Positioning Vocational Rehabilitation in Early Intervention Recovery Models
Abstract

A discussion on how medical, insurance case managers and health care practitioners have devalued vocational rehabilitation services for injured claimants requesting assistance in the late stages of the case instead of as part of early intervention triage. The benefits accrued when implementing vocational rehabilitation in the early stages of recovery are explored.

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Learning Objectives:

1. Understanding the application of vocational rehabilitation services at early stages of the claimant’s recovery;

2. Applying vocational rehabilitation techniques and strategies towards effective return to work initiatives;

3. Communication skills within the multi-comprehensive rehabilitation team environment.
The concept of early intervention is central to vocational rehabilitation, because the longer anyone is off work, the greater the obstacles to return to work and the more difficult it becomes to implement vocational rehabilitation services.
Treatment is directed to and has the primary goal of treating pathology and/or relieving symptoms. This may be sufficient to enable the person to continue or return to work, but that is an indirect or secondary outcome.
The goal of acute and post acute health care services is to restore capacity (physical, cognitive, emotional).

WORK IS USUALLY A TERTIARY OBJECTIVE

Frequently a family doctor or an external specialist will block efforts to introduce supported vocational services especially if the first RTW has failed.
Medical Case Managers and Claims Managers depend on investing in GRTW programs in the early stages of recovery: the pre-injury employer (job attached) is the focus.

2 year own-occ policy restrictions are applied and minimal services provided until policy expiration.

Medico-legal model: Assuming the claimant is capable of a GRTW, an Occupational Therapist (BC) will play a key role in GRTW programs.

Where is the Voc Rehab Consultant?
Vocational rehabilitation is directed to, and has the primary goal of, improving capability for work and translating that into actual work that is remunerative and/or conducive to quality of life. This may secondarily, and in the longer term, lead to improved symptoms.
When should we introduce Vocational Rehabilitation Services? The debate about timing?

- VR services should only be introduced once the claimant is medically cleared and “job ready”; 

- VR services should be introduced once it has been established that a return to the pre-injury employer will not be successful due to significant post injury complications;

- Vocational Rehabilitation should be introduced as a “last ditch effort”.

- VR services should be introduced as soon as a claim has been identified;
Return to Work Stages

- Same Job
  - Same Employer
- Different job
  - Same Employer
- Same or Similar job
  - New Employer
- New Job (existing skills)
  - New Employer
- New Job (new skills)
  - New Employer
“FREE FALL”

- What happens if the GRTW fails and the work trial has collapsed?

- 27% of GRTW’s (with pre-injury employer) FAIL.

  (Insurance Bureau of Canada 2010)

- Psychological impact on the claimant may become as significant an issue as the injury itself.
Return to Work Stages

- Same Job, Same Employer
- Different Job, Same Employer
- Same or Similar Job, New Employer
- New Job (existing skills), New Employer
- New Job (new skills), New Employer

MOTIVATION
The Mental Health Commission of Canada reports that 21.4% of Canada’s working population suffer from a mental illness that potentially affects his/her productivity at work. (benefits canada.com, June 2013)

There is an urgent need to improve vocational rehabilitation interventions for mental health problems, which are now the largest and fastest growing cause of long-term incapacity.
At the time of returning injured workers/claimants to their pre-injury employer (job attached) the VR has the opportunity of assisting in the placement of the client and monitoring as an agent of the healthcare team to secure work site durability as well as report to the team functional concerns that may require interventions.
Early Identification: Red Flags

- High rate of absenteeism prior to disability
- Performance problems or disciplinary action in the year prior to disability;
- Pending litigation;
- Disability exceeds 21 days;
- Pre-existing disorders (i.e., psychiatric, repetitive strain injuries, somatic complaints, WCB injuries, substance abuse issues, etc.)
- Multiple diagnoses;
- Non-compliance with treatment plans;
- Others?
Here is what we learned from promoting early interventions

Vocational rehabilitation is an active process where the claimant participates within and is supported by the workplace and the healthcare team.
Vocational rehabilitation services are a process of active change, promoting and facilitating the journey from sickness to work. Vocational rehabilitation thrives where there is a multi-comprehensive, multi-provider approach— but in an inter-disciplinary manner where the claimant, the workplace employer and health professional(s) and treating specialists all work together towards a common goal.

