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## **Changing perceptions about sickness and work: judging capacity for work and locating responsibility for rehabilitation**

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### **Abstract**

The Government's welfare to work agenda is premised on changing expectations and attitudes regarding the relationship between sickness and/or disability and work. At the core is an assumption that work is a good way of enhancing the well-being of working age people. There are also economic gains in ensuring potential benefit claimants move back into employment. This paper focuses on policy around job retention and vocational rehabilitation and argues that there are lessons to be learned from research about the need to change expectations and attitudes amongst several sets of stakeholders. In 2003, the Government set out to boost the evidence base for effective practice in vocational rehabilitation through the Job Retention and Rehabilitation Pilot and its focus on person-centred case management. Qualitative findings from the pilot's evaluation show that employees', employers' and health professionals' perceptions of the relationship between work and health can provide barriers to rehabilitation. This paper discusses ways of changing perceptions adopted within the pilot, and highlights the importance placed on informing and empowering individuals, collaborative working and providing timely and flexible support. In the light of these findings, recent policy announcements and plans indicating the Government's ongoing efforts to effect change in perceptions and attitudes are critically examined.

### **Introduction**

The Government's welfare to work agenda is premised on changing expectations and attitudes regarding the relationship between sickness and/or disability and work. No longer are sick and disabled people to be regarded as incapable of making valuable contributions in workplaces. The clear message is that attention should primarily be paid to what people can do and look to accommodate them within workplaces. At the core is an assumption that work is a good way of enhancing the well-being of working age people. Work is also advocated as a way of making a valuable contribution and fulfilling responsibilities to family, community and society at large.

This article argues that there are lessons to be learned from research about the need to change expectations and attitudes amongst several sets of stakeholders involved in rehabilitating sick employees. There may need to be significant changes in the perceptions of employees, employers and health professionals if the ideal of a motivated worker, supportive employer and fully involved healthcare system is to be achieved and help significant numbers back into employment. Research findings also suggest ways in which changes in perceptions might be achieved.

Changes in perceptions seem necessary whether the issue is job retention and speedy return to work, or returning to employment after a lengthy period out of work. The focus in this article is on job retention and vocational rehabilitation: how people who still have jobs can be helped to return to work before their employment is curtailed. It is argued that focusing attention on job retention and rehabilitation is important to the success of the government's welfare to work agenda, for research has shown that the earlier workers are helped after becoming sick or disabled, the earlier they are likely to be able to return to work (DWP, 2006). As such, an effective job retention and rehabilitation strategy could play a significant role in reducing the incapacity bill.

The first part of the article looks at the policy and research context leading up to the *Job Retention and Rehabilitation Pilot (JRRP)* in 2003. The JRRP was a government funded randomised controlled trial, testing a person-centred case management approach to rehabilitating workers who were sick or injured. Using empirical findings from the evaluation of the JRRP project, the paper then explores two linked themes, about which it is argued that key players' perceptions can hinder or help job retention and rehabilitation, and around which JRRP sought to change expectations and attitudes. The themes are:

- making judgments about people's capacity for work; and
- locating responsibility for vocational rehabilitation.

For each of these themes, employees', employers' and health professionals' perceptions are examined before the various ways in which JRRP sought to challenge perceptions are explored. Policy developments since JRRP are then introduced before the final part of the paper critically examines these current plans in the light of lessons learned from the JRRP.

## **The policy and research context**

### *Policy*

The Government's welfare to work agenda argues that work is a good way of enhancing well-being amongst individuals and communities. One theoretical framework, used by Waddell and Burton in their recent work for the DWP (Waddell and Burton, 2006), explains why work is a good in society and is based on the following observations:

- work is considered the most important and valued means of acquiring economic resources, essential for material well-being and participation in society;
- it meets psychosocial needs about individual identity, social roles and status where employment is the norm; and
- alongside socio-economic status, work determines social gradients relating to health and mortality.

There are a number of motivations in particular behind the Government's policy aims in this area. By arguing that work has a positive influence on personal well-being there are aims to increase the number of sick and disabled people in work and, consequently, to reduce the number of people who are financially assisted by incapacity benefits. Waddell and Burton's (2006) recent review of 400 pieces of scientific research evidence has provided substantial and persuasive grounding for the Government's case, confirming that work is good for people's health and wellbeing and that being out of work can be damaging to both body and mind. A return to work after sickness or injury can improve health by as much as absence from work has damaged it, though this may depend on the nature and quality of work.

Aside from contributions to personal well-being, there is potential for positive influences on local communities where people who move into work are lifted out of poverty and health and wealth inequalities are reduced. The economic gains of ensuring working age people are in work are also substantial not only in boosting productivity and minimising costs to employers, but in wider beneficial effects for the national economy and savings for the welfare bill. In 2005/6 30 million working days were lost to ill health and injury, costing employers an estimated £12 billion (HSE, 2006; DWP, 2006). In recent years, an average of 120,000 people each year have made a claim for incapacity benefits after a spell of sick pay (DWP, 2006) and over the last two decades the number of people claiming incapacity benefits has trebled (House of Commons Work and Pensions Committee 2003a, 2003b). In 2003 the figure stood at 2.7 million people, at an expense of £16 billion a year. There is also an issue of social inequality, as there remains a large disparity between the employment rates of disabled people (50%) compared to non-disabled people (80%) (Riddell *et al.*, 2005) and this has an effect on standards of living and incidence of poverty.

