

Experiences and Impacts of the Job Retention and Rehabilitation Pilot

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Background

The Job Retention and Rehabilitation Pilot (JRRP) was a randomised controlled trial designed to test three interventions aimed at increasing the return-to-work rate of people who were off sick from work. The trial ran from April 2003 for two years, in six areas of the UK. The primary objective was a return to work for at least 13 consecutive weeks.

The trial was aimed at people who were in employment of 16 hours or more who had been on sickness absence for between six and 26 weeks. There was a range of marketing methods, and those interested in taking part telephoned a 'contact centre'. A series of questions were used to test eligibility and to screen in people unlikely to return to work without help. The screened in group were randomly allocated to one of four equally sized groups:

- a health intervention;
- a workplace intervention;
- a combined (workplace and health) intervention;
- a control group.

Design of the research

The research summarised here involved four components: the randomised controlled trial (RCT), and three qualitative research studies with service users, with people in the control group, and with JRRP provider staff.

In total 2,845 people entered the trial and were randomised, very close to 711 being allocated to each of the four randomisation groups. All 2,845 were asked to take part in an interview after their involvement in the trial: this interview was the main source of data on outcomes for the four groups. 2,161 (76 per cent) of the 2,845 agreed to be interviewed.

The qualitative research with service users involved a panel of 36 people who were interviewed six times – initially face-to-face and then by telephone at monthly intervals. The control group study involved 46 participants, interviewed once. The research with provider staff involved interviews with five people in a management capacity, and six group events with case managers.

Being off sick and entering the trial

The qualitative research showed that going off sick was not usually a planned event, which meant that people had limited opportunity to try to avert it or to discuss strategies with employers. Sickness absence brought boredom, frustration, isolation and feelings of guilt, and as it went on affected people's mental wellbeing. It also had financial implications which people had usually not considered when they went off sick. They generally had limited knowledge about the state benefits that would be available if they were off sick long term.

There were varied experiences of the NHS and of employers. Some GPs appeared to manage sickness absence more actively than others, and there were delays waiting for diagnostic tests and treatment. People generally wanted regular contact with line managers, but with the emphasis on their health and wellbeing rather than on when they would return to work, until they felt well enough to do so.

When they joined JRRP, they had limited knowledge about the services available. The operation of the RCT meant that little information could be given in advance about the different interventions. Where people had specific aspirations or requirements these mostly related to health, but motivations to take part were usually quite vaguely expressed.

The 2,845 people who entered the trial were slightly more likely to be women than men (57 per cent female); older on average than the UK labour force; and predominantly white (92 per cent). The most common health conditions cited were musculoskeletal (33 per cent) and mental and behavioural (30 per cent). Fourteen percent described their sickness absence as due to an injury.

Services received

Around 15 per cent of those randomised to one of the three intervention groups formally withdrew before receiving any intervention. A further 15 per cent did not withdraw but said at interview they had not received an intervention.

The services received differed from person to person. For those assigned to the health intervention group the most commonly used services were: physiotherapy (36 per cent); complementary therapy (30 per cent); psychotherapy (26 per cent) and referral to a medical specialist (23 per cent). For those assigned to the workplace intervention group the most commonly used services were: ergonomic assessment (42 per cent); and employer liaison/mediation (22 per cent).

For those assigned to the combined intervention group, health interventions were more common than workplace interventions (32 per cent receiving physiotherapy, but just 11 per cent receiving an ergonomic assessment and 22 per cent employer liaison/mediation). Almost a third (30 per cent) of participants in the combined intervention group underwent cognitive behavioural therapy (CBT).

The case management role emerged as an important part of the service. Staff described it involving: identifying needs and service responses; facilitating and coordinating use of services; supporting and empowering service users, and providing specific help or treatments. People valued highly the support they got from regular contact with case managers.

Staff felt that important aspects of the service were: being able to intervene early; taking a holistic approach tailored to the individual; being readily available to clients; flexibility in the use of budgets, and being able to provide intensive and focused interventions.

Satisfaction and effectiveness

Experiences of the services were varied and some people felt their needs were met very effectively. However, others identified types of help they would have liked but were not given, and this was not always explained by what was available within the different intervention groups. People described suggestions or offers from staff which were not followed up, and forms of help appeared not to have been consistently offered in similar cases.

Staff described external barriers to their work, particularly among employers and GPs. They found it sometimes hard to get access to employers, and said that they could be unsupportive and inflexible, with varied levels of understanding of sickness absence management and vocational rehabilitation. GPs, staff said, also did not always do enough to manage sickness absence actively or to focus on rehabilitation, and were sometimes over cautious in the advice they gave about returning to work.

Relationships and communication

Although people were generally happy with the proposals made by staff, they did not usually appear to be very actively involved in decisions about services. They generally looked to staff to initiate and maintain contact, although there were exceptions. This approach meant that contact could fall away, staff were not told of relevant changes in circumstances, and people were sometimes left in limbo not knowing whether or not they would be contacted again.

