Vocational rehabilitation, case management and occupational health

Vocational rehabilitation is the restoration to health and capability to work of individuals incapacitated by mental or physical disease, or by injury. It is high on the national agenda. Securing Health Together [1], the Health & Safety Executive’s (HSE) long-term occupational health strategy for England, Scotland and Wales, has made availability for rehabilitation for all who require it as one of its key 2010 targets. Further, the Partnership Board of Securing Health Together has a stated aim of developing a nationwide vocational rehabilitation service. The Support Programme Action Group, as part of a model for delivery of nationwide occupational health services, includes rehabilitation services as one of its priorities. There have been calls for greater emphasis on rehabilitation both from employers and from employees’ representatives. Each acknowledges the central role that occupational health must play. We, in turn, as occupational health professionals, need to be aware of the emphasis being placed on vocational rehabilitation. We must decide what steps we need to take so that we can answer the challenges ahead, hopefully with evidence-based best practice such as that in the Faculty’s guidelines for the management of low back pain at work [2].

Provoked by the targets set out in Securing Health Together, some of the principal stakeholders have been voicing their opinions on vocational rehabilitation. Many of these echo the sentiments long held and proclaimed by ‘jobbing’ occupational health professionals. Until now, this has only been acknowledged by a few enlightened employers or employee representatives.

In December 2001, the CBI (formerly the Confederation of British Industry) produced a report [3] entitled ‘Business and Healthcare for the 21st Century’. In this report, they sought to highlight the direct cost to UK business of sickness absence of nearly £11 billion a year, with an overall cost to society of nearer £23 billion a year. They suggested three ways of tackling and reducing these costs: by businesses taking greater ownership and responsibility for the management of sickness absence; improving the delivery of publicly funded health care; and innovative thinking on the longer-term funding of health care.

The CBI point out that some businesses are better than others at managing workplace absence and employee health care, and that best practice needs to be shared and encouraged. This includes policies to address long-term sickness absence. It also includes the provision of rehabilitation to prevent the progression of long-term sickness absence leading to early exit from the labour market and dependence on benefits and/or pension schemes. CBI research has indicated that in organizations where the responsibility for managing absence is held at a senior level, absence rates are significantly lower. The availability of an appropriate level of expertise of occupational health provision is seen as key to the delivery of these policies, acknowledging that the case load and knowledge of general practitioners (GPs) are such that they are not likely to see the early return to work of their patients as a priority. In addition, National Health Service (NHS) waiting times to see specialists or therapists, particularly for those with musculo-skeletal conditions, act as a delay to recovery, and have led to employers seeking treatment through the private sector. The report seeks to stimulate further research on active rehabilitation policies and arrangements, and to promote the benefits of such policies. In particular, it emphasizes the benefits of competent occupational health provision.

The Trades Union Congress (TUC) [4] go one stage further than advocating increased ownership of sickness absence by employers. They call on the government to use the forthcoming Safety Bill to give employers a legal duty to develop a rehabilitation policy as part of their health and safety policy. They do not believe that the Securing Health Together target of a 30% reduction in sickness absence caused by work-related ill-health by 2010 will be achieved without either a legal duty on employers to plan rehabilitation or a major expansion of the rehabilitation services available.

From within the medical profession there have also been contributions to the debate. The British Society of Rehabilitation Medicine (BSRM) [5] has highlighted the need for greater availability of active vocational rehabilitation. They recognize this will reduce the costs to state and industry, reducing the numbers of those relying on benefits and improving the quality of life for those involved. It seeks greater access to vocational rehabilitation services, recognizing the current deficiencies in the NHS, which it sees as having lost the culture and skills required to appreciate facilitating employment as one of its key roles. It points out that whilst GPs certify fitness to work, they do not practice vocational rehabilitation as perhaps they should. It sees the ‘uneasy relationships between GPs, hospitals and occupational health practitioners’, with poor recognition of the potential value of occupational health services in facilitating employment rehabilitation. This is highlighted by a recent discussion paper in the British Journal of General Practice [6]. The paper acknowledges the difficulties faced by GPs in certification of fitness to work, with little mention of the role that occupational health could play to facilitate this. The
conclusion drawn is, perhaps simplistically, that there needs to be greater ownership of the problems by GPs, and more training. The BSRM advocates multi-professional liaison and the adoption of the case management approach, which it sees as being effective in assisting individuals back to work. It encourages further education on these issues and calls for a new Institute for Vocational Rehabilitation Research.