Changing expectations and attitudes is an ambitious agenda, not least because time is essential in altering established perceptions, cultures and practices. However, such changes seem more and more necessary in order to see a sizeable number of sick and/or disabled people make transitions into paid employment. In recent years, piecemeal developments through employment programmes, such as *New Deal for Disabled People* (NDDP), has had an impact, but largely it seems in helping 'easier to help' people who have seen improvements in their health, already have qualifications and are motivated to work. Research evaluating the NDDP suggests that people whose health condition continued to limit their activity tended to find self-employment more accessible than getting work with an employer (Kazimirski *et al.*, 2005; Stafford *et al.*, 2006). Boosting civil rights through the enactment of the Disability Discrimination Act (DDA) 1995 and 2005 has also had only moderate effects on employment activity of sick and disabled people. Recent research evidence (Simm *et al.*, 2007) shows that, despite having mostly positive attitudes towards employing disabled people, employers continue to interpret the concept of 'disability' narrowly, focusing attention on sensory and mobility impairments and excluding illnesses and diseases such as cancer and HIV. However, there are also signs that the DDA has improved circumstances for sick or disabled job applicants, with employers who are aware of the DDA provisions (most likely to be larger public and voluntary establishments and those with experience of employing disabled people) more likely to make recruitment adjustments such as training staff in disability awareness, guaranteeing disabled applicants an interview and checking at interview whether any adjustments would be required.

This article concentrates on policy and research regarding job retention and vocational rehabilitation. The people of concern here are those who have not yet made a claim for benefits and are described as being on long-term sickness absence from work (most commonly defined as more than 4-6 weeks absence). Policy to bolster provision for job retention and rehabilitation has seemed almost a poor relation compared to the high profile reform of incapacity benefits and the piloting of the Pathways to Work scheme which offers a range of employment and health support.

### *Research*

The evaluation of the JRRP has made a substantial contribution to what is otherwise a limited evidence base on long-term absence from work and rehabilitation in the UK<sup>1</sup>. Up until 2003, much of the evidence had been gathered through small case studies and some work had been done in pulling together research findings from around the world in reviews. The majority of the UK research had pursued the following lines of investigation:

- studying sickness absence in particular work settings and sectors, such as the police service (e.g. HMIC, 1997)
- reviewing measures to prevent sickness absence (e.g. Edwards and Burnard, 2003)
- investigating the provision of measures to rehabilitate employees and what works best (e.g. Holroyd, 1999)

However, some more comprehensive and representative research has laid the groundwork in what is known about sickness absence and its management. A survey by the Institute for Employment Studies used a representative sample of 1,250 workplaces to find that a majority had some form of policy on disability and rehabilitation and that two-thirds said they were prepared to spend money in accommodating the return of a sick/disabled employee (Honey *et al.*, 1994). Philip James, Ian Cunningham and Pauline Dibben (James *et al.*, 2000; James *et al.*, 2002; James *et al.*, 2003; Dibben *et al.*, 2001) have led the field in conducting studies of sickness absence and the policies and practices put in place by employers to manage it. Their work portrays a less positive image of employers not always delivering in practice the most effective forms of help to their sick or disabled employees. Findings show a tendency for employers' policies to contain an unbalanced emphasis on short-term rather than long-term absence, leading sometimes to tension between discipline and support for the sick or injured individual; that implementation of well-meaning policies may be undermined by work pressures and a lack of adequate training and clear guidance for line managers who are primarily responsible for contact with individuals; that budget restrictions are influential in considerations about adjustments; and, despite frustration at waiting times, most employers rely on the NHS to provide medical advice and treatment (Dibben *et al.*, 2001; James *et al.*, 2002). Occupational health services can prove valuable in giving advice, undertaking medicals and liaising with GPs (James *et al.*, 2002), but they are not commonplace in workplaces (in 2002, 15 per cent of British companies provided basic occupational health support and only three per cent offered comprehensive support (Institute of Occupational Medicine, 2002)).

Empirical work to identify good practice in rehabilitating people with work-related stress, a major cause of workplace absence, has also added to the available evidence (Thomson *et al.*, 2003). Together, the research on good practice (e.g. TUC, 2002; Thomson *et al.*, 2003; James *et al.*, 2000) has identified the following factors as influential in helping sick and disabled people keep their jobs:

- devising and raising awareness of policy frameworks and guidelines which are clear about the action to be taken and on whom responsibility lies
- early intervention and treatment
- good communication and coordination between the employee and all levels of personnel at the workplace
- agreeing a return to work plan
- access to occupational health services
- making adjustments to suit the needs of the individual

On the other hand, failing to provide rehabilitation support, comprising medical treatment and vocational help such as functional evaluations and training, was identified as a barrier to vocational rehabilitation.

In spite of the research that has been done, there are obvious gaps in the evidence base for retention and rehabilitation (though the JRRP has attempted to fill some). In 2003, James *et al.* developed a conceptual framework of best practice, to aid employers in devising and delivering effective workplace rehabilitation, but they state themselves how their framework

is weakened by the lack of depth and quality in the evidence base in this area. In the most part, what is known about taking sick leave, and the policies and practices to manage it, comes mainly from the perspective of employers only, leaving the views and experiences of employees relatively unexplored. There may be evidence about employers' sickness and rehabilitation policies, but less is known about how far such policies are effectively implemented. Similarly, little is understood about the nature and scale of the roles played by line managers and employer-provided occupational health services in keeping in contact with absentees and actively guiding their return to work.

