Taking part in a randomised control trial: a participant’s eye-view of the Job Retention and Rehabilitation Pilot

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A report of research carried out by the National Centre for Social Research and the Social Policy Research Unit on behalf of the Department for Work and Pensions
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Acknowledgements

The authors of the report are very grateful to all those involved with the Job Retention and Rehabilitation Pilot for the help and co-operation which they have given to the National Centre for Social Research (NatCen) and Social Policy Research Unit (SPRU) evaluation team. Members of the team have paid several visits to each of the service providers, and we would like to express our thanks for the way in which managers and staff have made every effort to comply with our requests for information. Members of the evaluation team have also paid a number of visits to the Contact Centre team in Glasgow, who have always been extremely welcoming and constructive.

We would like to thank Jane Sweeting, Laura Smethurst, and Leah Harris from the Disability and Work Division at the Department for Work and Pensions who have provided unstinting advice and support to the evaluation team. We have also valued the advice and help we have received from Sue Bell, Patrick Marsden and Contract Management Group in Sheffield and the JRRP Steering Group. Our thanks to all our colleagues within the evaluation and randomisation teams.

Finally, we give our sincerest thanks to the volunteers who have not only agreed to take part in the trial, but have also given up their time to complete one or both of the surveys or the qualitative panel study interviews. Their willingness to give us their time and trust, at a difficult time in their lives, is the most important contribution to the evaluation of all.
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Summary

Introduction

This report presents findings on the characteristics and experiences of participants in a randomised control trial, the Job Retention and Rehabilitation Pilot (JRRP). This trial is being evaluated by the National Centre for Social Research (NatCen), in collaboration with the Social Policy Research Unit (SPRU) at the University of York, and the Urban Institute (Washington DC).

JRRP was developed to test interventions which might decrease the length of sickness absence and increase job retention for people off work sick for between six and 26 weeks. The trial was run in six areas of the UK and potential volunteers were screened by a central Contact Centre from April 2003 to December 2004. Only those eligible and ‘likely’ to lose their job were accepted and randomised to one of four equally sized groups: a Workplace, Health or Combined Intervention or a Control Group. The Workplace intervention had to focus on bringing about change within the individual’s workplace environment and could give advice only about the workplace or how people work. The Health intervention had to be delivered away from the workplace, treat the mind or body of the participant and could give advice only about health. The Combined intervention could be any or all of these.

In total, 2,845 people were screened and randomised. They were invited to an interview by a service provider in order to watch a short video that described the trial procedures; to learn of their Intervention Group and what might be involved; to be asked to give written consent; and, to have a plan of treatment (‘Action plan’) drawn up.

This introductory report is based on partial data from a qualitative panel study, two partially-completed surveys of participants and the screening instrument. Full reports will follow on the JRRP services and their impact, costs and benefits, as well as an assessment of the trial itself.
Characteristics of respondents

The majority of survey respondents were women (57 per cent) and most were in their 30s, 40s or 50s. Nine in ten were White, with the largest ethnic minority groups being Indian and Caribbean (both two per cent). Two-thirds were married or living with a partner, 40 per cent without any dependant children at home, and 27 per cent with children. Sixteen per cent were living alone, and seven per cent were single parents.

Most held some qualifications, either a degree or equivalent (20 per cent), A levels or similar (27 per cent) or below (32 per cent), and only 17 per cent had none. Almost all had had a very stable working life, with 88 per cent having spent most of it in steady jobs. So very few (one per cent) had spent a lot of time out of work for health reasons.

The most common health conditions at the time they went off sick (they could name more than one condition) were diseases of the musculoskeletal system and connective tissue (42 per cent), mental and behavioural disorders (41 per cent), injury/poisoning (21 per cent) and circulatory diseases (ten per cent).

Among respondents in the qualitative panel, two had become unemployed shortly after getting in contact with JRRP, having been dismissed on the grounds of ill-health. One employer had been quite supportive prior to the point of dismissal, the other not. In both cases, healthcare services (outside JRRP) seemed to have had little impact on improving respondents’ fitness for work.

