



Údarás Náisiúnta Míchumais
National Disability Authority

International
Good Practice in
**Vocational
Rehabilitation:**
Lessons for Ireland

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2016

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Acknowledgements

The authors of this report wish to acknowledge the work and support of the following people and organisations. Particular thanks are due to the national correspondents in the four main participating countries in the research. These were:

- Dr. Elizabeth Kendall, Professor and Director of Research (Healthy People, Healthy Places) and Dr. Vanette McLennan, Griffith University, School of Human Service and Social Work, Brisbane, Australia
- Dr. Kathryn McPherson, Professor of Rehabilitation (Laura Ferguson Chair). Auckland University of Technology, Health and Rehabilitation Research Centre, New Zealand
- Dr. Anna-Liisa Lamsa, Research Manager, Luovi College, Finland.
- Andreja Svajger, Occupational Therapist, University Rehabilitation Institute, Republic of Slovenia, Vocational Rehabilitation Centre, Ljubljana, Slovenia.
- Dr. Malachy Bishop, Professor of Rehabilitation Counselling, University of Kentucky, United States

Our thanks are also due to Ms. Claude Delfosse, Project Coordinator, European Platform for Rehabilitation, Brussels, Belgium, who organised and managed the data collection activity from the eight EPR members. In addition, we would like to thank the EPR members from Denmark, France, Germany, Lithuania, the Netherlands, Norway, Portugal and Spain who contributed information on the situation of vocational rehabilitation in their countries.

In addition, the authors would like to acknowledge the contributions of the members of the advisory group and in particular Ciaran Diamond, Department of Social Protection; Brian Miller, Health Service Executive; Ann McGrane, Department of Health; Anne Good, NDA and those who contributed written submissions including John Church, Fit for Work Coalition; Helen Cornelissen, the Association of Occupational Therapists of Ireland (AOTI); Nikki Gallagher, SOLAS; Cliona Loughnane, Irish Heart Foundation; Gráinne McGettrick, Acquired Brain Injury Ireland; Donal O'Malley, Irish Association of Social Workers; and Richard Stables, Headway

We would also like to thank the NDA staff, Marion Wilkinson and Eithne Fitzgerald, who provided advice and guidance in the development and execution of the study.

List of Acronyms

ACC	Accident Compensation Corporation NZ
AT	Assistive Technology
CBI	Confederation of British Industry
CIPD	Chartered Institute of Personnel and Development
COE	Council of Europe
CPD	Continuing Professional Development
CRS	Commonwealth Rehabilitation Service, Australia
CTP	Compulsory Third Party insurance, Australia
ComCare	Workers Compensation provider Australia
DACT	The Disability Activation Project
DGUV	Der Deutschen Gesetzlichen Unfallversicherung (German Accident Compensation Board)
DMS	Disability Management Services Australia
DES	Disability Employment Services Australia
DSP	Department of Social Protection
DOH	Department of Health
DJEI	Department of Jobs, Enterprise and Innovation
DES	Department of Education and Skills
ESS	Employment Service of Slovenia
FAS	Foras Áiseanna Saothair (Training & Employment Authority)
FCE	Functional Capacity Evaluation
FET	Further Education and Training
FIOH	Finnish Institute of Occupational Health
IB	Illness Benefit
IBEC	Irish Business and Employer Confederation
GDP	Gross Domestic Product
MSD	Ministry of Social Development NZ
NDA	National Disability Authority
ILO	The International Labour Organisation
ISSA	The International Social Security Association
OECD	The Organisation for Economic Co-operation and Development
OR	Occupational rehabilitation
OSERS	Office of Special Education and Rehabilitation Services (USA)
PATHS	Providing Access to Health Solutions NZ
PDI	Pension and Disability Institute Slovenia
ROI	Return on Investment
RTW	Return to Work
SII	Social Insurance Institute (KELA) Finland
SOLAS	Seirbhísí Oideachais Leanunaigh Agus Scileanna (Further Education and Skills Services)
STP	Specialist Training Programme
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
VR	Vocational rehabilitation

Glossary of Terms

Accommodation: An adaptation to the work environment or conditions that is intended to facilitate a person with a disability to carry out the functions of a job.

Acquired Disability: A reduction in functional capacity or impairment that a person develops or acquires during their life span as a result of an injury or physical, sensory, mental or neurological health condition.

Adult and Basic Education: Compensatory education for people with literacy and numeracy difficulties.

Allied Health Interventions: Interventions provided by allied health professionals including physiotherapists, occupational therapists, psychologists and psychotherapists or counsellors.

Assistive Technology: Any item, piece of equipment, software, product or system of provision that increases, maintains, or improves the functional capabilities of a person with a disability.

Active Inclusion: A strategy that aims to promote the social inclusion and social protection of those furthest from the labour market by tackling issues of minimum income, access to quality services and inclusive labour markets in an integrated way.

Bonus-malus Insurance System: An incentive programme that sets employers workers' compensation insurance premiums on the basis of their claims experience, generally over the previous three years. Employers with a good track record in accidents and return to work of employees are granted a discount on their premiums. Employers with a poor claims experience are required to pay a higher premium.

Case Management: A collaborative process, including advocacy, communication and service coordination, that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a person's health and service needs. Return to work case management focuses specifically on return to work outcomes.

Community Employment: An active labour market programme/intervention that provides a person with a disability or others with an opportunity to gain experience working in a part-time or fixed-term contract job that usually provides a benefit to the local community.

Condition Management: Training for patients in how they can best manage the symptoms and limitations associated with specific health conditions.

Disability Activation Project: A set of pilot projects that sought to explore a variety of routes towards ensuring that people with disabilities were enabled to avail of progression, education and development opportunities in the world of work.

Disability Management: A proactive approach to promote the health and productivity of the workforce that includes prevention of workplace illnesses or injuries; job retention for workers experiencing reduced work capacity and return to work for absent employees through occupational rehabilitation and case management.

Early Intervention: The principle that making contact with absent employees, and providing necessary interventions in a safe and timely manner while the person has an employment contract, can enhance successful return to work and result in net savings for employers. While the average early intervention milestone is usually between one week and three months, it can vary widely depending on the severity and complexity of the health condition.

Employee and Family Assistance: A 24 hour confidential telephone service for the employees and their families, financed by a company as an employee benefit, to provide advice about how to cope with urgent issues and to direct them to appropriate support services.

EmployAbility: A national employment service, under the auspices of the Department of Social Protection in Ireland, dedicated to improving employment outcomes for job seekers with disabilities (formerly known as the Supported Employment Programme).

Ergonomics: The science of designing the workplace, keeping in mind the capabilities and limitations of the worker.

FÁS: The previous statutory agency responsible for promoting job opportunities and training in Ireland.

FET Specialist Training Programme: A national programme in Ireland, funded by SOLAS and administered by the Education and Training Boards, which provides vocational training courses which target the needs of people with disabilities.

Flexible Benefits: A scheme through which a person returning to work or embarking on employment can retain a proportion of his or her social protection income support.

Functional Capacity Evaluation: An assessment, usually carried out by a physiotherapist or occupational therapist, which evaluates an individual's health status, and body functions and structures, and compares them to the demands of the job and the work environment.

Functional Capacity Building: Interventions intended to build the stamina, endurance, physical capacity and psychosocial resilience. It can include physiotherapy, occupational therapy and pain management in a simulated or real work setting.

Job Capacity Assessment: An assessment of a person's work strengths and needs and environmental barriers to determine the most appropriate vocational rehabilitation service within the Australian system.

Job Coach: A support worker who provides individualised support to a person with a disability to develop job readiness, find suitable employment and receive on-the-job support to adjust to the workplace.

Job Demands Analysis: A process that assesses the work environment, working conditions and job role to identify the physical and psychosocial demands of an employment position.

Job Matching: A process through which a person's physical and psychological strengths and needs are compared to the demands of a job to evaluate suitability and identify required accommodations.

Job Trials: A situational assessment carried out in a real work situation to assess a person's work readiness, identify support needs and determine their vocational interests and preferences.

Occupational Activities: An HSE programme that offers participants a range of health, personal and social supports while engaging in productive work.

Occupational Guidance Service: An HSE service that provides information, guidance and support to people with disabilities including school leavers and their families regarding adult day support services and how to access these services.

Occupational Rehabilitation: A range of services and supports aimed at people with acquired disabilities who already have a job with the primary objective of facilitating return to work in the original job or an alternative with or without accommodations or supports.

One-Stop-Shop: A comprehensive service that provides a single entry point into the welfare system. They can be an umbrella organisation covering several agencies,

online portals with links to a variety of services or fully integrated and physically co-located services.

Open Employment: Part-time or full-time employment in the competitive labour market, with or without support, earning wages equivalent to workers carrying out the same duties in the same occupation, sector or industry.

Social Economy: Not for profit organisations and social enterprises that prioritise social objectives and social values including the creation of job opportunities for people with disabilities.

Social development: Interventions intended to enhance a person's capacity to participate effectively in social situations and to manage their relationships within and external to the workplace.

SOLAS: The Further Education and Training Authority responsible for funding, planning and co-ordinating training and further education programmes.

Supported Employment: A system designed to support people with disabilities, and other marginalised groups, to find and keep a job in integrated work settings, through the support of a job coach.

Transferrable Skills Analysis: A process that identifies the occupational, personal and social skills accrued by a person during previous work and life experience that can be used in an alternative job.

Transitional Work: A temporary alternative or modified work opportunity which can be assigned to an employee who is injured or ill and is returning to work.

Vocational Rehabilitation: A range of services aimed at people with disabilities, who are currently unemployed or economically inactive, with the primary objective of placement in employment with a new employer.

Wage Subsidy: A subsidy that is paid to an employer who employs a person with a disability to compensate for the reduced productivity of the worker.

Work Capacity Evaluation: An assessment, which can include a functional capacity evaluation, job demands analysis and job matching, that determines a person's physical abilities, limitations, and readiness to return to work.

Chapter 1. Background and terms of reference

1.1 Context of the project

In October 2015, the Irish Government published a comprehensive ten-year strategy for the employment of people with disabilities. Given that about three quarters of people of working age with a disability experience its onset in adulthood, the strategy includes a focus not only on those who have disabilities from birth or childhood, but also on those who acquire a disability during the course of their working lives¹. The action plan under the employment strategy provides for an advice paper from the National Disability Authority on a national vocational rehabilitation service, to support return to work after onset of a disability, and this research on international good practice was commissioned to inform that advice.

The aim of this project was to inform and guide national policy by gathering information and evidence on national systems, infrastructure, policies and practices in the area of vocational rehabilitation. A key issue here is how to ensure the effective integration of medical and vocational support services. The project is intended to complement the work of the National Neuro-Rehabilitation Strategy and the review of literature conducted for the National Council for Special Education on further education, training and rehabilitation for people with disabilities or special education needs².

It is important to emphasise that the current study builds on over 15 years of research and commentary on the Irish system of response to people with acquired disabilities. It sets out to bring together previous studies relating to the Irish context, current international research into good practice and a systems analysis

of vocational rehabilitation in 12 countries, together with comments from a US expert in this area. It aims to provide evidence to inform policy development in the areas of return to work, sustaining employment and finding new employment, for people who develop disabilities during their working lives, regardless of the cause of disability.

1.2 Objective of the research

The objective of the research is to provide information on selected relevant national models for organising vocational rehabilitation services that can guide discussions on the most appropriate model for Ireland. The focus is on international good practice at national level or state level (within federal systems) in the field of vocational rehabilitation systems, and on what Ireland can learn from such practice.

The definition of vocational rehabilitation used here has been synthesised from a number of sources³. It is characterised as a process that enables people with disabilities to overcome barriers to accessing, maintaining or returning to employment. Elements of the process can include:

- Assessment and appraisal
- Goal setting and intervention planning
- Provision of health advice and promotion, in support of employment
- Support for self-management of impairments and health conditions
- Making adjustments to the medical and psychological impact of a disability

¹ e.g. CSO Quarterly National Household Survey, Disability in the Labour Force module Q2 2002, http://www.cso.ie/en/media/csoie/releasespublications/documents/labourmarket/2002/qnhs_moduleondisabilityinthelabourforceqtr2002.pdf; Statistics Canada: **A Profile of Persons with Disabilities among Canadians Aged 15 Years or Older, 2012**. Accessed [25/08/2015]: <http://www.statcan.gc.ca/pub/89-654-x/89-654-x2015001-eng.htm>

² Department of Health. (2011) **National Policy and Strategy for the Provision of Neuro-Rehabilitation Services in Ireland 2011-2015**. Dublin, IRL: Author. Duggan, C. & Byrne, M. (2013) **What Works in the Provision of Higher, Further and Continuing Education, Training and Rehabilitation for Adults with Disabilities? A Review of the Literature**. Trim, IRL: National Council for Special Education

³ Chan F, Reid C, Kaskel LM, Roldan G, Rahimi M, Mpofu E. (1997) 'Vocational Assessment and Evaluation of People with Disabilities', **Physical Medicine and Rehabilitation Clinics of North America** 8 (2), pp. 311-325.
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Escorpizo, R., Reneman, M. F., Ekholm, J., Fritz, J., Krupa, T., Marnetoft, S-U., Maroun, C. E., Guzman, J. R., Suzuki, Y., Stucki, G. & Chan, C. C. H. (2011) A 'Conceptual Definition of Vocational Rehabilitation Based on the ICF: Building a Shared Global Model', **Journal of Occupational Rehabilitation**. 21 (2), pp. 126-133. Retrieved [24/08/2015] from: <http://vroegteinterventie.nl/wp-content/uploads/2012/10/def-voc-rehab.pdf>
Casey, P. & Cameron, I. (2014) **Principles of Best Practice in Occupational Rehabilitation for AIA Australia**. Melbourne, AUS: AIA Australia. Retrieved [24/08/2015] from: http://www.aia.com.au/en/resources/3b9ba88044c4d35380b1f40af27d2d40/Occ_rehab_best_practice_framework_0714.pdf

- Case management, referral, and service co-ordination
- Psychosocial interventions
- Career counselling, job analysis, job development, and placement services
- Functional and work capacity evaluations
- Planning for worksite accommodations
- Provision of assistive technologies
- Workplace awareness-raising programmes
- Proactive workplace preparations for return to work

The Glossary provides definitions of the majority of these terms.

An important distinction is made within the literature between vocational and occupational rehabilitation. The former generally refers to services and supports to assist people with disabilities not in work to gain employment. The latter refers to interventions to assist employed people who are long-term absent to return to their own job or an alternative. The distinction was not as evident in the practice and terminology used in the jurisdictions studied. Many systems used the term vocational rehabilitation as an umbrella term for both processes. It is important to note that, unless specified, this report uses the term vocational rehabilitation to cover both job-seeking and return to work, in the context of acquired disability.

1.3 Approach taken to the work

1.3.1 Research activities

The terms of reference for the project called for a number of key research activities. These were:

- A review of relevant literature and web resources
- Contact with key vocational rehabilitation networks
- Interviews with key informants in the four jurisdictions
- Focus group consultation with key Irish stakeholders and providers

These research activities were to be the basis of a comparison between the Irish situation and four other jurisdictions with a view to identifying lessons for the establishment of a comprehensive vocational rehabilitation system in Ireland. Appendix 6 gives some more detail on individual elements of the methodology and approach used.

1.3.2 Selection of jurisdictions

The first stage in undertaking the work was to select the four jurisdictions to be used for comparative

purposes. The selection criteria included requirements for countries to have well-developed vocational rehabilitation systems and sufficiently different systems from each other to allow contrasting approaches to be explored. In addition, it was important to ensure that the researchers had good contacts in these jurisdictions so that the research could be carried out efficiently, especially in the light of the timeframe for the research.

After a review of possible jurisdictions for inclusion in the study, the following four were selected:

- **Australia**, which has invested substantial effort in refining its approach to vocational rehabilitation and operates on a national and state level. Early intervention and active participation are the driving principles of the approach. It operates a dual system in which people with work and non-work illnesses and injuries are covered by different systems of provision. Due to the differences in provisions between Australian States, it was decided to focus on one state – **Queensland**. This allowed the study to focus on the key elements of the approach, rather than be side-tracked into describing inter-State differences.
- **Finland**, which is of interest for its maintenance-of-work-ability approach which views the right to rehabilitation as a central component of a system for protecting workers' health and productivity⁴.
- **New Zealand**, which is unique in that it operates a no-fault approach to all injuries including work accidents, road traffic accidents and domestic accidents. It has recently revised its system of provision of vocational rehabilitation on the basis of a comprehensive review. In the new system both job seeking and job retention are addressed.
- **Slovenia** is a new EU member state that has energetically revised its approach to vocational rehabilitation over the last ten years. It has taken a top-down approach by putting in place a coherent policy and legislation context for the development and delivery of medical and vocational rehabilitation. Continuity of provision and the seamless transition from one phase of rehabilitation to subsequent phases is a key objective.

Additional international inputs were obtained from a further nine countries with a range of different types of vocational rehabilitation system. These were drawn from the membership of the European Platform for Vocational Rehabilitation, a network of vocational rehabilitation agencies throughout Europe and the USA. The EU countries included in this part of the

⁴ Ilmarinen J. (2009) 'Work Ability – A Comprehensive Concept for Occupational Health Research and Prevention', *Scandinavian Journal of Work Environment & Health*, 35 (1), pp. 1–5.

study were: Denmark, France, Germany, Lithuania, The Netherlands, Norway, Portugal and Spain. The USA was included because it has a long history in the delivery of vocational rehabilitation (since 1918), a strong legal basis for services and a well-structured system of provision⁵.

These additional jurisdictions were not studied in the same depth but used to provide supplementary information to the four main study jurisdictions – here the aim was to obtain feedback from the experts in these countries on some key issues that emerged from the main part of the study, rather than providing an in-depth description of their systems.

1.3.3 Research questions

The terms of reference for the project outlined a set of research questions to describe the vocational rehabilitation systems in each jurisdiction. After initial investigation with key informants as to how feasible it would be to obtain information on these topics in the jurisdictions concerned, a final set of questions were agreed with the NDA as outlined below.

Legal and policy context

- Definition of vocational rehabilitation; target group description; eligibility criteria; legal basis for the system; government department and agency responsible; type of service providers; system financing; annual budget/expenditure; number of beneficiaries per annum; and outcome indicators

Structure and content

- Vocational rehabilitation services e.g. information and advice about vocational rehabilitation; case management; vocational assessment; guidance and counselling; and functional capacity evaluation

Referral and information sources

- Sources such as company occupational health services; HR; disability/injury management programmes; insurance claims managers; rehabilitation case managers; therapists; doctors; social services; medical and health services

System of delivery

- Movement from general health services to medical rehabilitation (MR) and on to vocational rehabilitation
- The role of rehabilitation case management
- Relationship between local/regional vocational rehabilitation services and national agencies or government bodies
- How are frontline services organised and delivered

Financing and resources

- How are vocational rehabilitation services funded
- How are service contracts awarded
- Total and per capita costs of a typical vocational rehabilitation service
- Staff mix in terms of job titles, skills, qualifications
- Cost benefit ratios or return on investment
- Academic or professional development courses

Organisational and individual incentives and support

- Person-focused incentives and supports, e.g. interpreter services, workplace personal assistance, flexible benefits for people with disabilities who enter employment
- Employer-focused incentives and supports, e.g. positive action; wage subsidies; productivity related financial supports; and employment quotas
- Provider-focused incentives, e.g. outcome-related financing

Approaches to quality and accreditation of services

- Vocational rehabilitation quality control and service accreditation systems; professional certification mechanisms; key performance outcome measures

Conclusions and lessons learned

- Evaluation studies on the impact of vocational rehabilitation
- Aspects of the system that represent good practice, the factors that are critical for success and system impact
- Advice on designing a system for providing vocational rehabilitation services

1.3.4 Specification of the target group

In this study the primary focus is on people who acquire disabilities during their working lives. Throughout the report they are referred to as people with acquired disabilities. This includes people with a wide range of impairments which may arise from injuries or as a result of physical, sensory, mental or neurological conditions. They include people with chronic illness, acquired brain injury (including stroke), musculoskeletal impairments including spinal and other physical injuries and arthritis, back pain, hearing or visual impairments, progressive health conditions, such as multiple sclerosis and mental health problems. Both internationally and in Ireland, the two largest groups of those with acquired disabilities are people with musculoskeletal conditions

⁵ NDA (2011) **Employment Policy & Practice for People with Disabilities in Three International Jurisdictions: A Contemporary Developments in Disability Services Paper**. Dublin. IRL: National Disability Authority.
OSERS (2014) **RSA: Programs and Projects**. Washington, DC, US: Office of Special Education and Rehabilitation Services. Retrieved (24/08/2015) from: <http://www2.ed.gov/about/offices/list/osers/rsa/programs.html>

or people with mental health difficulties, and these groups each account for roughly a third of all those concerned.

The focus of the study included those who may be long-term unemployed, those who are economically inactive, or those employed but absent from their jobs for an extended period of time.

The main characteristic they share is that their disabling conditions have resulted in reduced work capacity and they require specialist interventions and supports to access, maintain or return to employment.

Chapter 2. The context for vocational rehabilitation

The overall context for this examination of vocational rehabilitation is the Comprehensive Employment Strategy for People with Disabilities which has as its fourth strategic priority 'To promote job retention and re-entry into work'.

This Chapter provides an overview of the field of vocational rehabilitation, its potential beneficiaries, and its intended benefits at both individual and societal levels, drawing on the literature. This provides a context for interpreting the analysis of systems in 12 jurisdictions and the comparison with the current components of vocational rehabilitation in Ireland outlined in the next two chapters.

2.1 International obligations on vocational rehabilitation

International conventions and codes of good practice specify access to timely and effective rehabilitation as a right for people with disabilities. The UN Convention on the Rights of Persons with Disabilities (UNCPRD) (Articles 26 and 27); the International Labour Organisation's (ILO) Convention on Vocational Rehabilitation (No.159) and Recommendation (No. 168) and the ILO Code on Managing Disability in the Workplace, each address this right (ILO, 2002, 2008)⁶.

UN Convention on the Rights of Persons with Disabilities

Article 27 of the UN Convention on the Rights of Persons with Disabilities (UNCPRD) requires states to promote vocational and professional rehabilitation, job retention, and return-to-work programmes for people with disabilities. The UNCPRD⁷ supports the right of people with disabilities to early intervention; a multi-disciplinary assessment and services, close to where they live, to support job retention and return to work.

ILO Convention, Recommendation, Code on Vocational Rehabilitation

The ILO Convention on vocational rehabilitation (No.159) and Recommendation (No. 168) requires a national policy on vocational rehabilitation which is available to all categories of people with disabilities. According to the ILO Convention, vocational rehabilitation services involve vocational guidance, vocational training and placement services which should be initiated at an early stage with the cooperation of medical and social rehabilitation providers (ILO 2008). The ILO Code on Managing Disability in the Workplace emphasises the importance of rehabilitation in ensuring a person can secure, retain and advance in suitable employment (Article 6.2)⁸.

Ireland has ratified the ILO Convention on Vocational Rehabilitation (No.159) and Recommendation (No. 168) which specify vocational rehabilitation as a right. This includes vocational guidance, vocational training and placement services⁹. Under this Convention, Ireland is required to put in place and regularly review a national policy on vocational rehabilitation for all categories of people with disabilities. The policy must be supported by coordinated measures which are properly regulated and which involve early intervention and a coordinated approach by medical and social rehabilitation providers. The professional development of rehabilitation counsellors and other vocational rehabilitation staff is also required.

What these international obligations involve

The effective operation of a system of vocational rehabilitation requires the cooperation of employer and worker representatives not only in policy and system development, but also in frontline delivery. This needs to be regarded as an integral part of social security

⁶ UN Enable (2006) **UN Conventions on the Rights of Persons with Disabilities**. New York, US: Author. Retrieved (24/08/2015) from: <http://www.un.org/disabilities/default.asp?navid=15&pid=150>

ILO (2008) **Vocational Rehabilitation and Employment (Disabled Persons) Convention (No. 159) and Recommendation (No. 168): United Nations Convention on the Rights of Persons with Disabilities**. Geneva, CH: International Labour Organisation.

ILO. (2002) **Managing Disability in the Workplace. ILO Code of Practice**. Geneva, CH: International Labour Organisation.

UN Enable (2006) **UN Conventions on the Rights of Persons with Disabilities**. New York, US: Author. Retrieved (24/08/2015) from: <http://www.un.org/disabilities/default.asp?navid=15&pid=150>

ILO (2008) **Vocational Rehabilitation and Employment (Disabled Persons) Convention (No. 159) and Recommendation (No. 168): United Nations Convention on the Rights of Persons with Disabilities**. Geneva, CH: International Labour Organisation.

⁷ UN Enable (2006) **UN Conventions on the Rights of Persons with Disabilities**. New York, US: Author. Retrieved (24/08/2015) from: <http://www.un.org/disabilities/default.asp?navid=15&pid=150>

⁸ ILO. (2002) **Managing Disability in the Workplace. ILO Code of Practice**. Geneva, CH: International Labour Organisation.

⁹ ILO (2008) **Vocational Rehabilitation and Employment (Disabled Persons) Convention (No. 159) and Recommendation (No. 168): United Nations Convention on the Rights of Persons with Disabilities**. Geneva, CH: International Labour Organisation.

¹⁰ ILO (2008) **Vocational Rehabilitation and Employment (Disabled Persons) Convention (No. 159) and Recommendation (No. 168): United Nations Convention on the Rights of Persons with Disabilities**. Geneva, CH: International Labour Organisation.

and social protection systems¹⁰. The coordination of a range of measures to promote the employment of people with disabilities in the open labour market is at the core of an effective vocational rehabilitation system. This implies that incentives for employers, the provision of reasonable accommodations or assistive devices and the elimination of environmental barriers must be coordinated with other measures such as adult basic education; activities of daily living training; social support mechanisms; and social enterprises that aim at transition to open employment.

2.2 Terminology and approaches internationally

In many countries, systems have evolved over time rather than being designed from scratch, and consist of collections of regulations, provisions and services that are not necessarily coherent in nature. In addition, countries differ in the structure of their welfare systems in terms of key variables such as funding and eligibility. Moreover, there are regional variations in some federal states, all of which contribute to the complexity of how vocational rehabilitation is conceived and delivered.

The concepts used and the context for vocational rehabilitation vary considerably between jurisdictions and over time. In general, systems have evolved over time rather than being designed as a piece. So, there is variation in how vocational rehabilitation is defined and delivered, and differences in terminology used internationally. In particular, international terminology varies depending on whether the person being assisted is currently employed, or is now unemployed or economically inactive.

Vocational services for unemployed or economically inactive people with disabilities are referred to as 'vocational rehabilitation' in most jurisdictions. The potential beneficiaries can be:

- People with congenital or developmental disabilities, or impairments acquired in early childhood who are exiting secondary or tertiary education and seeking employment on the open labour market,
- People with acquired disabilities who are seeking a job either for the first time or after an extended period of inactivity.

Consequently, the goal of vocational rehabilitation is placement in employment with a new employer. This requires a range of activities which include assessment and career exploration, independent living/personal assistance and further education and training (see Table 2.1).

In 2000, the Council of Europe broadened the traditional focus of vocational rehabilitation to include support for employers and both specialised and mainstream training and guidance as key components of a national disability employment strategy¹¹.

Services for workers with acquired disabilities who remain employees can be referred to by different terms such as 'disability management' or 'occupational rehabilitation'. The two main components are job retention and return to work for employed workers. The primary goal is to work with the person and their employer to facilitate return to work. As this is aimed at people who already have a job, it is not necessary to address vocational guidance, job seeking skills or vocational training. Consequently, the main activities involved include such elements as functional capacities evaluation, allied health interventions and on-the-job support (see column 2 of Table 2.1).

In Germany and Canada and a number of other jurisdictions, the pillar of action aimed at employed people is referred to as Disability Management (DM)¹². DM quality standards are promoted and governed by the International Disability Management Standards Council¹³. In other locations, return-to-work services for ill or injured workers are referred to as occupational rehabilitation¹⁴, tertiary prevention¹⁵, injury management and rehabilitation¹⁶, workplace rehabilitation¹⁷ and work disability prevention. In a number of jurisdictions, vocational rehabilitation services also provide occupational rehabilitation.

¹¹ COE (2000). **Employment strategies to promote equal opportunities for persons with disabilities on the labour market**. Strasbourg, FR: Council of Europe.

¹² Harder, H. & Geisen, T. (Eds.) (2011) **Disability Management and Workplace Integration**. Surry, UK: Gower Publishing Limited.

Gensby U, Lund T, Kowalski K, Saidj M, Jørgensen AMK, Filges T, Irvin E, Amick BC III, Labriola, M. (2012) **Workplace Disability Management Programs Promoting Return-to-Work: A Systematic Review**. Campbell Systematic Reviews 2012:17.

¹³ <http://www.idmsc.org/pages/index.html>

¹⁴ Casey, P. & Cameron, I. (2014) **Principles of Best Practice in Occupational Rehabilitation for AIA Australia**. Melbourne, AUS: AIA Australia. Retrieved [24/08/2015] from: http://www.aia.com.au/en/resources/3b9ba88044c4d35380b1f40af27d2d40/Occ_rehab_best_practice_framework_0714.pdf

¹⁵ Institute for Work and Health (2006) 'What Researchers Mean by Primary, Secondary and Tertiary Prevention', **atWORK** 43, Winter p 2. Retrieved [24/08/2015] from: http://www.iwh.on.ca/system/files/at-work/at_work_43.pdf

¹⁶ Office of Regulatory Services (2010) **What is Injury Management and Rehabilitation? Version 6**. Canberra, AUS: Retrieved [24/08/2015] from: <http://www.worksafe.act.gov.au/page/view/1455/title/what-is-injury-management-and#Injury%20Management>

WorkSafe ACT (2013) **Workers Compensation - Injury Management Processes: Guidance Note WSACT GN 0052**. Canberra, AUS: Office of Regulatory Services, Australian Capital Territory Department of Justice and Community Safety. Retrieved [24/08/2015] from: <http://www.worksafe.act.gov.au/publication/view/1257>

¹⁷ Health Service Executive (2013) **HSE Policy and Procedure - Rehabilitation of Employees Back To Work after Illness or Injury: Revision No 4.13**. Dublin, IRL: Author. Retrieved [24/08/2015] from: http://www.hse.ie/eng/staff/Resources/hrppg/Rehabilitation_Policy.pdf

Table 2.1 below seeks to capture the different international concepts of vocational rehabilitation, occupational rehabilitation, and disability management and the elements associated with each definition. Definitions of the terms used in Table 2.1 are provided in the Glossary

All of these activities may also be made available to people participating in vocational rehabilitation and to people benefiting from employer-based disability management programmes.

Terminology for the present study

This study is focused specifically on people with acquired disabilities whether they are in employment or are economically inactive, who account for roughly three quarters of people with disabilities of working age¹⁹. It therefore covers the elements in all three columns above. In this study, the term 'vocational rehabilitation' is taken to encompass the international terms 'vocational rehabilitation' and 'occupational rehabilitation'.

Table 2.1. Vocational and Occupational Rehabilitation and Disability Management

Vocational Rehabilitation (VR)	Occupational Rehabilitation (OR)	Disability Management (DM)
Intended Beneficiaries	Intended Beneficiaries	Intended Beneficiaries
<ul style="list-style-type: none"> ● Unemployed People with Disabilities ● Society 	<ul style="list-style-type: none"> ● Ill or Injured Workers 	<ul style="list-style-type: none"> ● Employers ● Workers ● Society
Intended Outcomes	Intended Outcomes	Intended Outcomes
<ul style="list-style-type: none"> ● Labour Market Inclusion ● Reduced Dependency ● Reduced Poverty 	<ul style="list-style-type: none"> ● Return to Original Job with or without Accommodations ● Redeployment 	<ul style="list-style-type: none"> ● Labour Market Inclusion ● Reduced Dependency ● Reduced Poverty ● Reduced Prevalence of Disability ● Healthy and Productive Workforce ● Reduced Disability Costs ● Increased Profitability
Components Unique to VR	Components of OR Shared with VR and DM	Components Unique to DM
<ul style="list-style-type: none"> ● Assessment & Career Exploration ● Independent Living/Personal Assistance ● Further Education & Training ● Job Matching ● Job Seeking Skills ● Job Trials ● Job Placement Support ● Supported Employment ● Social Development ● Adult & Basic Education 	<ul style="list-style-type: none"> ● Functional Capacities Evaluation ● Allied Health Interventions ● Condition Management ● Case Management and Service Coordination ● Counselling & Guidance ● Building Functional Capacity ● Disability Awareness Training ● On-the-Job Support ● Job Demands Analysis ● Assistive Technology and Accommodations ● Ergonomics 	<ul style="list-style-type: none"> ● Accident Prevention and Safety ● Health Promotions ● Employee and Family Assistance ● Early Contact ● Early Intervention ● Transitional Work Options

¹⁸ Loisel, P. & Anema, J. R. (2013) **Handbook of Work Disability: Prevention and Management**. New York, US: Springer Science + Business Media.

¹⁹ The actual estimates vary by data source, e.g. National Disability Survey 2006 (c 70%) and QNHS 2002 (85%). Central Statistics Office (2002) **Quarterly National Household Survey: Disability in the Labour Force Second Quarter 2002**. Dublin, IRL. Retrieved (24/08/2015) from: http://www.cso.ie/en/media/csoie/releasespublications/documents/labourmarket/2002/qnhs_moduleondisabilityinthelabourforceqtr22002.pdf

2.3 The vocational rehabilitation process

2.3.1 Steps in the vocational rehabilitation process

In 1997 Chan et al characterised vocational rehabilitation as a dynamic process, involving a set of sequential processes, beginning with initial referral and ending with successful employment, which addresses the full range of needs of a person. Activities in the vocational rehabilitation process are implemented in parallel and the timeframes overlap²⁰.

In general, the vocational rehabilitation process starts with assessing individual needs and strengths and matching these with interests and job demands. Through a process of assessment, counselling and guidance, the jobseeker is helped to select a field of employment and an occupation that is within the scope of their abilities. The rehabilitation professional ensures that they gain the knowledge, skills and qualifications required, gain access to functional capacity-building interventions, if necessary, and develop social competences and job search skills. Adult basic education and further education and training are important interventions for people with low education

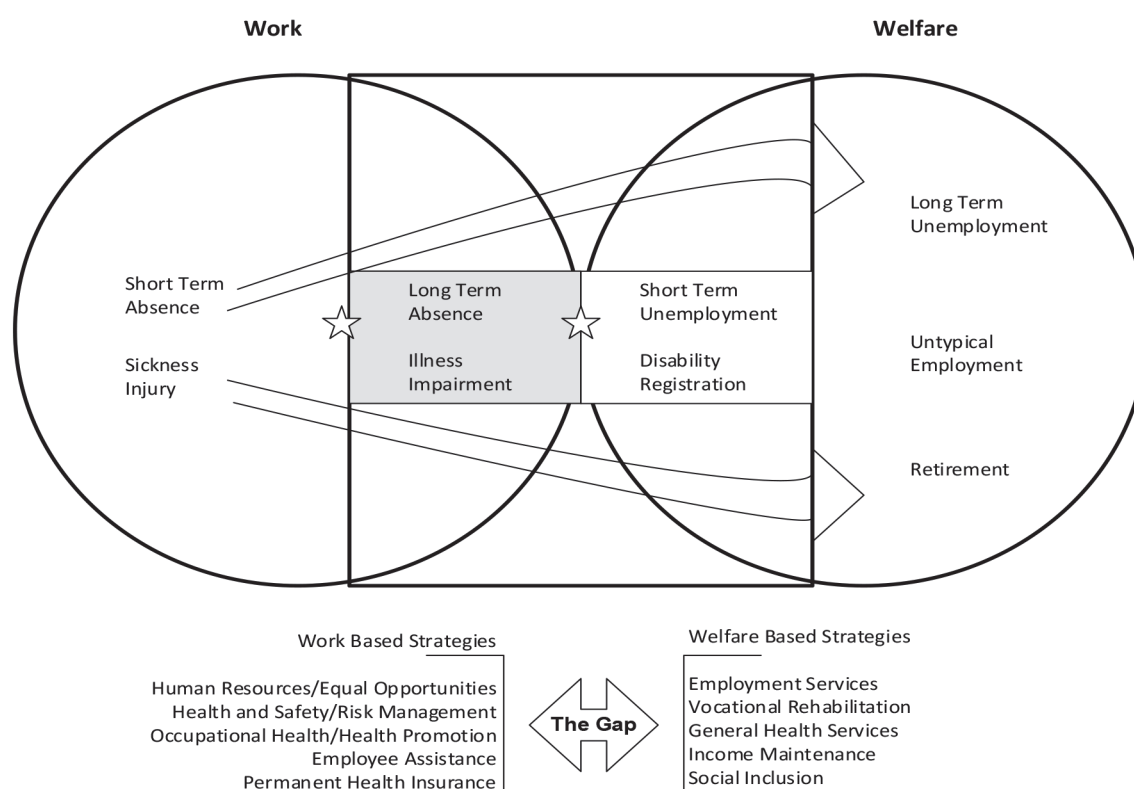
and qualifications. The rehabilitation professional then acts as a support in identifying suitable job opportunities and acting as an intermediary with a potential employer to arrange work experience or a job interview. As part of the placement process, the rehabilitation professional carries out a job site visit and a job demands analysis to identify the accommodations and assistive technologies that may be needed by the person. An important characteristic of vocational rehabilitation is that it operates within the community and integrates where possible into mainstream services and activities.

Sections 2.7 and 2.8 in this chapter look in more depth at issues around early intervention, and linkages between medical and vocational rehabilitation.

2.3.2 Schematic representation to illustrate system gaps

In the absence of seamless vocational rehabilitation pathways, the onset of a disability for an adult of working age may instead result in a journey from the labour market to social exclusion²¹. Figure 2.1 illustrates diagrammatically how separate streams of support for those in work and those who have already left employment can leave a gap in the middle. Prevention

Figure 2.1. The Work-to-Welfare Gap²²



²⁰ Chan F, Reid C, Kaskel LM, Roldan G, Rahimi M, Mpofu E. (1997) 'Vocational Assessment and Evaluation of People with Disabilities', *Physical Medicine and Rehabilitation Clinics of North America* 8 [2], pp. 311-325.

²¹ Wynne, R. and McAnaney, D. (2004) *Employment and Disability: Back to Work Strategies*. Dublin, IRL: The European Foundation for the Improvement of Living and Working Conditions.

²² Adapted from Wynne and McAnaney (2004)

measures through the health system (health promotion) and in the workplace (occupational health and safety) aim to protect people from developing or acquiring an impairment. The left hand part of the figure illustrates the point at which a health condition is acquired or developed. Most people cope with this through periods of short term absence. Within this group of workers, absences are relatively rare and of short duration. Many will be in receipt of sick pay from their employer or from social security. About 70 per cent of all absence can be attributed to short absences of less than six weeks.

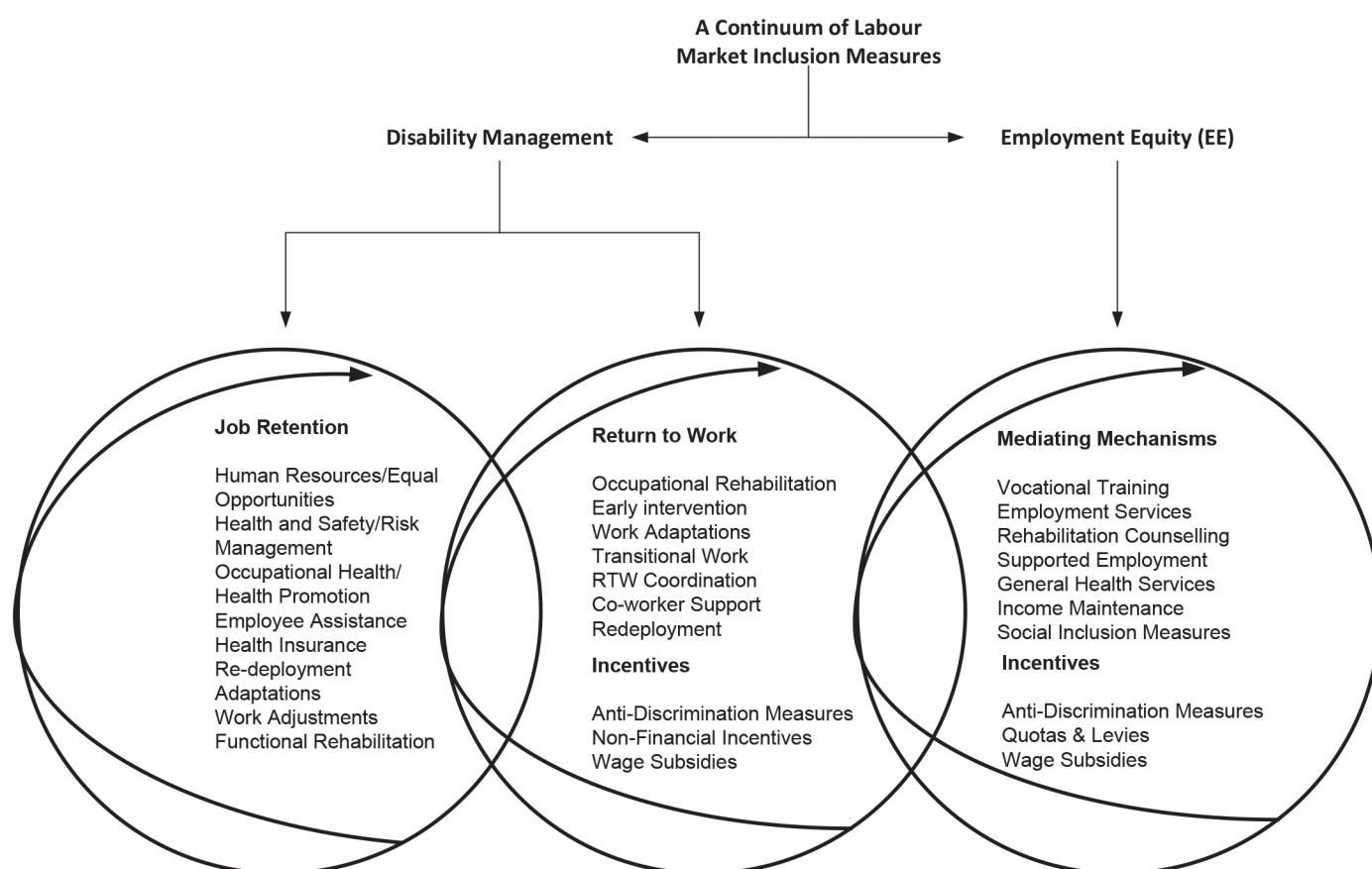
In some cases, however, the health condition can put a person's employment at risk, and measures are required to prevent them from progressing to unemployment, economic inactivity and benefits dependency.

