability

We use reverse marketing techniques - marketing for vacancies that match the specific, individual requirements of our caseloaded clients. Those accessing our services have a much higher chance of success when placed into work they want to do and can see progression within. Identifying appropriate employers and understanding the environments in which clients are most likely to stay, and thrive, are essential and require a skilled, professional advisor. Research undertaken by Dr Robert Grove also highlights the importance of a good job match, and satisfaction once in work, in ensuring sustainability of outcomes.[19] The return to work process, in common with the earlier transition from inactivity to activity, needs to be a partnership between health and employment specialists. Continuing health interventions help clients to perceive their journey as one of many phases, rather than a giant leap. They also actively demonstrate the importance of a holistic approach throughout the process.

19 From 'The Psychology of Worklessness', a presentation delivered at the launch of the UnumProvident Centre for Psychosocial and Disability Research at the University of Cardiff, 1 July 2004







Long-Term Objectives

Question 4: What are your longer-term objectives for vocational rehabilitation, and what can Government do to help you deliver your objectives?

Ingeus UK have identified five key long-term objectives for the delivery of vocational rehabilitation. These are:

- A cost-benefit analysis to assess the real cost of supporting a significant number of people on inactive benefits;
- Integration of relevant health services into mainstream employment provision;
- Increasing the requirement for activity for people on inactive benefits;
- Improving the professionalism of both employment and rehabilitation services;
- Developing improved links with employers - engaging them in the process of design and research.

Full Cost-Benefit Analysis

Many of the suggestions, recommendations and ideas associated with vocational rehabilitation have a high unit cost. The difficulties involved in delivering this level of service without a critical mass of clients and a contract of substantial length have already been discussed. Our model for the New Deal for Disabled People in Birmingham is viable because it is co-located with another programme and can share capital costs. The cost of maintaining such a large population on benefits is estimated to be over £16 billion per year. The additional financial and associated social, emotional and opportunity costs are currently not adequately quantified, but are equally significant. If a vocational rehabilitation service that builds from a comprehensive assessment, and directs activity

towards need, is to be provided, then the costs will necessarily be higher than simply providing an employment programme with more one-to-one support. We would argue that the return will clearly justify the expenditure. Indeed, as the British Society of Rehabilitation Medicine working group report identifies, international experience shows that financial benefits do not occur until the second or third years of such programmes. A cost-benefit analysis is being undertaken as part of the Pathways to Work evaluation; however these pilots are focusing on the flow of new claimants, rather than the stock. A full cost-benefit analysis needs to be undertaken in order to understand better the resource opportunities that exist to develop a holistic, professional response.

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Integrating Services

There is currently a lack of integration, indeed co-ordination, between health and employment services. An integrated approach which addresses issues concurrently rather than sequentially needs to be spearheaded and championed. This may require a review of current contracting regimes in order to better facilitate a joined up approach. Current referral and access mechanisms could be much improved for all stakeholders by creatively addressing the ways in which services are presently purchased and combined.

There are significant numbers of clients currently claiming JSA and accessing mainstream services who require integrated rehabilitation and vocational support. These people currently either fail to engage with the programme, or engage but are unsuccessful in finding work within the timescales of the programme. Some are unable to cope with the increased levels of activity demanded by the programmes and leave JSA for Incapacity Benefits. We have found that providing Cognitive Behaviour Therapy to our clients has helped many of those who would be considered amongst the most disadvantaged move closer to the labour market. The increased cost of this level of service needs to be measured against the costs of New Deal and Employment Zone returners. It needs to be established to what extent the numbers of returners could be decreased if the interventions they receive initially are more effectively tailored to their needs.

GPs need to be involved in this process. They are fundamental in terms of the primary care services they provide, their ability to refer to specialists and their role as issuers of sick notes. Current structures do not facilitate integration; it can be difficult for GPs with limited time to find out about available vocational services that they could refer patients to. It is essential to understand how GPs can best function within a vocational rehabilitation framework.

Activity not Incapacity

There is a danger that mandating vulnerable clients to programmes can exacerbate existing social inclusion. Working towards employment is more likely to be successful when the client is engaged, empowered and feels in control. However, this needs to be balanced against a background of long-term non-intervention, and clients who are de-motivated and depressed. This should not result in a punitive approach, but rather the provision of regular opportunities for clients to access advice about work, additional support and specific employment possibilities. Currently NDDP providers do not have direct access to client lists; not only could marketing costs be better directed if such access were permitted, but all those eligible to take advantage of this additional support would have the opportunity to find out about the services available.

We would argue that any increase in the level of ‘responsibility’ needs to be met with an increase in ‘rights’, including sufficient financial incentives such as the Return to Work credit, and an immediate entitlement to return to previous levels of benefits if work becomes difficult once again. The costs of such guarantees need to be measured against the ongoing expense of maintaining a significant population on Incapacity Benefits until retirement. This highlights the need for a full cost-benefit analysis.

