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No one written off: reforming welfare to reward responsibility
Response of the British Society of Rehabilitation Medicine

The British Society of Rehabilitation Medicine (BSRM) represents doctors who practise in Rehabilitation Medicine. It was formed in 1984 and is a registered charity (Reg. No. 293196).

The Society encourages doctors in all clinical specialties to be involved in education and research into the management of disability. Membership of the BSRM is open to all registered medical practitioners interested and concerned with its objectives and has nearly 400 members from all nations within the UK.

General comments

The BSRM shares with the government the aspiration that those with physical or emotional impairments (using the meaning implied by the World Health Organisation[1]) should be able to contribute to their society through work. This follows from the desire of many of those with disabilities to work[2;3], and the knowledge that the health of many is impaired through being out of work[4].

Specific comments

1.14 It is the experience of rehabilitation professionals that services have to be tailored to individual need.

1.27 The Lifetimes Homes Standards are useful but additional design considerations are also required because:

- wheelchair-dependent individuals tend to gain weight and thus need wider and stronger wheelchairs[5].
- Some people with severe and complex disabilities use indoors wheelchairs with exceptionally wide turning circles, such as are required for indoor-outdoor powered chairs (EPIOCs) and for functions such as standing and tilting.

1.28 We agree that a simplified benefits system would enable health professionals to have a greater understanding of its range and functions which, mostly, we do not currently have, and thus cannot assist our patients in even the simplest manner.

2.31 The BSRM welcomes a joined up approach to assisting those with drug dependency to re-integrate into the community. Surely similar arguments hold for those with alcohol dependency which is now recognised as one of the UK's most rapidly growing medical problems[6]

2.41/2 The BSRM strongly supports the view of the Royal College of Psychiatrists that all psychiatric teams should have a member who is knowledgeable about vocational rehabilitation (VR)[7]. The BSRM has recommended that each health locality (currently each PCT) should employ a health professional skilled in VR who has the skills to

collaborate with the Disability Employment Adviser (DEA) within the local Jobcentre Plus[3]. In addition to the mental health problems noted in this document, there are well known physical issues relating to both drug and alcohol abuse.

Question 7

The BSRM cannot comment on the details of drug programmes, but in general, we believe that clinical and vocational rehabilitation should be linked – a view shared with the Royal College of Psychiatrists[3;7].

2.64-6 This consultation makes no reference to schemes that would enable lone parents to maintain pre-existing skills during the early years of parenting. Schemes such as the now defunct Women Doctors Retainer Scheme might be worth re-considering for parents of either sex with scarce skills, where a prolonged period out of contact with their profession may inhibit an eventual return to work (RTW). Financial support to encourage retaining skills through 1-day per week or 1-2 evenings per week might facilitate this.

Questions 10-11

Personal Advisers should be trained to consider offering 'retainer-type' schemes for those with pre-existing skills as well as offering retraining when such skills have been lost. Generally, the BSRM believes in incentivising people rather than compulsion.

2.77 The BSRM welcomes this proposal – many young people lose out on education due to emotional, learning or physical impairments. Education for those with severe physical and or intellectual impairments is a juggling act between embracing the needs for education, training for independent living, time for physical rehabilitation and counselling as well as preparation for the world of work. Work experience seems important. Individual educational needs will vary and need to be provided in both fully integrated and highly specialised schools (BSRM – unpublished data). Such education is time-consuming.

2.78 To be clear – the mentoring process is vital to continue after work has recommenced to facilitate long-term retention of employment.

2.84 Volunteering should not be restricted to the voluntary sector. Many local authority departments – and in particular social services and their day centres, can act as catalysts for a RTW.

3.1 Unfortunately, some employers still prefer a 'retirement' approach.

3.2 Whilst appreciating the success of the initial Pathways to Work Pilots, each project now runs on a smaller budget and the results need continued monitoring. The crucial point is that if clients are well treated by the health professionals initially, with appropriate involvement of VR principles and practice in the early stages of injury or ill health, many would never be off work long enough to need IB.

3.2.1 Whilst the BSRM agrees with 3.2, health delivery currently lacks the focus on work that is needed. Rehabilitation services are generally lacking and are commissioned piecemeal in the absence of any strategy from the DH. Appropriate, timely rehabilitation will reduce sickness absence.

3.3 The BSRM strongly supports a focus on ability rather than disability. Much depends on the competency of doctors involved in performing Work Capability Assessments (WCA). The BSRM has contributed to training in the past but believes that the participation of Rehabilitation Medicine should be routine rather than occasional, so that the employment potential of, and rehabilitation facilities available for people with complex disabilities is better understood by assessors.