In the right hand segment of Figure 2.1 are people who are unemployed or economically inactive. A range of general and specialist active labour market measures are focused on this target group including vocational rehabilitation. Generally, eligibility for such services requires being in receipt of a social protection allowance, benefit or pension and/or being designated as being disabled.

In the central segment of the Figure are the processes that can result in a person, who needs to take long-term absence from work, moving from employment to unemployment. During the period of long term absence, the person will maintain the attachment to the employer. He or she is counted as employed by employment services and in labour market statistics. Even though the person may have a significant impairment, they are not entitled to the services available for unemployed or inactive people with disabilities. In order to access these supports and services, the person must give up employment and apply for a disability pension. This is the work-to-welfare gap. This gap is evident in many systems particularly for workers with non-occupational illnesses and injuries.

Figure 2.2 illustrates the mechanisms that can be put in place to address this gap, and the two main pillars of action at societal level. The first pillar comprises measures designed to respond to people who are currently employed. At the far left of Figure 2.2 are the measures aimed at workers who are still at work and which aim to promote and protect health and productivity. These are strategies that either reduce the likelihood of developing a health condition that puts

Figure 2.2. A continuum of labour market inclusion measures²³



²³ Adapted from Wynne and McAnaney (2004)

employment status at risk, or to respond in a timely manner to the needs of people with acquired disabilities to reduce the chances that the condition will become chronic or that the person will need to resort to sickness absence.

These interventions can be termed primary and secondary prevention respectively²⁴.

The central part of the figure specifies the measures needed by workers with acquired disabilities who maintain an attachment to their employer, i.e. they address the needs of people in the work-to-welfare gap. The effectiveness of these services depends upon delivery in an early but safe manner before people become 'disabled' from an administrative perspective. Such services must address the impact of the health condition and return to work. The aim must be to return the person to the original employer in their job. If this is not an option, placement in an alternative with or without adaptations should be the goal. This is what is referred to as tertiary prevention²⁵.

In the right hand side of the figure, the second pillar involves measures to achieve equity in employment outcomes for people with developmental impairments or people with acquired disabilities who are economically inactive. These are effectively the welfare-based mechanisms described above. These can be identified in the majority of jurisdictions in various forms.

2.4 The economic and social impact of acquired impairments

Comprehensive information on the economic costs of

acquired disability is difficult to find, but data from the UK and elsewhere suggest that the direct and indirect costs involved in absence from work due to sickness are substantial. Estimates for Ireland in terms of costs to employers were €818 per employee annually which represented a total cost estimate of approximately €1.5bn (IBEC, 2011)²⁶. Based on data from other jurisdictions, it can be extrapolated that the costs of long term absence in Ireland are in the region of €0.65bn.

A number of common themes can be identified across countries. Details of the data presented below are presented in Appendix 5.

2.4.1 Prevalence and characteristics of absence

- In the UK, days lost to sickness absence account for between 2–3 per cent of total working days, over 40 per cent as a result of long term absence. Public sector absence rates were substantially higher²⁷.
- Average rates of absence per employee ranged from 8.4 days in UK to 10 days in Canada (Conference Board of Canada, 2013)²⁸.
- Public sector absence rates were substantially higher than those in the private sector²⁹.
- Non-work related illness and injury were by far the most common reason for absence³⁰.
- Long term absence accounted for 32 per cent of absence in the UK³¹.
- The duration of absence rates for older workers in the UK was over double that of younger employees (13.2 days compared to 5.9 for younger workers)³².

2.4.2 Direct and indirect costs of absence

- Estimates of the economic costs included between £13.4bn and £17bn STG in the UK; \$16.6 CND in

²⁴ Institute for Work and Health (2006) 'What Researchers Mean by Primary, Secondary and Tertiary Prevention', *atWORK* 43, Winter p 2. Retrieved (24/08/2015) from: http://www.iwh.on.ca/system/files/at-work/at_work_43.pdf

²⁵ Institute for Work and Health (2006) 'What Researchers Mean by Primary, Secondary and Tertiary Prevention', *atWORK* 43, Winter p 2. Retrieved (24/08/2015) from: Differences in terminology http://www.iwh.on.ca/system/files/at-work/at_work_43.pdf

²⁶ IBEC (2011) **Employee Absenteeism: A Guide to Managing Absence**. Dublin, IRL: Irish Business and Employers Confederation. Retrieved from: [http://www.ibec.ie/IBEC/DFB.nsf/vPages/Research_and_surveys-Employer_issues-ibec-guide-to-managing-absence-16-05-2013/\\$file/Employee%20Absenteeism%20-%20A%20Guide%20to%20Managing%20Absence.pdf](http://www.ibec.ie/IBEC/DFB.nsf/vPages/Research_and_surveys-Employer_issues-ibec-guide-to-managing-absence-16-05-2013/$file/Employee%20Absenteeism%20-%20A%20Guide%20to%20Managing%20Absence.pdf)

²⁷ Barham, C. & Leonard, J. (2002) **Trends and sources of data on sickness absence**. *Labour market trends*. London, UK: Office for National Statistics.

CBI (2006) **Absence minded: Absence and Labour Turnover**. London, UK: Confederation of British Industry. Retrieved (24/08/2015) from: <http://www.orghealth.co.uk/uploads/articles/Absence%20and%20labour%20turnover%20survey%20-%20CBI%20AXA.pdf>

²⁸ CIPD (2008) **A Barometer of HR Trends and Prospects**. London, UK: Chartered Institute of Personnel and Development. Retrieved (24/08/2015) from: <http://www.re-integrate.eu/resources/a-barometer-of-hr-trends-and-prospects-2008.pdf>

Conference Board of Canada (2013) **Missing in Action: Absenteeism Trends in Canadian Organizations**. Ottawa, CA: Author. Retrieved (24/08/2015) from: <http://www.conferenceboard.ca/e-library/abstract.aspx?did=5780>

²⁹ CBI (2006) **Absence minded: Absence and Labour Turnover**. London, UK: Confederation of British Industry. Retrieved (24/08/2015) from: <http://www.orghealth.co.uk/uploads/articles/Absence%20and%20labour%20turnover%20survey%20-%20CBI%20AXA.pdf>

CBI (2011) **Healthy returns? Absence and Workplace Health Survey 2011**. London, UK: Confederation of British Industry. Retrieved (24/08/2015) from: http://www.cbi.org.uk/media/955604/2011.05-healthy_returns_-_absence_and_workplace_health_survey_2011.pdf

³⁰ BusinessNZ. (2013) **Wellness in the Workplace: Survey Report 2013**. Wellington, NZ: Author. Retrieved (24/08/2015) from: http://www.businessnz.org.nz/_data/assets/pdf_file/0005/74615/Wellness-in-the-Workplace-Survey-2013-Report.pdf

³¹ CBI (2011) **Healthy returns? Absence and Workplace Health Survey 2011**. London, UK: Confederation of British Industry. Retrieved (24/08/2015) from: http://www.cbi.org.uk/media/955604/2011.05-healthy_returns_-_absence_and_workplace_health_survey_2011.pdf

³² CBI (2011) **Healthy returns? Absence and Workplace Health Survey 2011**. London, UK: Confederation of British Industry. Retrieved (24/08/2015) from: http://www.cbi.org.uk/media/955604/2011.05-healthy_returns_-_absence_and_workplace_health_survey_2011.pdf

Canada; \$1.26bn NZD in New Zealand and €1.5bn in Ireland (IBEC, 2011)³³.

- The cost of workplace illness and injuries alone in Australia was \$57.5bn AUD and had increased by 68 per cent over five years³⁴.
- Costs per employee ranged from between £537 to £760 in the UK (CIPD, 2007); \$837 NZD in New Zealand; and €818 in Ireland³⁵.
- Estimates of employer costs ranged from 2.4 per cent to 2.9 per cent of payroll in Canada and the US respectively³⁶. In New Zealand, it was estimated that the cost for each employer was about \$35,146 NZD depending on the size of the enterprise³⁷.
- Indirect costs included increased workload, disrupted work processes, stress, reduced morale and quality of outputs and overtime³⁸.

2.4.4 Social costs of acquired disabilities

It is widely acknowledged that the number of people of working age entering the disability benefits system in most developed economies is increasing and likely to become unsustainable³⁹. The consequences of this trend for the quality of life of people with acquired

disabilities and their families in terms of economic and social exclusion, dependency and poverty is extremely negative.

People with disabilities are more likely to be on temporary contracts, to be paid lower wages and to be more economically insecure. More than one out of five persons with disabilities are at risk of poverty in the EU (21.1 per cent) as compared to 14.9 per cent for persons without disabilities. There is an increasingly high level of inequalities in access to health and social services for people with disabilities in the EU⁴⁰. Gannon & Nolan noted that the onset of disability during working age resulted in a 20 per cent drop in the likelihood of employment and recommended an emphasis on job retention⁴¹.

The employment rate of people with long standing health problems and disabilities in the EU-28, in 2011, was estimated to be almost 20 percentage points below that of people without such difficulties. The employment rate was one of the lowest in the OECD at 33 per cent⁴². The situation has changed little in the intervening years⁴³. The obverse of employment is non-employment which includes those actively seeking work

³³ CBI (2006) **Absence minded: Absence and Labour Turnover**. London, UK: Confederation of British Industry. Retrieved (24/08/2015) from: <http://www.orghealth.co.uk/uploads/articles/Absence%20and%20labour%20turnover%20survey%20-%20CBI%20AXA.pdf>

Conference Board of Canada (2013) **Missing in Action: Absenteeism Trends in Canadian Organizations**. Ottawa, CA: Author. Retrieved (24/08/2015) from: <http://www.conferenceboard.ca/e-library/abstract.aspx?did=5780>

BusinessNZ. (2013) **Wellness in the Workplace: Survey Report 2013**. Wellington, NZ: Author. Retrieved (24/08/2015) from: http://www.businessnz.org.nz/__data/assets/pdf_file/0005/74615/Wellness-in-the-Workplace-Survey-2013-Report.pdf

IBEC (2011) **Employee Absenteeism: A Guide to Managing Absence**. Dublin, IRL: Irish Business and Employers Confederation. Retrieved (24/08/2015) from: [http://www.ibec.ie/IBEC/DFB.nsf/vPages/Research_and_surveys-Employer_issues-ibec-guide-to-managing-absence-16-05-2013/\\$file/Employee%20Absenteeism%20-%20A%20Guide%20to%20Managing%20Absence.pdf](http://www.ibec.ie/IBEC/DFB.nsf/vPages/Research_and_surveys-Employer_issues-ibec-guide-to-managing-absence-16-05-2013/$file/Employee%20Absenteeism%20-%20A%20Guide%20to%20Managing%20Absence.pdf)

³⁴ Barnett, K. & Hordacre, A. (2010) **The Role of the Workplace in Return to Work: Discussion Paper presented to WorkCoverSA**. Adelaide, AUS: Australian Workplace Innovation and Social Research Centre (WiSeR). Retrieved (24/08/2015) from: https://www.adelaide.edu.au/wiser/pubs/pdfs/wiser201017_discussion_paper_the_role_of_workplace_in_return_to_work.pdf

³⁵ CBI (2006) **Absence minded: Absence and Labour Turnover**. London, UK: Confederation of British Industry. Retrieved (24/08/2015) from: <http://www.orghealth.co.uk/uploads/articles/Absence%20and%20labour%20turnover%20survey%20-%20CBI%20AXA.pdf>

CBI (2011) **Healthy returns? Absence and Workplace Health Survey 2011**. London, UK: Confederation of British Industry. Retrieved (24/08/2015) from: http://www.cbi.org.uk/media/955604/2011.05-healthy_returns_-_absence_and_workplace_health_survey_2011.pdf

BusinessNZ. (2013) **Wellness in the Workplace: Survey Report 2013**. Wellington, NZ: Author. Retrieved (24/08/2015) from: http://www.businessnz.org.nz/__data/assets/pdf_file/0005/74615/Wellness-in-the-Workplace-Survey-2013-Report.pdf

IBEC (2011) **Employee Absenteeism: A Guide to Managing Absence**. Dublin, IRL: Irish Business and Employers Confederation. Retrieved (24/08/2015) from: [http://www.ibec.ie/IBEC/DFB.nsf/vPages/Research_and_surveys-Employer_issues-ibec-guide-to-managing-absence-16-05-2013/\\$file/Employee%20Absenteeism%20-%20A%20Guide%20to%20Managing%20Absence.pdf](http://www.ibec.ie/IBEC/DFB.nsf/vPages/Research_and_surveys-Employer_issues-ibec-guide-to-managing-absence-16-05-2013/$file/Employee%20Absenteeism%20-%20A%20Guide%20to%20Managing%20Absence.pdf)

³⁶ Mercer. (2010) **Survey on the Total Financial Impact of Employee Absences**. Chelmsford – MASS, US: Kronos Incorporated.

³⁷ BusinessNZ. (2013) **Wellness in the Workplace: Survey Report 2013**. Wellington, NZ: Author. Retrieved (24/08/2015) from: http://www.businessnz.org.nz/__data/assets/pdf_file/0005/74615/Wellness-in-the-Workplace-Survey-2013-Report.pdf

³⁸ Mercer. (2010) **Survey on the Total Financial Impact of Employee Absences**. Chelmsford – MASS, US: Kronos Incorporated.

³⁹ OECD (2003) **Transforming disability into ability: Policies to promote work and income security for disabled people**. Paris, FR: Organisation for Economic Cooperation and Development. Retrieved from: <http://www1.oecd.org/publications/ebook/8103021E.PDF108>

OECD (2009) **Pathways onto (and off) Disability Benefits: Assessing the Role of Policy and Individual Circumstances**. OECD Employment Outlook 2009: Tackling the Jobs Crisis. Paris, FR: Organisation of Economic Cooperation and Development.

⁴⁰ Hauben, H., Coucheir, M., Spooren, J., McAnaney, D., & Delfosse, C. (2012) **Assessing the Impact of European Governments' Austerity Plans on the Rights of People with Disabilities: European Report**. European Foundation Centre, Brussels. Retrieved (24/08/2015) from: http://www.efc.be/programmes_services/resources/Documents/Austerity%20E http://www.enil.eu/wp-content/uploads/2012/12/Austerity-European-Report_FINAL.pdf

⁴¹ Gannon, B. & Nolan, B. (2006) **The Dynamics of Disability and Social Inclusion**. Dublin, IRL: Equality Authority.

⁴² Eurostat (2014) **Disability statistics – labour market access**. Retrieved (29/08/2015) from: http://ec.europa.eu/eurostat/statistics-explained/index.php/Disability_statistics_-_labour_market_access

⁴³ OECD (2010) **Sickness, Disability and Work: Breaking the Barriers**. Paris, FR: Organisation of Economic Cooperation and Development. Retrieved (24/08/2015) from: <http://www.oecd.org/ireland/46461490.pdf>

⁴⁴ Wolf, P. & Agafitei, L. (2014) 'EU Labour Force Survey 2011 & Statistics on Income and Living Conditions: First results for persons with disabilities'. Presented to the Joint Eurostat-EDF meeting 'Persons with disabilities at work: the invisible workers?' organised under the DISCIT project. Brussels, BE: December 2014. Retrieved (24/08/2015) from: http://www.novamente.pt/wp-content/uploads/2015/05/Disability-statistics-ESTAT_Pascal-Wolff.pdf

(unemployed) and those who have withdrawn from the labour force, who are economically inactive.

Unemployment rates for people with disabilities across the OECD are over 40 per cent higher than people without disabilities⁴⁵. In Ireland, at the end of 2007, the unemployment rate for people with chronic health problems or disability was estimated at 20.1 per cent in comparison with an OECD average of 13.7 per cent. The unemployment rate in Ireland for people with disabilities was estimated to be over 15 per cent and the employment rate to be slightly over 30 per cent. When these figures are viewed in relation to the other EU jurisdictions included in the current analysis (see Table 2.2), it can be seen that only Spain exceeds Ireland in terms of the disability unemployment rate and that all jurisdictions outperformed Ireland in relation to the employment rate.

However, these comparisons should be viewed with caution. International comparisons of disability employment rates are prone to significant national variations in the proportion of people self-reporting a long-standing health problem or disability. Further, the proportion of non-employed people with disabilities who regard themselves as 'unemployed' (i.e. actively seeking work) and those who regard themselves as outside the labour market (i.e. economically inactive) varies across jurisdictions.

Table 2.2. Unemployment and Employment Rates for People with Disabilities⁴⁶

	Unemployment Rate	Employment Rate
DE	10-15%	50-60%
DK	10-15%	40-50%
ES	20-25%	40-50%
FI	5-10%	60-70%
FR	10-15%	50-60%
IRL	15-20%	30-40%
LU	5-10%	60-70%
NL	5-10%	40-50%
PT	10-15%	50-60%
SI	10-15%	40-50%

Although survey questions are the same in all European jurisdictions, there are substantial variations in the proportion of people self-reporting disability. For example, jurisdictions in which a greater proportion of the population self-report a disability, often have higher disability employment rates. Thus, Greece and Malta, in which relatively few people report having impairments (between 7 per cent to 8 per cent), have low disability employment rates (31-32 per cent). In contrast, Finland and Slovakia, in which the self-reported rate of activity limitations is around 25 per cent, have disability employment rates of over 50 per cent⁴⁷.

Despite the complexity behind these figures, it is important to note that Ireland with a 15 per cent prevalence of self-reported disability, has one of the lowest disability employment rates in Europe and that many commentators have drawn attention to a number of areas for improvement in the Irish approach to social protection. Specifically, attention has been drawn to the need for early intervention mechanisms, the need to profile and target people likely to return work for services and supports and the need to reduce the inflow into disability related benefits.

2.4.5 Costs for social protection systems

A number of factors are implicated in the steady outflow from the active labour market into unemployment or economic inactivity. Higher numbers of older people are opting for early retirement on health grounds compared to the number of younger people with acquired disabilities exiting the workforce. This is an issue that is likely to increase given the ageing of the workforce. The participation rates for people between 55-64 years is 45 per cent. This is half the rate for younger workers. Over 60 per cent of people with disabilities over 45 years of age have chronic health conditions that are not work-related, and that are likely to deteriorate⁴⁸.

This places a substantial cost on social insurance and systems of social protection as well as reducing governments' discretion in terms of expenditure. Sickness and disability spending, excluding early retirement, accounts for about 10 per cent of total social expenditure across Europe⁴⁹. In 2008, the OECD estimated that 6.5 per cent of Irish people of working

⁴⁵ OECD (2010) *Sickness, Disability and Work: Breaking the Barriers*. Paris, FR: Organisation of Economic Cooperation and Development. Retrieved [24/08/2015] from: <http://www.oecd.org/ireland/46461490.pdf>

⁴⁶ Based on the EU Labour Force Survey 2011 and Statistics on Income and Living Conditions, Extracted from Wolf & Agafitei (2014)

⁴⁷ Watson, D., Kingston, G. & McGinnity, F. (2012) *Disability in the Irish Labour Market: Evidence from the QNHS Equality Module 2010*. Dublin, IRL: Equality Authority and the Economic and Social Research Institute. Retrieved [24/08/2015] from: https://www.esri.ie/publications/search_for_a_publication/search_results/view/index.xml?id=3663

⁴⁸ OECD (2010) *Sickness, Disability and Work: Breaking the Barriers*. Paris, FR: Organisation of Economic Cooperation and Development. Retrieved [24/08/2015] from: <http://www.oecd.org/ireland/46461490.pdf>

⁴⁹ OECD (2008) *Sickness, Disability and Work: Breaking the Barriers Vol. 3. Denmark, Finland, Ireland and the Netherlands*. Paris, FR: Organisation for Economic Cooperation and Development.

age were in receipt of disability income support. This was higher than the OECD average (5.7 per cent). Ireland had the third highest number of people between the ages of 20 to 34 years in receipt of disability benefits⁵⁰.

More recent figures from Eurostat suggest that while total Irish social protection expenditure is in line with the EU average (29.6 per cent of GDP in 2011 in comparison with an EU average of 29.1 per cent)⁵¹, the proportion of that spending which is on illness and disability was significantly over the EU average. The proportion of Irish social protection spending on sickness/healthcare and disability was 49.5 per cent compared with the EU average of 37.1 per cent⁵². The Department of Social Protection budget in 2015 provided for an estimated expenditure of €3.39 billion on the illness, disability and carers programme, amounting to 17.5 per cent of total departmental expenditure.

2.4.6 Measures to address costs of disability payments for social protection systems

The management and control of social protection budgets may sometimes address administrative or procedural issues at the margin rather than tackling the underlying phenomena that are driving costs. Measures such as changing eligibility criteria, declassifying people as disabled, being more vigilant about social welfare fraud or reducing the overall value of benefits may deliver short-term gains in terms of system costs, but they do not address root causes and may result in moving people from one system of benefits dependency to another⁵³.

Other approaches focus on removing the poverty trap which can effectively reduce the disposable income of those moving from benefits to paid employment. This situation can be addressed through flexible benefits that gradually reduce with income, tax credits or wage subsidies. While these approaches can assist some individuals to move into the active labour market, they may have little impact on the inflow of people into the disability net.

It could be argued that some policies can be counterproductive and actually incentivise the move into the disability benefits net. As an example, sickness and

disability benefits funded from general taxation or social insurance, which are high in comparison to net wages, (this is referred to as the replacement ratio), can act as an incentive to workers who are experiencing health problems to withdraw from work. This also allows employers to externalise the costs of disability into the social protection system. This process encourages a move into disability income support mechanisms by workers with health impairments. It may be that the level of inflow of new recipients thus incentivised could effectively cancel out the impact of other measures to control expenditure on social welfare disability payments.

Enhancing job retention and re-entry into work after onset of a disability, and reducing the outflow from the labour market, would give rise to savings on social welfare disability payments and early retirement costs.

2.5 OECD multi-country study – findings relevant to vocational rehabilitation

In 2003, the OECD highlighted that people who were in receipt of a disability pension were highly unlikely to exit the system to employment⁵⁴. It was estimated that disability benefit recipients had a less than 2 per cent chance of exiting the system to employment in any year following their disability. As a result it initiated the *Sickness, Disability and Work – Breaking the Barriers* project⁵⁵. In 2009, the synthesis report concluded that ‘disability benefit take-up is a one-way street’ (p.10)⁵⁶.

Three key themes emerged – the need to reduce the inflow into sickness and disability benefits, the need to raise the employment rates for people with acquired disabilities and the need to raise the outflow from permanent disability benefits. Early vocational rehabilitation was identified as one strategy that can reduce the inflow to, and enhance the outflow from, disability pension systems.

The OECD concluded that the scope of employment and rehabilitation measures available needed to be broadened to include assessments of work capacity

⁵⁰ OECD (2008) *Sickness, Disability and Work: Breaking the Barriers Vol. 3. Denmark, Finland, Ireland and the Netherlands*. Paris, FR: Organisation for Economic Cooperation and Development.

⁵¹ Eurostat (2013) ‘Ireland’s spend on sickness, health and disability among highest in EU’ Retrieved (23/09/2015) from: http://ec.europa.eu/ireland/press_office/news_of_the_day/social-protection-spending-in-the-eu_en.htm

⁵² Note this comparison includes all health spending as well as social welfare disability payments

⁵³ Lindsay and Houston (ed.) (2013) *Disability benefits, welfare reform and employment policy*. London: Palgrave Macmillan

⁵⁴ OECD (2003) *Transforming disability into ability: Policies to promote work and income security for disabled people*. Paris, FR: Organisation for Economic Cooperation and Development. Retrieved from: <http://www1.oecd.org/publications/ebook/8103021E.PDF108>

⁵⁵ OECD (2010) *Sickness, Disability and Work: Breaking the Barriers*. Paris, FR: Organisation of Economic Cooperation and Development. Retrieved (24/08/2015) from: <http://www.oecd.org/ireland/46461490.pdf>

⁵⁶ OECD (2010) *Sickness, Disability and Work: Breaking the Barriers*. Paris, FR: Organisation of Economic Cooperation and Development. Retrieved (24/08/2015) from: <http://www.oecd.org/ireland/46461490.pdf>

rather than, solely, the extent of impairment. It recommended that rehabilitation should be offered before granting benefits. In other words, an assessment of a requirement for a disability benefit should include the potential to benefit from vocational rehabilitation and the provision of temporary disability benefits to enable a person to take part. Other broader measures included changing the balance between tax and benefit systems to make work pay and engaging employers more fully in the rehabilitation process. One way that this could be achieved would be to base employer social insurance contributions on an experience rating of their performance in bringing employees back to work. Other accompanying mechanisms proposed included wage subsidies and job coaching even on a long term basis.

The OECD *Breaking the Barriers Synthesis* report concluded that key factors in reducing the inflow into disability benefits and enhancing the outflow included “getting the right services to the right people at the right time” (p. 145)⁵⁷. The disability policy indicators associated with increased disability benefit recipient rates included benefits accessibility and generosity, lenient sickness absence policy and anti-discrimination legislation. Indicators associated with reduced rates included medical and vocational assessment, vocational rehabilitation, sheltered and supported employment and incentives.

Measures recommended included assisting people with acquired disabilities to retain their jobs and assisting the new hiring of job seekers with disabilities. This requires that the different actors across sectors work together and that there is clear accountability. There was also a requirement for more effective tools and resources and a greater investment in vocational rehabilitation. The need for enhanced coordination between public employment services and benefits authorities was also noted.

The OECD contends that vocational rehabilitation should be seen as an early option or as a requirement for access to income support. As such an application

for a disability payment should be treated as a request for vocational rehabilitation. It recommended that vocational rehabilitation must work in tune with other policies and measures such as anti-discrimination legislation; employment incentives; more stringent obligations on employers in relation to sickness absence; individual placement and support models (supported employment); more dynamic sheltered employment options; wage subsidies; one-stop-shops and incentives for authorities and providers to achieve more effective outcomes⁵⁹.

2.6 The role of early intervention in promoting employment retention

The importance and positive impact of early intervention in return to work for workers and employers was identified in a systematic review⁶⁰. Early contact ranged from one to 12 weeks after onset. Gradually introducing rehabilitation while the person is still actively working, or as soon as it is safe, is associated with more effective outcomes⁶¹. The average early intervention milestone ranges between one week and three months. However, it can vary with the severity and complexity of the health condition. For example, a review of 26 studies into Traumatic Brain Injury (TBI) and employment outcomes concluded that early access to rehabilitation (between 12 and 24 months) can positively influence return to work⁶².

Similarly, a two-year pilot program in New South Wales (InVoc) demonstrated that participants in vocational rehabilitation were considerably more likely to be in paid employment after 24 months in comparison with the national average (50 per cent compared with 31 per cent respectively)⁶³. In this study, patients with spinal injuries were offered early access to vocational rehabilitation in parallel with post-acute interventions such as physiotherapy and occupational therapy during their inpatient stay. Hay-Smith et al concluded that early intervention introduced the concept of return to work early in the rehabilitation process for people with spinal

⁵⁷ OECD (2010) *Sickness, Disability and Work: Breaking the Barriers*. Paris, FR: Organisation of Economic Cooperation and Development. Retrieved [24/08/2015] from: <http://www.oecd.org/ireland/46461490.pdf>

⁵⁸ OECD (2010) *Sickness, Disability and Work: Breaking the Barriers*. Paris, FR: Organisation of Economic Cooperation and Development. Retrieved [24/08/2015] from: <http://www.oecd.org/ireland/46461490.pdf>

⁵⁹ OECD (2010) *Sickness, Disability and Work: Breaking the Barriers*. Paris, FR: Organisation of Economic Cooperation and Development. Retrieved [24/08/2015] from: <http://www.oecd.org/ireland/46461490.pdf>

⁶⁰ Franche, R.L., Cullen, K., Clarke, J., Irvin, E., Sinclair, S. & Frank, J. (2005) 'Workplace-Based Return-To-Work Interventions: A Systematic Review of the Quantitative Literature', *Journal of Occupational Rehabilitation*, 15 (4), pp. 607-631.

⁶¹ Dutta, A., Gurvey, R., Chan, F., Chou, C., & Ditchman, N. (2008) 'Vocational Rehabilitation Services and Employment Outcomes for People with Disabilities: A United States Study', *Journal of Occupational Rehabilitation*, 18 (4), pp. 326-334.
Main, L., & Haig, J. (2006) 'Occupational Therapy and Vocational Rehabilitation: An Audit of an Outpatient Occupational Therapy Service', *British Journal of Occupational Therapy*, 69 (6), pp. 288-292.

⁶² Kendall, E., Muenchberger, H. & Gee, T. (2006) 'Vocational Rehabilitation following traumatic brain injury: A quantitative synthesis of outcome studies'. *Journal of Vocational Rehabilitation*, 25 (3), pp.149-60.

⁶³ Johnstone, D. & Cameron, I. (2014) *Evaluation of the InVoc Pilot – Early Access to Vocational Rehabilitation Services (for People with Spinal Cord Injury): Interim Report*. Sydney, AUS: Rehabilitation Studies Unit, Sydney Medical School, Sydney University.

cord injuries⁶⁴. This effectively gave participants 'hope' of a meaningful life including return to work. Actual interventions could be provided later in the process as appropriate. In addition, returning to a pre-injury employer was associated with a considerably shorter time to getting back to work in another study⁶⁵.

In 2003, the Renaissance project explored the impact of targeted early interventions to prevent chronic disability for disability benefit and injury benefit recipients with low back pain in Ireland⁶⁶. Participants were assigned to three categories: simple back pain, nerve root pain and potentially serious spinal pathology. Results indicated that early intervention for benefit applicants with low back pain significantly decreased progression to chronic disability and the duration of claims and delivered over half a million euros in cost savings. This exercise showed the value of effective early intervention.

A study carried out by the Fit for Work Europe consortium identified the link between the duration of absence for people with musculoskeletal impairments returning to work and early intervention⁶⁷. An essential principle of good practice was to balance the need for a recovery period with the benefits of work. It recommended that early actions should be based on collaboration between the person, medical professionals and the employer and include access to physiotherapy and/or medication where appropriate.

Further, there is a growing consensus that vocational rehabilitation in the domain of social affairs should take a more proactive approach to intervention prior to loss of employment⁶⁸. Early intervention can prevent many of the negative personal, social and economic correlates of long term absence and economic inactivity. It can help workers retain general and specific occupational skills that could be lost in a more prolonged period of inactivity. Ultimately, a focus on job retention can increase the duration of employment and prevent the

deterioration of physical health and psychological wellbeing. It can lessen the likelihood of progression to benefits dependency and enhance quality of life outcomes⁶⁹.

2.7 The potential for vocational rehabilitation to reduce disability dependency

Vocational and occupational rehabilitation can be described at a number of levels including policy and legislation, implementation mechanisms, social or workplace context and the individual. Each of these levels interacts to either enhance or inhibit the success of the vocational or occupational process⁷⁰. Table 2.3 illustrates how macro factors, such as legislation and policy, interact with services, the person's characteristics and economic conditions to result in return to work or exit from the labour market.

The starting point for an effective system comprises policy and legislation that aim to reduce welfare dependency and increase employment rates, as part of an inclusive labour market or social protection strategy. This emphasis needs to be reflected in departmental responsibilities, the mission of statutory agencies and the funding mechanisms for services. The strategy needs to be actualised through the provision of vocational and occupational rehabilitation. Contractual and funding arrangements for service providers need to include quality assurance mechanisms and key performance indicators (KPIs) to measure the impact of the strategy on individuals.

Vocational and occupational rehabilitation services need to address the return-to-work barriers or facilitators in the social and workplace environments. They must be customised to the characteristics of the person, in terms of age, gender, education etc., and respond to the level and complexity of impairment.

⁶⁴ Hay-Smith, E.J.C., Dickson, B., Nunnerley, J., & Anne Sinnott, K. (2013) 'The Final Piece of the Puzzle to Fit In': An Interpretative Phenomenological Analysis of the Return to Employment in New Zealand after Spinal Cord Injury', *Disability & Rehabilitation*, 35 (17), pp. 1436-1446.

⁶⁵ Krause, J. S., Terza, J. V., Saunders, L.L., & Dismuke, C.E. (2010) 'Delayed Entry into Employment after Spinal Cord Injury: Factors Related to Time to First Job', *Spinal Cord*, 48, pp. 487-491.

⁶⁶ Leech, C. (2004). *Preventing Chronic Disability from Low Back Pain: Renaissance Project*. Dublin, IRL: Stationery Office, Government Publications. Retrieved [24/08/2015] from: <http://www.welfare.ie/en/downloads/renaissance.pdf>

⁶⁷ Bevan, S., McGee, R. & Quadrello, T. (2009) *Fit For Work? Musculoskeletal Disorders and the Irish Labour Market*. Lancaster, UK: The Work Foundation – Lancaster University, Fit for Work Europe. Retrieved [24/08/2015] from: http://www.fitforworkeurope.eu/Website-Documents/ffw_Ireland311009.pdf

⁶⁸ Tansey, T., Strauser, D., Frain, M., Bishop, M., Chiu, C-Y., Kaya, C., & Chan, F. (2015) 'Differential Vocational Rehabilitation Services Patterns Related to Job Retention and Job Seeking Needs of Individuals with Multiple Sclerosis', *Rehabilitation Research, Policy, and Education*, 29 (2), pp. 109-121.

⁶⁹ Allaire, S. H., Niu, J. B., & LaValley, M. P. (2005) 'Employment and Satisfaction outcomes from a Job Retention Intervention Delivered to Persons with Chronic Diseases', *Rehabilitation Counseling Bulletin*, 48 (2), pp. 100-109.

Fraser, R. T., McMahon, B., & Danczyk-Hawley, C. (2003) Progression of Disability Benefits: A Perspective on Multiple Sclerosis. *Journal of Vocational Rehabilitation*, 19, pp. 173-179.

Rumrill, P.D., & Roessler, R.T. (2015) 'An Overview of Multiple Sclerosis: Medical, Psychosocial, and Vocational Aspects of a Chronic and Unpredictable Neurological Disorder', *Rehabilitation Research, Policy, and Education*, 29 (2), pp. 122-134.

Tansey, T., Strauser, D., Frain, M., Bishop, M., Chiu, C-Y., Kaya, C., & Chan, F. (2015) 'Differential Vocational Rehabilitation Services Patterns Related to Job Retention and Job Seeking Needs of Individuals with Multiple Sclerosis', *Rehabilitation Research, Policy, and Education*, 29 (2), pp. 109-121.

⁷⁰ Chamberlain, M. A., Fialka-Moser, V., Schüldt-Ekholm, K., O'Connor, R. J., Herceg, M. & Ekholm, J. (2009) 'Vocational Rehabilitation: An Educational Review', *Journal of Rehabilitation Medicine*, 41, pp. 856-869. Retrieved [24/08/2015] from: <http://www.medicaljournals.se/jrm/content/?doi=10.2340/16501977-0457&html=1>

Table 2.3. The effect of different system levels on outcomes of VR⁷¹

If factors prevent work resumption						Work Resumption			If factors facilitate work resumption
					⬇ (-)	Principles of social welfare/social security law		⬆ (+)	
				⬇ (-)	Application of the laws		⬆ (+)		
				⬇ (-)	Rehabilitation effectiveness/resources		⬆ (+)		
			⬇ (-)	Co-operation in rehabilitation		⬆ (+)			
			⬇ (-)	Economic factors, labour market		⬆ (+)			
		⬇ (-)	Medical factors		⬆ (+)				
		⬇ (-)	Personal factors		⬆ (+)				
	Out of Working Life								

A similar system perspective on vocational and occupational rehabilitation has been adopted in this review of the operation of vocational rehabilitation in Ireland and other jurisdictions.

2.8 Linking medical rehabilitation to vocational rehabilitation

The transition from medical, post-acute or functional rehabilitation to vocational or occupational rehabilitation is a critical stage in the pathway to work for people with acquired disabilities⁷².

The process is presented in Table 2.4⁷³. It begins when symptoms emerge for a person while they are at work.

For many people the health problem can be addressed through short term absence and medical treatment. However, for some people the health condition may require inpatient or outpatient medical care and extended absence (Chamberlain et al., 2009)⁷⁴.

If a person experiences reduced capacity, medical rehabilitation may be required. Where this does not resolve the problem, referral to vocational or occupational rehabilitation may be appropriate. This can

involve combinations of medical and health treatments including medication or physiotherapy and employment-focused strategies such as adapted work conditions or workplace environment, a gradual return to work or assistive technology.

The vocational rehabilitation phase culminates in a decision about return to work or progression to a disability pension. Successful outcomes include return to work to one's own job, an alternative job with the original employer or redeployment to another employer.

According to Chamberlain et al, effective vocational and occupational rehabilitation systems require that four main actors work in collaboration⁷⁵.

- The person must keep in contact with the employer, be honest with occupational health services and rehabilitation providers and be willing to discuss which parts of the job can be done
- The employer must keep in contact with the person, understand sickness absence and return-to-work policies, inform supervisors and line managers about potential challenges and facilitate a phased return-to-work (RTW) and accommodations

⁷¹ Adapted from Chamberlain, Fialka-Moser, Schüldt-Ekholm et al. 2009 p.860

⁷² Waddell, G., Burton, K., Nicholas, A. K., Kendall, A. S., (2008) **Vocational Rehabilitation, What works, for whom, and when?** London, UK: Department of Work and Pensions, U.K.

⁷³ Adapted from Chamberlain, Fialka-Moser, Schüldt-Ekholm et al. 2009 p.856

⁷⁴ Chamberlain, M. A, Fialka-Moser, V., Schüldt-Ekholm, K., O'Connor, R. J., Herceg, M. & Ekholm, J. (2009) 'Vocational Rehabilitation: An Educational Review', **Journal of Rehabilitation Medicine**, 41, pp. 856–869. Retrieved [24/08/2015] from: <http://www.medicaljournals.se/jrm/content/?doi=10.2340/16501977-0457&html=1>

⁷⁵ Chamberlain, M. A, Fialka-Moser, V., Schüldt-Ekholm, K., O'Connor, R. J., Herceg, M. & Ekholm, J. (2009) 'Vocational Rehabilitation: An Educational Review', **Journal of Rehabilitation Medicine**, 41, pp. 856–869. Retrieved [24/08/2015] from: <http://www.medicaljournals.se/jrm/content/?doi=10.2340/16501977-0457&html=1>

Table 2.4. Linking medical and VR processes⁷³

1	At Work with symptoms			↓
2	Disease or injury			↓
3	Medical Care			↓
4	Rehabilitation			↓
4a	Medical Rehabilitation			↓
4b	Vocational/Occupational Rehabilitation			↓
	Medical e.g. multidisciplinary functional restoration programme	↔	Non-medical e.g. National insurance system, employers, employment office, social services	↓
5	Decision			↓
6	Return to work	↔	Disability Pension	

- The social insurance or welfare system must:
 - Advise on eligibility for benefits, assess work capacity and organise work trials and experience
 - Communicate with the workplace, carry out job analyses and provide retraining where required
 - Provide support to the employers and person during the process
- The health system must:
 - Provide functional rehabilitation, teach coping strategies and support the person in managing the health condition after RTW
 - Liaise with employers and advise on functional restrictions on RTW and adjustments to the environment or assistive equipment

AIA Australia, a life insurance company, proposed another perspective on the medical-vocational transition, one that can provide insight into how the links between the various phases of rehabilitation should ideally interconnect and the duration of each stage of the process. This is presented in Table 2.5.

The table illustrates that many people recover and

return to work without intervention. This works best when workers and employers are educated about job retention strategies. Workers need to be empowered and supported to disclose at an early stage if they are experiencing difficulties at work. Some will require acute care and extended absence. It is essential to identify people who need assistance in getting back to work during the acute and sub-acute phases of treatment. This assistance will most frequently include clinical and occupational interventions that address individual functional capacities and workplace factors. People who do not make the back-to-work transition after 90 days will require intensive rehabilitation and return-to-work supports and interventions.

Case management and awareness of resources are two important mechanisms that can ensure the process operates in a synchronised manner. Case management is a collaborative process, including advocacy, communication and service coordination⁷⁶. The return-to-work case manager assesses, plans, implements, coordinates, monitors, and evaluates the options and services to achieve a successful return-to-work outcome⁷⁷.

⁷⁶ Rosenthal, D., Hursch, N., Lui, J., Zimmerman, W., & Pruett, S.R. (2005) 'Case Management Issues within Employer-Based Disability Management', in F. Chan, Fong, Leahy, Michaels & Saunders, Jodi Lynne (Eds.), **Case Management for Rehabilitation Health Professionals (2nd Ed.)**, Vol. 1, pp. 330-365. Lake Osage – MO, US: Aspen Professional Services.

⁷⁷ OCWP (2007) **OWCP Procedure Manual Part 3 – Rehabilitation**. Washington – DC, US: Office of Workers' Compensation, US Department of Labour. Retrieved [24/08/2015] from: <http://www.dol.gov/owcp/procedure-manual/rehab.pdf>
Chamberlain, M. A, Fialka-Moser, V., Schüldt-Ekholm, K., O'Connor, R. J., Herceg, M. & Ekholm, J. (2009) 'Vocational Rehabilitation: An Educational Review', **Journal of Rehabilitation Medicine**, 41, pp. 856–869. Retrieved [24/08/2015] from: <http://www.medicaljournals.se/jrm/content/?doi=10.2340/16501977-0457&html=1>
Casey, P. & Cameron, I. (2014) **Principles of Best Practice in Occupational Rehabilitation for AIA Australia**. Melbourne, AUS: AIA Australia. Retrieved [24/08/2015] from: http://www.aia.com.au/en/resources/3b9ba88044c4d35380b1f40af27d2d40/Occ_rehab_best_practice_framework_0714.pdf

Table 2.5. The stages and duration of OR

Population with initial work incapacity				
Recover at work →	Acute phase- 30 days work incapacity →	Sub-acute phase- 30-90 days work incapacity →	Chronic phase- 90 days work incapacity	
Phase of disability – intervention				→
Most RTW without intervention	Optimal window for effective clinical & occupational management			Entrenched incapacity intensive rehab
AIA Australia – intervention				→
Educate & influence recover at work strategies →	RTW risk identification →	Response to risk →	RTW support and intervention	
Encourage early notification				
Empower and support				

Raising the awareness of those who make referrals, e.g. GPs, occupational health services and medical specialists, of the potential benefits of vocational rehabilitation can ensure that those who require services are appropriately referred⁷⁹. An analysis of referral sources to the public vocational rehabilitation system in the state of Kentucky, identified self or other referrals (50 per cent), school (17.7 per cent) and medical professionals (13.2 per cent) as the most frequent sources of referral. The authors concluded that educating physicians, medical providers, and medical case managers about vocational rehabilitation services and improving coordination of vocational rehabilitation with medical and allied health services were important areas for improvement.