Outside of the workplace, the roles of GPs and occupational health professionals in relation to vocational rehabilitation and how they combine has not been thoroughly explored<sup>2</sup>. However, Beaumont's review of the little literature available and Delphi study, in which a consensus of opinion amongst leading stakeholders was agreed in a statement, offers a useful evidence base from which to start (Beaumont, 2003a; 2003b) and, as will be shown, the JRRP findings build on it. The view of the stakeholders canvassed in Beaumont's Delphi study was that the GP's role is constrained by time, lack of knowledge, concerns about confidentiality and maintaining their role as the patient's advocate, and having 'no recognised structure within the UK NHS...to refer for OH advice' (2003b). Whilst the participants felt that occupational health professionals may provide excellent advice, they are not always present in workplaces. According to the stakeholders who took part, communication between GPs and occupational health professionals is often poor and can be adversarial. In looking forward, the statement stresses the need for teamwork and for responsibility for leading vocational rehabilitation to be shared by GPs and occupational health professionals, as well as other practitioners involved with patient care such as physiotherapists, occupational therapists and osteopaths.

#### *The Job Retention and Rehabilitation Pilot*

In 2003 the Government sought to make a substantial addition to the body of evidence on vocational rehabilitation by testing a person-centred case management approach on a large scale. The Job Retention and Rehabilitation Pilot operated from April 2003 for two years in six sites in the UK, through four independent providers. Eligible clients needed to be in employment of at least 16 hours a week and to have been off work sick for between 6 and 26 weeks. Access to the service was by self-referral only. Each provider employed a team of case managers and practitioners who facilitated access to health and workplace support or provided it themselves. The project was run as a randomised controlled trial which sought to test how best to help people back to work using three intervention groups and a control group. One stream of interventions gave people workplace support only, such as devising detailed return to work plans including phased returns to normal duties, conducting functional capacity assessments, giving advice about suitable adaptations to work stations and adjustments to working conditions. A second stream offered only health care support, including, not exclusively, faster access to some medical tests and treatment, physiotherapy, complementary therapies, and forms of counselling. A third intervention group provided clients with a combination of workplace and health support, as fitted their individual needs. People in the control group were only denied access to the case managers and forms of support on trial, and were able to make use of any private and public provision that they would have used if the trial had not existed. The primary aim was to achieve a return to work of at least 13 weeks. During its operation, the pilot providers saw 2,845 clients.

The research to evaluate the pilot comprised an impact assessment and qualitative studies. The findings from the impact analysis (Purdon *et al.*, 2006) were surprising, showing that no one intervention group made a significant difference in helping people back to employment compared to the control group (almost identical return to work rates for each

intervention group and control group at 44-45%). Some impacts were observable, but not large enough to be statistically significant. Thus, JRRP may have made a positive impact on shorter returns to work and helped more people with an injury to return to work, compared to the control group. Although this kind of analysis showed no significant impact on the target population, the qualitative research offered insights into how key players were affected by the pilot and what were effective ways of changing expectations and attitudes regarding returning to work. The qualitative research also provided some evidence to suggest why more of the volunteers were not helped back to work. This paper draws on this qualitative evidence from a number of research studies conducted by the Social Policy Research Unit at the University of York and the National Centre for Social Research during 2003 to 2005. The research included longitudinal and cross-sectional work on the experiences and views of 23 provider staff and 82 pilot participants, including people assigned to the control group (Farrell *et al.*, 2006); two studies involving 44 employing organisations, looking at employers' practice regarding sickness absence and their perspectives on the contribution of JRRP to some of their employees (Nice and Thornton, 2004; Thornton and Nice, 2006 unpublished); and a study investigating how GPs manage sickness absence, which included 24 GPs (Mowlam and Lewis, 2005).

The next section of the article draws on the research to evaluate the JRRP and discusses two themes – judging capacity for work and locating responsibility for vocational rehabilitation – which emerged as significant in helping and hindering people in their return to work.

### **Judging capacity for work**

#### *Employees', employers' and GPs' perceptions*

Research findings from JRRP show that some perceptions amongst employees, employers and GPs about capacity for work can be obstructive, or at least not supportive, to making a timely and effective return to work.

Research with JRRP clients (Farrell *et al.*, 2006) showed that in being off sick from work for a lengthy period of time some people began to think that they could not work or found it harder to think what kind of work they could do. They may still have possessed an underlying desire to be at work, but this did not always seem to them to be a realistic goal. For many, there were anxieties about making health worse by returning to work.

