Vocational rehabilitation: a complementary service

Professor Michael O'Donnell and **Joy Reymond** explain how to get the most out of vocational rehabilitation.

Occupational health (OH) has a long history of protecting employees from exposure to hazardous conditions and substances at work, and helping those who do become ill to remain in, or return to work, whether or not their problems were work-related.

Given the hazards often faced by people at work, employers wanted the reassurance that their staff had been medically assessed and found to be fit for work, before they let injured employees back to work. This model has worked extremely well in traditional industries where hazards could be identified and controlled, and it was relatively obvious how any disability would affect the employee's ability to carry out their occupation. However, while the relationship between work and health has been easily identifiable in the past, at times it has only been evident to those with a medical degree – for example, the issue of asbestos exposure.

Looking back 30 years, considerations for ill-health early retirement [1] were not a frequent part of an OH practitioner's work, although this has become more common in recent years.

Changing times

The changes in population disease incidence and prevalence have driven changes in the population that the OH physician or nurse is now treating or managing. Many more people recover from heart disease and cancer and can live productive lives, presumably including a return to work.

A generation ago the most common disability was musculoskeletal, but in recent years its prevalence as a cause of long-term incapacity has declined, along with improvements in the medical treatment of such disorders, again leading to a greater likelihood of return to work. At the same time, there have been significant increases in less medically severe/defined disorders, such as mental ill-health.

While distressing to the individual con-

cerned, these disorders are less likely to be life-threatening or visibly disabling, and therefore OH practitioners are less able to rely on a traditional medical and hazard assessment model to assist the individuals to remain in or return to work.

A breakdown by diagnosis of 2008 group income protection claims, at corporate insurer Unum, provides a useful snapshot of the frequency of each of the major long-term conditions suffered by clients' employees.

Although the world of work has changed, some OH traditions have remained. One legacy of this 'older world' is seen where employers and doctors still engage in correspondence about an employee's fitness to work, rather than focusing on what will really help the employee to get back to work.

In this changing environment, OH practitioners also face questions about conflict of interest: are they there to treat employees, advocate for them, or to provide advice? And if they are providing advice to the employer, does this create a further conflict as to who is their client? Waddell and Burton[2] have convincingly shown that stable, secure employment is beneficial for health, and this shows that the interests of employers and staff should usually coincide.

So what employers and employees need has changed, and different skills are needed for this different world.

Challenges

To deal with the challenges of today, the OH professional needs not only medical knowledge, but also skills in more traditionally HR-related areas such as communication, negotiation, mediation, industrial relations management and, in some instances, general diplomacy. Traditional OH training has tended to focus on areas such as health promotion (and illness prevention), health screening, toxicology, occupational hygiene, and assessing fitness for work. These are all still important skills (for instance, occupational asthma remains an important industrial health issue in some industries). However, when it comes to dealing with someone who feels that work is affecting their mental health, the OH practitioner may find that their training has not prepared them to manage this effectively.

The current consensus is that the medical model is no longer appropriate for use in the workplace, and that the bio-psychosocial model of disability provides a better explanation for how people become and remain incapacitated by common health problems.