Four respondents with recurrent medical conditions had already made a graduated return to work before the first panel interview. In three cases, employers were perceived to have had a positive attitude towards their employees, with regular contact to check on progress. The fourth employer was initially supportive, but as time went on the respondent began to feel under pressure to return to work as they feared they might be dismissed. The healthcare services (outside of JRRP) did have a role to play in these returns-to-work, particularly General Practitioners (GPs) who provided both healthcare and return-to-work support.

The remaining respondents were all absent from work at the start of the panel study. The role of employers, GPs and other healthcare professionals in helping them move closer to a return-to-work was varied. At one extreme there were those employers who wanted their staff to return to work but only when they were ready. Such employers tended to maintain regular informal contact, to discuss with the employee how they might return, provide support from occupational health staff, and in one case, fund private healthcare treatment. At the other extreme were employers who lacked flexibility. Contact with management or occupational health staff was much less frequent, or non-existent. Discussions typically focused on setting a return-to-work date but not on how to facilitate the process. This put pressure on some employees to return before they were ready. Where employees could not demonstrate that they could return by the required date, some discussions turned to termination of employment.
Options like redeployment or graduated returns were rarely suggested by this group of employers. Requests by employees were generally turned down as impractical or for other reasons. Whilst employees were expected to keep employers updated, there appeared to be no reciprocal updating of employees about their jobs and workplace. As a consequence, they tended to be suspicious of the employer’s motives for contacting them. There were reports of contacts which had made respondents feel they were being checked up on. Similarly, the involvement of occupational health staff was perceived by some as a means for their employer to gather evidence for dismissal.

Contact with healthcare professionals and their involvement in progress back to work was also varied. Typically GPs had the most contact, but hospital consultants and community psychiatric nurses (CPNs) were also sometimes involved. Participants found it more supportive where GP (and in one case CPN) contact was more regular, where sick notes were frequently reviewed (e.g. every two weeks), where referrals were made not only within the National Health Service (NHS) but also to outside services including JRRP, and where GPs raised the subject of returning to work.

Participants’ experiences of entering the trial

A high percentage of volunteers found out about the trial through their GP or other health care professional (36 per cent), employer (28 per cent), or from adverts at the GP’s surgery (14 per cent). Among panel study participants, the most common source was also GPs. In some cases GPs strongly encouraged their patients to get in touch with JRRP whereas others had just passed on leaflets or telephone numbers.

Less than one per cent of Outcome Survey respondents heard about the trial direct from a provider staff member. This confirms that the trial design successfully precluded service providers from contact with volunteers before they were randomised (to prevent any contamination of the Control Group). The survey also provided evidence that coercion into the trial by employers was rare (one per cent said that their employer had instructed them to take part).

Some panel study respondents appeared not to have clear reasons for joining JRRP. Instead their motivation had been that it was free, voluntary and ‘could do no harm’. Some said they would try anything to help them get back to work. They found it difficult to recall specifically what they had understood about JRRP before joining, but everyone understood that it was designed to help them return to work (among survey respondents, 84 per cent thought it would help with this). In addition there was a common perception that the service would focus on improving health.

Given that some clients knew very little about the service, they tended to have quite limited expectations of JRRP. Nevertheless, some were looking for specific services, most commonly health treatments and JRRP was perceived as being able to provide them more quickly. It was less common for people to have expectations concerning workplace services.
Nine in ten survey respondents had told their friends/family about taking part in JRRP, and nearly all said their reactions were positive (72 per cent) or neutral (23 per cent). Most (72 per cent) said their GP knew they were taking part, nearly all of whom were said to have been positive (75 per cent) or neutral (18 per cent) about this. On the whole GPs’ (and some occupational health staff) reactions to JRRP were also described as positive by panel study respondents.

Sixty-eight per cent of survey respondents said that their employer knew that they were taking part, of whom a clear majority (60 per cent) were positive. Only nine per cent reported a negative reaction, higher than among friends/family or GPs. The most common reason was that the employer resented the involvement of a third party.