2.8 Evidence of Effectiveness

Studies evaluating the effectiveness of rehabilitation are often specific to a single health condition, e.g. chronic pain, and are frequently not focused on employment and job retention⁸⁰. Chamberlain et al. (2009) reviewed a number of studies that evaluated the impact of multimodal rehabilitation on work outcomes⁸¹ for people

with a variety of acquired disabilities and highlighted a number of positive outcomes. Some of the key findings on the effects of these interventions included:

- Reductions in the amount of sick leave, and in the duration of sickness absence
- Fewer people progressed to disability benefits or pensions
- Return to work outcomes were more frequent
- Intervening within the first 12 weeks of absence was more effective
- Coordinated services increased outcomes and effectiveness
- Vocational rehabilitation that focused on early RTW and open employment achieved higher earnings and independent employment outcomes

The National Neurorehabilitation Strategy 2011-2015 cited a number of studies of vocational rehabilitation for people with acquired brain injury, which showed earnings of participants significantly exceeded programme costs.⁸²

Cost benefit and cost effectiveness was demonstrated in some studies e.g.

⁷⁸ Adapted from Casey & Cameron 2014 p. 10

⁷⁹ Fleming, A., Bishop, M., Crystal, R.M., Kinyanjui, B., Dunkley, L.R., Tiro, L., & Dornbusch, A. (2015) **Kentucky Comprehensive Statewide Needs Assessment 2015**. Lexington-KY, US. University of Kentucky Graduate Program in Rehabilitation Counseling.

⁸⁰ Gobelet, C. & Franchignoni, F. (2006). **Vocational Rehabilitation**. Paris, FR: Springer-Verlag.

⁸¹ Chamberlain, M. A, Fialka-Moser, V., Schüldt-Ekholm, K., O'Connor, R. J., Herceg, M. & Ekholm, J. (2009) 'Vocational Rehabilitation: An Educational Review', **Journal of Rehabilitation Medicine**, 41, pp. 856–869. Retrieved (24/08/2015) from: <http://www.medicaljournals.se/jrm/content/?doi=10.2340/16501977-0457&html=1>

⁸² National Policy and Strategy for the Provision of Neuro-Rehabilitation Services in Ireland 2011-2015 p. 30-31. Studies cited showed payback for vocational rehabilitation programmes in 2.5 years (West et al 1991); earnings exceeding programme cost fourfold (Wehman et al 1994); and employment rates of over 40% for severely brain-injured people following participation in vocational rehabilitation (Murphy et al 2006).

- In Sweden, the return on investment (ROI) for vocational rehabilitation was estimated to be 10 to 1
- Coordinated vocational rehabilitation outperformed control services resulting in a saving of €6000 per annum per person)

A cost-benefit study carried out in The Netherlands on the rehabilitation of people with stroke, heart failure or chronic pain estimated an average cost benefit ratio of over 4:1.⁸³

A review, carried out for WorkCover SA, concluded that although vocational rehabilitation had a demonstrated impact on disability claimant rates and recovery, the evidence on return to work outcomes was equivocal and the costs of vocational rehabilitation high.⁸⁴ The key to effectiveness is early intervention (before job loss) while employer engagement is still active. The report concluded that early intervention could enhance labour market inclusion; reduce dependency and poverty; decrease the prevalence of disability; promote a healthy and productive workforce; reduce disability costs to society and to employers; and increase the profitability of enterprises and impact positively on GDP.

There is evidence that vocational rehabilitation reduces absence from work and thus costs to society:

- Employers in the UK with rehabilitation and flexible work arrangements lost only 2.7 days per employee (12 days were lost by the worst performing organisations)⁸⁵.
- Disability management programmes were estimated to reduce long-term absence rates by up to 60 per cent and disability costs by between 30–50 per cent in Canada⁸⁶.

The economic impact of vocational rehabilitation was

the primary driver for the development of the public vocational rehabilitation system in the US and continues to be an important imperative in the face of growing health care, long-term disability and early retirement costs. The structure of disability benefits systems and their eligibility criteria have been implicated in inhibiting the return to work of recipients and increasing the fiscal burden on society⁸⁷. In addition, the requirement for applicants to demonstrate that they are too disabled to work creates a systemic disincentive to engaging in active labour market measures and vocational rehabilitation opportunities. This can result in a range of negative personal, social and economic outcomes and long term benefits dependency⁸⁸.

It has been estimated that the investment in vocational rehabilitation by public social security systems is likely to be recouped within two to four years simply on the basis of increased income tax revenues of participants successfully placed in employment⁸⁹. Further, the return on investment for the individual can be substantial. For example, in a study in Virginia, it was estimated that on average the earnings of participants who engaged in vocational rehabilitation exceeded income without vocational rehabilitation by a factor of seven over ten years⁹⁰. Another study that reviewed the impact of vocational rehabilitation services on people with multiple sclerosis (MS) in the US estimated that the ROI associated with providing services to people with MS was in the region of 8:1⁹².

These findings are supported by the conclusions of a number of meta-analyses and systematic reviews of evidence for the positive economic impact of disability management and early vocational rehabilitation interventions.

⁸³ Kok, L., Houkes, A. & Niessen, N. (2008) **Kosten en Baten van Revalidatie**. Amsterdam: NL: SEO Economisch Onderzoek.

⁸⁴ Price Waterhouse Cooper (2011) **Vocational Rehabilitation Framework: Model Options Final Report**. Adelaide, AUS: WorkCover SA. Retrieved (24/08/2015) from: <http://library.safework.sa.gov.au/attachments/55092/Vocational%20rehabilitation%20framework%20-%20model%20options.pdf>

⁸⁵ CBI (2006) **Absence minded: Absence and Labour Turnover**. London, UK: Confederation of British Industry. Retrieved (24/08/2015) from: <http://www.orghealth.co.uk/uploads/articles/Absence%20and%20labour%20turnover%20survey%20-%20CBI%20AXA.pdf>

⁸⁶ Zimmermann, W (2014) **Towards International Standards in Disability Management**. International Disability Management Standards Council Presentation, Brussels February 2014

⁸⁷ McMahon, B.T., Danczyk-Hawley, C.E., Reid, C., Flynn, B.S., Habeck, R., Kregel, J., & Owens, P. (2000) 'The Progression of Disability Benefits'. **Journal of Vocational Rehabilitation**, 15, pp. 3–15.

⁸⁸ McMahon, B.T., Danczyk-Hawley, C.E., Reid, C., Flynn, B.S., Habeck, R., Kregel, J., & Owens, P. (2000) 'The Progression of Disability Benefits'. **Journal of Vocational Rehabilitation**, 15, pp. 3–15.

Rumrill, P.D., & Roessler, R.T. (2015) 'An Overview of Multiple Sclerosis: Medical, Psychosocial, and Vocational Aspects of a Chronic and Unpredictable Neurological Disorder', **Rehabilitation Research, Policy, and Education**, 29 (2), pp. 122–134.

⁸⁹ Hanophy, J. (2012) 'Testimony of the Council of State Administrators of Vocational Rehabilitation (CSA vocational Rehabilitation) on Work Incentives in Social Security Disability Programs', **Journal of Vocational Rehabilitation**, 36 (1), pp. 13–20.

⁹⁰ Dean, D., Pepper, J., & Schmidt, R. (2014) 'State Vocational Rehabilitation Programs and Federal Disability Insurance: An Analysis of Virginia's Vocational Rehabilitation Program', **IZA Journal of Labor Policy**, 3 (7), pp. 1–19

⁹¹ Tansey, T., Strauser, D., Frain, M., Bishop, M., Chiu, C-Y., Kaya, C., & Chan, F. (2015) 'Differential Vocational Rehabilitation Services Patterns Related to Job Retention and Job Seeking Needs of Individuals with Multiple Sclerosis', **Rehabilitation Research, Policy, and Education**, 29 (2), pp. 109–121.

⁹² Tompa, E., de Oliveira, C., Dolinschi, R., & Irvin E. (2008) 'A Systematic Review of Disability Management Interventions with Economic Evaluations', **Journal of Occupational Rehabilitation**, 18 (1), pp. 16–26.

Hoefsmit, N., Houkes, I., & Nijhuis, F. J. (2012) 'Intervention Characteristics that Facilitate Return to Work after Sickness Absence: A Systematic Literature Review', **Journal of Occupational Rehabilitation**, 22, pp. 462–477.

2.9 Social protection systems and vocational rehabilitation

2.9.1 Potential pathway to vocational rehabilitation

Social protection systems can offer a key pathway into vocational rehabilitation. Claims related to short-term disability absence, which may develop into long-term absence claims and ultimately a long-term disability pension, can provide a systematic alert of potential long-term withdrawal from work due to onset of a disability.

Delayed access to support measures may be counterproductive and cut across the well-established principle of early intervention. In Ireland, the Partial Capacity Benefit introduced in 2012 has a threshold period of six months on Illness Benefit before it takes effect (Invalidity Pension recipients do not require a waiting period to access the PCB scheme).

Where eligibility for rehabilitation measures is linked to being inactive or unemployed and in receipt of a long-term disability payment, this can serve to exclude those workers who are long-term absent but still in principle have a job to go back to. Such systems may offer an incentive to people to resign their jobs in order to benefit from rehabilitation interventions. They may serve to increase the number of people on disability rolls. This is indeed evident in many jurisdictions⁹³.

2.9.2 Activation

Activation mechanisms, and in particular job-search monitoring, benefit conditionality and referral to Active Labour Market Programmes (ALMPs), need to operate in coordination with welfare and unemployment benefits⁹⁴. Personalised face to face counselling and monitoring are important components of this process. However, there are challenges in transferring activation strategies to recipients of disability benefits. Coordination between the diverse actors involved in the benefits/employability process for someone with a health condition is a primary challenge. These include health agencies, providers of rehabilitation and employment services, insurers and employers. One coordination measure suggested is a 'one-stop-shop' with a focus on moving welfare applicants away

from benefits dependency by addressing their health and occupational needs before determining eligibility for long-term benefits. In this regard, vocational and occupational rehabilitation are important mechanisms.

2.9.3 Retraining and redeployment

Retraining and redeployment are important strategies when a worker is unable to return to his or her original job. Reassignment is an option when appropriate accommodations are not possible or insufficient to allow a worker to carry out the essential functions of the original position, or such accommodations would result in a disproportionate burden for the employer⁹⁵.

In a 2006 survey of 2002 long term absent workers in five jurisdictions, the proportion of respondents who had been redeployed differed depending on the jurisdiction. The highest proportion of redeployment was identified in The Netherlands. Twenty-six per cent of Irish respondents returned to a different employer⁹⁶. Redeployment outcomes in the Linking In project were lower. Three per cent of participants returned to a different job with the same employer. No one returned to a different employer, although 15 per cent were attending education or training which would imply that they were aiming to return to work in a different job⁹⁷.

Redeployment can take a number of forms. Internal redeployment, either temporary as part of a gradual return to work or permanently, involves placing the worker in a different position with the same employer. External redeployment can be in a similar job with a new employer or in a different job with a different employer.

External redeployment needs to be coordinated by a vocational rehabilitation professional who develops a return to work plan in consultation with the worker, rehabilitation service providers and the person's medical professional.

External redeployment requires a number of specific interventions including:

- Transferable skills analysis
- Vocational assessment
- Work trials
- Vocational counselling

⁹³ Stattin, M. (2005) 'Retirement on Grounds of Ill Health', *Occupational & Environmental Medicine*, 62, pp. 135–140.

OECD (2003) **Transforming disability into ability: Policies to promote work and income security for disabled people**. Paris, FR: Organisation for Economic Cooperation and Development. Retrieved from: <http://www1.oecd.org/publications/ebook/8103021E.PDF>108

OECD (2009) **Sickness, Disability and Work. Keeping on Track in the Economic Downturn. Background Paper**. Paris, FR: Organisation for Economic Cooperation and Development

⁹⁴ Martin, M. P. (2014) **Activation and Active Labour Market Policies in OECD Countries: Stylized Facts and Evidence on their Effectiveness**. Policy Paper No. 84. Bonn, DE: Institute for the Study of Labour (IZA).

⁹⁵ National Disability Authority (2015) **'Retaining employees who acquire a disability A guide for employers'**. Dublin, Irl: Author.

⁹⁶ Stress Impact Consortium (2006) **'Integrated report of Stress Impact: On the impact of changing social structures on stress and quality of life: Individual and social perspectives Work Package 8'**. Guildford, UK: University of Surrey. Retrieved [15/11/2016] from: <http://www.surrey.ac.uk/psychology/projects/stress-impact/files/Stress%20Impact%20Integrated%20Report.pdf>

⁹⁷ WRC Social and Economic Consultants (2015) **'Evaluation Report on Linking In'**. Dublin, Irl: Author.

- Job seeking skills such as writing a CV, submitting job applications, interview skills and being accountable
- Retraining⁹⁸

According to the OECD, the permanent redeployment of an injured employee must not be considered until all work options have been exhausted within the original work area⁹⁹.

2.10 Findings for Ireland on acquired disability and vocational rehabilitation

2.10.1 Findings from OECD country report for Ireland

As part of the wider OECD project on disability and employment, there was a country report on Ireland, which has pertinent observations relevant to vocational rehabilitation. According to the OECD, vocational rehabilitation is relatively poorly developed in Ireland¹⁰⁰. They characterised Ireland's system as a corporatist model in which disability benefits were relatively accessible with well-developed employment programmes, but a low emphasis on vocational rehabilitation and supported employment. Investment in vocational rehabilitation was low in comparison with other OECD countries and the approach to disability benefits was predominantly passive. For example, in the 12-month period between qualifying for Illness Benefit and the potential to transfer to the long-term Invalidity Pension scheme, no intermediate assessments or contact with claimants were in place.

The majority of vocational rehabilitation options were centre-based rather than community-based and primary components included special vocational training. There is a general acknowledgement that centre-based activities are only one component of vocational rehabilitation and that special vocational training should represent only a proportion of these activities.

Placement to open employment in Ireland from vocational rehabilitation was substantially below many other OECD countries. These conclusions of the OECD report may need some updating in the context of changes that have since taken place¹⁰¹.

Key conclusions of the OECD report are presented below along with supporting evidence from relevant reports:

Compelling case to enhance Irish vocational rehabilitation system

- The costs to employers of long term absence were in the region of €0.65bn¹⁰². Irish disability rates were higher than the OECD average - 6.5 per cent compared to 5.7 per cent in 2008 - inflow rates have increased since then. Ireland had the third highest number of people aged 20 to 34 in receipt of disability benefits. At the end of 2007, the unemployment rate for people with chronic health problems or disability was estimated at 20.1 per cent in comparison with the OECD average of 13.7 per cent. The employment rate of people with health problems or disability was one of the lowest in the OECD. Ireland, with a 15 per cent prevalence of self-reported disability, has one of the lowest disability employment rates in Europe¹⁰³.

There is no systematic support for employment reintegration

Support for this conclusion can be found in a report prepared by WRC Social and Economic Consultants in 2008¹⁰⁴.

- The Irish system for engaging with, and addressing the needs of, long-term absent workers is underdeveloped. This is the case for both occupational and non-occupational illness and injury.
- Long-term absent workers are without proactive support and assistance from either employer or the state.
- The lack of linkages between health providers and vocational services was identified.

⁹⁸ ComCare [n. d.] 'Redeployment'. Canberra, AU: Australian Government'. Retrieved (15/11/2016) from: https://www.comcare.gov.au/recovery/returning_to_work/suitable_employment/redeployment

⁹⁹ Organisation for Economic Cooperation and Development (2007) 'Sickness, Disability and Work Breaking the Barriers (Vol 2): Australia, Luxembourg, Spain and the United Kingdom'. Paris, FR: Author.

¹⁰⁰ OECD (2008) **Sickness, Disability and Work: Breaking the Barriers Vol. 3. Denmark, Finland, Ireland and the Netherlands**. Paris, FR: Organisation for Economic Cooperation and Development.

¹⁰¹ For example, the commencement of the Comprehensive Employment Strategy for People with disabilities, the introduction of the Partial Capacity Benefit scheme, and the break-up of FÁS with employment support measures now in the Department of Social Protection (Intreo), and vocational training in the Department of Education and Skills (Solás). There is also newer evidence of relatively positive responses and outcomes from special training programmes for people with disabilities. McGrath, J. & Milicevic, I. (2014) **The 2013 Follow-Up Survey of Former FÁS Trainees who Exited Training in May and June 2012**. Dublin, IRL: FÁS / SOLAS, Research and Planning, Skills and Labour Market Research Unit. Retrieved (24/08/2015) from: <http://www.solas.ie/docs/2013FollowUpSurvey.pdf>

¹⁰² IBEC (2011) **Employee Absenteeism: A Guide to Managing Absence**. Dublin, IRL: Irish Business and Employers Confederation. Retrieved from: [http://www.ibec.ie/IBEC/DFB.nsf/vPages/Research_and_surveys-Employer_issues-ibec-guide-to-managing-absence-16-05-2013/\\$file/Employee%20Absenteeism%20-%20A%20Guide%20to%20Managing%20Absence.pdf](http://www.ibec.ie/IBEC/DFB.nsf/vPages/Research_and_surveys-Employer_issues-ibec-guide-to-managing-absence-16-05-2013/$file/Employee%20Absenteeism%20-%20A%20Guide%20to%20Managing%20Absence.pdf)

¹⁰³ OECD (2010). **Sickness, Disability and Work: Breaking the Barriers – Ireland: Key Findings**. Paris, FR: Organisation for Economic Cooperation and Development. Retrieved from: <https://www.oecd.org/ireland/46461490.pdf>

¹⁰⁴ WRC Social and Economic Consultants (2008) Research Report on Acquired Disability and Employment: Final Report. Prepared for the Department of Enterprise Trade and Employment. Dublin, IRL: WRC Social and Economic Consultants.

- The primary contact during absence (94 per cent) for people long term absent is the GP and only 15 per cent had contact with another professional. The majority of GPs who participated in a survey of health professionals did not consider that they had any role in the return-to-work process¹⁰⁵.
- The primary sources of return-to-work advice was provided by GPs, family and friends.
- The uptake of programmes that were in place to promote and facilitate retention and reintegration by employers was low. No procedures were in place to engage with employers or to support them in returning long-term absent employees to work. Early intervention is key¹⁰⁶.
- There is a consensus on the benefits of early, intensive, coordinated rehabilitation and the requirement to have recognised links between the different phases along a continuum of support¹⁰⁷.

One phase of this continuum is having vocational rehabilitation programmes to assist people with acquired disabilities to attain or retain employment. In contrast, there was a shared view that vocational rehabilitation is poorly developed in Ireland, investment in vocational rehabilitation is low compared with other OECD countries and the approach to disability benefits is predominantly passive¹⁰⁸.

2.10.2 Summary of other relevant research for Ireland

A number of other specific studies have examined acquired disability and return to work in Ireland.

In 2001, the RETURN project highlighted the absence of

appropriate responses in Ireland to people with acquired disabilities while in employment¹⁰⁹. The lack of effective responses to both occupational and non-occupational acquired disabilities in Irish disability and employment legislation and services was noted¹¹⁰. Since that time a number of other studies have highlighted gaps in the Irish system including the lack of early intervention for this target group¹¹¹. The lack of coordination between health providers and vocational services has been noted. Gaps in the Irish system of employment guidance for people with acquired disabilities have also been identified¹¹².

The 2005 Stress Impact study reported on 362 Irish workers on short term illness benefits who responded to a survey after 12 weeks' absence from work and to a follow up questionnaire 26 weeks later. This provides an insight into the perspectives of welfare recipients on the Irish system¹¹³. The cause of absence for a large majority of respondents was a physical condition (70 per cent), a further 17 per cent had a primarily mental health condition and 13 per cent indicated both a mental health and a physical condition. Fifty per cent of the respondents considered themselves to be in good health. About 40 per cent of respondents indicated that they still had a job after 6 months. The primary contact during absence (94 per cent) was a GP and only 15 per cent had contact with another professional. Only 34 per cent of respondents had returned to work full time and 8 per cent part-time at the time of the follow up survey. This was about half the rate for a broadly comparable group in The Netherlands.

In 2003, the OECD noted that there were a number of elements that could enhance benefit and employment

¹⁰⁵ McAnaney, D. and Wynne, R. (2006) 'Stress, Absence and Reintegration: Perceptions and Practice of Professionals in Six European Member States', *International Journal of Disability Management Research*, 1 (1), pp. 31-42.

¹⁰⁶ In the context of the importance of early intervention, it should be noted that Partial Capacity Benefit (introduced in 2012) is not available to support return to work until after 6 months, well outside of the guideline for early intervention.

¹⁰⁷ WRC Social and Economic Consultants (2008) **Research Report on Acquired Disability and Employment: Final Report**. Prepared for the Department of Enterprise Trade and Employment. Dublin, IRL: WRC Social and Economic Consultants.

¹⁰⁸ OECD (2008) **Sickness, Disability and Work: Breaking the Barriers Vol. 3. Denmark, Finland, Ireland and the Netherlands**. Paris, FR: Organisation for Economic Cooperation and Development.

¹⁰⁹ McAnaney, D., Webster, B., Lohan, M. and Wynne, R. (2001) 'Disability Management: A System of Response or a Response to a System?' *The Australian Journal of Rehabilitation Counselling*, 7 (1), pp. 1-22.

Thorne, J., McAnaney, D., Biggs, H. and Wynne, R. (2002) 'The Development and Utility of an Interactive Assessment Protocol for Evaluating Company Based Responses in Managing Employees on Long-Term Absence', *Australian Journal of Rehabilitation Counselling*, 8 (2), pp. 50-63.

Wynne, R., McAnaney, D., Thorne, J., Hinkka, K. and Jarvisalo, J. (2005) 'The RETURN Project - Between Work and Welfare: Improving Return to Work Strategies for Long Term Absent Employees', in Mannila, Simo and Jarvikoski, Aila. (Eds.) **Disability and Working Life**. pp. 74-100. Helsinki, FI: Rehabilitation Foundation, Helsinki University Press.

¹¹⁰ Wynne, R. and McAnaney, D. (2004) **Employment and Disability: Back to Work Strategies**. Dublin, IRL: The European Foundation for the Improvement of Living and Working Conditions.

¹¹¹ McAnaney, D. & Wynne, R. (2005) 'Employment Retention, Early Intervention, Social Inclusion and Emerging Disabilities'. In the proceedings of the **NDA 4th Annual Disability Research Conference Disability and Employment: What the Research Tells Us**. Dublin, IRL: National Disability Authority.

¹¹² McAnaney, D. and Wynne, R. (2006) 'Stress, Absence and Reintegration: Perceptions and Practice of Professionals in Six European Member States', *International Journal of Disability Management Research*, 1 (1), pp. 31-42.

Wynne, R., McAnaney, D., O'Kelly, C., and Fleming, P. (2006) **Employment Guidance Services for people with disabilities - Conceptual framework and structured inventory of initiatives**. Dublin, IRL: The European Foundation for the Improvement of Living and Working Conditions.

Optiwork (2007) **Optimising Strategies for Integrating People with Disabilities into Work**. Retrieved [24/08/2015] <http://www.optiwork.org>

¹¹³ McAnaney, D. & Wynne, R. (2005) 'Employment Retention, Early Intervention, Social Inclusion and Emerging Disabilities'. In the proceedings of the **NDA 4th Annual Disability Research Conference Disability and Employment: What the Research Tells Us**. Dublin, IRL: National Disability Authority.

systems for people with disabilities¹¹⁴. Some of these are relevant to this report including individualised rehabilitation programmes, early intervention, incentives for employers to engage in active recruitment and to retain employees with acquired disabilities, expert assistance to assist in navigating benefit options and coordination between the various schemes.

The recommendations of the *Sickness, Disability and Work: Breaking the Barriers* initiative for Ireland (OECD, 2008) reflected the earlier recommendations, particularly in relation to co-ordination, early intervention and systematic referral to activation options for people with disabilities¹¹⁵. A threefold approach was recommended that reduced the inflow into sickness and disability benefits, raised the employment rates for people with acquired disabilities before they acquired a formal disability designation and increased the outflow from usually permanent disability benefits through effective re-integration measures.

In 2006, the *Strategy for Engagement* document drew attention to the fact that the core elements of the Irish employment strategy for people with disabilities were community employment, supported employment and vocational training,¹¹⁶ which was still the situation by 2015. A range of recommendations, relevant to vocational and occupational rehabilitation, were made which included to:

- Provide an employment and occupational assessment and guidance process for people applying for income support
- Profile applicants based on work capacity
- Intervene early at the point at which people encounter the welfare system for the first time
- Develop an individualised plan aimed at gaining or retaining employment
- Raise employers' awareness of the support available to assist in job retention
- Operate a single point of contact for benefits, employment services and Further Education and Training (FET)

- Offer rehabilitation measures beyond the medical sphere
- Include people with disabilities in the National Employment Action Plan assessment
- Increase expenditure on active labour market measures for people with disabilities
- Remove benefits traps within the social protection payments system

The positive outcomes of early intervention and rehabilitation were noted in a cost-benefit analysis of the Personal Injuries Assessment Board (Hogan, 2006)¹¹⁷.

Ronayne (2008) noted that "*rehabilitation*" is used in Ireland mainly in a medical/health context and the term "*persons with work incapacities*" is rarely used in policy discussion in Ireland with most policy documentation referring to "*people with disabilities*" or "*people with long-standing illnesses or disabilities*" (P:1)¹¹⁸.

Grubb and colleagues noted in 2009, that no distinction is made in Ireland between rehabilitation specialists and other employment services officers¹¹⁹.

In 2011, McGuinness et al. underlined the need to control access to income-maintenance schemes, such as disability benefits in order to reduce the level of economic inactivity¹²⁰.

A specific focus on acquired disability was adopted in a study commissioned by the Department of Enterprise, Trade and Employment and published in 2008¹²¹. The study focused on national measures to remove obstacles to job retention and reintegration for employed people with acquired disabilities regardless of the cause (i.e. work and non-work). The measures specified included an integrated disability management (DM) system, systematic contact at an early stage and supports to encourage individuals back to work.

The study carried out a survey of Illness Benefit (IB) recipients, an important source of income support for people with acquired disabilities. This highlighted the fact that work related injuries and diseases accounted

¹¹⁴ OECD (2003) **Transforming disability into ability: Policies to promote work and income security for disabled people**. Paris, FR: Organisation for Economic Cooperation and Development. Retrieved from: <http://www1.oecd.org/publications/ebook/8103021E.PDF>108

¹¹⁵ OECD (2008) **Sickness, Disability and Work: Breaking the Barriers Vol. 3. Denmark, Finland, Ireland and the Netherlands**. Paris, FR: Organisation for Economic Cooperation and Development.

¹¹⁶ WRC Social and Economic Consultants (2006) **A Strategy of Engagement: Towards a Comprehensive Employment Strategy for People with Disabilities**. Dublin, IRL: National Disability Authority.

¹¹⁷ Hogan, V. (2006) **A Cost-Benefit Analysis of the Personal Injuries Assessment Board**. Dublin, IRL: Personal Injuries Assessment Board. Retrieved [24/08/2015] from: <http://www.injuriesboard.ie/eng/News-Information/Publications-Archive/Cost-Benefit-Analysis-2006-.pdf>

¹¹⁸ Ronayne, T. (2008). **Introductory Note: Main Features of the Administration of Welfare and Labour Market Measures for People with Disabilities in Ireland. Vocational Rehabilitation and Income Security for People with Work Incapacities within the Framework of a Flexicurity Approach: Statements and Comments**. Dublin, IRL: WRC Social & Economic Consultants.

¹¹⁹ Grubb, D., Singh, S. & Tergeist P. (2009) **Activation Policies in Ireland, OECD Social, Employment and Migration Working Papers, No. 75**. Paris, FR: OECD Publishing. Retrieved [24/08/2015] from <http://dx.doi.org/10.1787/227626803333>

¹²⁰ Tergeist and Grubb, (2006) cited in McGuinness, S., O'Connell, P. J., Kelly, E. & Walsh, J. R. (2011) **Activation in Ireland: An Evaluation of the National Employment Action Plan. Research Series No. 20**. Dublin, IRL: Economic and Social Research Institute.

¹²¹ WRC Social and Economic Consultants (2008) **Research Report on Acquired Disability and Employment: Final Report**. Prepared for the Department of Enterprise Trade and Employment. Dublin, IRL: WRC Social and Economic Consultants.

for about a third of all health related impairments acquired during working life. The estimated cost of IB was estimated to be €270 million. About 30 per cent of respondents to the survey had a job to return to, another 40 per cent did not but wanted to return to another job and 30 per cent were most likely to progress towards retirement.

Recipients were categorised based on their different support and service needs. The job retention group needed early intervention supports between 6 and 12 weeks after absence. Even after 6 months, 60 per cent of IB recipients still had a job available to return to. The major challenge was no support and limited contact with the employer.

This group required a coordinated system of interventions, at national and local levels, (e.g. health, social protection and employment services) that specifically targeted return to own job or an alternative. Effective processes that matched the needs of applicants to appropriate services was required. A number of mechanisms were proposed to achieve coordination including a one-stop-shop, case management and defined protocols between service providers.

Only a quarter of employers responding to a survey, in this study, had formal job retention policies in place indicating a need for employer incentives to encourage a proactive response to employees with acquired disabilities.

The authors recommended:

In the first instance:

- Early intervention and profiling to reduce inflow into the systems by establishing claimants' employment status and work capacity at around 12 weeks
- Targeting each group with appropriate and coordinated services

Over time:

- Addressing the needs of existing beneficiaries to overcome the challenges of exiting the benefits system to employment
- Exploring interventions for workers with mental health problems through a pilot project

In parallel with:

- Actively engaging employers in the retention of long-term absent workers

- Encouraging IBEC to develop a code of practice
- Introducing an employer contribution to a vocational rehabilitation fund to redress the fact that the State was absorbing the major share of the costs of long-term absence

It was suggested that a useful strategy would be to engage agents to act on behalf of the state such as local development companies, private sector providers and non-governmental organisations.

A general consensus emerged from a survey of key actors and stakeholders in compiling the neuro-rehabilitation strategy on the benefits of early, intensive, coordinated rehabilitation and coordination between the different phases along a continuum of support¹²². The Strategy recommended community neuro-rehabilitation teams, which would have a role, inter alia, in developing local area networks comprised of both mainstream agencies and the Department of Social Protection in order to coordinate service delivery and service pathways, as well as coordinate vocational rehabilitation service delivery.

Progression to employment is a core objective of the National Disability Strategy¹²³. For example, an outcome indicator for the NDS is the employment rate of people with disabilities at the start and end of the plan period in comparison to the non-disabled workforce. Availability of Intreo supports to enable activation of people with disabilities on a voluntary basis through Intreo offices is a commitment in the Comprehensive Employment Strategy for People with Disabilities.

Across the different research studies, a number of barriers to effective processes were identified.

- An underdeveloped system for engaging with non-work related long-term absence
- A limited uptake of any programmes to promote and facilitate retention and reintegration, a lack of awareness of the schemes and a perception that they were too bureaucratic
- No requirement for employers to formally engage with, or provide return to work support, to long-term absent employees
- The absence of proactive support from either employers or the state to help long-term absent workers make return to work
- The primary sources of return to work advice were GPs, family and friends – It is important to note that GPs, interviewed in the Stress Impact study, did not

¹²² Department of Health. (2011) **National Policy and Strategy for the Provision of Neuro-Rehabilitation Services in Ireland 2011-2015**. Dublin, IRL: Author.

¹²³ National Disability Strategy Implementation Group. (2013) **National Disability Strategy Implementation Plan 2013-2015**. Dublin, IRL: Department of Justice and Equality - Disability, Equality, Mental Health and Older People.

¹²⁴ McAnaney, D. and Wynne, R. (2006) 'Stress, Absence and Reintegration: Perceptions and Practice of Professionals in Six European Member States', **International Journal of Disability Management Research**, 1 (1), pp. 31-42.

consider that they had any role in the return to work process¹²⁴

- No acknowledgement of the diverse support and service needs of recipients of Illness Benefit, Invalidity Pension, Occupational Injuries Benefit and Disablement Benefit
- The ineligibility of IB recipients for Education and Training Board training on the grounds that they neither unemployed or capable of work
- A lack of systematic support for employment reintegration for those re-assessed by medical assessors as capable of work (21% in 2006).

2.12 The case for vocational rehabilitation

To summarise the international and national evidence, the case for establishing effective vocational rehabilitation is based on social, individual, economic and fiscal benefits.

There is a strong case for intervening when an acquired health condition impacts on work capacity, whether that condition arises from an accident or illness, from an occupational or non-occupational cause. Over 50 per cent of those who reported a long-standing health problem or disability in a European survey indicated that it was as a result of non-work related diseases¹²⁵.

The number of people of working age entering the disability benefits system in most developed economies is increasing and likely to become unsustainable¹²⁶. Disability benefit recipients have less than a 2 per cent chance of exiting the system to employment in any year. This results in dependency and poverty for individuals, unsustainable social protection costs and increasing numbers of disability benefits recipients.

Sickness and disability spending excluding early retirement accounts for about 10 per cent of total social expenditure across Europe¹²⁷.

In contrast, vocational rehabilitation has a demonstrated impact on disability reciprocity rates and recovery.

Return on investment estimates for vocational rehabilitation have been estimated to range from 4 to 1 to 10 to 1. The investment in vocational rehabilitation by public social security systems is likely to be recouped within two to four years simply on the basis of increased income tax revenues of participants successfully placed in employment¹²⁸. Average earnings of people who engaged in vocational rehabilitation exceeded income without vocational rehabilitation by a factor of seven over ten years¹²⁹. Work related absence rates for employers offering access to rehabilitation were four times lower than worst performing employers.

Occupational rehabilitation before people exit employment has the potential to:

- Reduce the inflow into disability pension systems and early retirement
- Enhance labour market inclusion
- Reduce dependency and poverty
- Reduce the prevalence of disability
- Promote a healthy and productive workforce
- Reduce disability costs to society and to employers
- Increase the profitability of enterprises
- Impact positively on GDP.

2.12 International learning on what makes VR effective

The points below summarise the international learning on what makes vocational rehabilitation systems effective.

There is considerable diversity in the context for vocational rehabilitation both nationally and regionally, and in the concepts of vocational rehabilitation used. These are influenced by the socio-political characteristics of jurisdictions; the structure of social security and social protection systems; funding mechanisms; eligibility criteria; and active labour

¹²⁵ Dupre, D., & Karjalainen, A. [2003] **Eurostat, Statistics in Focus: Employment of Disabled People in Europe in 2002, Eurostat, Theme 3: Population and Social Conditions**. LU: Statistical Office of the European Communities. Retrieved [24/08/2015] from: <http://ec.europa.eu/eurostat/documents/3433488/5542140/KS-NK-03-026-EN.PDF/0b806b41-0898-45d2-ac99-0f085e983887>

¹²⁶ OECD [2003] **Transforming disability into ability: Policies to promote work and income security for disabled people**. Paris, FR: Organisation for Economic Cooperation and Development. Retrieved from: <http://www1.oecd.org/publications/ebook/8103021E.PDF108>

OECD [2009] **Sickness, Disability and Work. Keeping on Track in the Economic Downturn. Background Paper**. Paris, FR: Organisation for Economic Cooperation and Development

¹²⁷ OECD [2008] **Sickness, Disability and Work: Breaking the Barriers Vol. 3. Denmark, Finland, Ireland and the Netherlands**. Paris, FR: Organisation for Economic Cooperation and Development.

¹²⁸ Hanophy, J. [2012] 'Testimony of the Council of State Administrators of Vocational Rehabilitation (CSA vocational Rehabilitation) on Work Incentives in Social Security Disability Programs', **Journal of Vocational Rehabilitation**, 36 (1), pp. 13-20.

¹²⁹ Dean, D., Pepper, J., & Schmidt, R. [2014] 'State Vocational Rehabilitation Programs and Federal Disability Insurance: An Analysis of Virginia's Vocational Rehabilitation Program', **IZA Journal of Labor Policy**, 3 (7), pp. 1- 19

¹³⁰ ILO [2008] **Vocational Rehabilitation and Employment (Disabled Persons) Convention (No. 159) and Recommendation (No. 168): United Nations Convention on the Rights of Persons with Disabilities**. Geneva, CH: International Labour Organisation. Ireland signed the Convention in 2006 and is committed to ratification, and in 2015 published its Roadmap to Ratification (<http://www.justice.ie/en/JELR/Roadmap%20to%20Ratification%20of%20CRPD.pdf/Files/Roadmap%20to%20Ratification%20of%20CRPD.pdf>)

market policies. Nevertheless, there is a consensus that vocational rehabilitation needs to be an integral part of social security and social protection systems, and disability employment policy¹³⁰.

awareness of medical and health referral sources of the potential benefits of vocational rehabilitation can contribute to creating a continuum of vocational rehabilitation support.

- Vocational rehabilitation should operate in coordination with a range of other measures to promote the employment of people with disabilities in the open labour market¹³¹.
- An effective vocational rehabilitation response requires a system of policy and legislation, administrative processes, funding and delivery mechanisms, quality assurance and evaluation and monitoring.
- Early vocational rehabilitation was identified as an important strategy to reduce the inflow to and enhance the outflow from disability pension systems.
- Measures should include interventions to assist people to retain their jobs (occupational rehabilitation) and interventions to assist the new hiring of job seekers (vocational rehabilitation).
- The differences between vocational rehabilitation and occupational rehabilitation are the employment status of the beneficiaries and consequently the intended outcomes. Most vocational rehabilitation providers also provide occupational rehabilitation measures designed to respond to people who are currently at work. Occupational rehabilitation is seen as a tertiary occupational health prevention mechanism.
- It is generally understood that vocational rehabilitation involves a continuum of components from allied health to social and vocational interventions and supports.
- Vocational rehabilitation involves assessing individual needs and strengths; functional capacity building; counselling and guidance; job demands analysis and matching; vocational education; training; enhancing social competences; case management and service coordination; placement and on the job support; accommodations and assistive technology; and follow up support.
- Two important success factors in vocational rehabilitation are case management and linking health and vocational interventions.
- One of the primary challenges for effective vocational rehabilitation is achieving coordination between the actors involved in the benefits/employability process for someone with a health related impairment. The key actors include the health system, the social protection system, the employer and the person experiencing reduced work capacity as a result of a health condition. Case management and raising the

¹³¹ COE (2000). **Employment strategies to promote equal opportunities for persons with disabilities on the labour market**. Strasbourg, FR: Council of Europe.

Chapter 3. Comparison of vocational rehabilitation systems in other jurisdictions

In most countries, systems for vocational rehabilitation have evolved in a piecemeal way rather than being designed from scratch. These systems consist of collections of services, provisions and regulations that are not necessarily coherent in nature. In addition, countries differ in their economic and social contexts, and in the structure of their welfare systems in terms of such key variables as funding, coverage and eligibility. There are also regional variations within federal states. All of these factors contribute to the complexity of examining systems in different jurisdictions and drawing international comparisons. Nevertheless, there is much of value that can be derived by looking at different systems through a common lens.

3.1 Overview of the systems analysis

Chapter 3 presents the results of a systems analysis of 12 jurisdictions, four of which were based on a detailed template completed by a national expert (Appendix 2) and eight which were based on a structured questionnaire (Appendix 3).

The analysis of national systems was implemented in two stages. Firstly, the system profiles provided by the national experts from the four main jurisdictions (Finland, New Zealand, Slovenia and Queensland) were analysed. This compared them on a range of dimensions including the scope and focus of vocational and occupational rehabilitation, funding and costs, quality improvement processes and perspectives on good practices. Further details of the material in these jurisdictions is given in Appendix 4 which complements the synthesis in this chapter.

Secondly, a less intensive study was undertaken in another eight countries (Denmark, France, Germany, Lithuania, Norway, Portugal, Spain and the Netherlands).

This was done to extend the scope of the international context for vocational and occupational rehabilitation. In this part of the study, the responses of the four expert respondents were compiled and condensed into a structured questionnaire with a focus on systems of provision and components of vocational rehabilitation services. The respondents from the eight additional

countries were asked to indicate the extent to which these responses were representative of components of vocational and occupational rehabilitation systems in their own jurisdictions.

These responses were then analysed to generate a template against which the Irish system could be benchmarked.

The initial findings were reviewed by an expert in vocational rehabilitation from the USA and his remarks have been incorporated into the report.

Section 3.2 presents the components of vocational rehabilitation identified by the systems analysis based on 12 jurisdictions. Section 3.3 summarises the system level characteristics of vocational and occupational rehabilitation. Section 3.4 summarises the perspectives of the national experts in the four main jurisdictions on good practices in vocational rehabilitation. The detailed systems analysis is presented in Appendix 4.

3.2 Systems analysis of vocational and occupational rehabilitation

3.2.1 Insurance or tax funded

In general, it was possible to identify two systems of vocational rehabilitation provision. The first of these was funded out of general taxation and operated as an element of social protection and/or employment services. The second was an insurance funded system.

There were variations on this theme. In Finland, there were several systems funded out of general taxation that operated at local, regional and national levels. In Queensland, there is a national Commonwealth Rehabilitation Service (CRS) which operates on a provincial basis. This system is in the process of privatisation but it is too early to come to conclusions on this process. Vocational rehabilitation funded through insurance was available on a no-fault basis. In New Zealand, the insurance-funded system covered all accidents including occupational accidents and road traffic accidents, and was funded through levies on all insurance policies and administered by the Accident Compensation Corporation.

In the other jurisdictions, the insurance-funded systems

were specific to occupational injuries and illness and were financed through a combination of employer and worker contributions. These provided injured workers with rehabilitation to assist in job retention or return to work. Funding was made available for treatment and income continuance regardless of liability. In Queensland, there were two such systems – at State level one covered the private sector and the ComCare system covered public sector employees nationally. A similar distinction was seen in most of the other eight countries. These services were funded from a combination of national social, health and workers' compensation insurance. Only Denmark and Norway funded these types of services through general taxation. Portugal used a combination of national social insurance and taxation.

No-fault insurance

All insurance funded systems were 'no-fault' schemes in which insured persons were entitled to compensation, care and support regardless of liability. In Queensland, all occupational injuries and diseases were eligible, including road traffic accidents that occurred while commuting to and from work under two pieces of legislation – one for private sector workers and another for public sector workers. Each Australian state had an agency responsible for occupational health, safety and workers' compensation. The Queensland agency is WorkCover QLD, a statutory body funded by an employer accident insurance scheme, which sets premium rates based on economic sector and a *bonus-malus* element that takes into account an employer's claims history. It grants discounts for good performance and penalties for poor performance.

In New Zealand any citizen who was employed at the time of an accident (whether it took place at work or not) was entitled to compensation and services including rehabilitation on a no-fault basis. Every person and organisation buying accident insurance paid a levy which was used to fund the system.

In Finland, the system was funded through employer contributions and general taxation. Rehabilitation was an important element of occupational health services and any worker who experienced a reduction in work capacity for any reason was entitled to rehabilitation services offered by public, private, non-governmental and employers' own clinics. The system was based on the distinction between primary prevention, which aims to protect the health and productivity of the whole workforce; secondary prevention, which involves intervening to preserve the work ability of workers who have or are at risk of reduced work capacity through rehabilitation and workplace adaptations; and tertiary

prevention which focuses on assisting workers who are on long term sick leave to return to work in their own or other jobs. Vocational rehabilitation was considered to be an important tertiary prevention strategy.