Professionalism

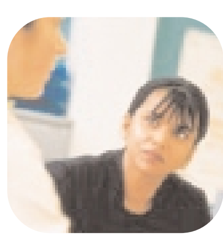
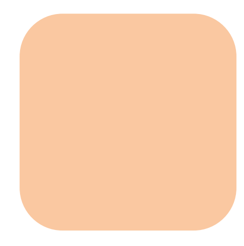
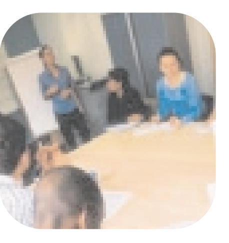
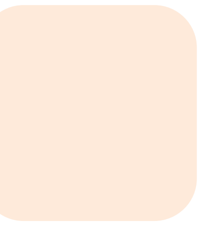
Professionalism is integral to the delivery of a high quality service. The arguments behind developing a new delivery model for both occupational and vocational rehabilitation are based on the recognition that both medical and employment expertise are required to deliver an effective, sustainable service to those people who are furthest from the labour market. This workforce needs to be selected, developed and empowered. The findings from the 2003 British Society of Rehabilitation Medicine report support this move. Their recommendations include the development of an agreed national framework; the undertaking of training programmes through universities and colleges in order to promote multi-professional research; and increasing awareness of the importance of employment to good health.

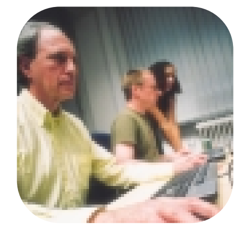
Improving links with employers

Employers should have much to offer this process, both in terms of providing work ‘conditioning’ programmes, and through identifying the key barriers they perceive when people who have been away from work with health issues return to the workforce. Work conditioning facilitates the return to work after any length of time away from the workplace. The employee gradually increases the frequency and length of work attendance over an agreed period of time. Up to this point they are unpaid. The goal is that this will then become a permanent, paid, role. Should that not happen, the client still has a much better understanding of what their work capabilities are, and a recent work reference which will aid their search for future employment.

Concluding Thoughts

The vocational rehabilitation approach has much to offer many of those people who are out of work with health problems. It should not, however, become a blanket approach. The needs of the individual must drive the design of the support required. Advisors need to be equipped and empowered to utilise vocational rehabilitation assessments and create action plans to support a transition to employment. This should involve the use of additional specialised support as appropriate. The integration of health and employment expertise and services at both strategic and operational levels is essential. Thought needs to be given to the most effective delivery model for this. Developing a holistic model also presents an opportunity to review the terminology currently used in this field. As has been identified, labelling is extremely important and the use of terms such as ‘incapacity’ and ‘New Deal for Disabled People’ run counter to the desire to create social inclusion and a more integrated service.



WorkDirections UK

WorkDirections UK is part of the Ingeus Group, supporting businesses with integrated human resource solutions, and providing governments with effective, accountable employment-focused welfare services. The group now employs around 850 people and delivers related services through subsidiaries in the UK and Australia:

- WorkDirections UK delivers innovative welfare-to-work services for people who are long-term unemployed on the Private Sector Led New Deal in Central and West London and the Employment Zone in Nottingham. New offices opened in 2004 for Employment Zone delivery in Birmingham, Brent, Haringey and Southwark. In April 2004 we also opened the New Deal for Disabled People service for clients in Birmingham;
- WorkDirections Australia provides employment services, as part of the Job Network, and supports individuals on initiatives such as the Personal Support Programme and Transition to Work. In 2000 WorkDirections became Australia's fourth-largest provider of Intensive Assistance. In 2003 WorkDirections was awarded 31 new welfare-to-work contracts across Australia;
- Inergise provides pro-active, outcome-focused Corporate Health services, in particular: injury management, injury prevention, rehabilitation programmes, occupational health and safety and related training;
- Clements provides recruitment services in: labour hire, office and administration (permanent and temporary), technology, corporate and executive;
- Invisage provides management training, IT training, accredited vocational training and traineeships.

WorkDirections is able to commit to performance with integrity as a result of:

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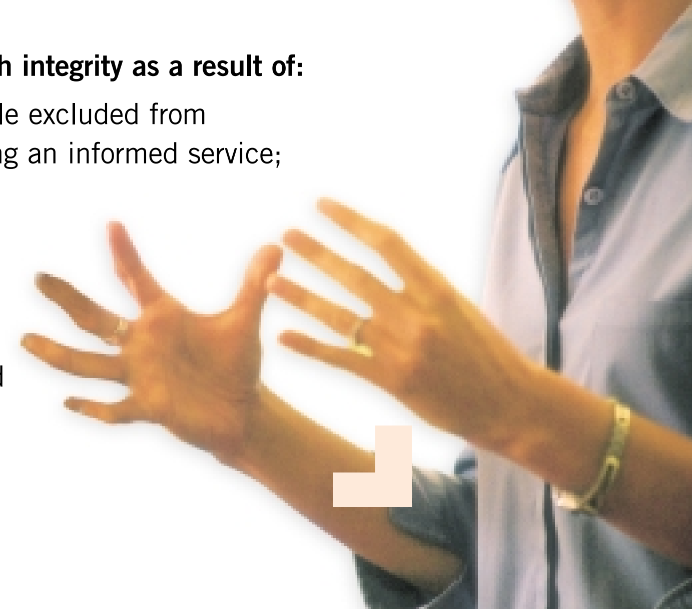
- A unique approach to our staff, with a depth of professionalism that gives us the skills to deliver;
- A delivery model, and associated processes, bringing together best industry practice;
- Premises and resources that empower their users and facilitate the move back to sustainable employment.



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