Impacts

The primary outcome for the trial was a return to work of 13 weeks or more. Comparing the rates of returns across the four randomisation groups gives a measure of the impact of the interventions (relative to the control group and relative to each other).

What was found in practice was almost identical return-to-work rates for each of the four groups: 44 per cent of those allocated to the health intervention group returned to work for at least 13 weeks; 45 per cent of those allocated to the workplace intervention; 44 per cent of those allocated to the combined intervention; and 45 per cent of those allocated to the control group. This implies that, overall, the JRR interventions had **no** impact on returns-to-work.

This overall finding masks some sub group impacts, although small sample sizes make interpretation difficult. For those who at the start of the trial reported they were off work sick with mental health problems it appears that the interventions may have actually reduced the likelihood of a return to work (59 per cent of the control group returned to work, compared to just 47 per cent of those in one of the intervention groups). In contrast, the interventions may have been most helpful to the minority of those off work sick because of an injury (36 per cent of those in the control group returned to work compared to 55 per cent of those in one of the intervention groups).

In terms of impact on self-reported health, it appears that the JRR interventions had a modest positive impact. One of the largest observed impacts is on mild depression, the prevalence of which appears to have been moderately reduced under the interventions (from 25 per cent in the control group to 20 per cent in the intervention groups).

Experiences of returning to work

Phased returns and lighter duties were important in facilitating returns to work, especially before people were fully fit. People appeared not to look readily to their GP for advice about whether they should return to work, talking more about the GP 'agreeing' with their own assessment that they were ready to return to work, or about having to 'convince' their GP. Returns to work were also prompted by concerns about job loss and financial pressures.

Among those who returned to work, some had very positive and smooth re-entries to work. But others were unable to sustain their return, because of continued ill-health, difficult or unsupportive relationships with employers, or for other reasons.

Explaining impacts

It is not entirely clear why the JRR interventions did not impact on employment. Piecing together the evidence, it appears that the most likely explanations for the 'no impact' finding overall are:

- that the interventions offered were not always seen to be appropriate to the clients or to meet their needs fully and that the service providers did not always encourage clients to be proactive and to initiate contact. There is some evidence that, in contrast, those in the control group were prepared to be pro-active on their own behalf;
- some of the primary reasons for returning to work, such as concerns about money or job tenure, would be outside of the control of the service providers;

- service providers faced barriers from employers and GPs that reduced the probability of their being able to gain a successful return-to-work.

Other possible explanations, such as the high withdrawal rate and the profile of people who entered the trial seem implausible, although it is possible that they made a contribution.

Other key messages

The features of a vocational rehabilitation service that are valued by staff and service users are:

- health services such as psychological therapies, interventions to boost strength and mobility, referrals to specialists, surgical interventions and complementary therapies;
- workplace support particularly employer liaison, advice on strategies for returning, assessments, vocational advice and help with job search and financial advice;
- active case management which empowers clients to take action;
- early intervention;
- holistic and tailored support, intensive where needed, supported by flexible budgets;
- effective and credible liaison;
- the ability to operate across professional and institutional boundaries.

The studies also provide support for initiatives to:

- encourage employers to engage actively with returns to work and to recognise the scope for job adjustments;
- enhance the vocational rehabilitation advice available to employers;
- encourage health professionals to manage returns to work and focus on this as an outcome;
- enhance vocational rehabilitation training for health professionals, and develop vocational rehabilitation services within the NHS.

The full reports of these research findings are published for the Department for Work and Pensions by Corporate Document Services (ISBN 1 84123 993 3. Research Report 339. March 2006. ISBN 1 84123 997 6. Research Report 342. March 2006).

They are available from Paul Noakes at the address below.

You can also download these reports free from: www.dwp.gov.uk/asd/asd5/rrs-index.asp

Other reports published as part of the JRRP evaluation are:

Mowlam A and Lewis J (2005) *Exploring how General Practitioners work with patients on sick leave* DWP Research Report No. 257 London: Corporate Document Services.

Nice K and Thornton P (2004) *Job Retention and Rehabilitation Pilot: Employers' management of long-term sickness absence* DWP Research Report No. 227 London: Corporate Document Services.

Stratford N, Farrell C, Natarajan L and Lewis J (2005) *Taking Part in a Randomised Control Trial: a participant's eye-view of the Job Retention and Rehabilitation pilot* DWP Research Report No. 273 London: Corporate Document Services.

Stratford N, Taylor R, Legard R, Natarajan L, Purdon S, and Shaw A (2005) *The Job Retention and Rehabilitation Pilot: Reflections on running a Randomised Control Trial* DWP Research Report No. 305 London: Corporate Document Services.

Other report summaries in the research series are also available from the website above and from:

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