Some JRRP provider staff believed that people's perceptions could be influenced by discussions with GPs (Farrell *et al.*, 2006). There were arguments that doctors' practice is informed by a 'sickness model', focusing on what is medically wrong and what can be treated, before contemplating work; and which is underpinned by a concern for patients' well-being and by doubts about whether work is in their best interests. Believing in the professional judgment of their doctor, some people were said to have adopted this 'medicalised' perception of their condition, and used it as an argument for why they could not work. In contrast, the staff who took part in the evaluation followed a bio-psychosocial model, which aims to incorporate all aspects of an individual's life in making assessments and offering help. Thus, they saw a close link between offering medical help and facilitating a return to work. It may be that work is completely inappropriate for some people and that an exclusive focus on their health needs, as opposed to what can help them at work, is the best course of intervention. However, some staff believed that GPs in general are not adequately informed about the health benefits of trying work and could be more encouraging in this respect to patients whose ill health and/or disability may not prevent them from doing some work.

This 'sickness model' and faith in the judgment of health professionals was assumed by employers to some extent. Research with employers (Nice and Thornton, 2004), JRRP

staff and clients (Farrell *et al.*, 2006) showed that employers' lack of knowledge about occupational health issues, their poor understanding of the effects of health conditions, and what staff described as inflexibility<sup>3</sup> and a lack of imagination, had sometimes informed their judgments about employees' capacity for work and had obstructed rehabilitation.

*Changing perceptions about capacity for work*

Valuable lessons can be learned from the JRRP project about how perceptions of capacity for work might be changed to help more people back into work.

A raft of interventions was employed by JRRP providers to help change the attitudes of clients regarding their own fitness for work and rehabilitation (Farrell *et al.*, 2006). First, it was important for case managers and practitioners to gain clients' trust in their expertise and in the supportive relationship they offered. Through a series of one-to-one meetings, case manager staff sought to motivate clients who were perhaps less focused on returning to work, and to provide a clearer vision of how a route back to work might be assembled and followed. Provider staff felt that these personal interviews provided a good opportunity to identify barriers to work perceived by individuals and to offer tailor-made support to tackle them. They were also thought to be an excellent forum for communicating information about the health benefits of working and the kinds of support available. Staff sought to tackle 'medicalised' perspectives of the client's position by focusing less on their medical status and focusing more on their functional capacity.

A number of healthcare interventions were designed to help individuals better manage, if not improve, their health conditions. According to staff, finding out that people with ongoing health problems can, to some extent, learn to cope with the effects of their condition whilst working was an important stage in developing clients' expectations. Receiving physiotherapy, Cognitive Behavioural Therapy (CBT), various complementary therapies and exercise programmes and advice were all ways in which people said they been helped to feel better and more able to cope with effects of their conditions, such as pain and fatigue.

The positive impact of JRRP for some clients was not explained merely by the range of interventions on offer, but also by the way in which it was delivered. Being proactive and intervening early were important, not only in stemming the deterioration in some people's health conditions and preventing the onset of additional problems, but also in sustaining and promoting positive thinking about being able to work again. Many of the interventions were geared towards encouraging early returns to work, even if people were still recovering or expected to continue to be affected by health problems. Thus, gradual returns to work, in which duties and hours at work might gradually increase over time, were advocated in discussions with employers.

It seems that effecting change in employers' and health professionals' attitudes was a much harder task compared to working with employees (Farrell *et al.*, 2006). Establishing and maintaining contact was not always easy, given employers' and GPs' other priorities and time constraints. As illustrated in the discussion below, employers and GPs' own sets of beliefs, workplace cultures and professional training and experience were also important in resisting change to their perceptions about rehabilitation for work.

Mediation with employers emerged as a multi-faceted way of supporting rehabilitation. In particular, it supported clients who did not feel confident about meeting formally with their employer. It was also a way of helping employers to recognise their responsibilities under the Disability Discrimination Act, and to identify practical ways in which they could support individuals back to work. In these ways, JRRP staff worked to change attitudes and expectations, so that employers could see more clearly the importance of rehabilitation and various ways in which rehabilitation might be possible, perhaps with support from external private and voluntary organisations.



Trying to contact GPs and establish a working relationship was found by JRRP staff to be problematic. Staff perceived constraints on GPs' time and rules about confidentiality and pilot contamination<sup>4</sup> as reasons for difficult working relationships. There were, therefore, few opportunities to change GPs' perceptions about people's capacity for work where these might be holding people back, and to encourage GPs to be more active in influencing patients' perceptions about work. One way of trying to effect change was in supporting clients in their relationship with GPs. In practical terms, this involved JRRP staff providing clients with information about available support, passing on to GPs the results of professional assessments such as functional capacity assessments, and encouraging clients to talk to their GP about possibilities for returning to work.

### **Locating responsibility for vocational rehabilitation**

#### *Employees', employers' and GPs' perceptions*

Some key stakeholders' perceptions about taking responsibility for vocational rehabilitation can also inhibit individuals' progress.

The extent to which sick employees were responsible for their own rehabilitation back to work varied amongst accounts from clients and JRRP staff (Farrell *et al.*, 2006). Some of the JRRP findings (Purdon *et al.* 2006; Farrell *et al.*, 2006) suggest that dependence on person-centred services can act to inhibit personal responsibility for progress; that in accessing support such as JRRP, people can become reliant on staff contacts and input and perhaps wait to be told what to do. Conversely, when people cannot access the particular help they need they take the initiative in helping themselves. Although it could be argued that the individual has some responsibility in striving to return to work it also seems clear that they cannot always do so alone. Inevitably, they will need medical input from health professionals and will need an employer who is, at the very least, willing to employ them, if not be supportive in facilitating a tailored return to work. Evidence from JRRP research shows that people are especially vulnerable when off sick from work and may need help to do things they would otherwise have felt confident to do on their own (Farrell *et al.*, 2006). Someone to help manage the various inputs and intricacies of their case and to identify appropriate support and steps to take was thought by both JRRP staff and clients to be especially helpful at this time.