Panel study respondents found it difficult to recall what took place before their first meeting with providers. Spontaneous references to the Contact Centre were rare, though some were able to recall elements of the conversation they had had. When prompted, most survey respondents (97 per cent) did recall having phoned the Contact Centre to join. Most also remembered being given an explanation of the project (96 per cent) and found it easy to understand (89 per cent). A large majority (88 per cent) of those who remembered the explanation said it was clear there was a chance that they might not get any extra help.

Having been allocated to the Control Group affected respondents’ recall or perception of the screening process. A higher proportion found the explanation confusing (seven per cent, compared to two per cent of the Intervention Groups). The proportion wanting more information was higher for Controls (15 per cent) than for the Intervention Groups (seven per cent). The most likely reason is that the Intervention Groups’ answers were affected by further explanations of the trial received from providers.

Nine in ten participants were able to recall a letter telling them the result of their randomisation. As might be expected, those allocated to the Control Group were disappointed. Asked to rate from 0 (very disappointed) to 10 (very happy) how they had felt, the mean score was 3.1. By contrast, those assigned to the Intervention Groups felt much happier, with scores averaging 9.4 among the Combined group, 8.3 among the Health group and rather less, 6.7 among the Workplace group.

Some panel respondents were clear about how the randomisation process worked and talked about it being a lottery or names picked out of a hat, or done by computer. There was also some awareness of there being a Control Group. In contrast, others had misunderstood, or could not recall how the groups were assigned. Even where people did appear to understand the concept, there was often some scepticism that this had determined their group. Instead, they believed that they had been assigned by providers according to their circumstances. Some of those unaware of the randomisation process also thought that they had been assigned according to their situation.
This variation in understanding is also evident among survey respondents: 50 per cent knew that random assignment had determined their group, but 36 per cent were unsure how it was chosen and 11 per cent thought that the provider had chosen it.

Participants’ first impressions of providers

On the whole, panel study participants had very positive first impressions of service providers. The way staff spoke to volunteers was commonly described as ‘friendly’, ‘courteous’ and ‘charming’. Participants also talked about how they were made to feel at ease by the ‘relaxed’ and ‘reassuring’ demeanour of staff, and also felt that they were ‘sympathetic’, ‘caring’ and genuinely ‘interested’ in their cases. People also talked about how they did not feel under any pressure either about a return-to-work or more generally. Staff were also often referred to as being ‘professional’, due to their organisational skills in assessing and managing cases, their commitment and enthusiasm compared to services outside JRRP, their knowledge about a health condition, and the time they were willing to spend explaining how an illness might develop.

Survey respondents also gained very positive first impressions of their case manager – 83 per cent felt that he or she had listened to what they had to say ‘very well’ and 13 per cent ‘quite well’. Most had their first meeting face-to-face at provider premises (74 per cent); for 12 per cent this was conducted on the phone and for eight per cent in their own home (the remaining five per cent dropped out before the meeting). Most (77 per cent) did not have any practical difficulties, but 13 per cent had problems getting there, five per cent with getting into the building, and four per cent with the cost of transport.

The initial meeting most commonly took place within two weeks after phoning the Contact Centre to join. An important part of the meeting was a short video which explained the research trial, which few panel study respondents spontaneously mentioned. They remembered it when asked, but recall of its content was limited. People did say, however, that it was relatively short, informative, easy to follow and reiterated most of what had already been explained by provider staff. When prompted, most survey respondents (87 per cent) remembered being offered the video, and of these, 97 per cent had watched it. Most (87 per cent) recalled they had found it clear and easy to understand.

One of the purposes of the initial meeting was to tell clients to which of the three Intervention Groups they had been assigned. Eighty per cent of survey respondents recalled being told this then, ten per cent said that they were told on another occasion, and six per cent that they were never told. Among those who did recall being told their group, about eight in ten accurately named it. Seven per cent of Workplace and six per cent of Health group respondents thought they were in the Combined group. Five per cent of the Combined group thought they were in the Health group.
Awareness of the groups also varied among panel study respondents. Some people were unaware that they were in a group at all, or were very vague about it. The concept of a specific group seemed unimportant to them: they were just grateful to be receiving any help at all. Among those who were aware of different groups, levels of understanding varied. Few used the terminology used by service providers, but instead often had their own distinct ways of referring to the different groups.