In all jurisdictions vocational rehabilitation services were designed to meet the needs of both job seekers with disabilities and workers with disabilities at risk of losing their jobs.

3.2.2 What agency is responsible

In Denmark, Spain and Norway, the same agencies were responsible for both occupational and vocational rehabilitation i.e. Municipalities in the case of Denmark, ONCE in Spain and NAV in Norway (Norwegian Labour and Welfare Administration). In Germany, the Accident Insurance Boards (Workers' Compensation Boards-DGUV) were responsible for occupational accidents and diseases and the Agency for Labour and the Pension Funds played this role for non-occupational health conditions. The Netherlands operated a unique system in which employers were responsible for funding up to two years of sickness benefit for an employee. Employers took out insurance to protect themselves against this eventuality and contracted with private service providers to assist their workers to get back to work. Employers in Norway also had responsibilities to monitor their absent employees and to call a meeting with all key actors including the Norwegian Labour and Welfare Administration after seven weeks. In Portugal, occupational rehabilitation was within the Social Security Agency's remit.

In Slovenia, there was a Pension and Disability Institute under the Ministry of Labour, Family, Social Affairs and Equal Opportunities which provided income support and rehabilitation services to workers who had had an occupational injury or illness and who had remaining work capacity.

3.2.3 Definitions of vocational and occupational rehabilitation

The definition of what constitutes vocational rehabilitation varied between jurisdictions. In Queensland, it was viewed as a process that aimed to improve the employment prospects of beneficiaries to obtain paid employment remunerated at standard rates in the open labour market. This was operationalised as making progress towards the open labour market, choosing, getting and keeping a job and returning to one's pre-disability job or an alternative. Making progress towards the open labour market can include developing strategies to cope with a disability, job seeking skills or engaging in volunteer work.

In New Zealand, vocational rehabilitation was concerned with reducing barriers to work in terms of getting a job or returning to work. Both the person and the employer were considered beneficiaries of the service and a social model was applied that aimed to build the capacity of the person and to remove physical and social barriers to work.

The Finnish definition was broader and included measures to improve the capacity of a worker who was currently in a job to cope with job demands, to return to work after absence and to address the barriers faced by job seekers in gaining employment – this was the only country, apart from a pilot initiative in Queensland, where services were available prior to becoming absent from work.

In Slovenia, vocational rehabilitation included services to prepare a person for appropriate work i.e. open, supported or sheltered work, obtain employment, remain in a current job, make progress in a career or assist a person to change careers.

The respondents from all other European jurisdictions apart from Spain indicated that the following definition was an excellent fit with vocational rehabilitation in their jurisdictions. The purpose of vocational rehabilitation is to:

- improve a person's capacity for work so as to help cope with work demands
- help them overcome impairments
- enter working life or
- return to work after absence

There was little consistency in definitions of occupational rehabilitation. In Denmark and Germany, it involved the provision of supports and interventions to ensure the maintenance and promotion of the employee's work ability and their staged return to work. The Netherlands had a broad definition but focused particularly on the process where workers with acquired disabilities were facilitated to retain their original or another job with their original employer. In Spain, it was defined as the process through which injured employees' functioning was maximised and/or a safe and early return-to-work was achieved. Norway, Portugal and France had definitions with a broader scope covering some of the characteristics of the other jurisdictions.

3.2.4 The legal basis for vocational rehabilitation

There was an explicit legal basis for vocational rehabilitation as an intervention within the context of social and/or labour affairs in each of the four jurisdictions of primary focus. In Australia, the

Disability Services Act 1986 makes explicit reference to vocational rehabilitation and assigns responsibility to the Department of Social Services and Department of Human Services. The benefits agency (Centrelink) has an important role to play in determining eligibility. Until recently the majority of services were delivered by the CRS although there is a currently a move to privatise vocational rehabilitation.

In New Zealand, the equivalent legislation is the *Disabled Persons Employment Promotion (Repeal and Related Matters) Act*, amended in 2007, which assigns the responsibility to the Ministry of Social Development and is funded under the Vocational Services for People with Disabilities budget line. Services are generally contracted out to private and not for profit providers.

In the Finnish system, vocational rehabilitation is addressed directly in the *Rehabilitation Benefits Act 15.7.2005/566* and responsibility resides with the Ministry of Social Affairs and Health and specifically with the Social Insurance Institute (KELA). Services are funded by employer and worker contributions (55 per cent) and general taxation (45 per cent) and delivered under contract by private for profit and non-profit providers.

The Slovenian *Vocational Rehabilitation and Employment of Persons with Disabilities Act (UL RS 16/07 – UPB2, 87/11)* assigns responsibility to the Ministry of Labour, Family, Social Affairs and Equal Opportunities and the Employment Service of Slovenia. Services are delivered by one public and a number of private (profit and non-profit) providers funded by general taxation (90 per cent of costs) and 10 per cent through selling services.

3.2.5 System actors and responsibilities

Table 3.1 summarises the responsibilities and actors in each of the four jurisdictions in which the detailed analysis was carried out.

These reflect the dual purpose of vocational rehabilitation to reduce the inflow into the disability system and to promote and protect employment for people with disabilities. In general, the vocational rehabilitation agencies were either responsible for pensions, employment or both.

In Slovenia, responsibility for vocational rehabilitation was spread across as many as five ministries, while in the other countries responsibility was more focused.

Table 3.2 presents the allocation of administrative responsibility in the other eight European jurisdictions.

In each of the jurisdictions reviewed, the majority of services were available under a combination of labour

Table 3.1 VR System Analysis – Responsibility and Actors

	SI	FI	QLD	NZ
Responsible Ministry				
Social Affairs	•	•	•	
Employment	•		•	•
Health	•	•		
Family	•			
Equal Opportunities	•			
Executive Agencies				
Disability Employment or Vocational Service	•		•	•
Pensions Agency			•	
Work and Income				•
Social Insurance Agency		•		
Rehabilitation Committee	•			
Duration				
Up to 24 Months	•		•	
Up to 36 Months		•		•
Post Placement Support			•	
Providers				
Public Sector	•		•	
Private For Profit	•	•	•	
Not-for Profit	•	•	•	
Community Based Organisations				•

and social affairs, organised at national, regional or municipal level. The main exceptions to this were functional capacity evaluation, capacity building and psychological supports which were located in the health domain.

3.2.6 Funding of rehabilitation

In all jurisdictions, funding for rehabilitation was available through private health and income protection insurance as well as from a range of social insurance and publically funded systems. In addition, most jurisdictions operated workers' compensation systems on a 'no fault' basis apart from the Netherlands and Denmark where occupational injuries were covered

Table 3.2 VR System Analysis - Administrative Responsibility

Executive Agencies	NL	DE	PT	FR	ES	DK	LT	NO
Disability, Employment or Vocational Service			•	•			•	
Public Employment Service	•	•						•
Vocational Education and Training	•							
Pensions		•						•
Workers Compensation		•	•	•	•		•	•
Private Insurance	•					•		
Work and Income								
Social Insurance or Welfare		•				•		
Municipalities						•		
National Organisation for the Blind					•			

through employer private insurance. Non-occupational illnesses and injuries were covered by a range of systems including public systems offered through health, social, pension, municipal and NGOs.

Vocational and occupational rehabilitation services were available through systems run by social protection and employment and funded for the most part out of general taxation. The services offered in the compensation insurance system only differed in terms of how services were procured and financed.

A statutory agency or agencies had clear responsibility for administering the vocational rehabilitation system in all jurisdictions, with the exception of Spain. Ministries

of Social Protection or Employment oversaw these agencies.

The EU jurisdictions differed in terms of the policy area in which vocational rehabilitation was located. In Portugal, the system operated solely in the domain of labour policy. In Lithuania, it was governed by social affairs and in Spain, by health and social affairs. In the other five jurisdictions, it operated at the intersection between labour and social affairs either because this was a single Ministry or because there was joint responsibility between two ministries. Additional responsibilities were assigned to education in the Netherlands, France and Denmark.

The sources of funding for vocational rehabilitation services were diverse. Spain was unique in its approach as it is lottery based. Four jurisdictions financed the system through some form of national social insurance (Germany, France, Lithuania and The Netherlands) and three out of general taxation (Denmark, Norway and Portugal). Statutory health insurance also funded services in Germany, France and the Netherlands and in Germany the pension funds were also involved.

3.2.7 Target groups and eligibility criteria

The target groups, eligibility criteria and services included in the scope of vocational rehabilitation varied across the systems.

In each system, the basis for eligibility involves administrative criteria such as residency, age, receipt of a social protection payment and an assessment of needs. There was little consistency in eligibility for occupational rehabilitation. Criteria included any person with a work related injury or illness, any person insured with a work disability, any person who was employed at the time of the injury and all salaried employees with a health problem that interfered with their work ability.

In Queensland and New Zealand, applicants must be in receipt of a social protection payment. In Slovenia, they must have legislatively defined disability status. In Finland, anyone who has the potential to benefit is eligible for the service. The duration of services spanned from six months to 36 months. In Queensland, ongoing support is available for those who require it.

In Queensland, any person of working age with a disability or health condition who is considered by the Disability Employment Service (DES) to need assistance is eligible for vocational rehabilitation. Similarly, people in New Zealand with acquired disabilities who require support, assistance or interventions to either get or retain a job are considered eligible. The Finnish

system of vocational rehabilitation covers both job seekers with disabilities and workers with reduced capacities. Workers who are considered to be at risk of a deterioration in work capacity within a year or two are also eligible. (This is based on an assessment of their 'work ability', a combination of self-assessment via questionnaire and medical tests). The target groups in Slovenia are people considered to be disabled under disability legislation, whether as a result of a congenital or an acquired condition.

In Queensland, the assessment of rehabilitation needs involves an Employment Service Assessment and a Job Capacity Assessment (See Figure A4.2, Appendix 4). These are used to distinguish which of three service streams is most appropriate for the person. The Disability Management Service is most suitable for people who are considered to be able to get a job or return to a job without the need for ongoing support. The Employment Support Service is for people who are likely to require sustained support and follow up. The Jeopardy Assistance service is for people who are still in work but need assistance to retain their jobs. This is a relatively new service and is still in development.

Eligibility criteria in New Zealand include a judgement that a person is at risk of long term benefits dependency on the basis of a medical and social assessment. In Finland, eligibility is determined by a multi-disciplinary assessment of need to determine the potential to benefit from vocational rehabilitation. The assessment in Slovenia is carried out by a Rehabilitation Committee which determines the legal status of the person under disability legislation and the need for vocational rehabilitation.

The eligibility criteria operating in the other jurisdictions varied substantially. In some countries, any person experiencing the permanent consequences of a disability was considered eligible if they had a reduced potential to secure, retain or advance in employment. Other countries emphasised the risk of long-term benefits dependency. France had a wide eligibility framework that covered anyone with a documented disability whether employed or unemployed if they were considered on the basis of a needs assessment to be able to benefit from vocational rehabilitation. This was also considered to be a criterion in Norway. In Denmark, anyone within the catchment area of a service not receiving another employment service was eligible.

3.2.8 Referrals and information sources

An important component of any service provision system is communication with people who could benefit from

the service and the referral pathways into the system. The most frequently used sources of information about vocational rehabilitation services and referral sources in each of the jurisdictions are presented in Table

3.3. In most jurisdictions, the social insurance /social protection system was a key source of referrals.

Table 3.3. VR Systems Analysis - Referral and information Sources¹³²

	NL	DE	PT	FR	ES	DK	LT	NO	SI	FI	QLD	NZ
Social insurance/protection												
Rehabilitation Case Manager	++		++			+		+	++	++	++	++
Social Security/Welfare Staff		+	++	++	+	++	++	++	+	+	++	++
Medical Social Security Assessment Professionals	+		+	++				+			++	+
Committee of Socio-Medical Expertise			+	+			++		+			
Service Providers												
Vocational Rehabilitation Provider Websites	++	+	+	++			++	+	++	++	++	++
Vocational Rehabilitation Services Marketing	+	+	++	+			+	+	++	+	++	
Health												
GP or Family Doctor	+	++	++				+	++		+	++	+
Physiotherapy or OT Professionals	++	+			+	+				+	+	+
Medical Specialists and Consultants	+	+		+			++	++	+	++		+
Community Health Centres			+	+						++	+	+
Hospital-based Medical Social Worker		+	++	++	+		+	+			++	+
Community-based Social Worker or Nurse			+	+	+		+	+			++	+
Employment services												
Public Employment Services Guidance Officers	++		++	++		++	+	+	++	++		+
Unemployment Centres	++	++	++	++	+	++	++	+	++	+		++
Private insurers												
Insurance Company Websites		+							++	+		+
Insurance Claims Manager		+	+		+					+	+	+
NGOs												
Disability Specific Organisations	+	++	++	++	++			+	++	++	++	+
Disability Equality Organisations		+	+		++			+	++	++	+	+
Disability NGO Websites		+	+		++		+	+	+	+	+	+
Public information sources												
Public Online Information Sources	+	+	+	++		++	+	+	+	++	++	+
Citizens/Community Information Services				+								+
Employers												
Human Resources	++	+	++	+	+	+		+	+	++	+	+
Company Occupational Health	++	++	+	++		+		+	++	++		
Disability/Injury Management Programme		++	++	+							++	

¹³² ++ - very likely; + - likely

The ten most likely information and referral sources were distributed across a number of domains including employers (Human Resources and Company Occupational Health Service); employment services (Unemployment Centres and Public Employment Services Guidance Officers); providers (Vocational Rehabilitation Provider Websites and Vocational Rehabilitation Services Marketing); NGOs (Disability Specific Organisations); public information sources (Public Online Information Sources) and social insurance/protection services (Social Security/Welfare Staff and Rehabilitation Case Managers). The GP or family doctor was specified as the most frequent referral source in the domain of health.

In jurisdictions where case managers operated they were rated as being frequently used.

3.2.9 Activities and components

The 12 national correspondents were asked to indicate the availability of a variety of services and the agencies involved in delivering them. The responses are presented in Table 3.4. Overall the responses were very consistent across the jurisdictions.

The vocational rehabilitation system in Queensland has three strands of service provision. People entering the system undergo a variety of assessments that focus on their rehabilitation and employment needs, their job capacity and their suitability for employment service supports. Participants are then assigned to one of three service streams¹³³. All services operate on the basis of an individual plan which is coordinated by a case manager. A wide range of interventions are available including building the capacity of the person

Table 3.4 VR Systems Analysis –Activities and Components

	Components	NL	DE	PT	FR	ES	DK	LT	NO	SI	FI	QLD	NZ
Assessment & Evaluation	Vocational Assessment	●	●	●	●	●	●	●	●	●	●	●	●
	Functional Capacity Evaluation	●	●	●	●	●	●	●	●	●	●	●	●
	Job/Person matching	●	●	●	●	●	●	●	●	●	●	●	●
	Work sampling or on the job assessment	●	●	●	●		●		●	●	●	●	●
Advice & Guidance	Information & Advice about Vocational Rehabilitation	●	●	●	●	●	●	●	●	●	●	●	●
	Guidance & Counselling	●	●	●	●	●	●	●	●	●	●	●	●
Vocational Education & Training	Specialised Vocational Education/Training	●	●	●	●	●	●	●	●	●	●	●	●
	Pre Vocational Training	●	●	●	●		●	●	●	●	●	●	●
Health & Wellbeing Support	Psychological Supports	●	●	●	●	●	●	●	●	●	●	●	●
	Physical/Functional capacity building	●	●	●	●		●	●	●	●	●	●	●
On the Job Support	Job Coaching	●	●	●	●	●	●	●	●	●	●	●	●
	Supported Employment	●	●	●	●	●	●		●	●	●	●	●
	Job search and placement services	●	●	●	●	●	●	●	●	●	●	●	●
Adaptations & Technologies	Workplace Adaptations	●	●	●	●	●	●		●	●	●	●	●
	Assistive technology	●	●		●	●	●		●	●	●	●	●
	Reasonable Accommodation	●	●		●	●	●		●		●		●
Service Coordination	Case management	●	●	●			●	●		●	●	●	●
Alternative Employment Options	Social enterprise	●	●	●	●	●	●		●	●	●	●	●
	Sheltered Employment	●	●	●	●	●	●		●	●	●	●	●
Other Supports	Access to adapted transport	●	●		●	●	●		●	●	●	●	●

¹³³ <http://www.humanservices.gov.au/spw/corporate/freedom-of-information/resources/disclosure-log/2013-01-10-guidelines-and-mandatory-requirements-for-jca.pdf>

and adapting the work environment. An assessment of ongoing support needs is carried out and this can result in the person receiving continuing support.

Since 2012, the New Zealand Accident and Compensation Corporation provides a new and comprehensive vocational rehabilitation service with a clear focus on early rehabilitation. The service, which has been developed in close association with the vocational rehabilitation sector, covers the clients' full spectrum of needs, from initial rehabilitation to getting a new job. It offers four related services delivered by rehabilitation professionals: a Standalone Workplace Assessment (which reviews the client's workplace to identify how they did their job prior to their injury); a Stay at Work service (which supports people to return to their jobs); a Work Readiness service (which rehabilitates people ready for new types of employment); and a Job Placement service (which helps people find new jobs).

Ministry for Social Development services operate on the basis of a focused case management plan which can include mainstream and tailored employment services, vocational training, job seeking skills and supports and on the job or self-employment support. Where appropriate, participants can access financial subsidies to assist in rehabilitation and employment.

The vocational rehabilitation pathway to employment in Finland begins with an assessment of rehabilitation strengths and needs and a vocational rehabilitation plan. Depending on needs, participants can access services related to job seeking and career coaching, rehabilitation psychotherapy, education or training, work based training trials and job coaching and subsidies or supports for job retention or self-employment.

The Slovenian system of vocational rehabilitation offers very similar options. The starting point is a needs assessment and planning process. Interventions include guidance, social skills development, job seeking support and workplace based systems such as on-the-job training, adaptations and assistive technologies or supported employment. On completion of each plan, an evaluation of the vocational rehabilitation process and the effectiveness of workplace supports is carried out. Follow up supports can be made available where this is required.

Overall the majority of services specified in the four expert reports reviewed were also identified in the majority of the eight other countries. There was a distinction between jurisdictions in which

case management was a component of vocational rehabilitation and those where it was not. Specifically, France, Spain and Norway did not provide case management services.

3.2.10 Incentives and supports

All systems reviewed offered incentives as well as services to help beneficiaries gain employment or return to work. These were focused at different levels of the system and could be positive or negative in nature. For example, an incentive for an individual could be the deferral of a pension until rehabilitation has been completed. An incentive for a service provider could be outcome-related funding. An incentive for an employer could be a requirement to employ a quota of workers with disabilities and the application of a sanction in terms of a levy for non-compliance. There is some controversy about the impact of such mechanisms but they are a part of the system to varying degrees in most countries. Table 3.5 summarises the incentives in operation in the 12 jurisdictions.

Incentives can be classified in terms of the actors that are targeted and the nature of the support or incentive. Person-focused incentives and supports involved financial grants, personal supports or equipment. Employer-focused incentives and supports could be financial or administrative. Financial incentives included subsidies or levies and administrative supports included recognition systems for good practice.

Almost all systems provided access to interpreter services, workplace personal assistance, advocacy assistance, equipment grants and in most cases, financial support for commuting to vocational rehabilitation and work. In addition, New Zealand, Finland and Slovenia provided financial support to people undertaking vocational rehabilitation. Slovenia was the only country that did not offer flexible benefits for people entering employment or did not review the entitlements of those who did not participate in vocational rehabilitation.

There was some consistency in the person-focused supports and incentives available in the eight supplementary jurisdictions reviewed. Apart from conditionality i.e. the withdrawal of benefits from people who do not participate in vocational rehabilitation which operates in Denmark, France, Germany and Norway, the other supports and incentives were indicated with only a few exceptions.

There was a greater variability across the jurisdictions with regard to employer-focused incentives. The only

Table 3.5 VR System Analysis – Incentives and Supports

		NL	DE	PT	FR	ES	DK	LT	NO	SI	FI	QLD	NZ
Advice	Assistance applying for grants	●	●	●	●	●	●	●	●	●	●	●	●
	Advocacy	●	●	●	●	●	●		●	●	●	●	●
Personal Assistance	Interpreters	●	●		●	●	●	●	●	●	●	●	●
	Workplace personal assistance	●	●	●	●	●	●		●	●	●	●	●
Adaptations	Equipment grants	●	●	●	●	●	●	●	●	●	●	●	●
	Grants for workplace accommodation	●	●	●	●	●	●	●	●	●	●	●	●
Financial Incentives	Financial support for commuting to VR and work	●	●	●	●		●		●	●	●	●	●
	Additional financial support of people participating in VR	●	●	●	●		●	●	●	●	●		●
	Flexible benefits for people who enter employment	●	●		●	●	●		●		●	●	●
	Withdrawal of benefits from people who do not participate in VR	●	●		●		●		●		●	●	●
	Wage subsidies	●	●	●	●	●	●	●	●	●	●	●	●
	Productivity-related financial supports	●	●	●	●	●	●			●			
	Levies for non-compliance with quotas	●	●	●	●	●				●			
Administrative Incentives	Positive Action (in favour of job seekers with disabilities)	●	●	●	●	●	●	●	●	●		●	●
	Employment quotas	●	●	●	●	●				●			
	Disability-positive accreditation for good practice employers	●	●	●			●		●	●			
	Disability Awareness Training for staff	●		●	●		●					●	

two incentives that applied consistently across all jurisdictions were wage subsidies and grants towards workplace accommodations. Slovenia offered the greatest number of employer-focused incentives including positive action, productivity-related financial supports, employment quotas, levies for non-compliance with quotas and disability-positive accreditation for good practice employers. Positive action to promote disability employment was also in place in Queensland and New Zealand. Disability

awareness training for staff was only available in Queensland.

There was less consistency in relation to employer supports and incentives amongst the other European jurisdictions. There was a policy of positive action in favour of job seekers with disabilities and a system of wage subsidies in all jurisdictions. Apart from Portugal, all jurisdictions provided grants for workplace accommodations. Other incentives were less frequently cited by respondents. For example, quotas and levies

were applied in four jurisdictions France, Germany, Spain and Portugal.

The majority of person- and employer-focused incentives and supports were offered through labour market agencies, with the exception of advocacy services. Only Queensland and New Zealand operated an element of outcome-related funding for providers.

3.2.11 Job retention services for employees at risk of job loss

Job retention services were most fully developed in Queensland and Finland. There were no specific services for at-risk workers in Slovenia. In New Zealand, all case managers across both the Ministry of Social Development and the Accident Compensation systems (MSD and ACC) can respond to queries by people still in work. However, the starting point for access is a GP referral.

Queensland – Job in Jeopardy Assistance Service ¹³⁴

Assistance for people with acquired disabilities at risk of losing their job is provided under the Job in Jeopardy Assistance programme (JJA). It operates through a tripartite arrangement between employer, the employee and a Disability Employment Service (DES) provider (either DMS or ESS). The core elements of the service include job tailoring or job matching within the current workplace and employment support. Outcomes are paid for on the basis that a worker is still working their normal hours with the same employer in their original job or an alternative after 26 weeks.

The main components for the programme are:

- Job redesign advice and assistance
- Workplace assessment to identify adaptations and modifications
- The procurement of specialised equipment for job maintenance

JJA services are targeted at workers with at least eight hours a week employment, averaged over the previous 13 weeks, and who are not in another Disability Employment Service (DES). People who meet these requirements can approach a Disability Employment Services provider directly for assistance. Outcomes

for JJA were very promising with over half the jobs of applicants protected. ¹³⁵

The main limiting factor identified in the 2014 evaluation was its limited reach (less than 1,000 participants as of June 2012) which is estimated to be less than 0.1 per cent of the potential number of beneficiaries ¹³⁶. The evaluation concluded that there was a strong case to be made for enhancing access to the programme and that there may be scope to assist more eligible people before they become unemployed. JJA tries to do this but fails because of its restrictive parameters. In particular, applicants can find it difficult to demonstrate that sickness or disability is the reason that employment is at risk and that they may not be able to meet the 13 week continuous employment criterion due to illness.

Finland – Maintenance of Work Ability (MWA)

MWA is a Finnish national strategy aimed at maintaining and improving workers' health, wellbeing and employability ¹³⁷. It involves collaboration between pension funds, occupational health services, employers and workers. It covers areas such as occupational health, health and safety, workplace health promotion, rehabilitation and reintegration, human resources and personnel development and organisational change. The MWA strategy was initiated by employers and trade unions and developed primarily by the Ministry of Social Affairs and Health. It has been integrated into national social partner agreements. The impact of the programme has been reviewed and results are considered very positive. There was a high level of employer and employee awareness and occupational health services had enhanced their capacity for early intervention. Job retention outcomes and health and wellbeing outcomes were significantly enhanced ¹³⁸.

In operating the programme, there is a feature which allows for interventions to improve work ability before health breakdown or absence might occur. An index of Work Ability can be used, whereby a combination of self-report questionnaire and medical tests help identify people (or groups) at risk of becoming long term absent due to health problems. Tailored intervention programmes may then be put in place to boost the work ability of the individual.

¹³⁴ <http://www.humanservices.gov.au/customer/services/centrelink/job-in-jeopardy>

¹³⁵ Department of Social Services (2014) **Evaluation of Disability Employment Services 2010-2013: Final Report**. Canberra, AUS: Australian Government. Retrieved [24/08/2015] from: <https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/evaluation-of-disability-employment-services-2010-2013>

¹³⁶ Department of Social Services (2014) **Evaluation of Disability Employment Services 2010-2013: Final Report**. Canberra, AUS: Australian Government. Retrieved [24/08/2015] from: <https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/evaluation-of-disability-employment-services-2010-2013>

¹³⁷ Ilmarinen J. (2009) 'Work Ability – A Comprehensive Concept for Occupational Health Research and Prevention', **Scandinavian Journal of Work Environment & Health**, 35 (1), pp. 1–5.

¹³⁸ Peltomäki, P., Hussi, T., Julin, H., Launis, K., Liira, J., Räsänen, K. (Eds.) (2002) **Maintenance of Work Ability Research and Assessment: Summaries**. Vammala, Finland: Ministry of Social Affairs and Health, Finnish Institute of Occupational Health, Social Insurance Institution.

3.2.12 The role of case management

A specific question of interest concerned the role of case management in the provision of services, as this is widely acknowledged to be an essential element of good return-to-work practice. In each of the four main jurisdictions studied, some form of case management was central to the service delivery model.

In Queensland, case managers play a key role in facilitating access to supports and, in some cases, provide vocational counselling. They coordinate and manage access to services in relation to the person's expressed goals. These services can be provided by a number of different suppliers and are paid for by the DES. For services beyond the scope of the DES, the case manager can support the person through education and emotional support. Case management resources are higher for people with more complex needs.

The case manager in the Ministry of Social Development services in New Zealand acts as a personal employment advisor who also provides coaching to build work readiness and job search skills. The emphasis is upon wellbeing and restoration of function including return to work. Case management is also at the core of the services offered by the Accident Compensation Corporation¹³⁹. There is a growing recognition of the need for case managers to work across sectors including health, education, social welfare and housing and to work across the two pillars of provision i.e. the ACC and the MSD systems.

The basis for the provision of services in Finland is an individual rehabilitation plan which is drawn up on the basis of a needs assessment with the individual and if appropriate with family members. It specifies the measures required across the domains of social welfare, labour and educational authorities, the Social Insurance Institute (KELA) and other agencies arranging rehabilitation. Medical rehabilitation service providers must ensure that they coordinate with other types of rehabilitation provided by other agencies.

In Slovenia, people are provided with advocacy, guidance and support by a multidisciplinary team including an occupational physician, social worker, psychologist, OT, rehabilitation technologist or trainer. The team is responsible for coordinating interventions across different legal contexts and for collaborating with other stakeholders including social systems and employers, particularly in relation to post-placement support.

Five of the other eight jurisdictions operated case management as part of vocational rehabilitation

provision. The main elements of case management were:

- Taking an active role in vocational counselling
- Drawing up a rehabilitation plan with each client and, if appropriate, family members, that specifies the need for services and supportive measures in line with the client's expressed goals and taking into account the needs assessment
- Coordinating rehabilitation measures including services offered by social welfare, labour and educational authorities and other agencies offering vocational rehabilitation
- Arranging medical rehabilitation services or treatment with healthcare providers
- Advocating, guiding and supporting the client and facilitating access to client supports
- Liaising with the professionals involved in the vocational rehabilitation process including occupational physicians, social workers, psychologists, OTs and trainers
- Operating across different legal contexts, maintaining contact and collaborating with all stakeholders
- Working with employers

3.2.14 Linking medical and vocational rehabilitation

Another key question concerned the ways in which the transition from the medical domain to the vocational domain is managed. The overall process would ideally involve a seamless continuum from acute medical care, to post-acute hospital based rehabilitation, then onto community based functional rehabilitation and finally on to vocational rehabilitation.

Queensland has a model where rehabilitation operates on three levels. Primary rehabilitation offers treatment and medical interventions. Secondary rehabilitation includes inpatient and outpatient post-acute functional rehabilitation. Tertiary rehabilitation refers to community-based interventions including social and vocational rehabilitation. Moving through these systems is done by onward referral where staff in an earlier stage of the system refer clients to later services. The system operates through medical practitioners, hospital-based allied health staff, and welfare and social security staff. Self-referral to tertiary rehabilitation providers is also possible. The case manager becomes involved during secondary rehabilitation.

The New Zealand system is based around a pathways approach to inclusion and is based on case manager involvement and GP referrals. However, it was reported that the approach needs improvement and particularly a greater awareness amongst GPs of the benefits of

¹³⁹ ACC [2012] **Vocational Rehabilitation Services A Quick Reference Guide**. Wellington, NZ: Accident Compensation Corporation. Retrieved [24/08/2015] from: http://www.acc.co.nz/PRD_EXT_CSMP/idcplg?IdcService=GET_FILE&dID=109418&dDocName=WPC120249&allowInterrupt=1

vocational rehabilitation is needed. While the process works relatively smoothly for people with an injury, the system is less effective for people with an illness.

There are some innovative approaches being trialled in direct referrals and early intervention. One example is a service for people with spinal cord injury that makes contact with injured people within hours or days of their injury in order to make an initial connection and to inform the person that return to work will be addressed at a later stage. For others with injury, discussions about work tend to occur on discharge home and contact by a case manager or rehabilitation practitioner.

For Finnish workers, the occupational health system is key in ensuring that people are referred to appropriate services. Early identification of vocational rehabilitation needs occurs through tools such as workplace surveys, health examinations and absenteeism follow-ups. Once the person engages with vocational rehabilitation services, the occupational health professional monitors the impact on the worker's performance. For people with acquired disabilities, the onus is on the medical rehabilitation service provider to ensure that the person is referred onwards to a rehabilitation needs assessment by the Social Insurance Institute. This is used to document the person's requirements in relation to the workplace, medical, social or vocational rehabilitation, employment services, education and training, health and social care services and social security.

In Slovenia, the medical profession should ensure that a person is referred to the Slovenian Employment Service. In addition, GPs can refer patients to medical rehabilitation programmes offered by the health system. Once within the system, social workers in the medical rehabilitation team can encourage the person to contact their local ESS adviser who can in turn refer the person to a vocational rehabilitation counsellor or, if they are eligible for insurance-based funding, advise the GP to make a referral to the Pension and Disability Institute.

None of the other eight countries had a formal process for supporting the transition of people from medical treatment and functional rehabilitation to the vocational rehabilitation system. Only four respondents could provide some detail on the issue (France, Germany, Portugal and The Netherlands). Most of these appeared to have a three-tiered system in place, similar to that operating in Queensland which involved primary rehabilitation (treatment and medical intervention), secondary rehabilitation (inpatient care and outpatient care) and tertiary rehabilitation (community-based

intervention, focusing on client life and vocational goals). This pathway operated on the basis of onward referral through the system by medical practitioners, hospital-based allied health staff, welfare and social security staff. Self-referral to tertiary rehabilitation providers was also possible. Other transition mechanisms were also possible, and included GPs or medical rehabilitation teams (social workers) advising clients to contact their local employment service for referral to a vocational rehabilitation counsellor (case manager).

3.3 System level characteristics of vocational and occupational rehabilitation

Information on impact indicators, quality systems, the training and certification of front line staff and costs of vocational rehabilitation systems were provided by the national experts in Queensland, New Zealand, Finland and Slovenia.

3.3.1 Impact indicators

All four jurisdictions had a set of impact indicators at different levels i.e. the person, the service, the system and society. These are presented in Table 4.6. All four jurisdictions collected information on

- Placements and employment outcomes
- Proportion of beneficiaries accessing training/skills development
- User satisfaction

However, beyond this, there was relatively little consistency across the four countries in the particular indicators used, with 26 indicators in total used across at least one of the four countries.

Queensland appears to have the most comprehensive list of indicators. The indicators included process and outcome indicators which addressed service efficiency and effectiveness, beneficiary perceptions and long-term impact.

In Queensland, one of the more comprehensive sets of indicators is specified in the Evaluation Strategy for Disability Employment Services 2010–2012 (DEEWR 2010)¹⁴⁰.

This included indicators of:

- Improved access to services such as the number of referrals and starts each month, the proportion of these that result in the person accessing recommended services with an Employment Pathway

¹⁴⁰ DEEWR (Department of Education, Employment and Workplace Relations). 2010. Evaluation Strategy for Disability Employment Services 2010–2012. Retrieved (24/08/2015) from <http://docs.employment.gov.au/documents/evaluation-strategy-disability-employment-services-2010-2012>
Job Access: Accessed (24/08/2015) <http://www.jobaccess.gov.au/content/about-disability-services-standards>

Table 3.6 VR System Analysis – Impact Indicators

Impact Indicators	SI	FI	QLD	NZ
Improved Access to Services				
Number of referrals	●		●	●
Proportion of the target population getting services		●	●	
Proportion of applicants accessing an appropriate service			●	
Meeting the needs of participants and employers				
Proportion of beneficiaries accessing training/skills development	●	●	●	●
Proportion of young people active in education, training or work based learning				●
Proportion of beneficiaries in active labour market programmes	●			
Collaboration with employers	●			
Employer perceptions of workers' skills			●	
User satisfaction	●	●	●	●
Quality of life impact of services	●	●		
Service Effectiveness				
Placements and employment outcomes	●	●	●	●
Proportion of employed beneficiaries seeking more hours			●	
Sustainability of employment outcomes		●	●	
Exits to early retirement		●		
Proportion of beneficiaries requiring ongoing support			●	
Drop out exits as a result of dissatisfaction			●	
Timely and Efficient Services				
Costs per place		●	●	●
Costs per sustainable employment outcome			●	●
Time to intervention – start of service			●	
Average time in service to successful outcome			●	
Provider perceptions of the programme	●		●	
Perceptions of referrers	●			
Long Term Impact				
Longer and better careers		●		
Reducing long-term dependency				●
Reducing future liability of the benefits system				●
Disability unemployment rates		●		

Plan and the proportion of the target population that this represents.

- Meeting the training and skills needs of participants and employers including the proportion of participants receiving training, the level of participant satisfaction with training provided, and employer perceptions that job applicants have relevant work skills and abilities.
- Service effectiveness i.e. employment placement and

sustainable employment outcomes. These include the proportion of participants starting employment during the programme; dropout exits attributable to dissatisfaction with the service; the proportion of participants who were employed three months and six months after the process; the proportion requiring ongoing support to remain employed three months and 15 months after exit; participant satisfaction; employer acceptance of services and the proportion

of employed participants who would like to work more hours.

- Timely and efficient services in terms of the proportion of referrals that result in service commencement within four weeks of referral; mean duration between first job placement and 26 week employment outcome; mean duration to exit as an independent worker; mean number of employers that contribute to 26 week employment outcomes; mean cost (programme payments) per 26 week employment outcome and the extent to which providers agree that the administrative load is lower under the Disability Employment Service.

There is little information available on how the information from these indicators are used in programme evaluation in Queensland. However, the Australian Government published a report on a countrywide evaluation which used the 26 impact indicators (Department of Social Services, 2014). A summary table of the results of this evaluation which compared results from between 2006–2010 to results between 2010 and 2012 is included in Appendix 4 (Table A4.17).

In New Zealand, the current emphasis is on forward liability for the welfare system as a whole with an emphasis on those out of work for reasons other than health or disability issues. As a result, a number of system-level outcome indicators for vocational rehabilitation have been specified including reducing long-term welfare dependency and the future liability of the benefit system. In addition, individual outcomes such as placements, user satisfaction and costs are measured,

Similarly, in Finland there is more focus on system level indicators such as longer and better working careers, number of sickness absences and the number of unemployed and absent employees and the number of people exiting the labour market through health-related early retirement.

In Slovenia outcomes for vocational rehabilitation are focused more upon the effectiveness and efficiency of current services rather than long-term impacts and particularly emphasise hard outcomes such as placement to the open labour market, supported employment, social enterprise (where employees with disabilities comprise more than 40 per cent of the workforce), and sheltered employment; participation rates; and the perceptions of beneficiaries, employers, service providers and referral organisations.

3.3.2 Early intervention guidelines

The issue of the nature of any guidelines that might exist

with regard to early intervention is of major importance, given the emphasis placed on early interventions by many researchers, policy makers and practitioners. However, only Finland had placed specific requirements upon employers to ensure that an absent worker with a health condition can access appropriate services while still in employment and at an early stage. The milestones of the '30-60-90 model' include a requirement for the employer to notify an occupational health service once the person has been out of work for 30 days. A sickness allowance becomes available within two months and a decision is made as to whether rehabilitation is required. At 90 days a physician assesses the residual work capacity and return-to-work opportunities in collaboration with the worker and employer.

The timeliness of services was considered to be an important indicator of the efficiency of system delivery, particularly in Queensland. This related to the time that applicants spent on waiting lists between referral and first contact rather than time to contact or intervention post the onset of a health condition.

In New Zealand, the emphasis in all service types is on keeping workers employed and preventing their dislocation from the workplace. All applicants are asked about their need for employment supports regardless of their employment status. As a result, the guideline for early intervention is 'as soon as possible' rather than being set at six weeks, as is sometimes the case elsewhere. In addition, the knowledge and awareness of GPs and family physicians about how to talk about the benefits of work and better links to primary care practices is being promoted so as to facilitate early contact.

There is a recommendation that intervention should occur early (as soon as possible) in the Slovenian standards for vocational rehabilitation. However, a lack of formal pathways between education, health and vocational rehabilitation (employment services) is a major barrier to achieving this objective for the majority of people with disabilities.

3.3.3 Training and education of staff

The presence of trained and appropriately educated staff to deliver vocational rehabilitation services will contribute to the effectiveness of the services to be delivered. National respondents in the four main countries of the study were asked to provide information on this issue. Not surprisingly, there was substantial variation in the training and qualifications of staff involved in these services.

In Queensland, staff generally have a qualification in

rehabilitation counselling, an allied health profession or in human services. There are two professional associations to which vocational rehabilitation professionals can affiliate – the Australian Society of Rehabilitation Counsellors and the Rehabilitation Counselling Association of Australasia. These organisations have their own standards for membership, an education programme and accreditation, with most requiring at least an undergraduate qualification.

In addition to bachelors and masters level degree programmes, WorkCover recognises continuing education and postgraduate courses offered by the Personal Injury Education Foundation. These include Certificates in Personal Injury Management, in RTW or Claims Management, a Graduate Certificate in Personal Injury Management and a Masters of Personal Injury Management. In some Australian States in-service training for professionally qualified staff is mandatory within three months of being recruited.

Professional qualifications for rehabilitation staff are less common in New Zealand. Auckland University of Technology has a qualification at both undergraduate and postgraduate level in case management and a postgraduate Diploma in Vocational Rehabilitation. There are a number of other professional development courses offered by other universities in vocational rehabilitation or occupational medicine but no other qualifications. Staff can affiliate to the Rehabilitation Counselling Association of Australasia.

Rehabilitation staff in Finland come from a wide range of disciplines who acquire their qualifications during the course of their careers. Continuing professional development (CPD) is provided by a range of organisations including rehabilitation service providers, universities and further education centres. Basic professional education is intended to foster an understanding of the implications of a range of impairments and the support services available. Advanced training addresses a number of specialisms in the field of vocational rehabilitation or employment. It includes the core values of rehabilitation (cooperation and customer-orientation), assessment of needs and strengths, collaborative goal setting and supported decision making. Other key skills addressed include communication with the customer and other employees, problem solving and group processes, cooperation and negotiation skills and the skills needed for working in multidisciplinary teams using a person-centred approach. Professional education also aims to change the attitudes of staff in vocational rehabilitation services.

There are no specific undergraduate or post-graduate courses in Slovenia. Staff are recruited from a range of disciplines including occupational medicine, psychology, social work, occupational therapy and training specialists. All staff are legally required to attend at least two professional development courses (1-2 days) provided by the Slovenian Association of Vocational Rehabilitation Providers. The courses address a range of basic and advanced skills and knowledge specific to the field vocational rehabilitation. The topics are proposed by service providers in their annual evaluations and feedback on individual courses. Professional education is also provided by the Development Centre for Vocational Rehabilitation which is also responsible for research, standards and evaluation.

3.3.4 Accreditation of services

If the qualifications of staff working in vocational rehabilitation services varies, so too does the approach to accrediting the services themselves. In Australia, the Disability Services Act of 1986 refers to the Disability Services Standards. There are 12 service quality standards supported by 26 key performance indicators (see Table 3.6 above). The Act specifies that a service provider must be independently assessed and certified against these standards in order to receive government funding. The Quality Strategy for Disability Employment and Rehabilitation Services, introduced in 2002, provides guidance for all Disability Employment Services programme providers on how to meet, as a minimum, the Disability Services Standards¹⁴¹. The standards covered the following areas:

- Rights
- Participation and inclusion
- Individual outcomes
- Feedback and complaints
- Services access
- Service management

In New Zealand, the primary mechanism for ensuring the quality of vocational rehabilitation is through the contracting process which specifies quality standards. This is the approach adopted in the case of both vocational rehabilitation services (MDS and ACC). Similarly, in Finland, the Social Insurance Institute specifies standards for both outpatient and inpatient rehabilitation in terms of general service standards for all providers, and service-specific standards for specialist services including vocational rehabilitation.