Do GPs' and employers' perceptions of their role accord with this need to provide individuals with personal support and advice? Research with GPs (Mowlam and Lewis, 2005) showed that a range of approaches to managing sickness absence are employed by GPs and there are different degrees to which they engage with and take responsibility for leading vocational rehabilitation. More active GPs identify with the need to keep work at the centre of their discussions with patients. At the other extreme there are GPs who are largely inactive regarding rehabilitation, focusing almost exclusively on treating the individual's health problem(s). Inactivity was described in a number of ways by JRRP clients and by staff who had spoken to clients about meetings with their GP, and included:

- a readiness to issue sickness certificates;
- minimal questioning about work;
- 'writing off' people by issuing sick notes of a long duration;
- providing inadequate information about health conditions and what could be done to help improve the condition, possibly within the workplace;
- delay or failure to refer patients to services, including those recommended by JRRP clinical staff. (Farrell *et al.*, 2006)

Caution about promoting work, or conviction not to, were ways in which staff felt some GPs held people back in making progress towards work. Here, the topic of work was not necessarily ignored, but was not the focus of GPs' discussions and treatment plans. GPs themselves offer various explanations for little activity in supporting rehabilitation to work (Mowlam and Lewis, 2005): some attitudinal, such as taking a more hesitant approach to diagnosis in order to avoid mistakes and concerns about providing equal access to treatment irrespective of working status; some educational, such as poor knowledge of occupational health advice; and some practical, such as time constraints and insufficient funding. Attitudes have necessarily been informed by training that, traditionally, did not promote vocational rehabilitation because there was uncertainty about work being in the best interests of the patient, and there were concerns that the doctor-patient relationship might be damaged.

Research as part of the JRRP evaluation (Nice and Thornton, 2004) suggests that some attitudes and working practices amongst employers regarding the idea of responsibility for rehabilitation could hold back or prevent client progress towards work. Larger organisations were generally found to be better placed to offer support, already providing occupational health services and sometimes counselling, but responsibilities were not always clearly allocated amongst personnel and good policy intentions did not always filter down to work effectively in practice in individual cases. There were sometimes tensions between line managers, human resources staff and in-house occupational health officers where boundaries between their roles and responsibilities were confused. Responsibility for rehabilitating sick employees seemed more burdensome for small and medium sized organisations which were less well resourced to manage rehabilitation. They did not have in-house professional expertise and, consequently, were more likely to need, but could not always afford, external advice and support. Some employers were cautious about accepting responsibility and were therefore in minimal contact with absent employees, for fear of being perceived as harassing them. There were also employers who wanted to be selective about their responsibility for supporting employees depending on the employee's relative value to the organisation, whether they had a diagnosis and prognosis for recovery, and the kind of condition they had and how well its effects were understood. A lack of knowledge of occupational health issues also held some employers back in assuming responsibility for managing their employee's return.

#### *Changing perceptions about responsibility for vocational rehabilitation*

An element of JRRP staff members' work with clients was to encourage them to take the initiative, to become motivated and feel empowered to take action for themselves in getting back to work (Farrell *et al.*, 2006). In some cases, the desired balance between sustaining contact and taking over, between empowering clients and creating dependency, was not always maintained. Where clients simply transferred their dependence on medical judgment to dependence on the direction of JRRP staff, clients' perceptions about assuming responsibility were unlikely to change.

In essence, JRRP was set up to provide services and support to individuals to help them return to work before they lost their jobs. They did not, however, work in a vacuum and there was often communication with employers and GPs and sometimes working relationships were formed. As a by-product of this collaboration, JRRP staff sometimes worked towards changing employers' and GPs' perceptions, where necessary, about the need not only to support rehabilitation but also to assume responsibility for it. Input from JRRP sometimes caused friction<sup>5</sup> among employers and GPs who felt they should have control over individuals' cases or were confused about the role of JRRP. This confusion was not helped by the research status of JRRP and the lack of clarity about the future of JRRP-type services.

Arguably, the way JRRP assumed responsibility and worked with individuals showed how GPs and employers might effectively take responsibility and work with employees in the future. JRRP case managers and practitioners working together provided the support and services that GPs and the health service at large could perhaps provide if vocational rehabilitation was a more central part of their agenda. More specifically JRRP staff:

- encouraged positive attitudes in clients and hoped to change perceptions about capacity for work by giving advice centred on what they could do at work;
- gave more time than GPs had available to listen to clients, discuss appropriate ways forward and devise detailed return to work plans;
- helped clients to get diagnoses and prognoses, and thus greater clarity in what they were facing, by accessing tests and treatment earlier than through GPs;
- chased up referrals and appointments on the client's behalf;
- supported clients waiting for NHS treatment by providing interventions such as complementary therapies, which maintained morale and confidence if not relief from some symptoms. (Farrell *et al.*, 2006)

Accompanying and supporting individual clients in mediation with their employers was a good way for JRRP staff to get to know organisations' policies and practices on managing sickness absence and return to work. Through productive relationships, some JRRP staff felt able to encourage employers to assume responsibility for supporting not only the client in question, but also to take learning from their work with JRRP and apply it to future incidences of sickness absence within the organisation.