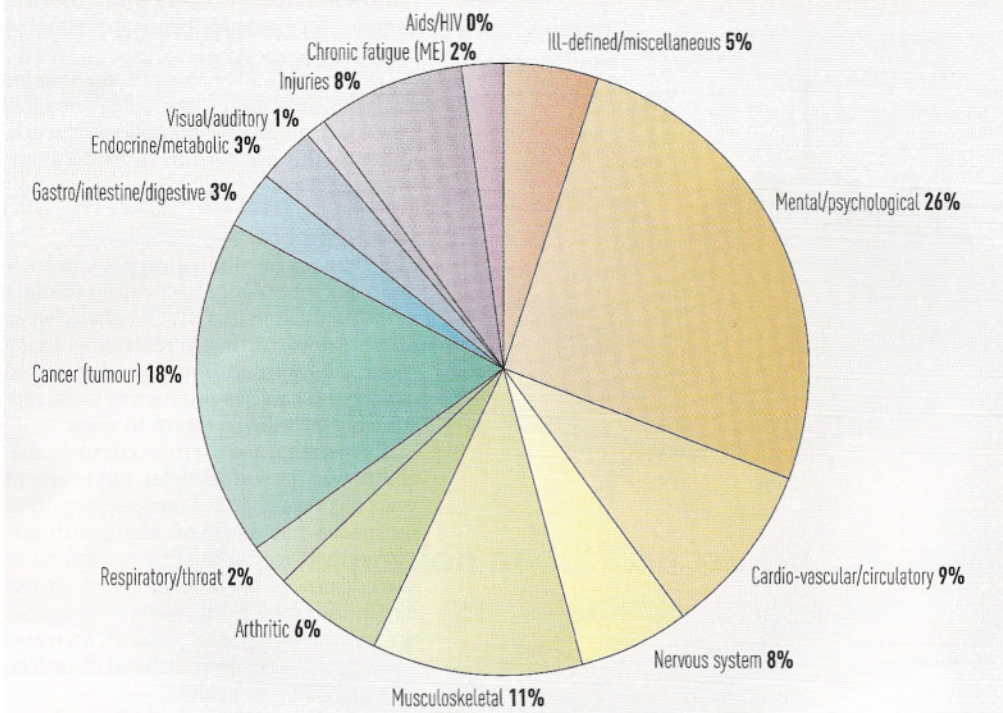
The key feature of this model is that it explains why people can be affected in different ways by apparently similar problems. We know, for instance, that a belief that work has caused a health problem can be associated with poor outcomes. Additionally, overcautious medical advice to avoid work can lead to adverse outcomes.

Many other factors – upbringing, attitude of employers, personality – all play a part in how people perceive and react to health problems. This is true not just of people with common health problems, but also those with serious and well-defined illnesses, such as cancer and arthritis.

So what we really need to look at in OH is the ability to understand these influences, engage positively with the individuals and their employers, and motivate them both towards less harmful outcomes.

These skills are not necessarily the sole province of traditional health practitioners such as doctors and nurses. With this in mind, a new approach to managing work and health is needed, and OH practitioners need to look for support to deliver a fully effective service to their clients.

REASONS FOR INCOME PROTECTION CLAIMS AT UNUM, 2008



Complementary therapy

Occupational health and vocational rehabilitation can be complementary. Some people see occupational medicine and vocational rehabilitation (VR) as competitors, but this view is potentially harmful to both professions. In reality, the deep knowledge of occupational medicine comes at a heavy cost, and may be excessive for the kinds of problems that most people present with in the workplace. There are only 700 fully qualified OH consultants in the UK, and it is hard to recruit and retain fully qualified OH nurses to serve the current demand.

Additional resources are unlikely to become available from the medical and nursing arena, so if OH is to respond to the ever-increasing demand for its services, it needs to look for alternative solutions. OH needs to be a broader church, and be more inclusive of related disciplines and professions which can bring a wider range of skills to the table.

One such discipline, which is on the rise in the UK, is vocational rehabilitation (VR). From the perspective of the insurance industry, developing a complementary rather than a competitive relationship with VR may be the solution.

Vocational rehabilitation

So what has VR to offer in the workplace?

Unlike medicine, VR is not a defined and regulated discipline, and can be almost as varied as the number of people practising it. This may explain the uncertainty that many people feel when considering whether they should be using a VR practitioner.

VR does, however, have a long history, and until the 1980s was a prominent aspect of the UK's health and welfare system. In other western countries, typically those with prominent workers' compensation systems, it has continued to flourish as a powerful means of restoring people to work and health. In Australia it is a recognised profession with university training and a balance of private- and public-sector practitioners.

Until recently the UK did not have a significant population of home-grown VR practitioners, with most professionals coming from North America and the Antipodes, but it is starting to experience a renaissance here, as evidenced by the recent development of standards (see 'On the mend', *Occupational Health*, July 2009), and the introduction of training programmes and qualifications.