There was little spontaneous discussion of what people thought about their group. However, there were some who were disappointed by their assignment, most commonly those assigned to the Workplace group who had contacted JRRP to receive a specific health treatment, in some cases on the recommendation of their GP. There was no evidence of disappointment among the Health or Combined groups.

Almost all survey respondents (93 per cent) recalled discussing giving their consent to take part at the initial meeting. Some form of consent procedure was also generally recalled by panel study respondents, though there was sometimes vagueness about what they had consented to. Clients most commonly recalled having consented to allowing their provider to access to medical records, despite this not being a requirement of the trial consent procedure. There was also some recollection of having consented to take part in the research trial, to allow providers to contact their employers and to demonstrate their understanding of the confidential and voluntary nature of the trial.

Almost all (96 per cent) survey respondents who attended the initial interview consented to join the trial at this time and three per cent declined. Of those who agreed to join, 93 per cent recalled signing a consent form. The most common reasons given for deciding to take part was to get back to work (43 per cent), to get general help or support (38 per cent), medical treatment or counselling (11 per cent), or simply to get better (six per cent).

Although no specific concerns were raised about the consent procedure by panel study respondents, it may be a cause for concern that there were wide variations in understanding. Nevertheless it was very clear to people that participation was voluntary and they could withdraw at any time. Most (90 per cent) survey respondents who gave consent realised they did not have to if they did not want to.

Panel study respondents’ described some form of assessment at the initial interview, usually in terms of a ‘meeting’, ‘interview’, ‘induction’ or ‘a quick talk’ involving a series of questions about health and work followed by a discussion of what services were planned. Most survey respondents recalled discussing their health (94 per cent), work (90 per cent), and the services or treatment they might get (86 per cent). Far fewer (15 per cent) discussed the issue of benefits or tax credits (help with these was not offered by all providers). Most (91 per cent) were happy with the discussion, but eight per cent felt that there were things they did not get the opportunity to discuss, the most common being benefits and tax credits (31 per cent), and more explanation of the services/treatments they would get (26 per cent).
The panel study found that these meetings were often carried out by the person who would later become the respondent’s case manager, and typically took from 20 minutes up to one and a half hours (although in one case, the assessment took the form of a series of appointments taking up most of a day).

Few people spontaneously mentioned having been asked what they wanted from JRRP, and there was a strong impression that suggestions were made by provider staff and that the only participant involvement was when they were asked if they had any opinions on or objections to what was planned. Despite this, on the whole, people said they were happy with this level of consultation and did not feel under any pressure to agree to anything they did not want. It was clear that some people lacked the knowledge about what services were available or about what individual services involved in play a strong role in deciding what services they wanted. Some clients, in the Combined intervention in particular, were unaware of the full range of services available. There was also an underlying impression that some were willing to accept the service/treatment being offered even where they had reservations. This is perhaps not surprising given the strong feelings of gratitude people tended to have towards JRRP.

Regardless of participants’ perceived level of involvement in the discussions that took place during assessments, impressions were on the whole positive, especially when compared to the NHS. The only real criticisms of JRRP, at this stage, came from those who were disappointed with their Intervention Group.

There were no reports of any participant involvement in any ongoing assessments of their cases, but it was evident that the services offered to clients developed over time as circumstances changed. In some cases, existing services were adapted in accordance with changes to people’s health conditions. In others, new services were introduced when others had either run their course or had not had the desired outcome.

The action plan was an obligatory part of the assessment procedure, whereby a plan detailing the services and treatments to be provided was agreed with the volunteer, who then signed it and was given a copy. However, there was no spontaneous mention of action plans during the panel study interviews (although when prompted, 81 per cent of Outcome Survey respondents did remember agreeing a plan). Once prompted, some sort of written document was recalled by some, although few could definitely recall having signed it or having received their own copy. Others did not recall any formal record of what was talked about, but were clear that a plan had been discussed.