The discussion now moves to look at policy developments since JRRP, and in particular how current plans aim to change perceptions.

### **What policy plans are there?**

Recent Government policy statements and plans do not support the establishment of a network of independent rehabilitation providers, like those trialled in JRRP, but focus on the roles of employers and health professionals (particularly GPs) in preventing sickness absence and promoting and providing greater support for sick and disabled employees. It is difficult to separate initiatives designed to promote capacity for work from those assigning responsibility for vocational rehabilitation. Policy embracing these two themes is therefore discussed as a whole.

Current Government policy endorses the emphasis on capacity rather than incapacity for work. The message is to rehabilitate not to reject people. There are ambitions to effect a change in expectations and attitudes amongst employers and health professionals, so that capacity for work is at the forefront of their thoughts and actions concerning individual employees. Recent statements of policy and strategy have been outlined in a number of documents:

- Health and Safety Commission's (HSC) *Strategy for Workplace Health and Safety* (2004)
- Department of Health (DH) White Paper: *Choosing Health: Making Healthier Choices Easier* (2004)
- Department for Work and Pensions (DWP), Department of Health, Health and Safety Executive (HSE) strategy paper: *Health, Work and Well-being: Caring for our future* (2005)
- Department for Work and Pensions Green Paper: *A New Deal for Welfare: Empowering people to work* (2006)

Arguably the most significant of these, and the one most closely devoted to the topic of job retention and rehabilitation, is the strategy paper, *Health, Work and Well-being*, as it brings together the DWP, DH and HSE in what the government describes as a 'ground-breaking partnership' (DWP/DH/HSE, 2005). Various descriptions of it as 'ambitious' and 'radical' by government itself, it places 'real responsibility not just in the hands of Government, but also with employers, individuals, the healthcare profession and stakeholders.' From the foundations set by this partnership has come a National Stakeholder Council and National Stakeholder Network; the appointment in August 2006 of Dame Carol Black as National Director for Health and Work to 'spearhead initiatives promoting and improving health in the workplace, ensuring that people with health conditions and disabilities are supported to enter, return to and continue in work' (DH press release, 25 April 2006); and a Charter, signed on 3 May 2006, signalling a commitment from 'captains of industry and key stakeholders from across the public and private sectors' to deliver a healthier future for working age people (DH/DWP/HSE press release, 3 May 2006). The welfare reform Green Paper published by DWP in January 2006 repeated the broad sentiments of the joint ministerial strategy paper. By including policy on vocational rehabilitation in this important policy paper the Government demonstrated how job retention fits next to the reform of incapacity benefits; more specifically, how it has a role in reducing the incapacity bill.

In essence, Government policy appears to be one of containing sickness and injury by prevention and early intervention, and of creating partnerships across traditional divides between employment and health, in order to do so. Prevention of sickness is the ideal. The *Choosing Health* White Paper aims to create healthy workplaces, making it clear that work matters, that it can improve health, that it can reduce health inequalities and improve life chances for people. Where health problems do develop the vision is of the mass of stakeholders – employees, employers, health professionals, insurers, and public, private and voluntary rehabilitation service organisations - working together to help people manage their health whilst staying at work. To help people stay at work or to return after absence, there is ready recognition that fast treatment and access to occupational health services are crucially important.

A range of initiatives, incentives, guidance and support has been suggested to encourage employers and health professionals to think first of how sick employees can be accommodated at work, and also to share responsibility for leading support for individuals. Broadly speaking, the key aims are to:

- build health promotion in the workplace (a review of survey articles showed that work-based health promotion programmes can reduce the rate of sickness absence and have a positive impact on the development of higher incidence health problems such as heart disease (Kreis and Bödeker, 2004));
- reinforce occupational health support;
- engage health professionals with the agenda to recognise the importance of work;
- improve access to investigation and treatment from health care providers;
- develop appropriate return to work support;
- challenge discrimination.

Most notable of the more defined plans, for the purposes of discussion in this article, are those that seek to build working partnerships between health and employment support, and those aiming to encourage changes in perceptions about what can be achieved and where responsibility for achieving it lies. Bringing health into the workplace has to some extent been evident since 1974 when the Health and Safety at Work Act placed duties on employers to

protect workers. Some employers, albeit largely those with greater resources, have since provided in-house or contracted occupational health services. Current plans extend such provision so that all employees have access to health advice and support in the workplace. Included here are incentives for organisations to provide their own occupational health service and, for smaller employers with more limited resources, to promote the use of *Workplace Health Connect* – a free service offering advice on occupational health and return to work issues, which should be available to all small and medium-sized enterprises (SMEs) by 2008.