The VRC is an active partner in the healthcare spectrum present in some form throughout the claimant’s recovery: it is not necessarily a separate program or service.
Vocational rehabilitation interventions have been shown to be ineffective for benefit recipients who have been on benefits and/or out of work more than 2 years. The available evidence therefore supports the rationale of providing any vocational rehabilitation intervention before people become trapped on benefits.

(OECD 2003; Thornton et al. 2003; Waddell & Aylward 2005).
The evidence suggests that structured vocational rehabilitation interventions are most effective between about 1 and 6+ months sickness absence, though the exact boundaries for the optimal ‘window of opportunity’ are unclear. It depends on the context just when the window commences, but as time passes the worker’s needs increase. The best evidence on the upper limit for effective interventions is between 3-6 months; there is progressively less evidence for effectiveness between 6-12 months, and very little for interventions after 12 months.

(Frank et al. 1996; Waddell et al. 2003)
There is general consensus that organization-level interventions (disability management, improved communication, early contact with absent worker, an agreed rehabilitation plan, flexibility in work organization and return to work arrangements) improve work outcomes.

(Egan et al. 2007; Lelliott et al. 2008; NICE 2008; Seymour & Grove 2005); Cox et al. 2000b; Damiani et al. 2004; Dong et al. 2002; Giga et al. 2003; Thomson et al. 2003; van der Klink et al. 2001)
The key element that would need to be created afresh is a single claims program that takes all those identified after about six weeks sickness absence and provides a) individual needs assessment, b) signposting to the appropriate help, and c) coordination of healthcare and workplace interventions to facilitate the return to work process.

(Hanson et al. 2006).
There is an urgent need to improve vocational rehabilitation interventions for mental health problems. Promising approaches include healthcare which incorporates a focus on return to work, workplaces that are accommodating and non-discriminating, and early intervention to support workers to stay in work and so prevent long-term incapacity.
Early Intervention Model: Europe

A Rehabilitation Assessment is conducted as soon as possible following an injury. The case manager works with the medical provider and vocational rehabilitation provider to determine restrictions/physical capabilities and communicates with the employer to identify modified/transitional duty return-to-work opportunities. Communication with employer, medical and rehabilitation providers and injured worker assists in returning the injured worker back to work more quickly, even while recovery continues.
Vocational Intervention Model

Multi-Comprehensive Health Care Team

Employer and Co-worker Support

Early VR Intervention and Sustained Monitoring

RTW

Realistic Goals

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Vocational Rehabilitation Services Model

Injury (21 days post)

Referral for Services

Job Attached (RTW pre-injury employer)

OT/VRC
• Placement
• 3 month follow-up
• 6 month follow-up

VRC: Vocational Rehab Consultant

Post Acute Complications (i.e. future surgery, TBI, PTSD)

OT/VRC
• MD interface
• Work Capacity Evaluation
• Employer/co-worker
• education
• Work hardening
• Pain management program
• Psychological counselling
• Neuropsychological assessment

Alternative Occupational Choices

VRC
• Vocational Assessment
• Physical Capacity Evaluation
• Retraining
• Placement services
• Job coaching
• Monitoring

• Avocational placement
• Community-based rehabilitation
• Financial compensation sources

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Beliefs about work that may form obstacles to return to work

- Belief that the health condition was caused by work (whether an accident or injury or the physical and mental demands of work);
- Belief that work is harmful, and that (return to) work will do further damage;
- Claimant's own fear of re-injury;
- Belief that sickness absence and rest are necessary for recovery;
- Belief that no one can or should return to work until the health condition is completely 'cured';
- Low expectations about return to work;
- Attribution of blame;
“What the mind can conceive, it can achieve.”

Napoleon Hill


OECD 2003; Thornton et al. 2003; Waddell & Aylward 2005


VRA. 2013. Vocational rehabilitation standards of practice. Vocational Rehabilitation Association, Canada