In Slovenia, the Ministry of Labour, Family, Social Affairs and Equal Opportunities encourages and co-finances

¹⁴¹ Department of Social Services: Quality Strategy for Disability Employment and Rehabilitation Services Accessed [24/08/2015] <https://www.dss.gov.au/our-responsibilities/disability-and-carers/program-services/for-service-providers/quality-strategy-for-disability-employment-and-rehabilitation-services>

providers to gain accreditation under the European Quality in Social Services Initiative (EQUASS)¹⁴². This system of accreditation was also evident in the majority of other European jurisdictions included in this study. The EQUASS system covers the following areas:

- Leadership
- Staff
- Rights
- Ethics
- Partnership
- Participation
- Person-centred
- Comprehensiveness
- Results orientation
- Continuous Improvement

The majority of service providers in Slovenia also implement the ISO quality management system.

Funding and costs

Although funding procedures varied between jurisdictions, the majority of vocational rehabilitation costs are covered out of general taxation, except where a person is covered by compensation insurance. Exceptions to this are Slovenia where providers are expected to generate 10 per cent of their income from other sources and Finland where 55 per cent of vocational rehabilitation costs are funded through employer and worker contributions.

Of particular interest is the 'case-based funding' that operates in Queensland in which the service provider receives fees for participants on a case-by-case basis, depending on the outcomes achieved. This method of funding services has been operating for over 10 years. Each service stream (Disability Management Services and Employment Support Services) is funded at different rates, in recognition of the more complex needs of ESS clients. The employment assistance phase which can

last up to 18 months is financed through six quarterly service fees. The optional extended employment assistance phase, which is granted after an Employment Support Assessment, can last a further 6 months and can involve two quarterly payments. The post-placement support phase in education or employment is paid through an initial placement fee and two outcome fees at 13 and 26 weeks. The ongoing support phase can be funded for people who require it on the basis of an annual Ongoing Support Assessment (OSA).

One part of the information collected from the national correspondents concerned the costs of implementing vocational rehabilitation on a national level. Some information was obtained in this regard, but the interpretation and comparison of this information has a number of difficulties. Issues here include:

- The availability of comparable statistics
- Differences in service levels
- Differences in the demography of jurisdictions
- Differences in costs of services
- Differences in eligibility and incidence

While the definition of what is covered in the statistics is different from one jurisdiction to the next, there are nevertheless very striking differences in the scale of intervention across the four jurisdictions as shown in the table below.

There are significant differences in the four jurisdictions below in the number of people availing of vocational rehabilitation services.

In Queensland, which has a general population of 4.7 million, about 148,000 people use disability employment services at any one time and the monthly turnover is about 10,000 people. In New Zealand, which has a population of 4.5 million, vocational services for people with disabilities cater for about 20,000 beneficiaries per annum. The population of Finland is about 5.3 million

Table 3.7 – Participants in VR and equivalent for Ireland's population

	Population	No. of participants in vocational rehabilitation	Equivalent for Irish population	Remarks
Finland	5.3m	77,000	69,000	Refers to rehabilitation services in relation to work
New Zealand	4.5m	20,000	21,000	Refers to vocational services for PWD
Queensland	4.7m	148,000	150,000	Refers to all disability employment services. Turnover is 10,000 a month
Slovenia	2m	1,800	4,300	Refers to vocational rehabilitation beneficiaries
<i>Ireland</i>	<i>4.76m</i>			

¹⁴² European Quality in Social Services Initiative [Accessed 24/08/2015]: <http://www.equass.be/>. This quality system is also used by one of the main Irish providers of vocational rehabilitation services, the Rehab Group.

and about 77,000 people access rehabilitation services in relation to work annually. About 22,000 of these receive rehabilitative psychotherapy only. There are about 1,833 vocational rehabilitation beneficiaries in Slovenia annually for a population of 2.0 million.

The wide variation in beneficiary numbers in each of the jurisdictions implies considerable differences in eligibility criteria for vocational rehabilitation as well as making it difficult to estimate a standard cost for these services. Nevertheless, it is possible to roughly calculate the costs of vocational rehabilitation in Finland and Slovenia. In Finland, the cost per member of the labour force is about €53 per annum, while in Slovenia it is about €10. Even allowing for the fact that there is a considerable difference in GDP per capita in the two countries, it is clear that Finland spends many times more on vocational rehabilitation than Slovenia. This is despite the fact that they have a comparable age structure (in terms of median age) in their populations. In Slovenia, the per annum cost per claimant is about €4,100 per year.

Equivalent cost information was not available for Queensland or New Zealand, but it was possible to obtain the information from Queensland on the staff costs associated with the WorkCover system. These amounted to Aus\$18,965 per full time staff member, which may be compared to an Irish figure for staff costs involved in vocational rehabilitation of €13,300. These costs are broadly in line with each other at 2015 exchange rates.

3.4 Perspectives on good practice in vocational rehabilitation

Each of the expert respondents in the four jurisdictions of primary focus was asked to reflect on their national system and to review national publications with a view to identifying elements of good practice or lessons learnt that could be applied to other countries. A number of broad themes emerged from their responses and these are summarised in Table 3.8.

3.4.1 Access to services

All respondents addressed the issue of access to services. In their view, an equitable system needs to operate effectively regardless of the geographical location or the nature or cause of the impairment. A national system of vocational rehabilitation should guarantee access to everyone who can benefit. Innovative approaches to this could include the development of online access to services.

3.4.2 Creating a continuum of services

There was consensus that a continuum of services needed to be in place that spanned from medical interventions through to support and follow up. Vocational rehabilitation needs to operate on a continuum in which it is viewed as part of a process of health promotion, protection and prevention. It should be linked forward to supported employment and follow up supports after placement to employment.

3.4.3 Early intervention

The national experts maintained that intervening early to reduce the impact of impairments that arise from injury or illness needs to be at the centre of the vocational rehabilitation system.

3.4.4 Engaging all actors in creating more responsive services

Most respondents proposed good practice mechanisms that involved collaborating with all actors. Vocational rehabilitation requires joined up working across multiple domains including employment, health, social protection and education. Consequently, the involvement of all stakeholders in the design, development and governance of the system is essential. Placing an emphasis on the potential impact of vocational rehabilitation in terms of reduced benefits dependency and enhanced quality of life can serve to engage all stakeholders. Beneficiaries need to be facilitated to take a proactive role in their assessment, profiling and planning processes as valued members of the vocational rehabilitation team. They should also be involved in evaluating outcomes and services.

3.4.5 Working more closely with employers

The role of employers in creating a more effective vocational rehabilitation approach was acknowledged by two respondents. Services cannot be effective in the absence of employer engagement. It is important for service providers to relate to employers as customers and to collaborate with their representative bodies. At a system level, it is essential that employers are encouraged to recruit and retain people with acquired disabilities and that any direct recruitment or retention costs are subsidised.

3.4.6 Implementing efficient quality improvement processes

Two respondents emphasised quality assurance as an important focus for the deployment of good practice. Services need to be accredited by an independent body. However, this activity needs to be balanced with the degree of administrative effort required. The potential

Table 3.8 Perspective on good practice from four jurisdictions

	SL	FI	QLD	NZ
Equitable access to services	●	●	●	●
Developing digital access to services			●	
Making service available in all locations, to all citizens and through multiple channels	●	●		
Ensuring the system works equally well for people with acquired disabilities as a result of illness as it does for people with injuries				●
Creating a continuum of services	●	●	●	●
Linking vocational rehabilitation to occupational health services		●		
Viewing prevention as a continuum of interventions from primary health and safety to tertiary vocational rehabilitation		●		
Finding ways to intervene early to prevent job loss and reduce the impact of impairments		●	●	
Profiling client needs and strengths as a starting point for intervention				●
Provide follow up supports even after placement to employment including workplace adaptations	●			
Engaging all actors in creating more responsive services	●		●	●
Actively involving service users in developing their own multidisciplinary plans and in evaluating services	●			●
The contribution of professional associations to improvements			●	
Enabling the involvement of all stakeholders in the design, development and governance of the VR process				●
Working more closely with employers	●			●
Responding to and collaborating with employers as direct customers of the services	●			●
Building collaboration with employer organisations	●			
Working with employers to create on-the-job training opportunities	●			
Finding ways to incentivise employers to recruit and retain people with disabilities including quotas	●			
Implementing efficient quality improvement processes	●		●	
The publication of good practice guidelines for services and staff			●	
Training and accreditation for case managers			●	
Independent quality assurance for services			●	
Balancing regulation and standards with efficient administration	●			
Strengthening the policy basis for VR	●			●
Focusing on the return on investment that VR can create in terms of reduced future liability and individual quality of life				●
Developing a legal basis for access to vocational rehabilitation	●			

for professionals to contribute to service improvement must be recognised. High quality professional practice is at the core of effective service delivery and this can be achieved through the production and distribution of good practice guidelines, making continuing professional development available particularly in case management processes and skills and encouraging a multidisciplinary approach.

3.4.7 Strengthening the policy basis for vocational rehabilitation

The need to strengthen the contribution of vocational rehabilitation in a number of policy domains was acknowledged by two respondents. This needs to be done through formal legislation or regulation. An important driver for this is the contribution vocational rehabilitation can make to reducing dependence on income support measures for people with acquired disabilities. In particular, vocational rehabilitation can have a significant impact in terms of disability pensions, early workforce exit into the retirement system on health grounds or long term unemployment, and thus on the sustainability of the social protection system in the context of an ageing workforce.

3.5 Conclusion

The main findings from the analysis were:

- In general, two systems of vocational rehabilitation provision were identified, one of which was funded from general taxation and operated as part of the social protection or employment services system and the other which was an insurance-funded system. All insurance-funded systems were 'no-fault' schemes where people were entitled to compensation, care and support regardless of liability.
- In all jurisdictions, vocational rehabilitation services were designed to meet the needs of both job seekers with disabilities and workers with disabilities at risk of losing their jobs.
- The most widely accepted definition of vocational rehabilitation was that it is a process and set of services aimed at improving a person's capacity for work so as to help them cope with work demands; help them overcome impairments; and assist them to enter or re-enter work.
- The target groups and eligibility criteria for vocational rehabilitation services varied across the systems, but the basis for eligibility involved administrative criteria such as residency, age and being eligible for a social protection payment. In addition, an assessment to determine the suitability of the person for services was used.
- The most common information and referral sources to vocational rehabilitation included employers; employment services; vocational rehabilitation providers; disability NGOs; public information sources and social insurance or protection services. GPs or family doctors were the most frequent referral source in the health area.
- The common components of vocational rehabilitation and occupational rehabilitation in the 12 jurisdictions were:
 - Assessment and evaluation
 - Advice and guidance
 - Vocational education and training
 - Health and wellbeing support
 - On-the-job support
 - Adaptations and technologies
 - Service coordination
 - Alternative employment options
 - Other supports
- All jurisdictions provided incentives and supports to make it easier for individuals and employers to gain employment or return to work. Incentives focused at different levels within the systems and they could be positive or negative.
- Only two jurisdictions (Queensland and Finland) had formal job retention services that sought to prevent workers from needing to resort to long-term absence. All jurisdictions catered for both unemployed/inactive and employed people and return to the person's original job was also part of the vocational rehabilitation services' brief.
- All jurisdictions had a system of service coordination and the majority had formal case management arrangements where a person was supported from the early stages of assessment and planning to case closure.
- There were no formal systems to refer people to vocational rehabilitation while undergoing medical treatment. The pathway generally operated by onward referral by medical practitioners, hospital-based allied health staff, welfare and social security staff. Self-referral to vocational rehabilitation providers was also possible in some countries. The Finnish occupational health system was the most systematic approach in which early identification operated through workplace surveys, health examinations and absenteeism follow-up.
- Only Finland operated specific early intervention guidelines known as the '30-60-90 model'. This involves employers notifying an occupational health service after 30 days of absence, the provision of a rehabilitation allowance at 60 days and intensive rehabilitation at 90 days where appropriate.

- In Europe, rehabilitation staff came from a wide range of disciplines and often acquired their expertise during the course of their careers through continuing professional development. In Queensland and NZ, rehabilitation staff were either certified rehabilitation counsellors or had an allied health or human services qualification.
- Some jurisdictions had quality systems that were specific to rehabilitation services. Services in Queensland operated under mandatory standards enshrined in national law. Services in many European jurisdictions operated under a voluntary standard - the European Quality in Social Services Initiative (EQUASS).
- Impact indicators reflected these standards and particularly focused on improved access to services; meeting training and skills needs of participants and employers; service effectiveness; and timely and efficient services.
- The perspectives of the respondents on good practice in vocational rehabilitation systems and services emphasised:
 - Strengthening the policy basis for vocational rehabilitation
 - Widening access to services
 - Creating a continuum of services
 - Engaging all actors in creating more responsive services
 - Working more closely with employers
 - Implementing efficient quality improvement processes

Chapter 4. Vocational and occupational rehabilitation in Ireland

4.1 Overview of the Irish approach to VR and OR

Chapter 4 has been compiled primarily from a document review and from the information available on the websites of the primary actors i.e. the Departments of Health, Social Protection, Education and Skills and Jobs, Enterprise and Innovation and Citizens Information. In addition, information was obtained through responses to an early draft of the report from representatives of the main stakeholders. Feedback was also obtained on the content of this chapter from a range of organisations involved in the area¹⁴³.

This chapter describes current vocational services and supports for people with acquired disabilities in Ireland against the background of the international context, previous reports that addressed the topic from an Irish perspective, and the system analysis of 12 countries.

4.2 Elements of occupational rehabilitation services in Ireland

Occupational rehabilitation (OR) is available in Ireland through a number of large public and private sector organisations and through private insurance providers of income protection and personal health insurance. Services are provided by a mix of in-company professionals and private sector providers. However, there is no standard model of provision of OR services.

One example of a large organisation offering OR to its employees is the Health Service Executive (HSE) and this illustrates how OR can work, at least in the public sector¹⁴⁴. The rehabilitation programme here aims at the early and safe return to work for employees who develop an illness or experience an injury. The programme offers services and supports to restore function and maximise independence and includes medical, functional, occupational, vocational and psychological interventions. The programme is based on an assessment of needs and involves early intervention and timely services in order to retain or return employees to suitable employment. The service

is provided by internal and external accredited qualified healthcare professionals appropriate to the needs of the individual. The components of the programme include timely interventions, based on assessed needs and an assessment of workplace contributing factors.

The HSE process is initiated by the completion of a functional capacity form by a medical professional. This can lead to a referral to the rehabilitation programme and the development of a rehabilitation and return-to-work plan which addresses objectives, restricted duties, hours of work and interventions and time frames. Additional services can be provided where return-to-work milestones have not been met. The process is concluded when the employee returns to his or her original job, is deemed not to be benefitting further from the interventions or fails to cooperate. Where a return to the original job is not an option, alternative arrangements can include retraining, redeployment, and access to income protection or retirement on ill health grounds. The HSE job retention policy for its own employees is consistent with good international practice.

A number of large private sector employers also offer similar employee benefits which are often delivered under contract by private specialist providers. These providers also operate on behalf of insurance providers. Services available include:

- Work capacity evaluation
- Functional capacity evaluation
- Worksite evaluation
- Ergonomics
- Vocational redirection evaluation
- Transferrable skills analysis
- Return to work case management
- Initial needs vocational rehabilitation evaluation

4.3 Elements of vocational rehabilitation services in Ireland

A search for the term 'vocational rehabilitation' on the Citizens Information website (2104), identified the main

¹⁴³ Fit for Work Coalition; the Association of Occupational Therapists of Ireland (AOTI); Irish Heart Foundation; Acquired Brain Injury Ireland; Irish Association of Social Workers; and Headway

¹⁴⁴ Health Services Executive (2013) **HSE Policy and Procedure - Rehabilitation of Employees Back To Work after Illness or Injury: Revision No 4.13**. Dublin, IRL: Author. Retrieved [24/08/2015] from: http://www.hse.ie/eng/staff/Resources/hrppg/Rehabilitation_Policy.pdf

elements of what is characterised as VR in Ireland. It refers to such services being available from the HSE through its community day centres, local employment and Intreo centres, the EmployAbility programme (Supported employment) of the Department of Social Protection (DSP) and the Specialist Training Programme of the Education and Training Boards (ETB)¹⁴⁵.

4.3.1 Further education and training – specialist training programme

The employment services function of FÁS (the public employment service) were transferred to the Department of Social Protection in January 2012. Subsequently SOLAS was formally established and, at the same time, FÁS was dissolved following the enactment of the Further Education and Training Act of 2013.

The SOLAS mandate is quite different from the FÁS mandate in terms of training. SOLAS is not a direct provider of further education and training (FET), unlike FÁS. The recently reorganised Education and Training Boards (ETBs) are the primary agency responsible for state-funded Further Education and Training (FET) – through the Department of Education and Skills and SOLAS.

The year 2014 saw a period of immense change in both the policies and structures of the FET Sector in Ireland. SOLAS brought together the (previously separate) FET areas and was given a very clear mission: *‘SOLAS will be tasked with ensuring the provision of 21st century high quality Further Education and Training programmes which are responsive to the needs of learners and the requirements of a changed and changing economy.’*¹⁴⁶

More specifically, in 2014, 19 former FÁS Training Centres transferred from SOLAS to their local Education and Training Boards. The transfers included budget, personnel, buildings, responsibility for contracted training and funding for community training centres, local training initiatives and *specialist training provision (STP)* in their respective regions. Throughout this major restructuring period, training courses, certification and services to learners all continued as normal.

During the transfer period, SOLAS also worked to establish itself and the new system, ensuring that it had the proper structures and resources in order to deliver

on its new mandate. A new organisational structure was developed in early 2014 which reflected the organisation’s new objectives. The publication of three key documents by SOLAS in the first half of 2014 outlined what the sector delivers on an annual basis and the direction in which the sector is moving¹⁴⁷. They included:

- The Further Education and Training Strategy 2014 – 2019 which provided a roadmap for the FET sector over the next five years. The strategy was prepared by SOLAS and approved by the Minister for Education and Skills.
- The SOLAS Corporate Plan 2014 – 2017 which outlined how SOLAS intends to deliver on its commitments in the Further Education and Training Strategy.
- The Further Education and Training Services Plan 2014 which, for the first time, provided an overview of what provision would be available from the FET sector for the circa 88,000 annual FET Learners in 2014.

The Further Education and Training Strategy (SOLAS, 2014) commits SOLAS, in collaboration with the Department of Education and Skills, the Department of Social Protection (Intreo) and the disability sector, to use its annual business planning process with the ETB sector to agree further education and training targets and associated supports for people with disabilities participating in FET. The intention of this process is that it will ensure that ... *persons with disabilities benefit from relevant training and education that enable their progression to employment opportunities; ensuring provision of vocational education for people with disabilities by the ETBs; and participation by persons with disabilities in education programmes* (p. 97)¹⁴⁸.

The SOLAS-funded FET Specialist Training Programme (STP) is provided through the ETB sector, a number of voluntary agencies and a network of community training centres. It includes a range of initial and specific training programmes. There are about 2,500 whole time equivalent places nationally and the budget is in the region of €37 million.

A 2014 evaluation of the STP concluded that while the proportion of beneficiaries accessing employment was low in comparison to other mainstream training, the programme contributed considerably to the trainees getting a job. The majority of people with disabilities

¹⁴⁵ SOLAS took over from FÁS as the new further education and training authority in October 2013. Between January and July 2014, the 16 Education and Training Boards took over responsibility for the FÁS training division.

¹⁴⁶ SOLAS (2014) **Further Education and Training Strategy 2014–2019**. Dublin, IRL: Author. Retrieved [25/08/2015] from: <https://www.education.ie/en/Publications/Policy-Reports/Further-Education-and-Training-Strategy-2014-2019.pdf>

¹⁴⁷ These documents are available to download at www.solas.ie

¹⁴⁸ SOLAS (2014) **Further Education and Training Strategy 2014–2019**. Dublin. Retrieved [25/08/2015] from: <https://www.education.ie/en/Publications/Policy-Reports/Further-Education-and-Training-Strategy-2014-2019.pdf>

¹⁴⁹ McGrath, J. & Milicevic, I. (2014) **The 2013 Follow-Up Survey of Former FÁS Trainees who Exited Training in May and June 2012**. Dublin, IRL: FÁS / SOLAS, Research and Planning, Skills and Labour Market Research Unit. Retrieved [24/08/2015] from: <http://www.solas.ie/docs/2013FollowUpSurvey.pdf>

who did access employment had been unemployed prior to participation in the programme¹⁴⁹. Over 80 per cent of participants were satisfied or very satisfied with programme characteristics such as overall satisfaction, course content, instructors, equipment and facilities. They also felt that the programme helped improve confidence, identify suitable job opportunities, and improve interview skills and new job skills. An earlier (2007) evaluation had concluded that the capitation fee for the STP be maintained at its then current level and increased in line with inflation. It also recommended that providers be encouraged to offer a wider range of services including assessment supports¹⁵⁰. Training should be embedded in a wider programme of action and be linked to job search strategies and supports. It is worth noting that eligibility for a FET course generally requires a person to be unemployed, redundant or no longer in full-time education, thereby excluding people who are in employment.

4.3.2 Employment services for people with disabilities

A full overview of the services and financial supports provided to people with disabilities through the Department of Social Protection is presented in Appendix 5. According to the DSP, the budget provides for an estimated expenditure of €3.39 billion on the illness, disability and carers programme which is estimated at 17.5 per cent of total Departmental expenditure in 2015.

Of specific relevance to this study are the income and work related supports for people with disabilities, which play an important role in supporting increased participation in the labour force, and which are summarised in Table 4.1. There is a commitment on the part of the DSP to enhance programmes for

people with disabilities by focusing on ability rather than disability and building their potential to achieve greater independence through education, training and employment. The Department is committed to a suite of specific actions under the Comprehensive Employment Strategy for People with Disabilities aimed at enhancing employment of people with disabilities¹⁵¹.

EmployAbility services

The EmployAbility and Community Employment programmes are the most directly relevant programmes to the current study. The EmployAbility Programme is delivered by a range of local and community organisations through supported employment partnerships. EmployAbility services are directly funded by the Department of Social Protection and the annual budget is approximately €10 million¹⁵².

The main components of the EmployAbility service are:

- Individual needs assessment
- Vocational profiling and career planning
- Individual employment plan
- Job sourcing and job matching
- On-the-job support and coaching
- Advice and support to employers
- Follow-up support and mentoring to both employers and employees

All of these services are core components of a VR service. The approach is based on the support of a job coach and the aim is to assist job seekers to gain employment in the open labour market.

Community employment

The Community Employment scheme (CE) is an active labour market intervention that provides an opportunity

Table 4.1 Services for People with Disability from the DSP/Intreo

	Objective	Eligibility
EmployAbility Service	1. To facilitate the integration of people with disabilities into paid employment in the open labour market 2. To provide supports to assist with this integration process 3. To meet the requirements of employers	● People with a disability who are job ready and need a job coach to help obtain employment in the open labour market ● People between 18 and 65 years
Community Employment	To provide people with an opportunity to engage in useful part-time work in their communities on a temporary, fixed-term basis.	● Disability Allowance (DA); ● Blind Pension (BP); ● Invalidity Pension (IP) ● Illness Benefit (IB) for 6 months or more

Source: Department of Social Protection 2014

¹⁵⁰ Indecon (2007) **Study of Efficiency and Effectiveness of Vocational Training Services and Rehabilitative Training Services for People with Disabilities provided by Specialist Training Providers**. Dublin, IRL: Indecon International Economic Consultants. Retrieved [24/08/2015] from: <http://www.voced.edu.au/content/ngv%3A35223>

¹⁵¹ Government of Ireland (2015) Comprehensive Employment Strategy for People with Disabilities

¹⁵² The evaluation of this programme published in 2016 is at <http://www.welfare.ie/en/downloads/IndeconEvaluationofEmployAbility.pdf>

to gain experience working in a part-time or fixed term contract job that usually provides a benefit to the local community. To be eligible a person must be in receipt of a DSP payment for economically inactive people or to be on Illness Benefit (which applies to employed people) for at least six months.

Programmes for employed people with disabilities

A common characteristic of both of the above programmes is the requirement for applicants to be unemployed or economically inactive. Information available from the websites and publications of the key Departments and the Citizens Information Service, and feedback from the primary stakeholders, provide no evidence of a state-funded vocational or occupational rehabilitation service for employed people with acquired disabilities or chronic illness.

Activation measures piloted under the Disability Activation Project

The DSP has been exploring more active measures for people with disabilities and piloted a number of approaches through a series of projects managed by Pobal. The Disability Activation Project (DACT) was a set of pilot projects that sought to explore a variety of routes towards ensuring that people were able to avail of progression, education and development opportunities in the world of work. The DACT projects commenced at the end of 2012 and ended in spring 2015. An independent evaluation of the programme was commissioned by the DSP, a key part of which was to identify what works with regard to increasing

the capacity and potential of people to participate in the labour market¹⁵³. There is a commitment under the Comprehensive Employment Strategy to identify which measures are capable, where appropriate, of being mainstreamed in the delivery of supports to people in the future, and to follow through on the lessons learned.

The DACT projects relevant to this report involve people with acquired disability and are briefly described in Table 5.2.

The projects were co-funded by the European Social Fund and the DSP and implemented in the Border, Midlands and Western region. Around €7 million was allocated to 14 projects under four strands:

- Improving access to employment
- Progression programmes for young people
- Support for progression and retention of people with an acquired disability
- Innovative employer initiatives

A number of core components of a system of VR or OR are inherent in the methods that were explored by these pilots including:

- Assessment of vocational needs and strengths (Work4You)
- Early Intervention and support (Linking In)
- Individual planning (Working with Arthritis; DAWN; ICTU Options)
- Case management and coordination (DAWN)

The Linking In project merits a more detailed review, given its focus on return to work case management for workers in small and medium size enterprises and

Table 4.2. Disability Activation Projects 2012-15¹⁵⁴

Project title	Organisation	Activities
Work4You	Peter Bradley Foundation/ Acquired Brain Injury Ireland	Establish three vocational assessment teams to support people with Acquired Brain Injury to remain in or re-enter the workforce
Linking In	National Learning Network	Developing early supportive interventions for people on Illness Benefit to promote reintegration specifically in the SME sector.
Working with Arthritis: Strategies and Solutions	University of Limerick / Arthritis Ireland	Developing individualised occupational therapy programmes to overcome barriers faced by people with arthritis in accessing, remaining in or returning to work
Project DAWN (Disability Activation for Work Nutrition)	Co. Roscommon Disability Support Group	One-stop shop for training and business incubation involving a case managed and Personal Development Plan approach
ICTU Options Programme	Irish Congress of Trade Unions	Individual progression plan mentoring involving the provision of FETAC accredited training and work placement opportunities

¹⁵³ The evaluation of these projects has been published at <http://www.welfare.ie/en/downloads/EvaluationofDACT-FinalReport-24September2015.pdf>.

¹⁵⁴ Pobal website: Accessed (31/08/2015) <https://www.pobal.ie/FundingProgrammes/dap/Pages/default.aspx>

that approximately 50 per cent of workers in the private sector in Ireland are employed by companies with less than 50 employees. There are considerable differences in both capacity and actual practice between employers in smaller and larger enterprises and the size of an enterprise is an important factor in designing return-to-work supports and services. Larger companies tend to have a greater capacity to respond to long-term absence. They often implement preventative services (such as medical, counselling and other therapeutic services), have insurance cover for long-term absence and, in good practice terms, operate formal retention policies¹⁵⁵.

Small and medium sized enterprises (SMEs), in contrast, are less well prepared to cope. This is not surprising when one considers that approximately 2 per cent of the workforce develops a long term illness in any one year. Thus, for the manager or owner of a small enterprise losing a worker to long term sickness is a rare event but one which can have a devastating impact on the capacity of the business when it happens. SMEs are less likely to have a dedicated HR function and lack experience of how to respond when a worker becomes absent due to ill health. They are also often highly dependent on each employee's unique contribution and absence of a key employee can cause significant challenges for the business. They are also less likely to be able to redeploy a worker to other work tasks even in a transitional return to work process¹⁵⁶. These issues affect micro-enterprises (businesses with less than 10 employees) to an even greater extent.

A qualitative study in Sweden interviewed the managers/owners of 16 enterprises which had had an employee on sick leave for more than 90 days during the previous two years. A number of areas for improvement in responding to long-term absent workers were identified¹⁵⁷. These included:

- A lack of experience of the absence and RTW process
- The absence of documented routines
- Well-meaning but ad hoc approaches
- Lack of clarity on the purpose of early contact
- A need for simple and cost-effective mechanisms
- A focus on smaller enterprises by the Social Security Agency
- A need for more easily available information for SMEs
- A greater role for occupational health professionals

The study recommended that the coordination role of the

Social Security Agency needed to be clearer for SMEs. The managers/owners needed enhanced knowledge of the challenges and responses to long-term absence. They needed access to earlier and more practical advice and collaboration, and communication between actors in the RTW process needed to be improved.

The Linking In project specifically targeted SMEs in terms of developing early supportive interventions for people on Illness Benefit to promote reintegration specifically in the SME sector. The lessons learnt from this project provide a good indication of the role that the DSP and Intreo can play in relation to SMEs. Specifically, the evaluation report on Linking In concluded that¹⁵⁸:

- The role of the DSP in referral and recruitment of clients is critical. A DSP letter to Illness Benefit recipients accounted for 60 per cent of beneficiaries. GPs only referred 7 per cent and an advertising campaign resulted in 19 per cent.
- The potential for referrals from employers and worker representative organisations needs to be explored. No referrals were received from employers.
- Potential beneficiaries of early return-to-work services ought to be screened for different levels of service needs. A limited number of beneficiaries will require a full case management service. Specialised return to work case management needs to be targeted at those in greatest need. Many participants only needed advice, guidance and signposting to appropriate services.
- Follow up procedures for clients who drop out of return to work services need to be in place.
- A greater engagement with employers is required. Many participants were reluctant to have the service contact their employers.
- The cost effectiveness of the disability case management approach piloted needs to be considered. Nevertheless, with a return to work rate of 48 per cent, the estimated impact on the Illness Benefit budget would be substantial.

4.3.3 Incentives and supports available in Ireland

There is a range of employment supports and incentives available to people with disabilities. A brief description of each of these is presented in Table 4.3.

Supports for job seekers with disabilities

Two incentives and supports for job seekers with disabilities are available. The *Job Interview Interpreter Grant* provides funding for job seekers with speech and

¹⁵⁵ WRC Social and Economic Consultants (2015) 'Evaluation Report on Linking In'. Dublin, Irl: Author.

¹⁵⁶ Gunnarsson, K., Larsson, M., Persson Schill, H. & Malin Josephson, M. (2014) 'Research Note: Return to work in small enterprises'. *Small Enterprise Research* 21 (2), pp. 229-237.

¹⁵⁷ Gunnarsson, K., Larsson, M., Persson Schill, H. & Malin Josephson, M. (2014) 'Research Note: Return to work in small enterprises'. *Small Enterprise Research* 21 (2), pp. 229-237.

¹⁵⁸ WRC Social and Economic Consultants (2015) 'Evaluation Report on Linking In'. Dublin, Irl: Author.

hearing impairments who want to attend job interviews. A job seeker can apply for funding to have a sign language or other interpreter (such as a family member) attend the interview with them. The *Disability Allowance Disregard* allows a person in receipt of Disability Allowance to earn up to €120 per week without any impact on his or her allowance and earnings between €120 and €350 assessed at a withdrawal rate of 50%.

Supports for employed people with acquired disabilities

There is a grant available to the employer of a person who acquires a disability. The *Employee Retention Grant Scheme* provides support for employers to retain employees who acquire an impairment that affects their ability to carry out their job. It is available only to the employer and not to an individual employee.

Supports and incentives of both job seeking and retention

Five incentives and supports for job seeking and job retention are also available.

The *Personal Reader Grant* is available to blind or visually impaired employees that require assistance with reading printed material at work. A person can apply for a Personal Reader grant if they:

- Are in employment in the private sector and need assistance with work-related reading

- Have recently become visually impaired and are in danger of losing their job
- Are going back to their original employer to do new or different work
- Their prospects for promotion are restricted because of reading difficulty due to visual impairment

It can be used to retain an employee in their current position or to provide training for another position. It can also be used to identify and provide accommodations.

The Wage Subsidy Scheme (WSS) offers financial support for private sector employers who employ people with disabilities. The current subsidy rate is €5.30 per hour. The employee must work a minimum of 21 hours per week for the employer to qualify. The maximum number of hours per week is 39 hours. The employee can retain his or her Medical Card, if meeting certain eligibility criteria. To qualify for a WSS, the employee should have a perceived productivity shortfall in excess of 20 per cent compared to a peer who does not have a disability. For people already in employment, WSS may only be considered where the person is less than 12 months in that employment and where a productivity shortfall is putting that employment in jeopardy.

Table 4.3. Disability Supports from DSP/Intreo¹⁵⁹

Title	Intended Beneficiaries
Job Seekers with Disabilities	
Job Interview	● Deaf, hard of hearing or has a speech impairment and is attending job interview
Disability Allowance Disregard	● A person who is in receipt of Disability Allowance may take up employment of a rehabilitative nature
Employees who acquire a disability	
Employee Retention Grant Scheme.	● Employers - the cause or nature of the illness, condition or impairment is not relevant for the purpose of this grant
Incentives and Supports for Job Seeking and Job Retention	
Personal Reader Grant	● Blind or visually impaired persons who are in employment who need a Personal Reader to assist with job related reading
Wage Subsidy Scheme (WSS)	● This employer support scheme is restricted to private sector employers only
Workplace Equipment Adaptation Grant	<ul style="list-style-type: none"> ● WEAG contributes towards the cost of an adaptation or equipment up to a limit of €6,350. It can be used to upgrade adaptive equipment which may have been funded previously. It may be applied for by either the employer or the employee. ● It can be for new (disabled) or existing employees or for self-employment
Disability Awareness Support Scheme	<ul style="list-style-type: none"> ● Open to all private sector organisations ● Available for raising the awareness of personnel at all levels and occupations
Partial Capacity Benefit	<ul style="list-style-type: none"> ● Open to people who currently receive either: <ul style="list-style-type: none"> ○ Illness Benefit for a minimum of six months ○ Invalidity Pension

¹⁵⁹ Source: Department of Social Protection 2014

The Workplace Equipment Adaptation Grant Support aims to assist unemployed people with disabilities to gain access to the open labour market by providing grants for “reasonable accommodations” (private sector only) and to support and encourage private sector employers in the employment of people with disabilities. It is available to newly recruited employees with disabilities, employees who acquire an impairment and employers or self-employed people with disabilities who need to make adaptations to their workplace or purchase specialised equipment. It may be applied for by either the employer or the employee.

The Disability Awareness Training Grant is intended to eliminate mistaken perceptions of people with disabilities and their capacity to be productive and effective. It contributes to the cost of training employees in disability awareness. This is available to an employer regardless of whether they have recruited a job seeker with a disability or have an employee who has developed or acquired an impairment.

Partial Capacity Benefit allows a person with reduced capacity to return to work and to continue receiving a reduced payment from the DSP. To be eligible for this, the person must receive an Invalidity Pension or, for at least six months, receive Illness Benefit (IB) (a contributory income support payment). From an early intervention perspective, having to be six months absent from work on IB represents a substantial delay in the return to work process. Beneficiaries need written approval from the DSP to qualify and they also need the approval of their doctor before taking up employment. There is little emphasis in the documentation on resuming employment. There is no restriction on earnings or number of hours a person can work and participation in the scheme is voluntary.

4.4. Commentary on gaps in Irish OR/VR services vis-à-vis other jurisdictions

The main components of vocational rehabilitation in Ireland are presented in Table 4.4. The elements available in the other 12 jurisdictions are also presented in order to place these in perspective. It is clear from

this table that only some of the core system elements can be identified in Ireland within EmployAbility and FET STP services. This is unlike many of the other 12 jurisdictions, (with the exception of Spain and Lithuania) where most if not all services were available. Five services are generally missing in Ireland compared to most other jurisdictions – functional capacity assessment, psychological supports, functional/physical capacity building, case management and access to adapted transport. However, some of these services are available to certain employees (e.g. the HSE), or where private sector employers have an insurance scheme that offers this facility.

4.4.1 People required to be unemployed/inactive before they can avail of VR

A significant factor in this, particularly as it relates to OR and early intervention in Ireland, is that the majority of employment related services require a person to be unemployed or inactive.

4.4.2 No systematic access to functional capacity evaluation, psychological supports or physical functional capacity building

Furthermore, there is no general facility for people, whether seeking employment or trying to return to a job, to access functional capacity evaluation, psychological supports or physical/functional capacity building as part of their rehabilitation plan. The presence of these elements in almost all other jurisdictions is an indication of the importance of its absence in the Irish context. This conclusion is supported by findings from the National Neuro-Rehabilitation Strategy¹⁶⁰, the submissions of stakeholders to this study¹⁶¹, and the National Survey of Stroke Survivors 2013¹⁶². The stroke study explores the factors facilitating and impeding a return to work following a stroke in an Irish context. Stroke affects about 10,000 Irish people each year and stroke survivors make up a considerable proportion of those with acquired disabilities. The report provides useful real life experiences of services and policies.

4.4.3 No systematic structured pathways to timely VR

A further weakness of the Irish system is that, even if many system elements are present, there is no

¹⁶⁰ Department of Health. (2011) **National Policy and Strategy for the Provision of Neuro-Rehabilitation Services in Ireland 2011-2015**. Dublin, IRL: Author.

¹⁶¹ Brennan, B., Corcoran, O., Irudayaraj, B., Kearney, S. A., Kelley, V., Lyons, E., L. Magee, L., K. Robinson, K. & Vine, S. (2012) **Vocational Rehabilitation for Clients with Chronic Pain and Musculoskeletal Disorders in Ireland: A Handbook for Occupational Therapists**. Dublin, IRL: Association of Occupational Therapists of Ireland.

Headway. [n. d.] **Rehabilitation following Acquired Brain Injury: A Headway Review of Guidelines and Evidence**. Dublin, IRL: Author. Retrieved [18/08/15] http://www.headway.ie/download/pdf/rehabilitation_review.pdf

¹⁶² Horgan, F., Walsh, M., Galvin, R., Macey, C. & Loughnane, C. (2014) **Systematic Review: Factors Associated with Community Re-Integration in the First 12-Months Post Stroke: A Qualitative Synthesis**. Dublin, IRL: National Disability Authority. Retrieved [24/08/2015] from <http://nda.ie/Policy-and-research/Research/Research-Publications/National-Survey-of-Stroke-Survivors-2014.html>

Horgan, F., Galvin, R., Brannigan, C., Walsh, M., Macey, C. & Loughnane, C (2015 forthcoming) **Exploring the Factors Related to Return to Work after Stroke**. Dublin: IRL: Royal College of Surgeons in Ireland, and National Disability Authority.

Table 4.4. VR Elements available in Ireland and 12 other jurisdictions

	Components	NL	DE	PT	FR	ES	DK	LT	NO	SI	FI	QLD	NZ	IRL	Unemployed	Employed
Assessment & Evaluation	Vocational Assessment	●	●	●	●	●	●	●	●	●	●	●	●	EmployAbility	●	
	Functional Capacity Evaluation	●	●	●	●	●	●	●	●	●	●	●	●			
	Job/Person matching	●	●	●	●	●	●	●	●	●	●	●	●	EmployAbility/ Employer Based Training	●	
	Work sampling or on the job assessment	●	●	●	●		●		●	●	●	●	●	EmployAbility/ Employer Based Training/ FET STP	●	
Advice & Guidance	Information & Advice about Vocational Rehabilitation	●	●	●	●	●	●	●	●	●	●	●	●	Citizens Information/ Intreo	●	●
	Guidance & Counselling	●	●	●	●	●	●	●	●	●	●	●	●	Intreo/HSE Employment Guidance	●	
Vocational Education & Training	Specialised Vocational Education/Training	●	●	●	●	●	●	●	●	●	●	●	●	ETB ¹⁶³	●	
	Pre Vocational Training	●	●	●	●		●	●	●	●	●	●	●	FET STP ¹⁶⁴	●	
Health & Wellbeing Support	Psychological Supports	●	●	●	●	●	●	●	●	●	●	●	●			
	Physical/Functional capacity building	●	●	●	●		●	●	●	●	●	●	●			
On the Job Support	Job Coaching	●	●	●	●	●	●	●	●	●	●	●	●	EmployAbility	●	
	Supported Employment	●	●	●	●	●	●		●	●	●	●	●	EmployAbility	●	
	Job search and placement services	●	●	●	●	●	●	●	●	●	●	●	●	EmployAbility/ Employer Based Training/ FET STP	●	
Adaptations & Technologies	Workplace Adaptations	●	●	●	●	●	●		●	●	●	●	●	DSP	●	
	Assistive technology	●	●		●	●	●		●	●	●	●	●	DSP	●	
	Reasonable Accommodation	●	●		●	●	●		●		●		●	DSP	●	●
Service Coordination	Case management	●	●	●			●	●		●	●	●	●			
Alternative Employment Options	Social enterprise	●	●	●	●	●	●		●	●	●	●	●	DSP	●	
	Sheltered Employment	●	●	●	●	●	●		●	●	●	●	●	HSE/DSP	●	
Other Supports	Access to adapted transport	●	●		●	●	●		●	●	●	●	●			●

¹⁶³ ETB Education and Training Board¹⁶⁴ FET STP Further Education and Training Specialist Training Programme

systematically structured approach to ensure that people access VR in a timely manner. In effect, the Irish social protection system is mostly passive in its response to people while they are employed. Apart from a number of pilot projects on active inclusion and early intervention, no coherent policy could be identified. Furthermore, no formal links exist between the health system and the limited VR-type services for which employed people are eligible.

4.4.4 No formal definition of or policy on vocational rehabilitation

Another sign of the lack of a formal system is that no formal definition of VR exists. A web search revealed no such reference in any Departmental documentation although a search for the term on the Citizens' Information website resulted in 15 hits. These included references to the HSE rehabilitative training programme, the community employment scheme, the EmployAbility service and the FET STP. In addition, the Citizens' Information Service provided information about disability payments relevant to people with disabilities seeking employment including Partial Capacity Benefit and Disability Allowance Disregard.

4.4.5 No legal basis for current Irish VR activities

In addition, no clear legal basis for the current Irish system of VR was evident, although employment strategies to promote the employment of people with disabilities were clearly central to the National Disability Strategy.

Divided Departmental responsibilities – no joined-up system

Responsibility for the services that do exist are generally divided between the Department of Social Protection and the Department of Education and Skills. EmployAbility services are provided by partnerships of local community organisations and vocational training was provided by a mix of public sector vocational and community training centres and NGO providers. The system is financed from general taxation and providers are required to meet targets for placements to open employment, progression to further education and training and certifications.

4.4.6 Occupational rehabilitation provision is patchy

As is the case for VR, the term 'occupational rehabilitation' was not defined in any Departmental documentation. However, it is offered by some large public and private sector employers to their own employees and by some insurance companies as part

of income protection and personal health insurance or in response to an accident where liability has been established. Services are provided by private sector companies and in some cases by in-house staff. Staff are usually qualified professionals in a relevant area.