The Vocational Rehabilitation Association (VRA) has provided a very helpful definition for the profession. VR is: "a process of facilitation, grounded by a belief in the dignity and worth of all people, designed to assist people with impairments or health conditions to secure employment and to integrate into the community. The process is interdisciplinary by nature, and may involve functional, bio-psychosocial, behavioural and/or vocational interventions".

To help further define the work of its members, the VRA has also clarified the scope of practice for the profession, and has produced a non-exhaustive list of activities which come under the general heading of VR. The techniques utilised within this pro-

cess may include, but are not limited to:

- assessment and appraisal
- goal setting and intervention planning
- provision of health advice and promotion, in support of returning to work
- support for self-management of health conditions
- career (vocational) counselling
- individual and group counselling focused on facilitating adjustments to the medical and psychosocial impact of disability
- case management, referral, and service co-ordination
- programme evaluation and research
- interventions to remove environmental, employment, and attitudinal obstacles
- consultation services among multiple parties and regulatory systems
- job analysis, job development, and placement services, including assistance with employment and job accommodations
- the provision of consultation about and access to rehabilitation technology.

Overlap and contrasts

The vast nature of the field of VR means that there will be some overlap with other professional bodies and their scopes of practice, and clearly this includes OH as currently provided.

Rather than seeing this as a threat, in general, we find that OH and VR work best together when they recognise one another's strengths. We see immense opportunities for OH to make effective use of VR to improve their overall outcomes.[3] While there is great variation in OH practice, and it may be unfair to many practitioners, there are some characteristics of OH provision which appear repeatedly in the workplace. Employers worry about the cost of prolonged and in-depth involvement and, as a result, OH intervention is typically brief (30 minutes or less per consultation). Much of it is carried out in writing with a focus on medical issues as they relate to fitness to work, with some guidance on workplace adjustments. In some cases these requirements also constrain the OH practitioner's ability to assist the employer to meet their obligations under the Disability Discrimination Act. Another issue is that OH professionals often find that the barriers to work in addition to the initial presenting health problem are non-medical: for example, work relationships, travel to work issues, personal or family difficulties.

In contrast, VR practitioners typically work at length with clients in the field, and much of their work is done in person. Ideally they will focus on assessment, fact-finding, support, problem-solving, negotiation, mediation and clear communication between the various parties, in addition to finding the appropriate resources to assist in a return to work. They are able to closely monitor progress on graduated returns to work, and to spot difficulties as they arise. They are therefore more likely to be able to respond in real time to avoid adverse outcomes.

Where OH practitioners are constrained in their ability to provide this level of support, they can partner with VR, which may be available through insurance or other avenues.

The first step for OH practitioners is to find out what insurance and other cover the employer already provides. For instance, income protection insurance should include VR services to help employees back to work during and after recovery from long-term illnesses. Where VR is available, the practitioner can begin fairly easily by agreeing to share information about cases which affect both parties. Medical and other confidential information can be shared in both directions, provided the employee has given their consent (See legal article, page 16), although many practitioners have found that this may involve the development of new consent forms.

Employer expectations

Employers are becoming much more demanding clients, and expect good communications between their various suppliers. They are also much more aware of the fact that they may have access to VR through insurers. This means that both OH and VR need to develop a collaborative approach, where OH professionals concentrate on their areas of medical expertise, leaving VR practitioners to focus on their areas of expertise as outlined above. The ideal is a fully integrated approach to case management.

Dame Carol Black's review has highlighted the problems faced by employers in the UK in managing sickness absence. She has championed a multidisciplinary approach to these issues and this speaks to our view that OH and VR are complementary. This places us at a crossroads: if leaders in OH and VR do not explore effective collaboration and co-operation the two disciplines, they run the risk of competing against each other. This could be to the benefit of neither approach, and could well derail any plans to effectively develop a credible strategy for helping ill and disabled people return to or remain in work in the UK. OH

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References

1› Review of Ill Health Retirement in the Public Sector HM Treasury July 2000
2› Is Work Good for Your Health and Wellbeing? Gordon Waddell, A Kim Burton, London TSO 2006
3› Training and certification programmes at www.unumworkmatters.co.uk