Revisions to action plans as the trial progressed were seldom reported, but there was a common perception that plans could be changed and would develop with time. For most survey respondents who recalled a plan, their treatment followed it exactly (45 per cent), or a great deal (29 per cent). However, changes to the planned treatment occurred for a sizeable minority, as it was only followed to some extent for 14 per cent, not much for five per cent and not at all for seven per cent.
Panel study respondents’ expectations and understanding of what JRRP could offer often began to change soon after initial meetings with providers. On the whole, expectations were higher at this point, as people were told about the help they would receive, but also due to their positive first impressions of providers. Raised expectations were particularly common among those who had not known what to expect when they initially contacted JRRP.

However, there was a group whose initial expectations were lowered once they learned what the provider had planned, such as one person who, having taken part with the intention of receiving some specific medical help quicker than was available on the NHS, was disappointed when allocated to the Workplace group.

Participants’ experiences of treatments

Regular contact with a single member of provider staff (assumed to be a case manager) was a common experience of panel study respondents, but sometimes it was not possible to identify a single point of contact. Contact was more regular where clients were in receipt of services (ranging from once a week to once a month), and much less regular where there were long intervals between services being delivered, they had ended or none had been delivered. During the first few weeks contact tended to be face-to-face, but subsequently by telephone, and was nearly always initiated by the provider. Participants seemed reluctant to make contact themselves.

The reported role of the case manager varied, ranging from checking progress, making recommendations and referrals, to delivering services and providing emotional and practical support. This support was very important as it was consistently talked about very positively. Benefits included a dedicated contact person; a listening ear who did not judge them; a motivator who was an important source of encouragement and moral support; someone to answer questions and provide useful advice.

Not all Intervention Group respondents received any help: five per cent withdrew before the first meeting and nine per cent had no further contact afterwards. A further 15 per cent had received no treatment or advice by the Outcome Survey interview and only one in ten of these expected any in the future. Twelve per cent had received advice but no practical help (although 16 per cent of these were expecting to). The remaining 58 per cent had received practical help. The Workplace group was most likely to withdraw, especially after the first meeting (when they found out which group they were in). They were also less likely to receive treatment (32 per cent compared to 67 per cent of the Combined and 74 per cent of the Health group). The Workplace group were much more likely to have received just advice or no advice/treatment at all.

Of those who did not withdraw, 23 per cent received Workplace support, most commonly arranging a change in working hours or conditions, or equipment to help them do their job. Fifty-eight per cent received Health support, mostly physiotherapy/therapeutic exercise, counselling, cognitive behavioural therapy or psychotherapy,
referral to a consultant or specialist, or complementary therapies. Almost three-quarters said that both the work- and health-related support were ‘very helpful’, and most of the remainder found them ‘fairly helpful’.

Just over half (52 per cent) of Outcome Survey respondents in the Intervention Groups who did not withdraw said that they received advice (as opposed to practical help/treatment) from or through the provider. The most commonly-mentioned advice was on how to improve health (63 per cent) and return to work (55 per cent). Respondents found the advice slightly less helpful than the practical support.

Panel study participants’ views about services varied. Experiences of physiotherapy were very positive, as they had often had a noticeable impact on health, as were those of occupational therapists, surgery, referral for medical tests, aromatherapy, acupuncture, Pilates, free gym membership, help with job applications and benefits advice. Some services received more mixed reactions, particularly psychological therapy. In the first cohort of the panel study, dissatisfaction with this was more common, while reactions of the second cohort were much more positive. This difference may be the result of improvements in the explanations and delivery of this type of treatment that might have happened over time. Hypnotherapy and service provider liaison with employers also received both positive and negative feedback. Careers advice and some of the associated tests were described as ineffective, as were some of the other workplace related services.

Some gaps in services were perceived, such as where the services wanted were not available in their Intervention Group, or because they were outside the remit of JRRP. Sometimes services were promised but not delivered, either due to funding, because they duplicated other services or were not considered appropriate. The survey shows that a large minority of Workplace group clients (42 per cent) said that services they wanted were not offered, most commonly medical treatment. The level of unmet demand for treatment was lower among Health (27 per cent) and Combined (21 per cent) groups.