Finally, the government itself is looking at rehabilitation issues under the auspices of the Department of Work and Pensions (DWP). This department is currently completing the second feasibility stage of the Job Retention and Rehabilitation pilots, with implementation planned for 2002. An extra £12 million has been set aside as part of the New Deal for Disabled People initiative to look at innovative approaches to rehabilitation, by targeting individuals at 6 weeks following certification and looking at the overall and relative impact of three different intervention strategies: work-focused intervention; boosting health care; or a combination of the two by random allocation and comparison with access to usual services. The DWPs Chief Medical Advisers Bulletin 2002 [7] contains a Desk Aid for certifying medical practitioners, which is a summary of the key points from the guidance document, IB 204 [8]. There is also a useful list of evidence-based recovery times from elective surgery and cardiac illness (e.g. post-operative recovery time to full activity including work following open cholecystectomy, 3–5 weeks).

There is clearly a common theme emerging: sickness absence inflicts a heavy price on UK business apart from the more insidious and difficult-to-quantify societal costs. Proactive vocational rehabilitation is a fundamental step in stemming this avoidable loss. The fact that this debate is now on the national agenda, and that it recognizes the important contribution of properly resourced and committed occupational health practitioners, should be endorsed and greeted with pride and satisfaction by the profession. Do we take the lead or simply wait for events to unfold?

Paul Nicholson, writing in this journal [9], has suggested that we need to move with the times and adopt a new consumer-focused definition of occupational medicine. This is to give greater clarity to our clients as to what we actually do, where we add value and what our unique contribution is. That definition includes the description ‘case manage people who are on sick leave, working with community health professionals to ensure the earliest return of functional capacity and return to work’. The profession should embrace this definition, highlighting our support for case management, with its greater emphasis on active rehabilitation and the role we have to play.

In understanding our role, our unique contribution is being in a position to influence the employee, their health care and the employer. We know that the reasons for long-term absence are multi-factorial and complex [10]. They involve aspects relating to the individual and their condition, both physical and psychosocial; the attitude and availability of primary and secondary health care; perceived and actual job demands; and management attitudes. Any combination of these factors may act as a barrier to a successful return to work. In the current climate, one way of overcoming these barriers is by case management. A typical model to develop with existing clients, and to promote to potential clients, is as follows:

- Raise the profile of rehabilitation with employers, by: bringing to their attention the common aspirations of the key stakeholders; stimulating the development of sickness absence policies; recognizing the importance of rehabilitation; and defining clearly the respective roles of management, employee, employee representatives and occupational health.

- A key role for the occupational health practitioner is to act as an informed facilitator and influencer. Responsibility and accountability for employment decisions must remain with management, but at an appropriately senior level to make a difference.

- Promoting and agreeing a common understanding of trigger points for involvement of occupational health, with an emphasis on discussion at an early stage of absence so that there is proactive management of each case.

- Liaison with primary care and specialists, making them aware of the provision of occupational health services and the availability of a phased return to work, with restricted or alternative duties to aid with rehabilitation.

- Exploring with employers the business case for funding of fast-track referrals, particularly where long waiting times exist in the NHS, e.g. musculo-skeletal and psychological therapies.

- Liaison with management and the employee as the employee prepares to return to work. This includes functional assessment to determine the physical and psychological requirements of the job to which the employee will return [11]. Crucially, this raises the expectation of the return to work in the mind of the employee, and fosters a sense of responsibility and ownership for the success of the outcome.

- Functional capacity assessment of the individual against the physical requirements of the job with the involvement of specialist advice where this exists, e.g. the Disability Service Team of the Employment Service [12]; and consideration of possible adjustments/alternatives in keeping with the Disability Discrimination Act 1998.

- An active graduated rehabilitation programme with the aim of sustaining a return to work and ultimately achieving a return to normal duties or maximum
potential. This may require appropriate discussion to ensure the returning employee is not financially disadvantaged through a phased increase of working time, which could prevent employees being able to return to work, but may require considerable flexibility on behalf of employers.

- Regular review during the rehabilitation process to monitor progress and understand any difficulties encountered. This is important to avoid the process being derailed and losing credibility, or to prevent rehabilitation becoming institutionalized and stalled, with loss of benefit to the employee and employer. Ideally, monitoring should be carried out by occupational health and line management.

Within this model for case management, there is considerable scope for multi-disciplinary working, and this reflects the sentiments of the Institution of Occupational Safety and Health in their recent publication ‘Professionals in Partnership’ [13]. Proactive rehabilitation is no longer considered to be the extended role of the occupational health nurse, but is now being taught as a core function in some centres. Individual occupational health services will need to define the respective role of the occupational health nurse and physician, and other occupational health practitioners. The relative level of input will vary according to the complexity of each case and with regard to the factors acting as barriers to a return to work.

As occupational physicians, we need to assert our own central role in rehabilitation, to ensure that we are well placed to respond to the calls for the development of services. We can best do this by influencing such initiatives as Securing Health Together, agreeing evidence-based and standardized functional capacity assessment tools, contributing to research, and incorporating the findings from ongoing research such as the Job Retention and Rehabilitation Pilots.

References