4.4.7 No case-management system to co-ordinate different supports from different providers

Another weakness of the Irish system is that no formal support (case management) is available in the wider system to coordinate interventions and supports from different providers and social protection. This is the case even though people may be provided with an individual plan and a key worker within a specific service.

4.4.8 Employment incentives and supports

The employment incentives and supports that are available to people with acquired disabilities in Ireland are presented in Table 4.5.

This compares the Irish system of supports and incentives with those from the other 12 jurisdictions. The most common incentives available in the other 12 jurisdictions related to advice, personal assistance, adaptations and financial incentives. Administrative incentives were generally less common.

4.5 How Ireland's incentives compare with other jurisdictions

Only one country (the Netherlands) reported the availability of all 17 incentives. In Ireland only nine of these exist, which is fewer than most of the other countries surveyed¹⁶⁵. It was notable that the other eight incentives all existed in the majority of the other countries surveyed.

The person-focused incentives and supports not readily available in Ireland include assistance to apply for grants or subsidies, advocacy, financial support for commuting to VR or work, additional financial support of people participating in VR¹⁶⁶, and conditionality i.e. the withdrawal of benefits from people who do not participate in VR. The only incentives and supports available to *employees* with acquired disabilities are equipment grants, the personal reader grant and flexible benefits (Partial Capacity Benefit), for which eligibility requires that the person is absent for over six months.

Only the Workplace Equipment Adaptation Grant is relevant to both individuals seeking to access or to remain in work. However, as is the case with services,

¹⁶⁵ Unlike many other countries, quotas only apply to the public sector in Ireland

¹⁶⁶ However, people participating in Rehabilitation Training may receive an additional €31.50 a week on top of their basic welfare payment (in spite of the name, this HSE-funded programme is mainly for school leavers, and is generally oriented towards lifeskills training rather than vocational training)

Table 4.5. Employment Supports (Ireland and 12 Other Jurisdictions)

		NL	DE	PT	FR	ES	DK	LT	NO	SL	FI	QLD	NZ	IRL	Unemployed	Employed	Employer
Advice	Assistance applying for subsidies/grants	•	•	•	•	•	•	•	•	•	•	•	•				
	Advocacy	•	•	•	•	•	•		•	•	•	•	•				
Personal Assistance	Interpreter services	•	•		•	•	•	•	•	•	•	•	•	DSP	•	•	
	Workplace personal assistance	•	•	•	•	•	•		•	•	•	•	•	Employ Ability	•		
Adaptations	Equipment grants	•	•	•	•	•	•	•	•	•	•	•	•	DSP	•	•	
	Grants for workplace accommodation	•	•	•	•	•	•	•	•	•	•	•	•	DSP	•	•	•
Financial Incentives	Financial support for commuting to vocational rehabilitation and work	•	•	•	•		•		•	•	•	•	•				
	Additional financial support of people participating in vocational rehabilitation	•	•	•	•		•	•	•	•	•		•				
	Flexible benefits for people who enter employment	•	•		•	•	•		•		•	•	•	DSP	•	After 6 months	
	Withdrawal of benefits from people who do not participate in VR	•	•		•		•		•		•	•	•				
	Wage subsidies	•	•	•	•	•	•	•	•	•	•	•	•	DSP			•
	Productivity-related financial supports	•	•	•	•	•	•			•				DSP			•
	Levies for non-compliance with quotas	•	•	•	•	•				•							
Administrative Incentives	Positive action (in favour of job seekers with disabilities)	•	•	•	•	•	•	•	•	•		•	•				
	Employment quotas	•	•	•	•	•				•				Public Sector			•
	Disability-positive accreditation for good practice employers	•	•	•			•		•	•							
	Disability awareness training for staff	•		•	•		•					•		DSP			•

the majority of employment supports and incentives are designed for job seekers with disabilities rather than employees needing to return to their own jobs.

The remaining grants and incentives are targeted at the employer. Of particular interest in the context of the current study is the Employee Retention Grant which would seem to be a potentially important mechanism from an OR perspective. However, the take-up of this grant is relatively low. The main limiting factor in its deployment is that it can only be applied for by an employer, the process is considered to be administratively complex and no assistance is available in completing the required documentation. This seems to be an unnecessarily restrictive approach to a mechanism that could have substantial impact for employees with acquired disabilities.

Based on documentary sources and material from key stakeholders, Figure 4.1 presents a map of the current elements of the current Irish system of vocational and occupational rehabilitation for people with acquired disabilities.

The box at the top of the diagram represents the starting point for people with acquired disabilities.

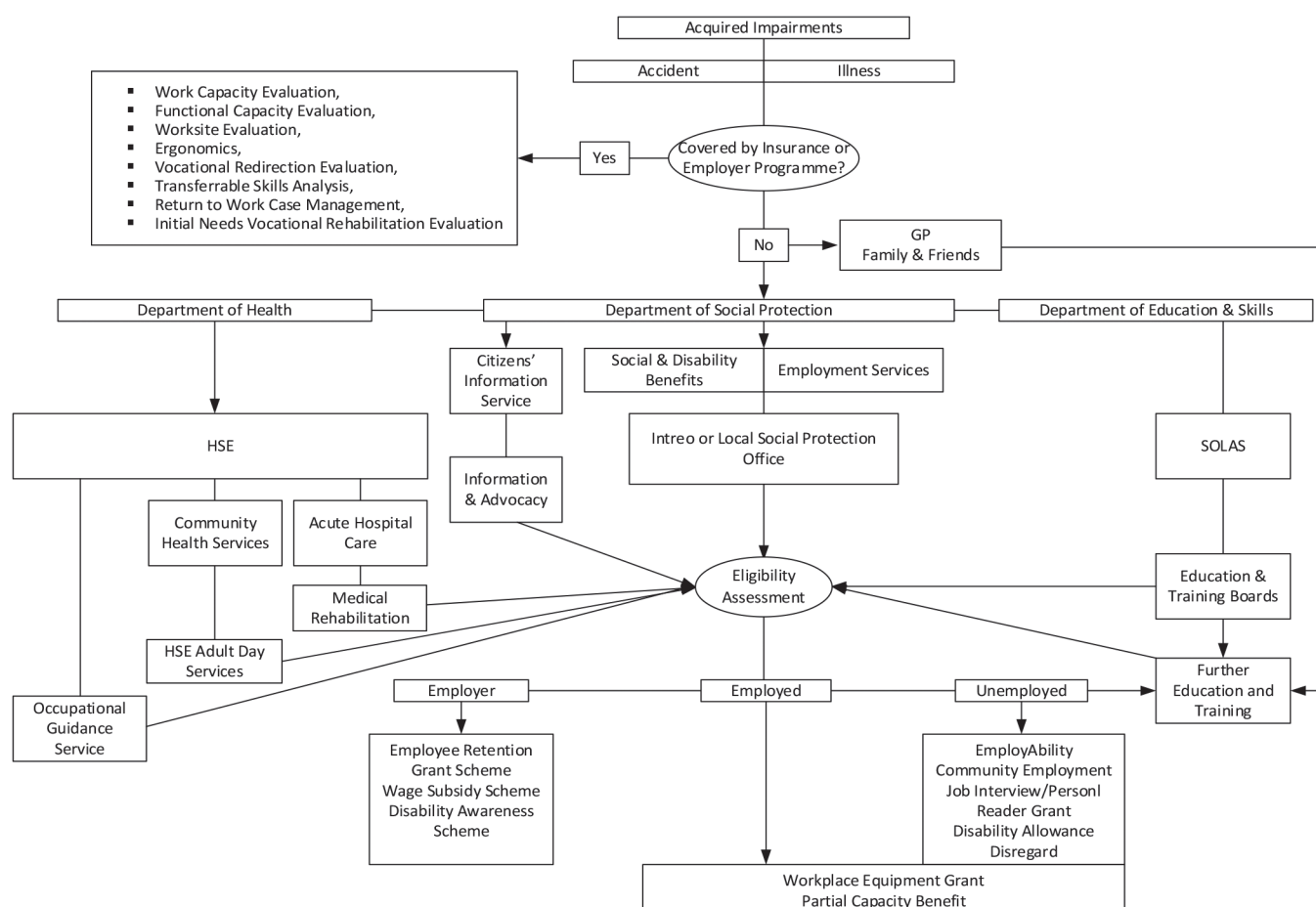
The first decision point concerns whether the person is covered by a relevant insurance policy or is working for a public or private sector employer who offers job retention or return to work supports to its own employees.

If a person has been involved in an accident, for which they are not liable, the settlement from the Personal Injuries Board can be used to purchase rehabilitation services. If the employee works for an employer such as the HSE, they will be offered OR under the agency programme. In these cases, which represent a small proportion of people with acquired disabilities in Ireland, a range of interventions and supports are available. These are usually provided by private companies on a fee for service basis. Return to work case management, which is considered as good practice by among others the ISSA return to work guidelines (2012), and the standards of the International Disability Management Standards Council, is an important element of these services.

4.5.1 Pathways to a VR service are ad hoc rather than systematic

In contrast, the pathway to services for the vast majority

Figure 4.1. Overview of the pathways to and elements of VR and OR in Ireland



of people with acquired disabilities in Ireland is not clearly defined. While referrals can and do happen, these are ad hoc and patchy rather than systematic. Many people are pointed by word of mouth towards local disability service providers where the system is explained to them. Others get advice from the Citizens' Information Service. It is also possible for people to follow a health pathway to move from acute medical care to medical rehabilitation where the vocational options are explained. People who receive services from HSE Adult Day Services may be pointed towards FET STP or EmployAbility services. HSE Employment Guidance Officers, where they exist, often assist people to identify the services they require.

The social protection pathway in Ireland usually starts with a person engaging with the benefits system or employment services in their local Intreo or Social Protection office. Onward referral occurs if they are deemed to have the potential to benefit from and be eligible for disability employment supports.

The decision on whether a person is eligible for a service or support appears to be located within the Intreo system. This occurs either directly by referring a person to a particular service, or indirectly by granting a payment that, by implication, means eligibility for a service. At the bottom of the diagram are the services and supports relevant to people with acquired disabilities. This clearly illustrates the lack of early intervention services and the general lack of services and supports for people who are employed and need to get back to work.

The pathway from acute care to medical and functional rehabilitation in Ireland is managed by the hospital in the case of inpatient treatment. There is less clarity about this link where medical care is provided on an outpatient basis. There is no formal procedure for people moving from medical care to vocational rehabilitation, although it is possible or likely that such services will be flagged by medical rehabilitation staff. The role of rehabilitation case management does not exist in Ireland either under the health or social protection remits.

4.5.2 Most VR services are publicly funded

The majority of services are offered directly by public services or by a variety of NGO or local supported employment partnership companies. EmployAbility is funded through the Department of Social Protection. Specialist training provision as part of the further education and training system (FET STP) is funded by the Department of Education and Skills, on the basis of

annual whole time equivalents. The cost effectiveness of and participant satisfaction with the FET STP have been externally reviewed and found to be acceptable.

4.5.3 No statutory standards for vocational rehabilitation personnel

There are no statutory occupational standards for rehabilitation personnel and the qualifications of staff vary widely from professionals with allied health or human services postgraduate degrees to people with technical or practical skills and experience. There is one postgraduate qualification related to VR in Ireland offered by University College Dublin – the Masters in Rehabilitation and Disability Studies.

4.5.4 Quality assurance systems are ad hoc, depending on OR/VR provider

There is no statutory system of quality control or assurance in Ireland that is specific to either VR or OR, although some service providers participate in specific quality accreditation systems including the Commission on Accreditation of Rehabilitation Facilities (CARF), the European Quality in Social Service process (EQUASS) and the Council on Quality and Leadership (Personal Outcomes) process. These are in addition to ISO and the European Foundation for Quality Management (EFQM) accreditation.

4.6 Conclusions

On the basis of the analysis of the international practice in Chapter 3, and the mapping of the Irish system in this chapter, the following conclusions have been reached:

- Ireland was the only jurisdiction that lacked a formal policy on vocational rehabilitation and that required people with disabilities to be unemployed or inactive to gain access to services
- Although the joint responsibility of the Department of Social Protection DSP and its Intreo service for benefits and employment reflects the approach adopted in most jurisdictions, statutory responsibility for vocational rehabilitation services in Ireland was unclear and the vocational rehabilitation and occupational rehabilitation elements that did exist were distributed between the Departments of Social Protection, Education & Skills, and Health
- A range of vocational rehabilitation services were being provided by some employers, through their own resources, and through private insurers.
- People were admitted onto both short-term and long-term disability payments on the basis of a medical assessment alone. No vocational assessment or

rehabilitation was provided during this process.

Assessments of vocational needs and strengths were available only after referral to a service, rather than at the point of application to the system.

- While many of the interventions, supports and incentives identified in the vocational rehabilitation systems in other jurisdictions were evident in Ireland, the current Irish system is complex and difficult to understand even for those working in the area, and no overall framework for service provision could be identified. Available services were primarily focused on individuals, with some financial supports for employers.
- Information and signposting for people was less than clear. No clear pathways from medical treatment and rehabilitation to vocational rehabilitation or occupational rehabilitation were identified. There was no formal individual assistance provided to people to navigate their way through the system.
- Referrals appeared to be made in an *ad hoc* way, rather through an individual vocational plan based on assessed needs and strengths. There was no individual follow-up to monitor progress, identify unmet needs and source additional interventions if required.
- Arising from this analysis, and drawing on areas of good practice in other jurisdictions, a number of significant areas for improvement were identified in the Irish system including:
 - Combining physiotherapy, occupational therapy and psychological interventions with employment interventions
 - Services that directly target the needs of employers who wish to recruit or retain a person
 - Eligibility criteria that target people with acquired disabilities who wish to return to work
 - Engaging the third of IB recipients, who are excluded from existing services on the basis that they have a job, in occupational rehabilitation services
 - Making employees with acquired disabilities eligible to apply for the Employee Retention Grant, for which employer take-up is limited
 - Reducing the six month requirement for Illness Benefit recipients to become eligible for Partial Capacity Benefit, which is a substantial barrier to early intervention and return to work
 - Introducing a formal service coordination or case management support to people with acquired disabilities to assist them to navigate what is a complex system

Chapter 5. Discussion and conclusions

5.1 Introduction

It is clear from the previous chapters that developing an effective response to the employment of people with acquired disabilities is a challenge in all of the jurisdictions reviewed. There is also a consensus that maintaining people in employment, when this is at risk as a result of acquired disability, has the potential not only to enhance the quality of life of the individuals but also to reduce the inflow into the disability payments and pensions system. In all jurisdictions reviewed, a system of vocational and occupational rehabilitation was at the centre of the national response to reduce welfare dependency and increase labour market participation.

The picture that emerged from the comparative review of vocational rehabilitation was complex and diverse, and no single framework for the organisation and content of an ideal system emerged from the jurisdictions examined. Each of the systems reviewed was unique, and each represented an accumulation of approaches and initiatives over time in response to a specific set of national circumstances.

A consequence of this is that specific initiatives and measures are difficult to transfer from one jurisdiction to another. The effectiveness of specific measures depends on many contextual factors that may not exist elsewhere. Further, there may be barriers to success within the 'host' jurisdiction that mitigate against the success of imported measures.

However, measured against the key features present in other countries' systems of vocational rehabilitation, it is clear that Ireland's current arrangements lack a number of the key features present in most jurisdictions reviewed, and that access to vocational rehabilitation in Ireland is ad hoc rather than based on a systems approach with clear pathways for those who acquire a disability in the course of working life.

The Irish system has not performed particularly well in relation to employment rates for people with disabilities or for returning people to work. In response to this, a number of reports have proposed recommendations over the past decade for changes to the Irish approach

to disability, employment and benefits particularly as they relate to people with acquired disabilities¹⁶⁷. Many of these recommendations are supported by the comparison of vocational and occupational rehabilitation systems carried out for this report.

A number of issues emerged from the comparison of national systems that are relevant to the Irish system (see summary of Chapter 4) and these are taken into account in the generation of the recommendations outlined below.

5.2 Summary of recommendations from previous reports on Ireland

Before presenting the findings of the current study, it is useful to revisit some recommendations that have been made in previous reports on Ireland.

These include recommendations to:

- Provide an individual approach and expert assistance to assist in navigating benefit options
- Reduce the inflow into sickness and disability benefits by recognising that sick leave is the most frequent route into disability benefit
 - Intervene early at the point at which people encounter the welfare system for the first time with activation measures
 - Introduce early intervention to avoid health conditions developing into more serious problems, potentially resulting in a disability benefit claim
 - Use profiling to reduce inflow into the systems by establishing claimants' employment status and work capacity at around 12 weeks based on the potential for job retention, redeployment or early retirement
 - Introduce employment assessment into procedures for qualifying for income support and a systematic referral to employment services to increase the activation options
 - Provide vocational and occupational guidance as part of the qualification procedure for income

¹⁶⁷ McAnaney, D. & Wynne, R. (2005) 'Employment Retention, Early Intervention, Social Inclusion and Emerging Disabilities'. In the proceedings of the **NDA 4th Annual Disability Research Conference Disability and Employment: What the Research Tells Us**. Dublin, IRL: National Disability Authority.
 WRC Social and Economic Consultants (2008) **Research Report on Acquired Disability and Employment: Final Report**. Prepared for the Department of Enterprise Trade and Employment. Dublin, IRL: WRC Social and Economic Consultants.
 OECD (2008) **Sickness, Disability and Work: Breaking the Barriers Vol. 3. Denmark, Finland, Ireland and the Netherlands**. Paris, FR: Organisation for Economic Cooperation and Development.
 OECD (2010) **Sickness, Disability and Work: Breaking the Barriers**. Paris, FR: Organisation of Economic Cooperation and Development. Retrieved [24/08/2015] from: <http://www.oecd.org/ireland/46461490.pdf>

support

- Raise employment rates for people with acquired disabilities by identifying and assisting them when they are not regularly employed, or unemployed but do not have a disability designation
- Support people to develop an individualised plan to gain or retain employment
- Actively engage employers in the retention of long-term absent workers
 - Raise employers' awareness of the support available to assist in job retention
 - Introduce incentives for employers to engage in active recruitment and to retain employees who acquire a disability
- Raise the outflow from usually permanent disability benefits through reintegration measures targeted at people facing challenges in moving from disability benefits to employment
 - Cater for diverse needs through a single point of contact for benefits, employment services and FET
 - Expand rehabilitation measures beyond the medical sphere
 - Include people with disabilities in the National Employment Action Plan assessment
 - Increase expenditure on active labour market measures for people with disabilities
 - Remove benefits traps within the social protection payments system
 - Strengthen coordination between actors and systems implicated in the disability process

The recommendations from previous studies remain relevant to what is required to upgrade and enhance the current Irish system in order to support people with acquired disabilities to retain their jobs, return to work or find alternative employment. The findings of the current study point to similar conclusions.

5.3 Factors to consider in learning from other jurisdictions

Before presenting the learning points that emerged from the current study, it is important to emphasise some of the factors that need to be taken into account when attempting to transfer an approach or methodology from one jurisdiction to another. These include:

- *The presence of a measure or a service in a jurisdiction is not sufficient to guarantee successful implementation of a new initiative.* For example, Occupational Health Services are the cornerstone of the Finnish

approach to vocational rehabilitation, but it would be a mistake to assume that the fact that these services exist in Ireland would mean that the role could be easily replicated here. In Finland, the number of occupational health professionals, their role in occupational health and public health and their orientation far exceed the situation of occupational health professionals in Ireland.

- *The links between services are often as important as the presence of the services themselves.* Perhaps the most important example of this is the relationship between public health services and rehabilitation services, and those between employers and the rehabilitation services. Successful vocational rehabilitation must entail the effective management of interfaces as well the provision of appropriate services.
- *The definition of initiatives, concepts and professional roles may need to be substantially adapted to a national context or jurisdiction.* Problems in transferring practice from one jurisdiction to another can arise from incompatibility between practice and context. An example of this is the concept and practice of disability management. This evidence-based approach to workplace health and productivity is more widespread where employer responsibility for absence and return to work is transparent, and services are financed through insurance contributions. Despite a high level of agreement about its importance, it has been slow to be adopted in systems funded through general taxation.
- *Successful systems provide adequate resources.* In all jurisdictions reviewed, specialist vocational rehabilitation services were widely available, easily accessible and properly resourced in terms of finance and human resources.

In addition to these considerations, it is clear that a hallmark of successful systems is that the main stakeholder groups work coherently towards the goal of successful vocational rehabilitation. In this regard, the orientation of public health services, rehabilitation services, employers and their representatives and the individuals concerned need to be in explicit alignment. From the public health point of view, the (re) integration of individuals to the workplace needs to be an explicit goal. From the employer and the individual perspective, it needs to be understood that the response to an individual with an acquired disability is to try to ensure a safe and timely return to work, whether in the original role or alternative role if that is indicated. Achieving such agreement on these perspectives requires a reorientation of attitudes and the removal of administrative barriers within the Irish system.

The discussion which follows is based on the findings of an analysis of the vocational rehabilitation systems from 12 jurisdictions as well as the perspectives of the researchers. It draws upon a diversity of opinion in relation to systems which differ in key respects. In that context, it is more appropriate to highlight issues and decision points in transferring lessons to be learnt from elsewhere, rather than to make explicit recommendations for specific courses of action. In many respects, developing a coherent and comprehensive vocational and occupational rehabilitation system for people with acquired disabilities in Ireland is less an issue of what the elements of such a system should be (though there are gaps), and more about broadening the eligibility criteria for VR services, re-orienting them to the target group and strengthening relevant elements where appropriate. The nature of the interactions between stakeholders and services in the system will determine the success of any system that is introduced.

5.4 Issues for consideration

5.4.1 Establishing appropriate and timely services, supports and interventions

i. The system addressing the needs of people with acquired disabilities needs to be reoriented.

The current system is almost solely focused on outflow from the disability payments system, and needs to incorporate mechanisms to reduce the inflow. Adopting a formal system of vocational and occupational rehabilitation which addresses the needs of both employed and unemployed people with disabilities would provide a platform for this. This requires that national policy explicitly targets people at risk of disability and job loss; the augmentation of current services to include return to work for employed people; changing current regulations to create access for employees to return-to-work grants; retraining of DSP staff; and developing and tendering for new services. Part of this reorientation would involve the creation of a concept and methodology for vocational and occupational rehabilitation system players and their retraining to enable the smooth working of the new system.

The services and supports required for the internal and external redeployment are very similar to those required by job seekers with disabilities and as a result there is a relevant service infrastructure operating within the Irish system. The Disability Case Management approach piloted by Linking In provides a model. In addition, the Specialist Training

Programme and the EmployAbility services are both fit for purpose in the event that a worker needs to transfer to a different job with the original or alternative employer. The additional interventions required would include access to vocational assessment, transferable skills analysis and vocational counselling.

ii. The activation role of DSP and Intreo is well developed and could serve as a model for a job retention/return to work service.

Activation involves engaging with working age recipients of specified social welfare payments/benefits to support progression to work or other positive options. The relevant characteristics of the activation process include:

- Having a case officer who is central to the process
- Participants are filtered into high, medium and low probability of exiting unemployment streams
- Each participant is provided with a Personal Progression Plan which is regularly reviewed
- Opportunities for employment, work experience or training/education are signposted,
- Non-participation can result in a reduction or withdrawal of income support

It is clear that a similar approach could be adopted for illness and invalidity benefit applicants. The main adjustment to the process would be that the criteria for filtering would be based on a probability of returning to work to the original employer or an alternative position. In addition, the case officer would signpost a different range of services including return-to-work advice and counselling; allied health therapeutic interventions and vocational rehabilitation services (e.g. EmployAbility services); information about the Employee Retention Grant, Workplace Equipment/Adaptation Grant, Wage Subsidy Scheme and Partial Capacity Benefit.

There are a number of prerequisites for this approach to be effective. Firstly, a Temporary Rehabilitation Benefit needs to be established for applicants who have a high probability of returning to work. Secondly, eligibility for Partial Capacity Benefit needs to be available after 12 weeks for people who are fit for work. Thirdly, the Employee Retention Grant needs to be extended to applications from individual workers who wish to return to work on the condition that their employer agrees. Fourthly, the Closed Certification Guidelines for General Practitioners¹⁶⁸ need to be disseminated and promoted more widely to GPs

and Occupational Health professionals¹⁶⁹. Finally, eligibility for vocational rehabilitation services such as EmployAbility needs to be extended to benefit recipients who are employed but long-term absent on health grounds.

- iii. **The design of the VR system needs to take account of the diversity of needs of the beneficiaries in terms of** type of health condition (musculoskeletal, pain, neurological, cardio-pulmonary, metabolic or mental health); employment status (employed, unemployed, economically inactive); cause (occupational and non-occupational); legal status (liability) and demographics. Flexibility is essential in the system as a whole, not only within a disability benefits-employment axis but also across systems including Health and Education and Skills and between providers of services.

The system also needs to cater for those who may return to their old job or occupation with appropriate supports and accommodations, and those who may require retraining and redeployment to alternative roles either in their current or an alternative employer, given their changed health/impairment circumstances.

- iv. **The importance of introducing early intervention processes** has been emphasised in every report on the Irish system over the past decade and was confirmed by the current jurisdictional comparison. The evidence from the Renaissance project was compelling. The challenges are:
- a. Gaining consensus among stakeholders (DSP, Intreo staff, employers, services and individual) about what this means in relation to return to work and disability prevention
 - b. Transforming this consensus into a substantive and properly funded action plan for reorganising and augmenting the current system
- v. **Health and return to work interventions, services and supports need to be introduced** including:
- c. Addressing the health and functional needs of people in combination with vocational interventions including Functional Capacity Evaluation
 - d. Targeting such interventions specifically at job retention and return to work for employed people with acquired disabilities

- vi. **Vocational assessment and guidance needs to be made available to people who are at risk of**

job loss and to applicants for disability income supports. This should involve an initial face-to-face interview by a trained professional that is based on file information, reports from allied health professionals, a structured needs analysis and, where required, the profile generated by a functional capacity or other evaluation. This should take place as part of the assessment process for permanent disability payment and after 12 weeks on Illness Benefit. The outcomes should include:

- e. Profiling of the person in terms of their needs i.e. return to their job, support for active job seeking or support for community participation
- f. An outline cross-sectoral plan that lays out the inputs and interventions

- vii. **The introduction of a temporary disability payment could ensure that people who are engaging in the vocational assessment, guidance and rehabilitation process have access to financial support.** This could divert people from reliance on long-term benefits. This Temporary Rehabilitation Payment should be considered on application for Disability Allowance and at 12 weeks for recipients of Illness Benefits and should be reviewed at least annually for each recipient.

5.4.2 Ensure coordination between systems, services and professionals

- viii. **The interfaces between services (and handovers of individuals) need to function effectively.** In particular, the interfaces between medical and vocational rehabilitation services and between vocational rehabilitation services and employers need to be proactively managed. An overview of a possible framework is presented in Figure 5.1.

It is difficult to capture all combinations and permutations involved in the operation of a coordinated system of vocational and occupational rehabilitation. Acknowledging these complexities, Figure 5.1 attempts to highlight the potential pathways to vocational and occupational rehabilitation in a joined up system in Ireland. It conceptualises what the three Government Departments, with relevance in this domain, need to do in terms of their responsibilities and the actions they and their agencies need to undertake.

It is also recognised that voluntary organisations, including those funded by the HSE under s 38 and s 39 of the Health Act 2004, play an important role in delivery of services, although not shown in the

¹⁶⁸ <https://www.welfare.ie/en/pressoffice/Pages/pr220915.aspx>

¹⁶⁹ Leech, C. (2015) 'Closed Certification Guidelines for General Practitioners'. Dublin, Irl: Department of Social Protection.

diagram. Coordination of statutory and voluntary activities is a key element.

In the top part of the framework the various routes to vocational assessment are illustrated. While the primary focus of this report is upon disabilities acquired during working life, it should be clear that people with disabilities that were acquired earlier could access a vocational assessment through the majority of the routes illustrated in the Figure. They can access vocational rehabilitation through the community health, second level/special and active inclusion pathways.

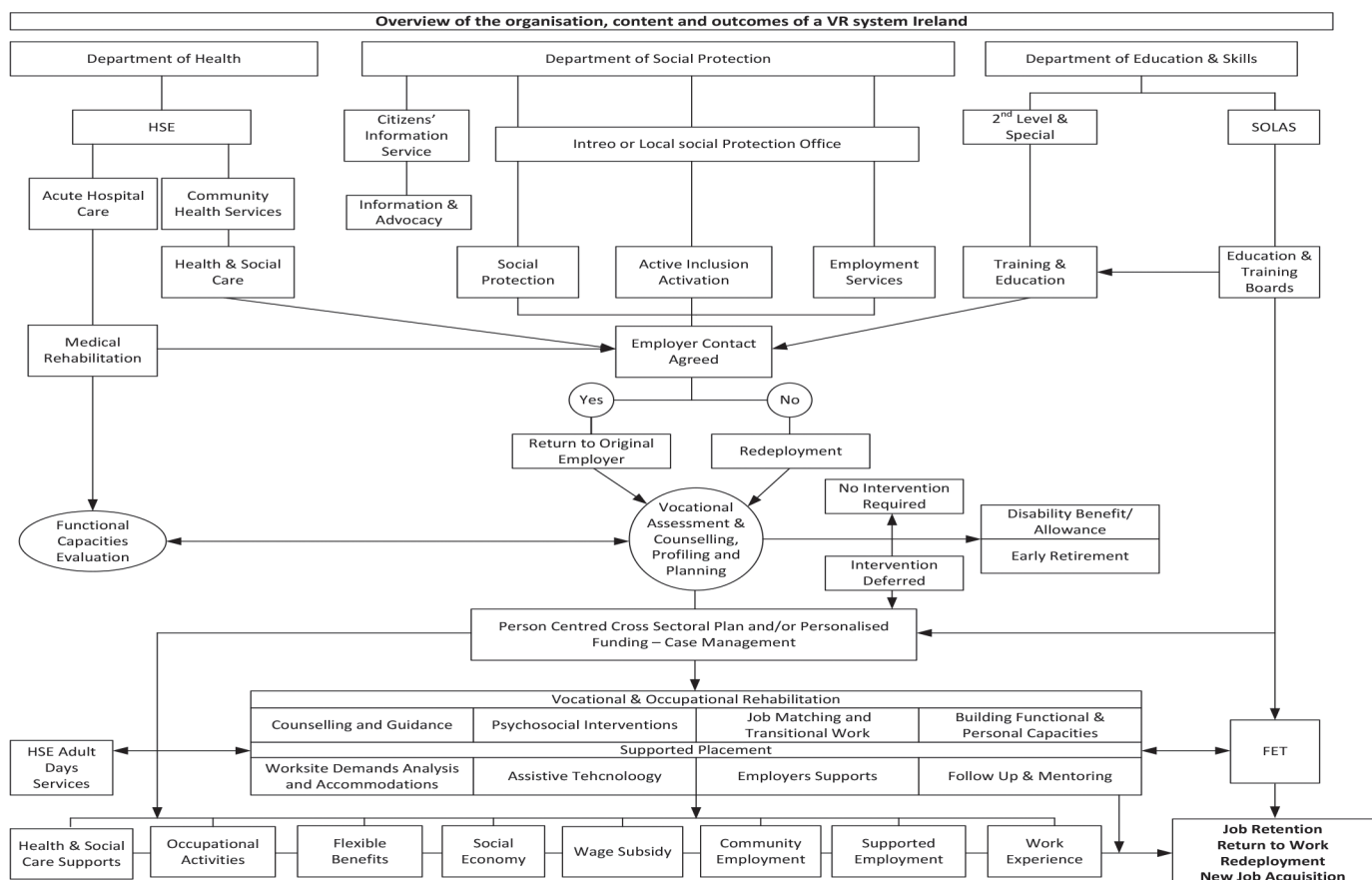
In the bottom part of the diagram, the main elements of the services that are needed are outlined. The key processes in this system are:

- The assessments that take place in relation to vocational potential and counselling, profiling and training, which would be under the auspices of the Department of Social Protection and its agents
- The evaluation of functional capacities, which are generally offered by allied health professionals. The double-headed arrow linking functional capacities evaluation to the vocational assessment process is intended to illustrate that the DSP can procure such

assessments if deemed necessary. Nevertheless, allied health professionals who offer these assessments should operate under the auspices of the Department of Health and its agents. If these assessments are to function effectively, they must be collaborative, be simultaneous and lead to a coherent package of services.

- In addition, there must be clear responsibility and accountability for ensuring that assessments are effective and that the appropriate service package is created. In effect, this may best be seen as an element of case management.
- ix. **Supports for employers need to be improved and publicised.** Currently, employers can receive a range of grants to support them in employing a person with a disability. These are generally confined to monetary grants and, while these are needed, services to support the employer in terms of information and supports after the employment process are also required. The (re)employment of people with acquired disabilities requires skills and knowledge that many employers, especially smaller employers, will not have.
- x. **Clarifying roles and responsibilities is key to designing a successful system.** Clarity is required

Figure 5.1. The organisation, content and outcomes of a possible VR system for Ireland



in terms of the roles of the main agencies involved; the locus of decision making in relation to vocational and occupational rehabilitation; the financing and purchasing of services; the monitoring of service effectiveness; and accountability for the success and failures of the vocational and occupational rehabilitation systems. Currently, these roles are dispersed and responsibility for them is often not clear.

xi. Occupational health services (OHS) will need to be strengthened and broadened in scope.

In particular, OHS should ensure that all employees are assessed not only for capacity to work, but also that the demands of jobs are assessed and matched to the capabilities of the returning individual. In addition, post-employment monitoring should take place. The roles adopted by OHS practitioners in Ireland and their numbers are inadequate for the amount of work that would be needed in an effective system.

xii. A case management service that embraces all the necessary communication and coordination is needed.

This should probably be situated within the DSP area of responsibility. The role should be clearly defined and wider in scope than many of the models examined in this report. In particular, professional development needs to be offered to case managers.

xiii. Client-led financing models should be considered.

This approach to the purchasing of services is being explored and implemented in many countries in relation to many aspects of disability-related services. The potential advantage of this type of financing model is that it puts discretion in the hands of the individual rather than the service provider or the benefits agency. In the current context, there is an easy opportunity to do so by making the Employee Retention Grant available to both employers and employees. As it currently stands, only employers can claim this grant, and evidence would suggest that the currently low take-up of the grant could be improved by allowing employees apply for it.

5.4.3 Broadening access to timely and appropriate services

xiv. Ensure that services and supports are available to all who could benefit from them.

Assuming that the current system is reoriented and augmented, the major challenge is to break down the barriers to access by:

- Aligning services for people with acquired disabilities as a result of injury with those for people with chronic illness so that transition to vocational and occupational rehabilitation is a standard onward referral for all who could benefit
- Introducing vocational rehabilitation and return-to-work targets for clinicians and medical rehabilitation providers in order to facilitate early intervention and promote transition. Progression to vocational rehabilitation and return to work could be introduced as clinical outcomes which are monitored for all patients of working age
- Ensuring that services and supports are easily available in terms of geographical coverage and the public and private sectors. The former requires designing services that are community based and mobile in that they can go to where the person is rather than requiring the person to commute. The latter requires that the supports, interventions and incentives introduced are not restricted to private sector employees, as is currently the case for the Employee Retention Grant, but are also available to public sector employees who need support to return to their jobs
- A critical element to support safe and timely access to vocational and occupational rehabilitation is the development of improved sources of information and signposting so that people with acquired disabilities or their family and friends, have immediate and accessible information. Information resources also need to be customised to the needs of employers, GPs and other health professionals. A single web resource could be established on the DSP website that allows online registration for a vocational assessment and guidance appointment and provides clear information about VR and OR. Easy read FAQs and a set of contact options could redirect people to any relevant stakeholders including insurers, IBEC, the HSA, hospitals and clinics, EBTs, NGO providers and other government departments
- Access to information about the benefits of vocational and occupational rehabilitation and how to access services should not be restricted to people who have already acquired a disability. A public education campaign should accompany the launch of the reoriented system that makes people aware that return to work is a real option. Awareness raising material could be distributed

to all insured people along with their policy information (including car and home insurance). The same materials could be included in the induction packs of new employees. Workplace and health professionals including GPs could also be provided with versions of the materials.

are required to strengthen co-ordination of service provision and funding.

- A code of practice to assist employers in the retention of long-term absent workers is needed. This should be supported by active engagement and awareness raising of the supports available

5.5 Concluding remarks

- It is important that measures are put in place to promote job retention and re-entry to employment of people with acquired disabilities, to advance this strategic goal of the Comprehensive Employment Strategy for People with Disabilities.
- The evidence is that vocational rehabilitation focused on early return to work and open employment results in higher earnings and independent employment outcomes for participants. Workers need to be empowered and supported to seek assistance from vocational rehabilitation providers at an early stage and provided with clinical and occupational interventions to address both individual functional capacities and workplace factors.
- Existing vocational rehabilitation interventions for current disability income support recipients need to be enhanced.
- A set of vocational and occupational rehabilitation interventions that come into play early is required. These should be offered at the point at which people encounter the welfare system for the first time with due consideration of the severity or complexity of their health condition.
- An employment or work capacity assessment service should be provided to disability income support applicants to assist them to evaluate their return to work options.
- Services and supports should be targeted based on a profile of an applicant's potential and motivation to return to their original employer in their own job or an alternative or to find work with another employer.
- A systematic referral to employment services and expanded rehabilitation measures, beyond the medical sphere, is required.
- An individualised plan to gain or retain employment needs to be developed for people with acquired disabilities.
- A single point of contact, or one-stop-shop, is needed that includes information on benefits, vocational and occupational rehabilitation services and further education and training (FET).
- Case management and defined referral protocols between health and vocational service providers

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Appendix 1 – Study Methodology

There were four major elements to the study and the methodology for each of these is described briefly below.

A1.1 Characterising the context for vocational rehabilitation

A key part of the work undertaken was to characterise the policy and general context for vocational rehabilitation. Of concern here was the development of a framework in which vocational rehabilitation systems could be described and understood. Accordingly, the focus of the work was on macro level issues in relation to vocational rehabilitation, for example on systems and policies and their effectiveness rather than on the issues relating to individuals, workplaces or specific interventions. Of specific interest here were issues such as:

- The definitions and terminology used in the area
- The potential beneficiaries of vocational rehabilitation
- Rehabilitation from a disability rights perspective
- Early intervention in the case of absence
- Multidisciplinary approaches to vocational rehabilitation
- The links between medical and vocational rehabilitation
- The effectiveness of vocational rehabilitation systems – what are its costs and benefits

Four sources of information were used to produce this perspective:

- Previous review work undertaken by the NDA¹⁷⁰
- Literature and reports produced by the authors in the recent past
- Literature suggested by the NDA
- A targeted internet search for material to fill in gaps in information and to update statistics

These information sources were then reviewed to produce Chapter 3 of this report.

It should be noted that this part of the work does not constitute a formal review of the scientific literature, but a method of producing a contextual perspective for vocational rehabilitation practice¹⁷¹.

A1.2 Study of national jurisdictions

The vocational rehabilitation systems of the four jurisdictions selected for inclusion in the study – Queensland, Australia, Finland, Slovenia and New Zealand – were to be the subject of detailed and intensive description. These were to be described by experts from these jurisdictions in the field who have published widely and who have international experience. The role of these experts was to comment on the approach being taken by the research team, to gather and report on the required information and to comment on the outputs of the work of the research team.

The early part of the study involved developing and piloting of a data collection instrument. Partially based on earlier work by the authors on employment guidance services for people with disabilities and work on national systems for vocational rehabilitation, it went through a number of stages of piloting and feasibility, implementation, checking and validation¹⁷².

These were:

1. A draft set of questions to be answered by the national correspondents was developed in consultation with the NDA (the data collection instrument)
2. These were circulated to the four national correspondents for review – in essence this was a feasibility study, where correspondents were asked to rate how possible it was to obtain specific pieces of information and to say how important the information was to understand their national system. They were also asked to comment on how easy it was to understand the questions being asked.
3. The data collection instrument was amended on the basis of the feedback from this stage and agreed with the NDA as being suitable for use in the main part of the study.
4. The national correspondents completed the data collection instrument in relation to their own jurisdiction and sent the results to WRC.

¹⁷⁰ For example, NDA (2011) **Employment Policy & Practice for People with Disabilities in Three International Jurisdictions: A Contemporary Developments in Disability Services Paper**. Dublin, IRL: National Disability Authority.

¹⁷¹ This approach was agreed with the NDA

¹⁷² Wynne, R., McAnaney, D., O'Kelly, C., and Fleming, P. (2006) **Employment Guidance Services for people with disabilities - Conceptual framework and structured inventory of initiatives**. Dublin, IRL: The European Foundation for the Improvement of Living and Working Conditions.-
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5. The returned data collection instruments were checked for completeness and clarity and then analysed to produce vocational rehabilitation systems descriptions for each jurisdiction.
6. The national correspondents were asked to comment on the descriptions of the vocational rehabilitation system in their own jurisdictions.

A description of the current Irish system was developed on the basis of previous work undertaken by the researchers and contributions from Irish stakeholders in parallel with this process.

A1.3 Information collection from additional countries

A further stage of information collection took place with selected members of the European Platform for Vocational Rehabilitation (EPR) - Denmark, France, Germany, Lithuania, The Netherlands, Norway, Portugal and Spain¹⁷³. This element of the work was co-ordinated by EPR. It investigated the same areas examined in the four in-depth studies of Australia, Finland, Slovenia and New Zealand, but to a lesser degree of detail. In addition, a review of the report was carried out by an expert in vocational rehabilitation from the USA¹⁷⁴.

The aim of this strand of the work was to supplement the main investigation with information from other jurisdictions, so that a more complete perspective could be obtained from other countries. In addition, this strand of the work enabled a broadening of the range of vocational rehabilitation systems to be included in the overall study.

This phase of information collection took place after the main research activities – this enabled the questions that were asked of these respondents to be refined. The questions that were asked of the EPR respondents followed the structure of those asked of the four main national studies. However, these respondents were asked to mainly to confirm the kinds of definition used for vocational rehabilitation and to confirm the content of various elements of their national systems rather than provide detailed description of their national systems.

Data collection was administered through the secretariat of the EPR and the quality of the data that was collected was managed by the WRC research team in collaboration with EPR.

A1.4 Consultation with Irish stakeholders

A number of the main stakeholders in the Irish vocational rehabilitation community were contacted individually to obtain their inputs to the mapping of the Irish system and contributions to the conclusions from the project. For time reasons, this took the form of a request for responses to a draft version of the chapters on the Irish system, and the draft conclusions and recommendations.

Responses were received from the Association of Occupational Therapists of Ireland, the Irish Association of Social Workers, the Fit for Work Coalition, the Irish Heart Foundation, Headway and Acquired Brain Injury Ireland, the Department of Social Protection, the Department of Health and SOLAS. In addition, the National Disability Authority facilitated a feedback session on the draft findings and conclusions with the authors and key policymakers in the relevant government departments along with vocational rehabilitation providers and user organisations.