Question 14

Yes. The BSRM strongly support the integration of VR principles into this process. The details of such principles are now well established[8;9].

3.22 The challenges will be greatest for those with physical problems who had previously been involved in manual work – musculo-skeletal problems remain the commonest cause of long-term sickness absence for manual workers[10]. This will require the development of much more professional musculoskeletal rehabilitation services if this ambition is to be achieved.

3.34 The BSRM strongly supports the development of Access to Work (AtW). Provision of wheelchairs, however, needs review. We believe that to achieve a greater number of wheelchair-dependent individuals in the workforce, powered wheelchairs should be made more readily available during prevocational rehabilitation, and **not** only when a job-offer has been made. In the absence of joined-up funding for equipment needed by those with physical disabilities, we would advocate the use of professional wheelchair services to provide independent advice about advantages/disadvantages of the available chairs – rather than the use of individual companies. It is unclear whether NHS services are invited to tender for AtW wheelchair provision. Whilst the NHS continues to limit chairs to those meeting basic 'clinical need' the voucher scheme offers a means of providing chairs with expensive features that might be needed for education or for work e.g. a 'riser' function. The DWP should in these circumstances pay for the remaining part of the voucher[11].

Question 15

Some of the obstacles for RTW are health-related and it is essential that those involved from the DWP understand the health issues involved. Thus the BSRM has advocated a higher standard of training with enhanced roles for the DEA to enable them to function effectively[12]. The BSRM believes that there needs to be close linkage between the DEA and a designated NHS VR individual or team as a prerequisite for optimising the chances of obtaining work for those with severe disabilities.

3.36-42.1

This consultation makes no reference to the increasing opportunities for those with severe physical disabilities for working from home despite the fact that this is an increasing trend within the workforce as a whole. Barriers to this remain the inadequacy of suitable housing for severely physically disabled individuals – and yet the provision of equipment from the AtW scheme should facilitate this[13]. There appear to be massive delays in obtaining a downstairs toilet for example, and yet the issues for those with musculo-skeletal impairments and difficulties in micturition have been long known[14]. There is no discussion about self-employment, which can sometimes be a good way forward for those with some forms of severe disability[13].

3.45 The BSRM welcomes the emphasis on meeting the needs of those furthest from the labour market – often with severe and complex disabilities which can be alleviated, in part, with skilled rehabilitation.

Question 18

There are a number of key features in avoiding unnecessary job loss. The first is to ensure that employer and employee remain in contact from the beginning of a sickness absence. Efficient employers have this as part of their absence management and introduce this to new employees in their induction programme. The concept of 'disability leave' was initiated by the Royal National Institute for the Blind and should be better known and utilised[15-19]. It enables employers and employees to recognise that a period of uncertainty has arisen related to health or disability, but prevents unnecessary early retirement.

3.68 This consultation does not discriminate between those with common mental health problems such as anxiety and depression – who may not need complex psychiatric management - and those with severe disabling psychiatric problems as described by the

Royal College of Psychiatrists[7]. The key in all these situations is to include VR principles and skills into the psychological programmes being envisaged.

Chapter 4

The BSRM is broadly supportive of the approach taken that employment is the best way to alleviate child poverty – but see comments 2.64-6 above.

5.14 The BSRM is sympathetic to this approach – thus members have commented on the inappropriateness of current NHS wheelchair provision for those with additional employment, emotional or employment needs see section 3.34 above.

Chapter 6

The BSRM greatly values the multitudinous roles fulfilled by informal carers and supports any method of reducing carer strain. The comments made relating to lone mothers with skills appear equally relevant to carers – see section 2.64-6.

7.20-2 We urge that 'ethnic minority groups' should not be discussed as though their needs were similar. The needs of a new emigrant are clearly very different from those of someone who was born into a UK-based community. Experience from just one hospital in North West London has identified three major, newly arrived and differing immigrant groups within its locality – from Afghanistan, Iraq and Somalia – many of whom were suffering from post-torture syndromes and spoke little English[20]. Clearly their needs are far removed from those of resident populations originally from the West Indies or South Asia. They require different forms of physical management and psychological support in order to master English well enough to learn new skills for the workplace. The BSRM welcomes the value placed on local initiatives which can address the locality-based problems described.

This response has been drafted by Professor Anne Chamberlain, Drs Andrew Frank & Vera Neumann and Professors Chris Ward & Tony Ward (President and 4 past Presidents) and has been seen and agreed by the Executive Committee of the BSRM and its Special Interest Group on Vocational Rehabilitation.

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