Policy plans also move in the opposite direction by seeking to locate employment support in healthcare premises. Currently, this is taking shape through a pilot in Pathways to Work areas, where Jobcentre Plus employment advisers are based in GP surgeries and provide a gateway service to patients interested to learn about available vocational support. The idea of putting Jobcentre Plus advisers in surgeries is one of a number of ways new policy aims to bring health professionals closer than ever before to engaging in work issues. In summary, therefore, the intention is to ‘support and engage GPs and other healthcare professionals to transform culture, attitudes and practice’ (DWP, DH, HSE, 2005). Working with the professional bodies for medical students, nurses, occupational therapists and physiotherapists<sup>6</sup>, the Government aims to give a higher profile to occupational health and rehabilitation for work and change practice amongst health care professionals by improving the education of new and experienced practitioners<sup>7</sup> and ensuring expertise is accessible for all GP practices<sup>8</sup>. In doing so it is hoped health practitioners can give earlier and more work-focused advice and treatment to inform the decisions of employees, employers and other clinicians. Their job would also include a responsibility to encourage change in the way individuals themselves think about their capacity to work, the role of work in their recuperation and the negative impacts of being off sick. According to Government plans, learning will be aided by the collection of best practice evidence in HSE guidelines and from the experiences of those involved in the innovative Condition Management Programme – a central part of the Pathways to Work scheme for incapacity benefits recipients, which seeks to enable better management of health conditions.

The final part of the article critically examines current policy plans regarding job retention and rehabilitation in the light of the lessons learned from the JRRP and other research.

## **Conclusion**

There is a growing evidence base for helping sick and disabled people back to work after they start receiving health-related benefits, through piloting and evaluating programmes such as *New Deal for Disabled People and Pathways to Work*. Attention has not been focused on learning how to help people who are still in employment but absent from work. However in the last couple of years, the JRRP project has provided valuable evidence to work with and there are Government plans to provide more help to people who are trying to retain jobs.

One lesson from the JRRP project is that independent vocational rehabilitation services can be an effective tool in changing perceptions about work. In possessing expertise and having time dedicated to the cause of job retention and rehabilitation, provider staff were able to work with individuals, show them options and gradually build expectations and motivation for work. Case managers and practitioners involved in JRRP also promoted vocational rehabilitation amongst employers, encouraged them to take up greater responsibility, educated them about available resources and demonstrated effective practice. Thus, there may have been gains here for employees who became sick after the employer’s contact with JRRP, and who were the beneficiaries of any revised practices and policies.

Working with GPs and finding ways of changing their perceptions about work and health was less straightforward however. The difficulties experienced by JRRP staff in gaining professionals' trust and interest perhaps indicate problems with government plans to put the health profession at the centre of vocational rehabilitation. Mowlam and Lewis's (2005) study provides some evidence that recently qualified GPs are more prepared to tackle work issues with patients and it could be interesting to monitor how doctor-patient relations develop amongst GPs who are more focused on work issues and more involved with other stakeholders, including employers. But, the hesitancy of other GPs may prove to be a continued barrier to change. The Government is aware of the lack of understanding among health professionals in general about the benefits of work and how current practice amongst GPs can inhibit vocational rehabilitation (DH/DWP/HSE press release, 6 September 2006). Thus, the proposals to improve GPs' education regarding work and health should fill this knowledge gap, but they are measures that will take time to take effect. GPs may also feel reluctant to put their weight behind the work and health agenda whilst general occupational health expertise within the NHS is poorly resourced. There may also be a more immediate need for policy responses to help remove practical barriers such as lack of time and insufficient funds for being proactive about work issues.

The idea of independent job retention and rehabilitation services, like those in JRRP, is missing from policy plans. However, there may be an argument for the use of such services as an interim measure. Many of the Government's plans will take time to take effect and although ultimately they may prove to be successful in the future, they do little to help people now and in the interim who are off sick from work, have little contact with the workplace and have a GP who is not proactive about fitness for work and does not know what kinds of vocational rehabilitative support would be most beneficial. Independent case-management services like those trialled in JRRP would seem to be well placed not only to support workers who are otherwise inadequately supported, but also to promote vocational rehabilitation amongst employers and GPs. The latter was undoubtedly an important part of the pilot's operation and could prove to be influential in the Government's endeavour to change perceptions on a large scale.

Even if there are to be no large-scale or interim implementation of JRRP-style services, the pilot did provide valuable learning that can inform and support Government plans to situate job retention and vocational rehabilitation with employers and GPs. Elements of practice which JRRP and other research has shown to make a positive impact on returning to work include taking early intervention, being proactive, providing a wide range of ongoing support focused on individual needs, and partnership working amongst stakeholders. In addition, a strong argument from the JRRP research is that having a case manager to draw together all the diverse elements and inputs in people's lives and to suggest ways of taking appropriate steps towards work, is helpful in changing perceptions about working and achieving returns to work. An important question, therefore, is whether these helpful elements are incorporated and supported within current policy plans? The following discussion seeks to answer this question.

Although one of the strong themes in the proposals is about working in partnership, there are scarce details on how employers, GPs and other stakeholders could be encouraged to work together in practice on an individual level. The idea of a designated case manager, charged with liaising between interested parties, might fulfil ambitions for greater partnership working. The research shows that having a case manager might be beneficial, but who could take responsibility for assuming this role? Any case manager would need to ensure they kept in regular contact with the employee and other stakeholders; explored fully individuals' needs; were proactive in seeking and implementing the right support; and were able to encourage and motivate the employee. Part of JRRP providers' success in executing this role was their

impartiality and their status as a Government project, which helped them strengthen the position of employees and to work between all stakeholders (Farrell *et al.*, 2006). A lack of similar impartiality might hinder the adoption of a similar role amongst employers and/or GPs. Indeed, professionals contracted to provide occupational health services might be the natural choice as case managers, given their concern with health in the workplace. Yet, the research shows that it is not always clear, especially to employees, in whose interests they ultimately act, what their role entails and how they work amongst and communicate with a multitude of stakeholders, including GPs (Farrell *et al.*, 2006; James *et al.*, 2002). And, in any case, the position of case manager would be unfilled where employers do not provide occupational health services. JRRP case managers also had a generous amount of time to spend on individual cases. It is doubtful that employers without occupational health provision and GPs could provide a similarly effective and seamless case management service when they have numerous other pressures on their time and resources.