Overall, the responses were very positive in relation to the draft conclusions and recommendations of the report and reflected a consensus that vocational rehabilitation services in Ireland are an area for improvement. The substantive content of each response has been incorporated into the body of the report.

¹⁷³ The EPR is a network of rehabilitation providers across Europe. See: <http://www.epr.eu/>

¹⁷⁴ Professor Malachy Bishop, University of Kentucky, United States

Appendix 2: Data collection template for main study of four jurisdictions

Legal and policy context

Please provide details of the two most common systems for the provision of vocational rehabilitation in operation in your region/state/country

System 1 and system 2

- Definition of vocational rehabilitation
- Target group description
- Eligibility Criteria
- Legal Basis for the system
- Govt. Department and agency Responsible
- Type of Service Providers (Public, Private, Not-for-Profit)
- How is the system financed? (General Taxation, social insurance etc.)
- Annual Budget/Expenditure on Vocational Rehabilitation in the Region
- Number of beneficiaries per annum
- Outcome indicators (including employment outcomes)

Structure and content

Indicate which of the elements in the list below are considered to be part of Vocational Rehabilitation services. What agencies are involved in delivering each?

Vocational rehabilitation elements

- Information & Advice about Vocational Rehabilitation
- Case management
- Vocational Assessment
- Guidance & Counselling
- Functional Capacity Evaluation
- Physical/Functional capacity building (Physiotherapy, OT etc.)
- Psychological Supports
- Pre Vocational Training
- Specialised Vocational Education/Training
- Job search and placement services
- Work sampling or on the job assessment
- Job/Person matching
- Job Coaching
- Supported Employment
- Social enterprise
- Sheltered Employment
- Reasonable Accommodation
- Assistive technology
- Workplace Adaptations

- Access to adapted transport
- Other elements not listed above

If the services available to people with occupational injuries or illnesses differ from what you have specified above, please describe the differences.

Review the list of referral and/or information sources below and, based on your experience and the views of service providers and case managers where available, indicate those which are the most likely sources of signposting and information about vocational rehabilitation services for people with disabilities or their families.

- Referral and Information Sources
- GP or Family Doctor
- Company Occupational Health Service
- HR
- Disability/Injury Management Programme
- Hospital-based Medical Social Worker
- Community-based Social Worker or Nurse
- Insurance Claims Manager
- Rehabilitation Case Manager
- Physiotherapy or OT Professionals
- Public Employment Services Guidance Officers
- Social Security/Welfare Staff
- Medical Social Security Assessment Professionals
- Medical Specialists and Consultants
- Unemployment Centres
- Community Health Centres
- Committee of Socio-Medical Expertise
- Vocational Rehabilitation Services Marketing
- Citizens and Community Information Services
- Disability Specific Organisations
- Disability Equality Organisations
- Public Online Information Sources e.g. Health, Employment, Social Security
- Insurance Company Websites
- Disability NGO Websites
- Vocational Rehabilitation Provider Websites
- Other frequently used (Please Specify below)
- Please describe how people move from general health services to medical rehabilitation (MR) and on to vocational rehabilitation. How is this process coordinated? Describe what is meant by early intervention in the field of vocational rehabilitation and how this overlaps with MR

- Please describe the role of rehabilitation case management plays in the system in ensuring that people can access the services and supports they requires across structural boundaries including health, welfare, education, employment/training
- If the measures above are different for people with occupational injuries or illnesses from what you have specified above, please describe the differences below.

System of delivery

- Please describe the relationship between local/regional vocational rehabilitation services and national agencies or government bodies
- Describe how front line services are organised and delivered
- If service are organised differently for people with occupational injuries or illnesses from what you have specified above, please describe the differences below.

Financing and resources

- Please describe how vocational rehabilitation services are funded (e.g. health funding, employment service funding, social security funding, insurers etc.) and the way in which service contracts are awarded (e.g. tendering or service contracts etc.)
- Please provide any hard data available in relation to the total and per capita costs of a typical vocational rehabilitation service (per head of working-age population) and/or the staff resources (ratio to working-age population); staff mix in terms of job titles, skills, qualifications.
- If any information on the cost-to-benefit ratio or return on investment, provide a brief summary below or provide us with a link to the documents
- List below any academic or professional development courses available for practitioners in the field of vocational rehabilitation (over and above generic allied health qualifications such as occupational therapy)
- If services are organised differently for people with occupational injuries or illnesses from what you have specified above, please describe the differences below.

Organisational and individual incentives and support

Please indicate the types of incentives and support available to support people with disabilities participating in vocational rehabilitation to access employment

Person-focused incentives and supports

- Interpreter services
- Workplace personal assistance
- Advocacy
- Assistance with applications for subsidies or grants
- Equipment grants
- Financial support for commuting to vocational rehabilitation and work
- Additional financial support of people participating in vocational rehabilitation
- Withdrawal of benefits from people who do not participate in vocational rehabilitation
- Flexible benefits for people with disabilities who enter employment
- Other person-focused incentives (Specify)

Employer-focused incentives and supports

- Positive Action (allowing positive discrimination in favour of job seekers with disabilities)
- Wage subsidies
- Productivity related financial supports
- Employment quotas
- Levies for non-compliance with quotas
- Grants for workplace accommodation
- Disability-positive accreditation for good practice employers
- Disability awareness training for staff
- Other employer focused incentives

Provider-focused incentives

- Outcome related financing
- Other provider focused incentives

If the incentives available to people with occupational injuries or illnesses differ from what you have specified above, please describe the differences below.

Approaches to quality and accreditation of services

Vocational rehabilitation - please describe any quality control and service accreditation systems that are in place for vocational rehabilitation services; professional certification mechanisms for rehabilitation practitioners and any key performance outcome measures that are used to monitor results

If the quality and accreditation of services for people with occupational injuries or illnesses differ from what you have specified above, please describe the differences below.

Conclusions and lessons learned

- Please summarise the finding, or provide us with links to, any evaluation studies into the impact of vocational rehabilitation in your jurisdiction that are available
- Based on your experience please propose the aspects of the system that you consider to represent good practice, the factors that are critical for success and what you consider to be the system impact of each type of services, under the following headings
 - Good practice factors
 - Key success factors
 - System impact
- What advice would you give to a colleague from another country who was responsible for designing a system for providing vocational rehabilitation services

Appendix 3: Data collection template for European Platform for Rehabilitation study respondents

Definitions of vocational and occupational rehabilitation

Each of the jurisdictions reported at least two formal delivery systems for vocational/occupational rehabilitation one of which addressed social welfare recipients with acquired disabilities and a second which addressed workers with acquired impairments including those with occupational injuries or illnesses. Feedback from the other jurisdictions generated the following definitions.

Please indicate the extent to which the definitions below reflect vocational rehabilitation as it exists currently **in your country** on a scale of 1 to 5, where 1=Completely Irrelevant and 5=Completely Relevant. Specify NA for Not Applicable

- The purpose of vocational rehabilitation may be to improve a person's capacity for work so as to help them cope with work demands; help him or her overcome impairments; and to enter working life or return to work after a lengthy absence.
- Vocational Rehabilitation consists of services for persons with disabilities defined as »services, carried out with the aim of preparing them for appropriate work, helping them to obtain or retain employment, progress in it or to change career.
- Vocational rehabilitation is the process by which people with disabilities are assisted to improve their opportunities for employment so they can achieve greater social inclusion, usually through gaining employment in the open labour market with remuneration at standard award rates
- Vocational rehabilitation consists of the provision of the supports, assistance and/or interventions required to assist people to attain a job or return to work when a health condition or impairment makes this difficult

Please indicate the extent to which the definitions below reflect occupational rehabilitation (OR) as it exists currently **in your country** on a scale of 1 to 5, where 1=Completely Irrelevant and 5=Completely Relevant Specify NA for Not Applicable

- OR involves the provision of supports and interventions to ensure the maintenance and

promotion of the employees' work ability, return to work and rehabilitation (secondary & tertiary prevention)

- OR is the process through which disabled workers with remaining work capacity are facilitated to retain their jobs or return to their original job or another job with their original employer.
- OR is the process by which an injured employee's functioning is maximised and/or a safe and early return-to-work is achieved
- OR is the process through which a person is assisted to (a) maintain employment; (b) obtain employment; or (c) regain or acquire vocational independence"

Policy and administrative responsibility

Please indicate departmental and statutory agency responsibility for **vocational rehabilitation** for economically inactive jobseekers with acquired disabilities

- Department Responsibility
 - Department of Education
 - Department of Health
 - Department of Social Welfare
 - Department of
 - Other (Specify)

Please provide below an English translation of the name of the agency or agencies with responsibility for **vocational rehabilitation services for economically inactive jobseekers with acquired disabilities in your country**

Please indicate Departmental and statutory agency responsibility for **occupational rehabilitation** for workers with acquired disabilities who need assistance to return to their own employer by placing a tick in the appropriate boxes

- Department Responsibility
 - Department of Education and Skills
 - Department of Health
 - Department of Social Protection
 - Other (Specify)

Please provide an English translation of the name of the agency or agencies with responsibility for **OR services for employed people with acquired disabilities in your country**

Financing for vocational and occupational rehabilitation

Please indicate the primary sources of funding for vocational rehabilitation services for economically inactive jobseekers with acquired disabilities in your country. You can indicate more than one source

- General Taxation
- National Social Insurance
- Statutory Health Insurance
- Pension Funds
- Other

Please indicate the primary sources of funding for OR services for employed people with acquired disabilities in your country. You can indicate more than one source

- General Taxation
- Workers' Compensation Insurance
- National Social Insurance
- Statutory Health Insurance
- Other

Eligibility criteria for vocational and occupational rehabilitation

Please indicate the eligibility criteria for vocational rehabilitation **services for economically inactive jobseekers with acquired disabilities** that are closest to those in place **in your country** on a scale of 1 to 5 where 1=Not close at all and 5=Exactly the same. Specify NA if the criteria are Not Applicable

- Any person employed or unemployed who is deemed to be able to benefit on the basis of a rehabilitation needs assessment based
- PWDs with permanent consequences of disability and whose prospects of securing, retaining and advancing in employment are substantially reduced.
- Any person not currently receiving a service by another employment service, who has a disability, injury or health condition, is aged between 14 and 65 years and who resides within the catchment area of the vocational rehabilitation service
- Any person at risk of long-term benefit dependency who are considered to be capable of job seeking and who meet residency and benefit eligibility requirements are eligible for employment services, and specialised vocational services

Please indicate the eligibility criteria for occupational rehabilitation (OR) **services for employed people with acquired disabilities** that are closest to those in place **in your country** on a scale of 1 to 5 where 1=Not close at all and 5=Exactly the same. Specify NA if the criteria are Not Applicable

- All salaried employees with a health problem that interferes with their work ability
- People with a work disability according to the pension and disability insurance legislation
- People with work caused (partly or fully) or work aggravated injury or illness
- Anyone who was employed at the time of their injury

Referral sources to vocational rehabilitation services

The most likely sources of signposting and information about **vocational rehabilitation and OR services for employed and unemployed people with acquired disabilities or their families** identified through the review of four jurisdictions are listed below, please indicate, in your opinion, how likely it is that each of these would refer to vocational rehabilitation **in your country**.

- GP or Family Doctor
- Company Occupational Health Service
- HR
- Disability/Injury Management Programme
- Hospital-based Medical Social Worker
- Community-based Social Worker or Nurse
- Insurance Claims Manager
- Rehabilitation Case Manager
- Physiotherapy or OT Professionals
- Public Employment Services Guidance Officers
- Social Security/Welfare Staff
- Medical Social Security Assessment Professionals
- Medical Specialists and Consultants
- Unemployment Centres
- Community Health Centres
- Committee of Socio-Medical Expertise
- Vocational Rehabilitation Services Marketing
- Citizens and Community Information Services
- Disability Specific Organisations
- Disability Equality Organisations
- Public Online Information Sources e.g. Health, Employment, Social Security
- Insurance Company Websites
- Disability NGO Websites
- Vocational Rehabilitation Provider Websites
- Other frequently used (Please Specify below)

Components of vocational rehabilitation

The list of components listed below have been identified in the four jurisdictions reviewed, please indicate which of these, in your opinion, are available to VR or OR service users **in your country** and where departmental responsibility lies.

- Information & Advice about Vocational Rehabilitation
- Case management
- Vocational Assessment
- Guidance & Counselling
- Functional Capacity Evaluation
- Physical/Functional capacity building (Physio, OT etc.)
- Psychological Supports
- Pre Vocational Training
- Specialised Vocational Education/Training
- Job search and placement services
- Work sampling or on the job assessment
- Job/Person matching
- Job Coaching
- Supported Employment
- Social enterprise
- Sheltered Employment
- Reasonable Accommodation
- Assistive technology
- Workplace Adaptations
- Access to adapted transport

Incentives and supports to vocational rehabilitation service users

The types of incentives and supports that were identified during the review of vocational rehabilitation and OR systems in four jurisdictions are listed below, please indicate whether these are available to support people with disabilities participating in **VR or OR to access employment or retain employment in your country** and where departmental responsibility lies.

- Person-focused incentives and supports
- Interpreter services
- Workplace personal assistance
- Advocacy
- Assistance with applications for subsidies or grants
- Equipment grants
- Financial support for commuting to vocational rehabilitation and work
- Additional financial support of people participating in vocational rehabilitation
- Withdrawal of benefits from people who do not participate in vocational rehabilitation

- Flexible benefits for people who enter employment
- Employer focused incentives and supports
- Positive Action (Positive discrimination in favour of job seekers with disabilities)
- Wage subsidies
- Productivity related financial supports
- Employment quotas
- Levies for non-compliance with quotas
- Grants for workplace accommodation
- Disability positive accreditation for good practice employers
- Disability awareness training for staff
- Access to adapted transport

The role of case management in the vocational rehabilitation and OR system

The role of the case manager was important in each of the four jurisdictions studied. Please review the descriptions of the case management role and indicate on a scale of 1 to 5 the extent to which each description resembles the role of the case manager **in your country**, where 1=Completely Different and 5=Exactly the Same. If you do not have case management in your country indicate this below.

- My country does not have a case management role as part of vocational rehabilitation or OR delivery
- The case manager draws up and coordinates an individual rehabilitation plan with each client and, if appropriate, family members, that specifies the need for services and supportive measures with client. The rehabilitation plan covers the necessary rehabilitation measures including services offered by social welfare, labour and educational authorities and other agencies offering vocational rehabilitation. Medical rehabilitation services of health care **must be** coordinated with the rehabilitation arranged by other agencies.
- The case manager advocates, guides and supports the client and liaises with the vocational rehabilitation team, (occupational physician, social worker, psychologist, OT, rehabilitation technologist [trainer]). They coordinate across different legal contexts, maintain contact and collaborate with all stakeholders, work across social structures/ systems and with employers.
- The case manager has a key role in facilitating access to client supports. They coordinate and manage services that are directed towards the client's expressed goals taking into account the assessment of vocational rehabilitation needs and funded by the

vocational rehabilitation systems. These may be provided by other agencies. They may also take an active role in vocational counselling. For services beyond the scope of vocational rehabilitation services, the case manager can support the client through education and emotional support.

- The case manager is a personal/employment advisor “coaching” to support a client to build work readiness, job search or the capacity to return to their original job. Case management is about the wellbeing of the client and return to function including RTW. The case manager needs to work across sectors including health, education, social welfare, housing etc. and across agencies

- A client is referred through the systems via medical practitioners, hospital based allied health staff, welfare and social security system.
- Self-referral to tertiary rehabilitation providers also possible.
- The advice of GPs (family doctors) is important. GPs make referrals to vocational rehabilitation.
- Hospital services advise people who have suffered injuries.
- Direct referral by the person is possible
- Case managers can also be important.

The pathways from medical rehabilitation to vocational rehabilitation or OR

The pathways from medical to vocational or occupation rehabilitation were described in each country study. Please review the descriptions of the pathways identified and indicate on a scale of 1 to 5 the extent to which each description resembles the pathways **in your country**, where 1=Completely Different and 5=Exactly the Same. Where a description is not applicable specify NA.

- For employed persons, the Occupation Health system is key in the assessment of rehabilitation needs.
- The need is detected by Occupational Health Service (OHS) using tools such as workplace surveys, health examinations and absenteeism follow-ups.
- The OHS monitors the work performance of an employee who has become disabled on account of illness or some other impairment and if necessary, to refer him/her for treatment or rehabilitation.
- Personal doctors refer clients to medical rehabilitation programmes inside the Health Care System.
- Medical rehabilitation teams (social workers) advise clients to contact their local ESS for referral to the vocational rehabilitation counsellor (case manager) or advise their GPs to refer them for vocational rehabilitation or OR .
- There is three-tiered system:
- Primary rehabilitation is treatment and medical intervention
- Secondary is inpatient care and outpatient care related.
- Tertiary is community-based intervention, focusing on client life and vocational goals.

Appendix 4: Vocational rehabilitation systems analysis – QLD, NZ, FI & SI

Systems

All jurisdictions had legislation governing the provision of at least two parallel systems of vocational rehabilitation/OR provision

A system operated within the domain of social protection

- QLD: Department of Social Services and of Human Resources
- NZ: Ministry of Social Development
- FI: Ministry of Social Affairs and Health
- SL: Ministry of Labour, Family, Social Affairs and Equal Opportunities

A 'no-fault' insurance based system:

- QLD: WorkerCover – Worker's Compensation – All occupation accidents and diseases
- NZ: Accident Compensation Corporation – All accidents
- FI: Occupational Health System – All health conditions arising amongst the workforce
- SL: Disability and Pensions Institute – Worker's Compensation – All occupation accidents and diseases

Table A4.1. Legal and policy context system 1 – System Descriptors

Country	System name	Legal Basis
QLD	Social Welfare System (Disability Employment Services)	Disability Services Act 1986. The Act refers to Disability Services Standards, with 12 service quality standards and 26 KPIs.
New Zealand	Non-injury related Vocational Rehabilitation (Ministry of Social Development)	
Finland	Support for rehabilitation	Social Insurance Institution's Rehabilitation Benefits Act 15.7.2005/566
Slovenia	Vocational Rehabilitation and employment of persons with disabilities	Vocational rehabilitation and employment of persons with disabilities act (UL RS 16/07 – UPB2, 87/11)

Table A4.2 Legal and policy context system 2 – System Descriptors

Country	System name	Legal Basis
QLD	Insurance-based Systems	Workers' Compensation and Rehabilitation Act 2003 (the Act); Safety, Rehabilitation and Compensation Act 1988
New Zealand	Injury related Vocational Rehabilitation (ACC)	Accident compensation Act
Finland	Occupational Health Services (OHS)	Occupational health services Act 21.12.2001/1383
Slovenia	Occupational rehabilitation	Pension and disability insurance act (UL RS 96/12 – ZPIZ-2).

Definitions of vocational rehabilitation/OR in the domain of labour/social protection

QLD: A process to assist people to make progress towards:

- The open labour market, choosing, getting and keeping a job
- Returning to one's pre-disability job or an alternative.

NZ: Reducing barriers to work in terms of:

- Getting a job for those who are unemployed
- Returning to work for those who have an existing employment contract.

FI: Measures to improve the capacity of people:

- Who are currently in a job to cope with job demands,
- Who are absent to return to work,
- Who are jobseekers to address the barriers faced in gaining employment

SL: Services to assist a person to:

- Prepare for appropriate work (open, supported or sheltered work)
- Gain employment
- Remain in a current job
- Make progress in a career or to change career

**Table A4.3 Legal and policy context system 1 -
Definitions of Vocational Rehabilitation**

QLD	Vocational Rehabilitation is the process by which people with disabilities are assisted to improve their opportunities for employment so they can achieve greater social inclusion, usually through gaining employment in the 'open' labour market with remuneration at standard award rates
NZ	'Loosely' defined in NZ as the support, assistance and/or intervention required to assist people to attain a job or return to work when a health condition or impairment makes this difficult
FI	People in working life whose work capacity has deteriorated/is at risk of deteriorating over the next few years. The purpose of Vocational Rehabilitation may be to: <ul style="list-style-type: none"> ● improve person's capacity for work so as to help them cope with work demands ● help them overcome an impairment and enter working life ● help them return to work after a lengthy absence
SL	NA

**Table A4.4 Legal and policy context system 2 -
Definitions of Vocational Rehabilitation**

QLD	The process by which an injured employee's functioning is maximised and/or a safe and early return-to-work is achieved
NZ	The purpose of vocational rehabilitation is to help a claimant to, as appropriate, (a) maintain employment; or (b) obtain employment; or (c) regain or acquire vocational independence
FI	Maintenance and promotion of the employees' work ability, return to work and rehabilitation (secondary & tertiary prevention)
SL	NA

**Table A4.5 Legal and policy context system 1 – System
Actors**

	Govt. Department and agency Responsible	Type of Service Providers
QLD	Australian Federal government Department of Social Services and Department of Human Services	Public and Private. Most clients (up to 2/3) were with CRS Australia (Commonwealth Rehabilitation Service). The last budget announced that CRS operations would cease after February 2015. The work will go to successful tenderers from the private and non-profit sector.
NZ	Work and Income is a directorate within the Ministry of Social Development (MSD).	Ministries, community based organisations, private suppliers, general mainstream service providers
FI	Ministry of Social Affairs and Health The Social Insurance Institute (SII)	Private and Not-for-Profit Service Providers
SL	Ministry of labour, family, social affairs and equal opportunities:	Public, private, not-for-profit

Table A4.6 Legal and policy context system 2 – System Actors

	Govt. Department and agency Responsible	Type of Service Providers
QLD	WorkCover QLD <ul style="list-style-type: none"> Queensland State Government The Department of Justice and the Attorney-General Comcare <ul style="list-style-type: none"> Australian Federal Government Department of Employment CTP <ul style="list-style-type: none"> Queensland State Government Office of Queensland Treasury and Trade More private sector insurance cover	Public and Private Providers
NZ	The Accident Compensation Corporation (ACC) is a separate Crown Entity	Public and private
FI	Ministry of Social Affairs and Health	Public and private
FI	Ministry of labour, family, social affairs and equal opportunities:	Public – Pension and disability insurance

Target groups and eligibility

QLD: any person of working age with a disability or health condition who is considered by the Disability Employment Service (DES) to need assistance to overcome barriers or interventions to build their strengths

NZ: People with disabilities or health problems which result in impairment and who require support, assistance or interventions to either get or retain a job

FI: Job seekers with disabilities, workers with reduced capacities and workers who are considered to be at risk of a deterioration in work capacity within a year or two

SI: Those considered to be disabled according to disability legislation whether are a result of a congenital or acquired condition.

Additional eligibility criteria included:

- Employment Service Assessment and a Job Capacity Assessment (QLD) (See Figure A3.2)
- Medical and Social Assessment of the risk of long-term benefits dependency (NZ)
- Multi-disciplinary Assessment of potential to benefit from Vocational Rehabilitation/OR (FI)
- Assessment of disability status and need for Vocational Rehabilitation/OR (SI)

Table A4.7 Legal and policy context system 1 – beneficiaries per annum

QLD	On 30 June 2012, the DES caseload numbered 148,327 participants, about equally divided between DMS and ESS.
NZ	Vocational Rehabilitation services - c. 20,000, mainstream employment, c. 300; general employment services also
FI	Vocational Rehabilitation of person with impaired work capacity - 13 385 beneficiaries (2013); Rehabilitative psychotherapy 22 561 beneficiaries; Discretionary rehabilitation 41 199 beneficiaries
SI	Average 1833 for 2010 – 2013 – referred from the ESS; Average 200 for 2010 – 2013 - referrals from the PDI

Table A4.8 Legal and policy context system 2 – beneficiaries per annum

QLD	<ul style="list-style-type: none"> • WorkCover QLD - 82 573 statutory claims, and 3729 common law claims • Comcare accepted 6278 claims, a reported 10% decrease from the previous year. This amounts to 16.3 claims accepted per 1000 FTE employees. • CTP - There were 4522 CTP claims lodged, a significant decrease from previous years. (2013-2014 financial year)
NZ	2013/14 year, 32,000 clients
FI	878,943 employees' or self-employed persons'
SI	367 in 2013

Table A4.9 Legal and policy context system 1 - Target group description

QLD	People with disability attributable to an intellectual, psychiatric, sensory or physical impairment, or a combination, which results in substantially reduced capacity. Also, people with permanent disability who need ongoing support services are a distinct sub-group
NZ	Clients with a disability who are eligible for jobseeker benefit are a target group for employment services. Some limits on this - The service is expected to be an appropriate option to address an individual need. Individual eligibility criteria are also specified for particular kinds of assistance
FI	Vocational Rehabilitation is aimed at people entering or already in working life whose work capacity has deteriorated or is at risk of deteriorating over the next few years.
SI	Unemployed persons with disabilities.

Table A4.10 Legal and policy context system 2 - Target group description

QLD	WorkCover QLD holds accident insurance contracts with over 150 000 employers, amounting to 1,935,800 employees as of 2013; Comcare insures 357,794 FTE employees as of 2014; all motor vehicle drivers; life insurers
NZ	People who have suffered personal injury for which he or she has cover; and is (i) entitled to weekly compensation; or ii) likely, unless he or she has vocational rehabilitation, to be entitled to weekly compensation; or iii) on parental leave"
FI	Coverage of OHS: 92 % of salaried employees'.
SI	Disabled workers with remaining work capacity

Table A4.11 Legal and policy context system 1 - Eligibility Criteria

QLD	Relevant criteria are: Not currently serviced by another DES provider or Employment Service, Have disability, injury or health condition; Aged between 14 and 65 years; Reside in the Employment Services Area or have a note recommending referral to DES
NZ	Clients at risk of long-term benefit dependency. Residency, benefit eligibility requirements and some individual criteria also apply. People on Supported Living Payment (who do not have work obligations) are eligible for employment services, and specialised vocational services target this group too. Where assessments state no expectation of job seeking, there is no entitlement to Vocational Rehabilitation
FI	Rehabilitation needs assessment based
SI	PWDs need to have been defined under the legislation and regulations, to have permanent consequences of disability and whose prospects of securing, retaining and advancing in employment are substantially reduced.

Table A4.12 Legal and policy context system 2 - Eligibility Criteria

QLD	Work caused (partly or fully) or work aggravated injury or illness
NZ	Complex! Anyone who meets the target group description is eligible – but within this – for each person there is an individual decision. Those not in work at the time of their injury are NOT eligible for Vocational Rehabilitation
FI	Salaried Employees
SI	People with a work disability according to the Pension and disability insurance act and entitlement to certain rights.

Activities and components

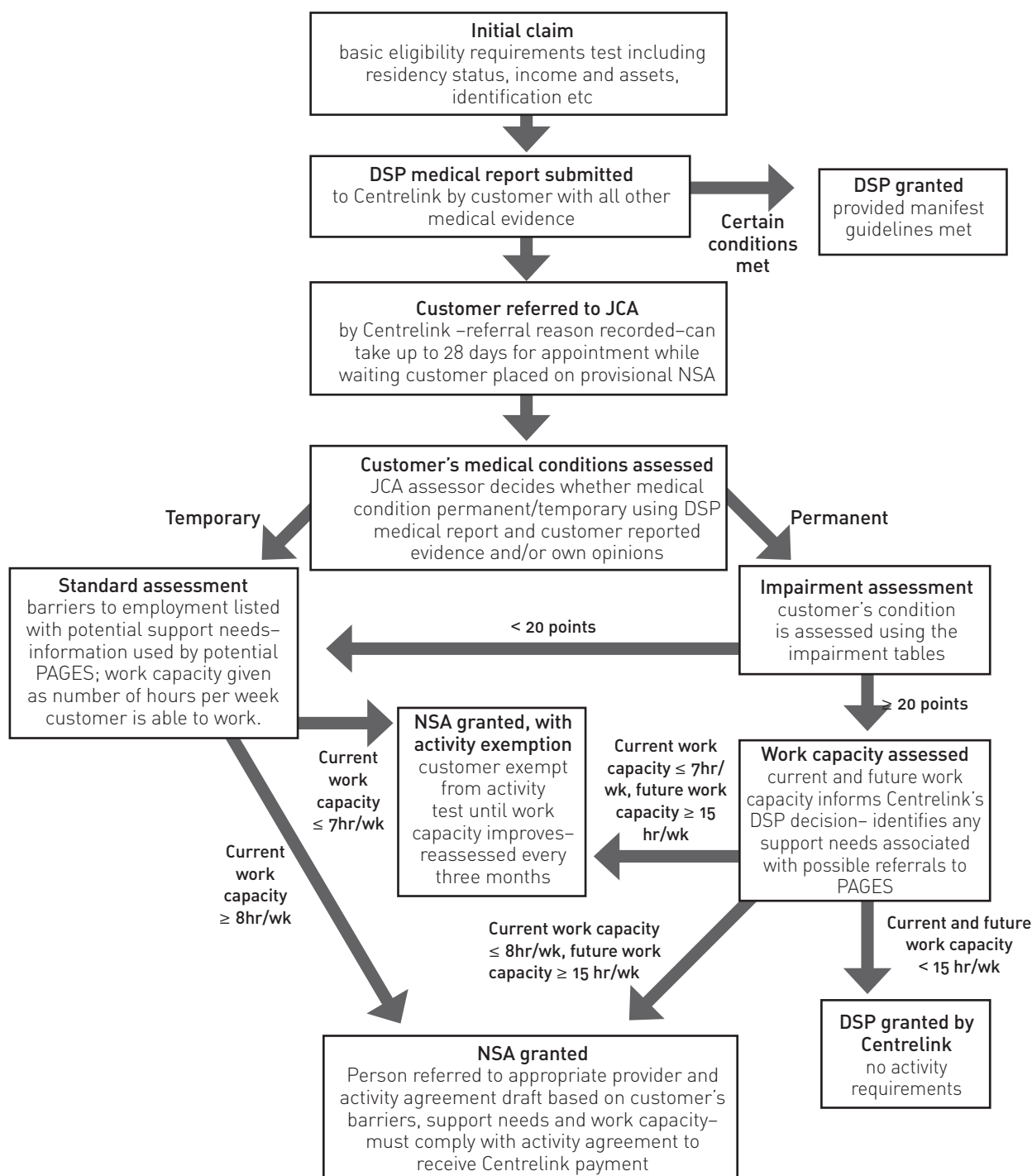
Table A4.13 Services and Activities Available

Services Offered		Aus	NZ	FI	SI
Information & Advice about VR					
Case management					
Vocational Assessment					
Guidance & Counselling					
Functional Capacity Evaluation					
Physical/Functional capacity building					
Psychological Supports					
Pre Vocational Training					
Specialised Vocational Education/Training					
Job search and placement services					
Work sampling or on the job assessment					
Job/Person matching					
Job Coaching					
Supported Employment					
Social enterprise					
Sheltered Employment					
Reasonable Accommodation					
Assistive technology					
Workplace Adaptations					
Access to adapted transport					
Other elements not listed above					
Present		Absent			

Figure A4.1 Activities and Components of Vocational Rehabilitation

Queensland	New Zealand	Finland	Slovenia
Department of Social Services and Department of Human Service	Ministry of Social Development	Ministry of Social Affairs and Health	Ministry of Labour, Family, Social Affairs and Equal Opportunities
Centrelink The Benefits Agency Disability Employment Services	Work and Income Department Vocational Service for People with Disabilities	Social Insurance Institute (KELA)	Employment Service of Slovenia Rehabilitation Committee
Assessment of Job Capacity, Rehabilitation and Employment Needs and Strengths	Assessment of Job Capacity, Rehabilitation and Employment Needs and Strengths	Assessment of Job Capacity, Rehabilitation and Employment Needs and Strengths	Assessment of Job Capacity, Rehabilitation and Employment Needs and Strengths
Individual Rehabilitation Planning, Case Management and Service Coordination	Individual Rehabilitation Planning, Case Management and Service Coordination	Individual Rehabilitation Planning, Case Management and Service Coordination	Individual Rehabilitation Planning, Case Management and Service Coordination
Job Retention and Return to Work Services	Counselling, Guidance and Rehabilitation Psychotherapy	Counselling, Guidance and Rehabilitation Psychotherapy	Counselling, Guidance and Rehabilitation Psychotherapy
Mainstream Employment Services	Mainstream Employment Services	Job Seeking and Career Coaching, Skills and Support	Job Seeking and Career Coaching, Skills and Support
Interventions to Maximise Employability	Job Seeking and Career Coaching, Skills and Support	Education and Training	Work Preparation and Social Skills Development
Follow Up, Monitoring, Support and Evaluation	Work Preparation and Social Skills Development	Work based Assessment and Trials	On the Job and Self Employment Coaching and Supported Employment
	On the Job and Self Employment Coaching and Supported Employment	Employment and Rehabilitation Subsidies and Supports	Education and Training
	Employment and Rehabilitation Subsidies and Supports	Workplace Adaptations, Assistive AT and Subsidies	Work based Assessment and Trials
	Workplace Adaptations, Assistive AT and Subsidies		
Employment Assistance/VR Phase: 6-24 Months Post Placement Support: 6 Months Ongoing Support	Up to 36 Months	12 – 36 Months	24 Months
Public Sector Provider Private for Profit Providers Non-Profit Providers	Community Based Organisations	Private For Profit Providers Non-Profit Providers	Public Sector Provider Private For Profit Providers Non-Profit Providers

Figure A4.2 Job Capacity Assessment Process (Australia)



Incentives and supports

Table A4.14 Incentives and Supports to Encourage Positive Vocational Rehabilitation Outcomes

Person focused incentives and supports				QLD	NZ	FI	SI
Interpreter services							
Workplace personal assistance							
Advocacy							
Assistance with applications for subsidies or grants							
Equipment grants							
Financial support for commuting to Vocational Rehabilitation and work							
Additional financial support of people participating in Vocational Rehabilitation							
Withdrawal of benefits from people who do not participate in Vocational Rehabilitation							
Flexible benefits for people with disabilities who enter employment							
Other person focused incentives							
Employer focused incentives and supports				QLD	NZ	FI	SI
Positive Action							
Wage subsidies							
Productivity related financial supports							
Employment quotas							
Levies for non-compliance with quotas							
Grants for workplace accommodation							
Disability positive accreditation for good practice employers							
Disability Awareness Training for staff							
Other employer focused incentives							
Provider focused incentives				QLD	NZ	FI	SI
Outcome related financing							
Other provider focused incentives							
Frequently		Occasionally		Not Identified			

Referral and information sources

Table A4.15 Referral & Information Sources for Vocational Rehabilitation Services

						QLD	NZ	FI	SI
GP or Family Doctor									
Company Occupational Health Service									
HR									
Disability/Injury Management Programme									
Hospital-based Medical Social Worker									
Community-based Social Worker or Nurse									
Insurance Claims Manager									
Rehabilitation Case Manager									
Physiotherapy or OT Professionals									
Public Employment Services Guidance Officers									
Social Security/Welfare Staff									
Medical Social Security Assessment Professionals									
Medical Specialists and Consultants									
Unemployment Centres									
Community Health Centres									
Committee of Socio-Medical Expertise									
Vocational Rehabilitation Services Marketing									
Citizens and Community Information Services									
Disability Specific Organisations									
Disability Equality Organisations									
Public Online Information Sources									
Insurance Company Websites									
Disability NGO Websites									
Vocational Rehabilitation Provider Websites									
Frequently		Occasionally		Rarely		Does not exist			

Impact Indicators

QLD:

- Improved access to services
- Meeting the training needs of participants and employers
- Service effectiveness (drop outs and employment outcomes etc.)
- Timely and efficient services

NZ:

- Services cost and effectiveness
- User satisfaction
- Reduced long-term welfare dependency
- Reduced future liability of the benefits system

FI:

- Longer and better careers
- Reduce sickness absence
- Exits from the labour market to unemployment and early retirement on health grounds

SI:

- Referrals
- Employment outcomes
- User satisfaction
- QOL impact
- Collaboration with employers
- Stakeholder satisfaction

Table A4.16 Legal and policy context system 1 - Outcome indicators

QLD	<p>Improved access to services</p> <p>Equitable access</p> <p>Meet the training and skills needs of participants and employers (education outcomes)</p> <p>More effective services (employment placement and sustainable employment outcomes)</p> <p>More timely and efficient services</p>
NZ	<p>Reducing long-term welfare dependency</p> <p>Reduction in future liability of the benefit system</p> <p>More young people in education, training or work-based learning</p> <p>RTW</p> <p>Sustained RTW</p> <p>Liability claim numbers</p> <p>Claim costs</p> <p>Satisfaction</p>
FI	<p>Longer and better working careers;</p> <p>Number of sickness absences/ employee;</p> <p>Number of early retired persons</p>
Si	<p>Number of referrals and inclusions</p> <p>Status of persons after vocational rehabilitation:</p> <p>Outcomes in different types of employment</p> <p>Participation in active employment policy measures</p> <p>Unemployment</p> <p>Non-employability</p> <p>Other: discontinuation (personal, health, motivational reasons)</p> <p>Collaboration with employers</p> <p>Service users' satisfaction with vocational rehabilitation</p> <p>Impact of vocational rehabilitation on quality of life of service users</p> <p>Service providers' satisfaction</p> <p>Referral organisations' satisfaction</p>

Table A4.17 Key indicators of participant outcomes in disability employment services in Australia

Programme objective	Key Indicator	DEN/VRS ¹⁷⁵ 2006-2010	DES 2010-2013
Improved access to disability employment services	Average referrals per month	10,871	10,061
	Average commencements per month	6,972	7,917
	Proportion of referrals that result in the participant commencing in the recommended programme	VRS: 75% DEN: 59%	DMS: 77% ESS: 70%
	Programme participants as a proportion of estimated target population	35%	42%
Participants receive skills development and skills transfer	Proportion of participants who received training and skills development from or through their DES provider (PPM survey)	N/A	DMS: 77% ESS: 82%
	Proportion of participants satisfied with the training and skills development provided by their DES provider (PPM survey)	N/A	DMS: 58% ESS: 55%
More effective services	Proportion of participants who obtain employment within 18 months of commencing service (Job Placement rate)	VRS: 34.8% DEN: 40.5%	DMS: 40.7% ESS: 40.1%
	Proportion of participants who are employed for at least 6 months, within 18 months of commencing service (26 Week Employment Outcome rate)	VRS: 7.2% DEN: 24.4%	DMS: 23.0% ESS: 22.0%
	Proportion of participants who are employed 3 months after end of Employment Assistance/Post Placement Support (PPM survey)	VRS: 32% DEN: Not collected	DMS: 42% ESS: 37%
	Proportion of participants who are employed 3 months after exit from Ongoing Support (PPM survey)	VRS: Not applicable DEN: Not collected	DMS-OS: 79% ESS-OS: 68% All OS: 71%
	Proportion of DEN participants employed when surveyed (PPM survey)(b)	DEN: 39%	N/A
	Proportion of employed participants who would like to work more hours (Dynamics of Australian Income Support and Employment Services Survey)	VRS: 43% DEN: 41%	DMS: 40% ESS: 41%
	Participant satisfaction with services (PPM survey)		
	(a) 12 months in Employment Assistance/Post Placement Support	Data not comparable	(a) 78%
	(b) Exited from Employment Assistance/Post Placement Support		(b) 74%
	(c) Exited from Ongoing Support		(c) 80%
	Service-related attrition—exits attributable to dissatisfaction with service	5%	5%
	Level of employer acceptance of services (percentage of employers who rate service as good or very good)	N/A	75%

¹⁷⁵ VRS (Vocational Rehabilitation Service) is targeted at the same beneficiaries as the current DMS (Disability Management Service). DEN (Disability Employment Network) is targeted at the same types of beneficiaries as the current ESS (Employment Support Service)

More timely and efficient services	Proportion of referrals that result in service commencement within 4 weeks of referral	86%	78%
	Median days between first job placement and 26 Week Employment Outcome	VRS: 174 DEN: 189	DMS: 178 ESS: 178
	Median number of days to exit as independent worker	VRS: 315 DEN: 423	DMS: 359 ESS: 384
	Mean number of employers per 26 Week Employment Outcome	VRS: 1.19 DEN: 1.56	DMS: 1.35 ESS: 1.35
	Mean expenditure (programme payments) per 26 Week Employment Outcome	VRS: \$33,000 DEN: \$30,500	DMS: \$27,500 ESS: \$33,500
	Per cent of DES provider sites that reported reduced administrative load under DES		8%

Source: Adapted from Evaluation of Disability Employment Services 2010–2013: Final report (Department of Social Services 2014, pp. iv – v)

The role of case management

QLD:

- Case managers have a key role in facilitating access to client supports.
- They coordinate and manage qualifying services, which may be provided by other agencies. Services are directed towards the client's expressed goals and financially compensated by the scheme.
- May also take an active role in vocational counselling
- The level of assistance provided is determined by the assessed/agreed need.
- For services beyond the scope of the scheme/provider, the case manager can support the client through education and emotional support.

NZ:

- MSD case management is a personal/employment advisor "coaching" to support a client to build work readiness and jobsearch.
- ACC and MSD have case management systems that emphasise wellbeing, return to function including RTW.
- Growing recognition of need for cross sector working from health, education, social welfare, housing etc and across ACC and MSD.

FI:

- An individual rehabilitation plan is drawn up for each client to assess need for services and supportive measures.
- The rehabilitation plan must be drawn up together with client and, if needed, family members.

- The rehabilitation plan defines, inter alia, the necessary rehabilitation measures taking account the services offered by social welfare, labour and educational authorities and the KELA and other agencies arranging rehabilitation.
- The medical rehabilitation services of health care must be coordinated with the rehabilitation arranged by other agencies.

SI:

- When referred to vocational rehabilitation by ESS, clients are advocated, guided and supported by the vocational rehabilitation team, (occupational physician, social worker, psychologist, OT, rehabilitation technologist (trainer))
- The team coordinates different legal contexts, contacts and collaborates with all stakeholders - social structures/ systems, employers, including provision of support after employment.
- PDI clients are referred to vocational rehabilitation only for assessment of their functioning and individual OR plan development. This plan is then implemented by the PDI case managers.

Move from health services to medical rehabilitation to vocational rehabilitation

QLD:

- Three-tiered system
- Primary rehabilitation is treatment and medical intervention

- Secondary is inpatient care and outpatient care related.
- Tertiary is community-based intervention, focusing on client life and vocational goals.
- A client is referred through the systems via medical practitioners, hospital based allied health staff, welfare and social security system.
- Self-referral to tertiary rehabilitation providers also possible.

NZ:

- Raising awareness amongst GPs has been needed.
- Works smoothly depending on bed availability and for people with injuries.
- Less so for illnesses
- GPs make referrals to vocational rehabilitation.
- New trials taking place on direct referral.
- Case managers are also involved.
- For sickness, early intervention is just getting started.

FI:

- For employed persons, the OH system is key in the assessment of rehabilitation needs.
- The need is detected by OHS using tools such as workplace surveys, health examinations and absenteeism follow-ups.
- OHS monitor the work performance of an employee who has become disabled on account of illness or some other impairment and if necessary, refer them for treatment or rehabilitation.

SI:

- Personal doctors refer clients to medical rehabilitation programmes inside the Health Care System.
- Medical rehabilitation teams (social workers) advise clients to contact their local ESS for referral to the vocational rehabilitation counsellor or advise their GPs to refer them to PDI for OR .

Quality systems

QLD:

- Legal requirement to meet 12 service quality standards supported by 26 key performance indicators based on independent Audit
- Quality Strategy for Disability Employment and Rehabilitation Services
 - Rights
 - Participation and Inclusion
 - Individual Outcomes
 - Feedback and Complaints

- Services Access
- Service Management

NZ:

- Quality assurance through tendering

FI:

- KELA sets standards for service providers

SI:

- European Quality in Social Services Initiative (EQUASS)
 - Leadership
 - Staff
 - Rights
 - Ethics
 - Partnership
 - Participation
 - Person-centred
 - Comprehensiveness
 - Results orientation
 - Continuous Improvement

Training and education of staff

QLD:

- Rehab Counselling , Allied Health or Human Services qualification and membership of an association of rehabilitation professionals
- Continuing education including course offered by the Personal Injury Education Foundation

NZ:

- Rehab specific qualification are less common
- PG qualifications in case management, vocational rehabilitation or occupational medicine

FI:

- Wide range of qualifications with systematic programme of continuing basic and advanced education

SI:

- Occupational medicine, psychology, social work, occupational therapy and training specialists
- At least 2 days of CPD per annum

Funding and costs

Most vocational rehabilitation costs are covered out of general taxation or compensation insurance except for:

- Slovenia providers must generate 10% of their income from other sources
- Finland - 55% of vocational rehabilitation costs are funded through employer contributions
- Queensland has case-based funding where the service provider receives fees for participants on case-by-case basis, depending on the outcomes achieved.

Comparative costs are difficult to calculate due to:

- Availability of comparable statistics
- Differences in service levels
- Differences in the demography of jurisdictions
- Differences in costs of services
- Differences in eligibility and incidence

Table A4.18 Legal and policy context system 1 – System Financing

	System financing	Annual Budget/ Expenditure on Vocational Rehabilitation
QLD	General taxation, except where disability is compensable. Case-based funding in employment services.	The Government will provide \$8.5 million over two years for a partial tender for the Disability Management Services component of Disability Employment Services
NZ	MSD services are funded by general taxation	Expenditure for Vocational Services for People with disabilities - \$88.3m in 2013/14 year; Expenditure for Mainstream employment - \$3.5m; Expenditure for PATHS - \$3.5m
FI	Social insurance Institution: - employers and employees 55 % of funding as a part of taxation; - state 45 % of funding (ß general taxation)	Vocational rehabilitation of person with impaired work capacity €27.9m (2013); Rehabilitative psychotherapy €35.1m; Discretionary rehabilitation €80.3
SI	Employment service of Slovenia (ESS). Small proportion is financed from the Pension and disability institute (PDI). Some vocational rehabilitation services are financed by private stakeholders	For referrals from the ESS in 2012: €6.3m; From PDI in 2012: up to €85,000

Table A4.19 Legal and policy context system 2 – System Financing

	System financing	Annual Budget/ Expenditure on Vocational Rehabilitation
QLD	WorkCover QLD - self-funded by a employer premiums and investment return. Comcare - funded by a premiums, government funding/grants and investment return. CTP - funded by premiums paid by car owner	WorkCover \$469m; Comcare \$507m;
NZ	Specific employer and employee levies, and motor vehicle levies	\$59m on vocational rehabilitation
FI	Financed by employers. Kela compensates part of the expenses to the employer if they are necessary and reasonable.	€599 million (€324/employee)
SI	Public – Pension and disability insurance:	€2,600,000X (2013 PDI annual report)

Table A4.20 Costs description

Contextual factors	QLD	Finland	Slovenia	New Zealand
Population (millions)	4.7	5.3	2.0	4.5
GDP per capita ¹⁷⁶ 2014	\$64,429	\$49,214	\$24,019	\$41,490
Median age (years) ¹⁷⁷	38.3	43.2	43.5	37.6
Cost information	WorkCover QLD employs approximately 730 FTE employees who service approximately 1.9m employees. The annual report 2013-2014 gives employee benefits as costing \$13,844,000.	Vocational rehabilitation services for persons with impaired work capacity €27,888,000 ; Medical rehabilitation services for the severely disabled €148,260 000; Rehabilitative psychotherapy €35,137,000 ; Discretionary rehabilitation €80,301,000	Total annual costs Vocational rehabilitation: €6,432,971 (2012); Working age population (2014): €922,325; Total annual costs OR: €2,600,000 (2013);	Not available
Labour force	2.5m	2.7m	0.9m	2.4m
Beneficiaries	148,000	77,000	1,800	20,000
% beneficiaries in Labour force	5.9%	2.9%	0.2%	0.8%
Average cost	Aus\$18,965 per staff member	Annual cost - €53 per member of the labour force (excluding severely disabled rehabilitation costs)	Annual cost - €7 per member of the labour force (vocational rehabilitation), €2.8 per capita for OR	NA

Perspectives on good practice in vocational rehabilitation systems and services

- Focus on service quality
- Staff development
- Early intervention
- Service user participation
- Comprehensive coverage
- Stakeholder collaboration
- Continuum of support

Specific recommendations

QLD:

- Independent quality assurance for services
- The publication of good practice guidelines for services and staff
- Finding ways to intervene early to prevent job loss and reduce the impact of impairments
- Developing digital access to services

- The contribution of professional associations to improvements in practices
- Training and accreditation for case managers

NZ:

- The profiling of clients' needs and strengths are a starting point for interventions
- Responding to employers as direct customers of the services
- Actively involving service users in developing their own plans and in evaluating services
- Ensuring that the system works equally well for people who develop impairments as a result of illness as it does for people with injuries
- Enabling the involvement of all stakeholders in the design, development and governance of the vocational rehabilitation process
- Focusing on the return on investment that vocational rehabilitation can create in terms of reduced future liability and individual quality of life

¹⁷⁶ <http://countryeconomy.com/gdp>

¹⁷⁷ <http://world.bymap.org/MedianAge.html>

FI:

- Viewing prevention as a continuum of interventions ranging from primary health and safety to tertiary vocational rehabilitation
- Linking vocational rehabilitation to occupational health care services
- Making service available in all locations, to all citizens and through multiple channels
- Finding ways to intervene early to prevent job loss and reduce the impact of impairments

SI:

- Balancing regulation and standards with efficient administration
- Finding ways to incentivise employers to recruit and retain people with disabilities Building collaboration with employer organisations
- Providing for the possibility that people will need follow up supports even after placement. Working with employers to create on-the-job training opportunities
- Financing workplace adaptations and supports
- Taking a multidisciplinary team approach to planning and implementation
- Creating a national system of provisions that guarantees everyone can access it
- A legal basis for eligibility for vocational rehabilitation

Appendix 5: Briefing note on employment supports for people with disabilities

Provided by Illness and Disability Policy Section,
Department of Social Protection, May 2015

Overview

- People with disabilities are a priority for the Department of Social Protection (DSP). Over recent years the level of income and employment supports for people with disabilities have been largely maintained, despite the fiscal challenges facing the State during this period.
- Budget 2015 provides for an estimated expenditure of €3.39 billion on the illness, disability & carers programme. This represents 17.5% of total Departmental expenditure in 2015.
- The Department also provides a wide range of income and work related supports for people with disabilities, which plays an important role in supporting increased participation in the labour force by people with disabilities. These include the Wage Subsidy Scheme and a supported employment programme (EmployAbility).
- The challenge is now to improve on these programmes for people with disabilities by focusing on ability rather than disability and to enhance their potential and achieve greater independence through education, training and employment.
- The Department is contributing to the implementation of the Comprehensive Employment Strategy for People with Disabilities,
- The WSS provides financial incentives to private sector employers to hire people with a disability for between 21 and 39 hours per week under a contract of employment.
- The basic subsidy rate is €5.30 per hour and the subsidy is incentivised under three strands, based on the number of employees with a disability engaged. The employer can benefit from one or all, simultaneously depending on the number of employees with a disability recruited by the employer under the scheme.
- **Strand I** - is a general subsidy for any perceived productivity shortfall in excess of 20% for a person with a disability, in comparison a peer who does not have a disability. An employee must work a minimum of 21 hours per week up to a maximum of 39 hours per week. The rate of subsidy is €5.30 per hour and is based on the number of hours worked, giving a total annual subsidy available of €10,748 per annum based on 39 hour week.
- **Strand II** - is based on the total number of employees with a disability in a company, an employer can apply for a grant to cover additional costs ranging from an additional 10% for 3-6 employees to a maximum of 50% of the wage subsidy for 23+ employees with a disability. Strand II grants are intended to cover the additional supervisory, management and other work based costs which may derive from the firm's decision to specifically employ more than two people who have a disability.
- **Strand III** - is where 30 or more people with a disability are employed, employers can avail of a grant of €30,000 per annum to assist with the cost of employing an Employment Assistance Officer. (This is calculated on cohorts of 30 employees and not on a pro-rata basis).

Wage subsidy scheme

- The Wage Subsidy Scheme (WSS) is a DSP employment support to the private sector for the employment of people with disabilities. The purpose of this demand - led programme is to increase the numbers of people with disabilities participating in the open labour market.
- Responsibility for WSS transferred from FÁS to the Department of Social Protection in January 2012.
- In 2014 some 1,550 employees were being supported through this programme at a cost of €12.6 million.

Disability Activation Project (DACT)

- The Disability Activation Project (DACT) was a set of pilot projects that sought to explore a variety of routes towards ensuring that people with disabilities were enabled to avail of progression, education and development opportunities within the world of work.

- The project was jointly funded by the European Social Fund and Department of Social Protection. The total budget was €7.13 million with 50% of all costs being met by the DSP and 50% by the ESF.
- There were 14 projects funded under DACT, all located in the Border, Midlands & West region). The project came to an end on 30 April 2015.
- The strategic aim of the Disability Activation Project was to increase the capacity and potential of people on disability/illness welfare payments to participate in the labour market, based on a case management approach.
- The objectives of the Project were to:
 - Focus on capability to work in respect of Social Welfare Customers on a disability/illness payment. Such capabilities will be identified, developed and formalised leading to a personalised progression plan for each individual participating in the project.
 - Develop and implement innovative models of activation involving a case-management approach which are designed to meet gaps in employment, pre-employment or progression programme provision for people with a disability.
 - Work with and/or support employers to develop initiatives to enhance people with a disability entry to, or retention in the workforce.
 - Support the progression of young people with a disability.
 - Support the progression and retention of people with an acquired disability.
- The Disability Activation Project was organised around four separate strands, all with similar eligibility and selection criteria but each having its own key focus.
 - **Strand 1 Improving Access to Employment**
 - Aim: To provide people with a disability with the appropriate progression, education and development opportunities to enhance their access to employment.
 - **Strand 2 Progression Programmes for Young People**
 - Aim: To support the development and delivery of customised progression programmes for young people with a disability.
 - **Strand 3 Support the Progression and Retention of People with an Acquired Disability**
 - Aim: To support the progression and retention of people with an acquired disability.

○ **Strand 4 Innovative Employer Initiatives**

- Aim: To support employers in the recruitment and retention of people with a disability in employment.

EmployAbility service

- The EmployAbility service (formerly known as the Supported Employment Programme) is a national employment service dedicated to improving employment outcomes for job seekers with a disability. It is based on the ethos that participation in employment can be achieved by people with a disability when they are able to avail of individualised supports that are based on their choices and preferences.
- The service was originally established in 2000 (under the aegis of FAS). Responsibility for the programme transferred to the Department of Social Protection in 2012. The service currently comprises 23 limited companies, each with a specific geographical remit and each fully funded by the Department of Social Protection. Budget 2015 provides €9.6 million to run the service.
- The three main aims of the service are:
 - Facilitate the integration of people with disabilities into paid employment in the open labour market;
 - Provide supports to assist with this integration process; and
 - Meet the requirements of employers.
- EmployAbility participants are people with disability who are “job ready” (typically able to work a minimum of 8 hours per week and motivated to work) and need the support of a Job Coach to obtain employment in the open labour market. The service is open to people between the ages of 18 to 65 years. The duration of the service is 18 months, but clients may re-engage in the service at any time, in line with their Individual Employment Plan.
- In December 2014, some 2,936 people were availing of the service, 910 of whom were in employment with supports and 194 of whom were in work experience.
- In light of the importance of this service, and in the context of a forthcoming Comprehensive Employment Strategy for People with Disabilities, a comprehensive review of the programme is currently being carried out by Indecon International Economic Consultants.
- The focus of the review is on the effectiveness and efficiency of the service in the context of the transfer of responsibility from FAS to the Department of Social Protection since 2012 and also in the context of the strategic development of a more focused and

integrated activation service in this Department in recent years.

- The review will seek to present proposals for the future delivery of the service, having regard to the level of demand for supported employment services; and the type of service required to effectively meet that demand.

Employment supports for people with disabilities

- The DSP has the responsibility for providing labour market services for disabled people, assisting them with finding paid employment or preparing them for employment through a training or employment programme. The Employment Support programmes are demand-led schemes in that the applicant applies directly to DSP for these grants.
- Expenditure on Employment Supports for People with Disabilities in 2014 was €0.34 million.
- The Reasonable Accommodation Fund assists employers to take appropriate measures to enable a person with a disability/impairment to have access to employment by providing a range of grants. These grants and supports include:
 - Workplace Equipment/Adaptation Grant,
 - the Personal Reader Grant,
 - the Job Interview Interpreter Grant, and
 - the Employee Retention Grant]
- The Disability Awareness Training Support Scheme provides funding so that employers can buy in Disability Awareness Training for their staff. The purpose of the training is to deliver clear and accurate information about disability and to address questions or concerns that employers and employees may have about working with people with disabilities.

Community employment

- Community Employment (CE) is an active labour market programme/intervention designed to provide eligible long-term unemployed people and other disadvantaged persons (including people with a disability) with an opportunity to engage in useful part-time work within their communities on a temporary, fixed-term basis. The Community Employment Programme has two options (strands):
- Part Time Integration Option (PTI), 1-year version of CE for those who have been in receipt of qualifying social welfare payments for 12 months or more.
 - Part Time Job Option (PTJ), 3-year version of CE,

(annually renewable contracts) for those who have been in receipt of qualifying social welfare payments for 3 years or more.

- Persons aged 18 years or over (35+ for PTJ) and are currently in receipt of any of the following payments from the Department of Social Protection (DSP):
 - Disability Allowance (DA);
 - Blind Pension (BP);
 - Invalidity Pension (IP);
 - Illness Benefit (IB) for 6 months or more.
- In December 2014 there were 1,817 people on CE schemes who had been in receipt of an illness or disability income support payment before they started on the scheme.

Income supports for people with disabilities

Disability Allowance.

- Disability Allowance is a means-tested payment for people with a specified disability whose income falls below certain limits and who are aged between 16 and are under 66. To qualify for a Disability Allowance a person must:
 - be substantially restricted in undertaking suitable employment arising from a medical assessment or examination of the person's disability;
 - be aged between 16 and under 66;
 - satisfy a means test;
 - be habitually resident in the State
- A person who is in receipt of Disability Allowance may take up employment of a rehabilitative nature. The first €120 of weekly earnings is disregarded in means test for the payment while earnings between €120 and €350 are assessed at 50%.

Blind Pension

- The Blind Pension is a means-tested payment paid to blind and visually impaired people who are habitually resident in Ireland. To qualify for the Pension a person's visual impairment must be certified by an ophthalmic surgeon.
- A person in receipt of a Blind Pension can earn €120 per week from rehabilitative employment. Earnings between €120 and €350 are assessed at a rate of 50%.

Illness Benefit

- Illness Benefit is a payment made to insured people who are unable to work due to illness and who satisfy

certain PRSI contribution conditions. To qualify for Illness Benefit a person must:

- Be unable to work due to illness.
- Be under the pensionable age (currently 66).
- Satisfy the contribution conditions.
- Illness Benefit is paid for a maximum of:
 - 2 years (624 payment days) to those who have at least 260 weeks reckonable social insurance contributions, or
 - 1 year (312 payment days) to those who have between 104 and 259 weeks reckonable social insurance contributions.
- A person in receipt of Illness Benefit cannot work while on this income support payment but they may do voluntary work in some cases. Persons in receipt of Illness Benefit for at least 6 months can apply for Partial Capacity Benefit (see below).

Invalidity Pension

- Invalidity Pension is a Pension paid to people who are permanently incapable of work because of illness. It is based on a claimant's social insurance contributions and is not means tested. To qualify for award of Invalidity Pension a claimant must satisfy both PRSI contribution and medical conditions as follows:
- Medical condition: A claimant must be regarded as permanently incapable of work, which is defined as: Incapacity for work of such a nature that the likelihood is that the claimant will be incapable of work for life or an incapacity which has existed for 12 months prior to the date of claim, and where the Deciding Officer or an Appeals Officer is satisfied that the claimant is likely to be unable to work for 1 year from the date of claim.
- PRSI Contributions condition: A claimant must have a total of at least 260 weeks contributions paid since entry into insurance, and must have 48 weeks PRSI paid or credited in the last complete tax year before the date of claim, (Governing Contribution Year) (PRSI paid in classes A, E and H are reckonable).

Partial Capacity Benefit

- Partial Capacity Benefit (PCB) is a new Scheme and is designed for people who have some capacity for work. If awarded, PCB will allow them to continue to receive a percentage of their IB or Invalidity Pension payment while working.
- Participation in the PCB scheme is voluntary. They must be in receipt of either Invalidity Pension or Illness Benefit. IB must be in payment for at least

six months at the date of application for PCB (the six months does not apply to Invalidity Pension).

- The rate of payment will depend on the personal rate of the qualifying scheme (IB or Invalidity Pension) from which the customer originates and the medical assessment of the customer's capacity for work as outlined below.

Medical Assessment	% of IB or InvP personal rate
Moderate	50
Severe	75
Profound	100

Disablement Benefit

- Disablement Benefit is a payment under the Occupational Injuries Scheme which is payable to an insured person, who suffers a loss of physical or mental faculty as a result of an occupational accident or a prescribed occupational disease, on or after 1 May 1967.
- Disablement Benefit may be paid as a once off gratuity or in the form of a Disablement Pension. The rate of benefit depends on the degree of disablement.

Other Schemes

- People with disabilities may also be eligible to avail of wider social welfare schemes such as the Back to Education Allowance and the Back to Work Enterprise Allowance.
- The Back to Education Allowance (BTEA) aims to give people who left school early and those without third level qualifications a second chance to attain educational qualifications so as to reduce their risk of long term unemployment. BTEA is paid at a standard weekly rate. In addition, an annual Cost of Education Allowance of €500 is payable. Education programmes can range from basic foundation courses through to third level postgraduate courses.
- The Back to Work Enterprise Allowance scheme encourages people getting certain social welfare payments to become self-employed. People taking part in the Back to Work Enterprise Allowance scheme can keep a percentage of their social welfare payment for up to two years.

Statistical Tables

Table A5.1: Estimated Budgetary expenditure (€ million): WSS, EmployAbility, PCB

Year	Wage subsidy scheme	EmployAbility	Partial capacity benefit ¹⁷⁸
2010	11.61	8.98	0
2011	11.25	8.84	0
2012	10.85	8.84	13.10
2013	10.85	8.84	8.50
2014	10.85	9.24	12.67

Source: Department of Social Protection

Table A5.2: Actual expenditure (€ million): WSS, EmployAbility, PCB

Year	Wage subsidy scheme	EmployAbility	Partial capacity benefit*
2010	10.87	8.5	0
2011	10.06	8.4	0
2012	10.57	8.10	2.11
2013	11.04	8.71	7.37
2014	12.59	8.43	9.97

Source: Department of Social Protection

Table A5.3: Number of participants: WSS, EmployAbility, PCB

Year	Wage subsidy scheme	EmployAbility	Partial capacity benefit*
2010	833	2,550	0
2011	916	2,903	0
2012	1,006	2,762	733
2013	1,159	NA	1,234
2014	1,548	2,936	1,432

Source: Department of Social Protection

¹⁷⁸ Partial Capacity Benefit was introduced in February, 2012

Appendix 6: Estimates of the prevalence and economic costs of sickness/disability absence

Country	Economic Impact	Date	Source
UK	Approximately 2.2 million days (2 per cent of total working days) were lost to sickness absence	2001	Barham & Leonard, 2002
	1.7 million scheduled working days were lost due to sickness absence	2004	Labour Force Survey (LFS)
	2.9 per cent of workers took at least one day of sickness absence.		
	Seven days per employee were lost to sickness absence (175 million working days) and £13.4bn in economic costs.	2006	Confederation of British Industry (CBI)
	43 per cent of all working time lost was the result of long-term absence (over 20 days)		
	Public sector absence was 44% higher than private sector and long term absence was 52% in comparison to 38%		
	The estimated cost to the public sector was about £5.8bn or £537 per worker per annum.		
	Employers with rehabilitation and flexible work arrangements lost only 2.7 days per employee (12 days were lost by the worst performing organisations).		
	Average annual sickness absence was 8.4 working days (3.7 per cent of the workforce) and 10.3 days in the public sector	2007	Chartered Institute of Personnel and Development
	The mean cost per employee was £659 per annum		
	In 2010 190 million days were lost and over £17bn in economic costs with a median of £760 per absent employee.	2011	Confederation of British Industry (CBI)
	Non-occupational health conditions were by far the most frequent cause.		
	Long term absence accounted for 32% of absence (CBI, 2011).		
	Work-related health conditions resulted in 27 million working days in 2011-12 with an economic cost of £13.8 bn in Great Britain	2012	Health and Safety Executive
	A quarter of the UK workforce (28 million people) had a long standing health problem.	2013	Department of Work and Pensions
Canada	Average annual sickness absence rate was 10 days per employees in 2011	2013	Conference Board of Canada
	The economic cost of absence was estimated to be in the region of \$16.6 billion in 2012 equivalent to 2.4 per cent of payroll		
	The duration of absence rates for older workers was over double the duration for younger employees (13.2 days compared to 5.9 for younger workers)		
	Disability management programmes reduced long-term absence by up to 60% and disability costs by between 30 – 50 per cent	2014	Zimmermann
Australia	The average cost of a work-related incident leading to a health problem in Australia amounted to \$125,700 in 2005-06 and had increased by 30per cent in five years	2010	Barnett & Hordacre
	The costs of workplace injuries and illnesses had increased by 68% over the same period to \$57.5 billion		

Country	Economic Impact	Date	Source
USA	The average cost of extended absences resulted in a 16% loss in productivity in 2010, which is equivalent to 2.9% of payroll costs.	2010	Mercer
	Indirect costs included increased workload, disrupted work processes, stress, reduced morale and quality of outputs and overtime		
New Zealand	Around 6.1 million days were lost to absence in 2012.	2013	BusinessNZ
	The median cost for each absentee associated with this was \$837.		
	The cost for each employer was about \$35,146 depending on the size of the enterprise.		
	\$1.26bn was lost to the economy in direct costs		
	Non-work related illness and injury were by far the most common reason for absence		
Ireland	The cost of absence to employers, was €818 per employee annually representing a total cost estimate of €1.5bn	2011	IBEC
	The costs of long term absence were in the region of €0.65bn.	2015	Estimated

Appendix 7: Return to work scenario¹⁷⁹

Introduction:

This appendix is intended to provide a concrete example of the development of a return-to-work plan for a worker who has acquired an impairment that places her job in jeopardy. The approach used to develop and implement a return-to-work plan varies depending on the legal, regulatory and funding context of a jurisdiction. For the purpose of this scenario, a number of assumptions have been made:

1. A service exists to assist ill and injured workers to return to work regardless of the cause of the health condition. This is similar to the Jobs in Jeopardy Assistance service in Queensland that was described in the main body of the text.
2. The service employs personnel to coordinate return to work who have a qualification in vocational rehabilitation.
3. The return to work coordinator works with employers and worker representatives in collaboration with the absent working in agreeing the return to work plan.
4. Funding is available for purchasing required rehabilitation interventions by allied health professionals such as physiotherapists and occupational therapists.

The materials that are used in this scenario have been accessed from a range of sources including a number of workers' compensation insurers in Canada. Equivalent materials are available from other sources. The sources are referenced in footnotes.

Details of the worker:

Victoria Samson is a 27-year-old resident attendant who works in a local nursing home caring for elderly persons. Last October she was assisting a co-worker to transfer a resident from the bed to her wheelchair when the resident became aggressive. The sudden movement caused Victoria to twist awkwardly. Victoria completed her shift but the following day when she woke up she

had significant low back pain and called in sick and arranged an appointment with her family doctor that afternoon.

Victoria was placed off work for a period of three months during which time she attended physiotherapy treatments and a work conditioning programme. Victoria believes she is now ready to return to work.

Establishing fitness to return to work:

The first stage of the process is to establish that Victoria is ready to safely return to work. A *Fitness to Return to Work Form* can be used for this purpose.

The documentation for Victoria is presented in Table A7.¹⁸⁰ This is a sample fitness to return to work form. During the development of a RTW process, a decision would be made as to how to communicate with the treatment providers to obtain the necessary functional abilities and limitations information.

The explanation of the terms for describing work demands include¹⁸¹

SEDENTARY WORK - Exerting up to 10 pounds of force occasionally and/or a negligible amount of force frequently or constantly to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

LIGHT WORK - Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently, and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for sedentary work. Light work usually requires walking or standing to a significant degree. However, if the use of the arm and/or leg controls requires exertion of forces greater than that for sedentary work, and the worker sits most of the time, the job is rated light work.

MEDIUM WORK - Exerting up to 50 pounds of force occasionally, and/or up to 20 pounds of force frequently,

¹⁷⁹ Extracted from McAnaney, D. (2014) **WHDM 313 The Field and Practice of Disability Management Manual Session 11**. Port Alberni, BC: Pacific Coast University for Workplace Health Sciences.

¹⁸⁰ The form in its original format can be found in Workplace Disability Management: A Guide to Establishing a Program in Your Workplace. St. John, NB: Author. Accessed [09/11/2016] at: http://www.mtpinnacle.com/pdfs/RTWBook_e.pdf

¹⁸¹ Government of Canada (2003) 'National Occupational Classification: Career Handbook'. Ottawa, ON: Author. Accessed [30/10/2015] at: <http://www5.hrsdc.gc.ca/NOC/English/CH/2001/Welcome.aspx>

Table A7.1 Return-to-Work Form

Employee's name:		Employer:	
Occupation: Resident Attendant		Date of current injury / illness:	
Return-to-Work Coordinator:		Fax #:	
Employee Consent			
I hereby authorise and request my treating physician (named below) to complete this form and release information concerning my physical abilities and limitations for the purpose of assisting with my Return-to-Work Program and the identification of safe return to work options.			
Employee's name: Victoria Samson		Signature:	
		Date:	
The following sections are to be completed by attending physician Once completed, please: Return this document to your patient, <u>OR</u> Fax it to the attention of the Return-to-Work Coordinator at the fax number indicated above			
Physician's name:		Fee: €	
Physician's signature:		Date: June 27, 2014	
Address:			
Telephone:		Fax:	
Findings and Recommendations			
<input type="checkbox"/> Return to full regular work duties			
* Time limited gradual return to regular work: 4-6 hours per day 4 days days per week, for 8 weeks			
* Return to modified / alternate work for 8 week(s) (Please complete checklists below identifying abilities and limitations)			
Follow-up: * None <input type="checkbox"/> Myself (appointment date: _____)			
<input type="checkbox"/> Dr. _____ in _____ days _____ weeks			
<input type="checkbox"/> Unable to return to work at this time			
Follow-up: <input type="checkbox"/> None <input type="checkbox"/> Myself (appointment date: _____)			
<input type="checkbox"/> Dr. _____ in _____ days _____ weeks			
Please indicate by checkmark (Ö) any limitations in the activities listed below		Please indicate by checkmark (Ö) employee's current physical abilities level in areas listed below (see definitions on reverse)	
	Limitations		
Physical activity	No	Yes	Physical activity
Prolonged sitting	x		Push
Prolonged standing		x	Pull
Prolonged walking		x	Lift
Squatting		x	
Kneeling		x	
Bending		x	
Overhead reaching	x		
Climbing / work at heights	x		
Fine finger manipulation	x		
Repetitive use of upper extremities	x		
Repetitive use of lower extremities	x		
Other (specify)			

and/or up to 10 pounds of force constantly to move objects.

HEAVY WORK - Exerting up to 100 pounds of force occasionally, and/or up to 50 pounds of force frequently, and/or up to 20 pounds of force constantly to move objects.

VERY HEAVY WORK - Exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects.

The more detailed the fitness to return to work form, the easier it is to complete the job matching exercise. In this example, the physician was only asked to comment on whether there were limitations or no limitations for each of the basic physical demands. In order to clarify whether Victoria can perform occasional sitting, bending, twisting and low level work the vocational rehabilitation professional has several options available to clarify:

- Contact the physician for further clarification: This can be problematic if the physician does not respond to calls, the vocational rehabilitation professional does not have consent to communicate with the physician, or the physician does not have the means to assess in the office the frequency of the physical demands.
- Contact the treatment provider (physiotherapist): Considering that Victoria completed a work conditioning programme, additional functional details should be available from the treatment provider.
- Request a functional baseline assessment: The information obtained would definitely be more detailed than the fitness for returning to work decision, however, this could also present delays in commencing the return to work schedule.
- Request the services of an occupational therapist: If the vocational rehabilitation professional is concerned with establishing a safe return to work plan with the information provided, an occupational therapy consultation could be requested to assess the worker on-site and facilitate the return to work plan design. There is a cost attributed to this service, however, ensuring the safety of the worker is essential for a successful return to work outcome.

Demands Analysis and Job Matching

The job tasks to which a worker returns after developing or acquiring a physical or psychological impairment must be reviewed to ensure that they match his or her capacity to carry them out, and if not the job should be modified.

An important approach in RTW planning is to compare job demands with what the assessment (or assessments) indicate the worker can or cannot do. Job matching is a process of using knowledge about the worker's abilities and skills, and competencies and identifying work demands and duties within specific jobs that a worker can optimally and safely perform.

A key step in the process of planning is to thoroughly understand the work abilities of a worker who may be experiencing temporary limitations that hinder performance of all regular job duties. This involves considering the current physical or cognitive or sensory capacities of the person and having knowledge of the potential for recovery of functioning. This knowledge is important to planning where and when to place the individual in a job with selected duties that they can perform and to then progress their duties in concert with rehabilitation or recovery. Part of the planning involves a full understanding of the job demands and what performance components are required to execute the job. For instance, it is important to know the physical, psychological, behavioural, cognitive, executive functioning skills, and the human interaction requirements, etc. of jobs along with the expected range of the intensity and frequency of such demands. Knowledge of the low and high intensity activities and their frequency as well as the endurance required to perform work tasks is essential to being able to job match in the RTW planning process. Finding a fit between current worker abilities and performance limitations with the demands of specific tasks is known as job matching. An example of how that might work is provided below.

The second document required for the job matching process is the job analysis. This is presented in Table A7.2. Once again a job analysis can be presented in many formats. In this case example a job task analysis is included that only reports physical demands. Other forms may focus specifically on cognitive demands or may combine both in one document. This form is available from the New Brunswick Workplace Health and Safety Commission (2006; pp. 22-23)¹⁸².

¹⁸² New Brunswick Workplace Health and Safety Commission. (2006) Workplace Disability Management: A Guide to Establishing a Program in Your Workplace. St. John, NB: Author. Accessed [09/11/2016] at: http://www.mtpinnacle.com/pdfs/RTWBook_e.pdf

Table A7.2 Job Task Analysis Form

Date:		Employer:				
Position Title: Resident Attendant		Supervisor:				
Work Schedule						
Sunday*	Monday *	Tuesday*	Wednesday *	Thursday*	Friday *	Saturday
Full Time*	Part Time <input type="checkbox"/>	Seasonal <input type="checkbox"/> - Details:				
Shift details (start time + duration): 7:00-7:00 (12 hour shifts)						
Rest / lunch breaks (when + duration): 1 x 30 min lunch/supper, 2 x 15 min breaks						
Schedule information (include consecutive days worked / days off / plus shift rotation details):						
2 days, 2 off, 2 days 2 days off, 3 days on, 3 days off (2 weeks of nights and 2 weeks of days)						
Essential Job Functions						
Assisting resident with self-care (feeding, bathing, dressing and toileting), mobility (transferring from bed to wheelchair, wheelchair to toilet, wheelchair to commode), quality of life activities (reading, talking, playing games)						
Equipment, Tools and Materials Handled						
Hoyer lift, transfer sheet, wheelchair,						

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Environmental Conditions Checklist					
Indicate by checkmark (x) the percentage of workday exposure to each of the conditions / hazards listed					
Category of Hazard	Environmental Conditions / Hazards	No exposure	0 to 33% Occasional	33 to 66% Frequent	66 to 100% Constant
Chemical Hazards	Gases / Vapors	x			
	Dusts / Fumes	x			
	Liquids / Solids	x			
Biological Hazards	Mould	x			
	Bacteria	x			
	Body fluids			x	
Physical Hazards	Outdoor weather conditions		x		
	Wet, humid conditions (Indoor industrial environment)		x		
	Extreme cold (Indoor industrial environment)	x			
	Extreme heat (Indoor industrial environment)	x			
	Work near moving mechanical parts	x			
	Risk of electric shock	x			
	Risk of radiation	x			
	Work at heights	x			
	Vibration	x			
Noise level	Quiet <input type="checkbox"/>	Moderate*	Loud <input type="checkbox"/>	Very loud <input type="checkbox"/>	

Personal Protective Equipment Required				
Gloves				
Physical Demands Checklist				
Indicate by checkmark (✓) the percentage of workday duration of the activity being analysed				
Physical activity (work positions)	Not required	Occasional 0 to 33%	Frequent 33 to 66%	Constant 66 to 100%
Sitting		x		
Standing		x		
Walking (even ground)			x	
Walking (uneven ground)	x			
Physical activity (work positions)	Not required	Occasional 0 to 33%	Frequent 33 to 66%	Constant 66 to 100%
Twist		x		
Bend / Stoop		x		
Squat		x		
Kneel		x		
Crawl	x			
Reach (forward)			x	
Reach (overhead)		x		
Reach (to side)		x		
Reach (across body)		x		
Balance		x		
Handling (simple grasp)			x	
Handling (firm grasp)			x	
Fine finger manipulation		x		
Operates foot controls		x		
Climb (stairs)	x			
Climb (ladders)	x			

Physical activity (strength level requirements)	Push	Pull	Lift				Carry			
			(floor to waist)	(floor to above shoulder)	(waist to waist)	(waist to above shoulder)				
Sedentary (occasional: 1 – 10 lbs)	x	x	x	x	x	x	x			
Sedentary (frequent: less than 1 lb)										
Sedentary (constant: less than 1 lb)										
Light (occasional: 11 - 20 lbs)	x	x	x	x	x	x	x			
Light (frequent: 1 - 10 lb)										
Light (constant: less than 1 lb)										
Medium (occasional: 21 - 50 lbs)	x	x	x							
Medium (frequent: 11 - 25 lb)										
Medium (constant: 1 - 10 lb)										
Heavy (occasional: 51 - 100 lbs)	x	x								
Heavy (frequent: 26 - 50 lbs)										
Heavy (constant: 11 - 20 lbs)										
Very Heavy (occasional: over 100 lbs)	x	x								
Very Heavy (frequent: over 50 lbs)										
Very Heavy (constant: over 20 lbs)										
Motor Vehicle Operation Requirements										
Ability to operate a motor vehicle required? Yes <input type="checkbox"/> No *				License required? Yes <input type="checkbox"/> No *	Type / Class:					
Type of Vehicle(s):										
Critical Worksite Measurements										
All beds are electrical, walk-in showers are available and tubs with hoist lifts are available. All toilet seats are raised with wheelchair accessible bathrooms										
Job Modification / Accommodation Options										
Modified duties including modified tasks and shift times are available through the disability management programme.										
Completed by										
Date:				Name:						
Position:				Signature:						

It's important to find out what job tasks a returning worker can safely and productively carry out without a need for intervention. However, much of accommodation focusses on finding solutions that resolve mismatches between what the person can do and what the job demands.

Once the job demands analysis has been compared to the assessment reports of functional abilities, it is now possible to review the physical and cognitive demands that don't match the pre-injury/illness position and to identify mismatches that might be a barrier to a return to work.

In the case study presented, Victoria has the following physical limitations that don't match her pre-accident job:

- Standing
- Walking
- Pushing
- Pulling
- Bending
- Twisting
- Low level work.

The next step is to specify the physical and cognitive demands that don't match job tasks. Again, the availability of a more detailed job analysis will facilitate this process. In this case study, the following job tasks are impacted by the Victoria's limitations:

- Ability to complete full standing tolerance required during shift to provide self-care and transfers with residents
- Ability to complete full walking tolerance required during shift to provide self-care and transfers with residents
- Limited when required to re-position client in bed due to decreased pushing strength
- Limited when required to re-position client in bed due to decreased pulling strength
- Limited when require to transfer client due to decreased pushing strength
- Limited when required to transfer client due to decreased pulling strength
- Limited bending tolerance to complete full bathing care from bedside with residents
- Limited bending tolerance to complete full dressing protocol with residents
- Limited twisting tolerance to complete full toileting protocol with residents

- Limited low level position tolerance to complete bathing, dressing and toileting protocol.

Once a comprehensive understanding of the job tasks that are impacted by the worker's limitations has been achieved, the vocational rehabilitation professional and the team can work together to identify strategies to remove barriers through accommodation. The members of the team that are absolutely necessary at this process step are the worker, the supervisor, the union or employee representative and the vocational rehabilitation professional. As a team, they work towards removing barriers to RTW.

Accommodation Planning and Implementation

Accommodation is the part of the return to work process that focuses on adapting or finding a job that a worker with a temporary or permanent impairment can safely and productively carry out. The process of accommodation planning and implementation is critical to the detail of the RTW plan. The DM team can explore return to work options in three categories:

- Engineering and design solutions
- Administrative and work flow solutions
- Worker solutions

In the case of Victoria's barriers to return to work, it is important the appropriate accommodations identified are presented in Table A7.3

The accommodation details form the largest part of the RTW plan. While the plan might include supports outside the workplace such as alternate transportation or nutrition counselling, a significant portion of the plan will focus on what the individual does in the workplace and how that needs to be changed or adapted.

At this point in the planning process, the vocational rehabilitation professional has a clear understanding of the abilities and limitations of the individual and the recommendations for accommodation. However, the process of job matching, identifying obstacles and proposing accommodations is not completed in isolation. As part of a DM team, the worker, the supervisor, the union representative, the insurer (if relevant), the treatment providers and the vocational rehabilitation professional may all play a role in laying a foundation for the plan.

Table A7.3 Accommodations Specified for Victoria

Limitation	Accommodation required	Recommendation
Decreased standing tolerance	Administration and work flow	Gradual return to work
Decreased walking tolerance	Administration and work flow	Gradual return to work
Decreased pushing strength	Engineering and design solutions	Review of available equipment for transfers
	Administration and work flow	Assignment of graduated resident assignment
	Worker solutions	Transfer training
Decreased pulling strength	Engineering and design solutions	Review of available equipment for transfers
	Administration and work flow	Assignment of graduated resident assignment
	Worker solutions	Transfer training
Decreased tolerance to bending	Administration and work flow	Gradual return to work
	Worker solutions	Review of body mechanics/work technique (appropriate use of equipment)
Decreased tolerance to twisting	Administration and work flow	Gradual return to work
	Worker solutions	Review of body mechanics/work technique (appropriate use of equipment)
Decreased tolerance to low level work	Administration and work flow	Gradual return to work
	Worker solutions	Review of body mechanics/work technique (appropriate use of equipment)

A sample work plan for Victoria with a gradual increase in hours worked over an eight week period is presented in Table A7.4.

Table A7.4: Proposed Schedule for Victoria Samson

Week #	Week of	Hours							Comments
		S	M	T	W	T	F	S	
1	July 1st	4	4			4	4		<ul style="list-style-type: none"> Worker will be assigned as an extra person on the shift, allowing necessary breaks for pain management strategies. <ul style="list-style-type: none"> Resident caseload will be assigned as: <ul style="list-style-type: none"> Level 1 residents weeks 1-3, Level 1 and 2 residents weeks 4-6 Level 1,2,3 residents weeks 7-8. Pain mgmt. strategies include: <ul style="list-style-type: none"> Stretching Ice Quality of life activities with residents-reading, chatting RTW plan review meetings: Week 3,6, 8 Any difficulties or concerns are to be reported to your supervisor immediately.
2	July 8th		6	6	6				
3	July 15th	6	6	8				8	
4	July 23	8			8	8			
5	July 29	10	10	10				10	
6	Aug 5th	10	10				12	12	
7	Aug 12th			12	12			12	
8	Aug 18th	12	12				12	12	

Date of Next Progress Review: July 16, 2013

Duties to complete: Assigned as an extra worker.

- Level 1 residents are categorised as light level transfers, non-aggressive and able to provide some assistance with the transfers.
- Level 2 residents are categorised as medium level, may be more aggressive when transferring and provide minimal assist during the transfer.
- Level 3 are categorised at the heavy level, may be aggressive and do not assist with the transfer.

Additional comments:

Prior to commencing the week of July 1st, 2013 an on-site assessment will be conducted with an external occupational therapist to provide the following education:

- Transfer training,
- Work simplification strategies,
- Pacing strategies.

Case Management/ Service Coordination

The case management/service coordination function in return to work is designed to ensure that services that would be helpful to a worker who has incurred an injury or an illness are provided if available. The case management process may be led by individuals who are part of the employer, or by practitioners who work directly for insurers or who are contracted as a third party.

Case management is not based on a single clearly defined set of guidelines that covers all eventualities. It depends on the structure of the employer, the insurer if any, the referral source and the role assigned to the external case manager, if one is in place. Depending on the specific situation, all accommodation planning and case management/service coordination may be provided by an internal professional who works for the employer or by an external professional who works for the insurer or who has been contracted by the insurer, or by both. There may also be situations in which there is both a professional who works for an insurer and who may focus more on treatment and rehabilitation services and a professional who works for the employer and who may be more involved in coordinating other services available within the community.

In this scenario, the case management/service coordination function is carried out by the return to work service provider. The case manager will focus on Victoria's broad situation and need for services, and not just on what happens at work. The case manager may need to address issues of her progress in the work conditioning programme, difficulties that Victoria is having with her homemaking and childcare duties and her strained relationship with her husband due to financial stress.



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