Will support be provided at an early stage and focused on individual needs under Government proposals? Making the argument to employers that it is in the interests of business to maintain good health and morale amongst staff, by being safety conscious and accommodating for individual needs, could mean some absence from work is prevented. Aims to make employers and GPs more aware of occupational health and return to work issues may mean that appropriate workplace support is provided early and addresses individual needs when absence from the workplace has occurred. Question marks remain, however, about the capacity in the NHS to respond quickly to workers' health needs. Asking GPs to be proactive about facilitating rehabilitation for work is challenging when they are faced with long waiting lists for appropriate medical tests and treatment. It seems that, for the link between work and health to be a priority amongst GPs and employers, it would also need to be a priority within the NHS as a whole. In which case, prioritising funding for training new occupational health professionals is much safer ground politically than suggestions for prioritising the treatment of working age or employed patients. A larger presence of occupational health staff may help to refocus aims within the NHS too, from focusing on sickness and incapacity to functionality and capacity. The appointment of a physician as National Director for Health and Work, described by the Chair of the HSC as 'an eminent figure in the medical field' will perhaps strengthen aims to bring work into healthcare services.

Will there be a wide range of support available? Through the *Framework for Vocational Rehabilitation* (DWP, 2004), the Government is seeking to build a new approach to vocational rehabilitation. In doing so it hopes to gather evidence of best practice in helping people return to work. The issue is then one of ensuring such guidance is disseminated to those who need it. There is a need for raising awareness locally in order to introduce stakeholders to guidance, identify local sources of support and build local networks. Funding a range of support to meet individuals' needs, as JRRP was able to do, may prove difficult for some employers. The Government aims to help SMEs by providing free telephone advice services, and whilst these may prove to be helpful they will not provide specific services that may be needed, nor the funding for them. Financial assistance for smaller employers may be necessary to ensure all employees have access to rehabilitative support.

In summary, policy statements do to some extent address concerns arising from research findings that employers and health professionals can obstruct or hinder people's progress in returning to work. They also recognise that shifts in attitudes regarding capacity for work and responsibility for vocational rehabilitation are necessary to effect lasting change on a national scale. This is an ambitious agenda, however, and trying to change attitudes, cultures, established practices and to engage a mass of interested parties in a shared agenda will take time. Also, the agenda may not be well received by everyone, including practising health professionals dealing with change, employers coping with many pressures and

employees who do not feel they can work. There is a need to be mindful that the assumption underpinning current policy - that work is good for well-being and that sick and disabled people can work - may be empowering to some people, but may put undue pressure on others. With more stakeholders engaging with the work and health agenda there may be more pressure on individuals to return to work when this is not an appropriate and/or desirable step.

## Notes

<sup>1</sup> Research from other European countries has also used mostly quantitative case studies and reviews to tackle similar and complementary topics, such as sickness certification practices amongst doctors (Soderberg and Alexanderson, 2003); women's experiences of long-term sick leave (Ockander and Timpka, 2003); and effective medical and workplace interventions for people with a particular kind of health problem, such as work-related psychological conditions (Blonk *et al.*, 2006).

<sup>2</sup> There is, however, a small stream of work on GPs' statutory role in issuing sickness certificates, looking in particular at tensions perceived in being a patient's advocate and a 'benefit gatekeeper' (Hiscock and Ritchie, 2001; Sawney, 2002; Hussey *et al.*, 2004).

<sup>3</sup> For example, some employers only contemplated taking back fully fit employees.

<sup>4</sup> Staff working with clients allocated to the workplace intervention group were not permitted to offer health care interventions or to become involved in clients' medical treatment. This was done to protect the segregation between health and workplace support, as the pilot was designed to test the effectiveness of each independently. It was unclear from discussions with staff whether they were allowed to contact GPs for background information when clients were receiving only workplace support. In any event, JRRP provider staff needed clients' permission to contact GPs.

<sup>5</sup> Giving contradictory advice, setting alternative return to work plans, telling patients they did not need JRRP or services offered, not returning calls and charging for medical reports were ways in which this tension was said to have been demonstrated.

<sup>6</sup> The Academy of Medical Royal Colleges and individual colleges and faculties; the Royal College of Nursing; the College of Occupational Therapists; and the Chartered Society of Physiotherapists.

<sup>7</sup> There are intentions to incorporate new health and work modules into under-graduate and post-graduate training, and online training modules are currently being developed for doctors and other health practitioners. The first online module on sickness certification received positive responses from users (DWP, DH, HSE, 2005).

<sup>8</sup> This involves developing, within PCTs, Practitioners with Special Interests in occupational health and piloting an occupational health advice line for GPs.

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