The Outcome Survey suggests that ‘contamination’ (i.e. inappropriate treatment for the Intervention Group) in terms of treatment did occur, but at reasonably low levels. Ten per cent of all Workplace and seven per cent of all Health group members were contaminated (according to a self-report measure), most commonly with help to arrange a gradual return to work, counselling/cognitive behavioural therapy or referral to a consultant/specialist. Contamination in terms of advice (i.e. advice about how to improve health given to Workplace clients or about how to return to work to Health clients) was more common (16 per cent of all Workplace and 13 per cent of all Health group members). Likely reasons are that provider staff experienced difficulties in interpreting the guidelines on advice-giving; they perceived conflicts of interest between the trial guidelines and ethical/professional guidelines; it was difficult to monitor whether advice was ‘contaminatory’; it was not obvious why debt/benefits advice was restricted to the Workplace group, and Workplace advice was seen as an integral part of some health treatments.
Opportunities for contamination of the Control Group to occur (i.e. if providers or other organisations gave them any help or advice which led them to change their behaviour) were limited by the design of the trial. The surveys provide evidence that very little contamination of this group occurred.

Accessibility to provider premises did not appear to have been problematic for most respondents, although some had problems getting to the venue, getting into the building or parking. Any comments made by panel study respondents about service provider premises and accessibility were, on the whole, positive. On the whole, communication was described as good where it concerned case managers, although there were some criticisms of how contact ended and some examples of poor communication. Liaison with employers was generally considered effective, but perceptions of communication with GPs were more mixed. There were also mixed views about how well provider staff communicated with each other and their subcontractors.

Among survey respondents who did not withdraw from the trial services before receiving any treatment, 12 per cent turned down some service offered to them, most commonly psychological therapy, refusing permission to contact their employer, physiotherapy, and complementary therapies. Among panel study respondents, there were few cases of clients rejecting specific services. Where they did, it was because the services were seen as inappropriate, there was a lack of time or desire among those already back at work, or they duplicated similar provision outside JRRP.

Twenty per cent of those who withdrew from the services did so because the provider had not contacted or offered them any treatment. Seventeen per cent had other treatment organised, 16 per cent had already or were about to return to work, 12 per cent did not feel well enough to return to work, eight per cent did not like the treatment on offer, and seven per cent thought they were going to get better anyway. Among the panel study, there were three cases of complete withdrawal from JRRP. Dissatisfaction with services received was the reason in each case.

It was rare for panel study participants to receive any formal notification that contact had ended. Typically, contact became less and less frequent to a point where it was assumed to have ended. In other cases, contact ended more abruptly. Where contact had ended and people felt that JRRP had nothing left to offer them, it was generally accepted. However, there were some who were clearly disappointed as they felt that they could still benefit from help in getting back to work. Some had become reliant on the practical and emotional support from their case managers.

Participants talked about how providers had told them they could make contact whenever they needed, but there was little evidence of clients making any contact themselves. Some evidence suggested that people felt they would be wasting their case managers’ time if they did so.
Concluding remarks

The picture emerging from these preliminary analyses is that Intervention Groups participants had, on the whole, a positive experience of taking part in the trial. They felt that they received clear explanations about the trial, were generally pleased to be assigned to these groups, and had positive initial impressions of provider staff and premises. In general, they were impressed with the speed with which treatments were arranged and felt that the treatments and advice received were helpful. The practical and emotional support provided by case managers was particularly appreciated. However, there were some problems: according to the survey some experienced delays in meeting with providers for the first time and a small proportion never did so or received any treatment (although this was by choice for many). Some had problems getting to the provider’s premises. Client involvement in deciding on their treatment appeared to be limited, and some were unhappy with their treatment – Workplace clients in particular were likely to feel they had not received the treatment they wanted.

The evidence on the Control Group’s experiences is more limited, but it is clear that they experienced disappointment with their group. However, they were on the whole satisfied with the explanation they received about the trial, and most realised that there was a chance that they would not receive any help.

Key emerging findings which may have policy implications are:

- A more positive attitude towards returning to work among employers and GPs was important in the cases of those who had gone back to work shortly after contacting JRRP. Some of those who remained off sick described much less supportive attitudes.

- The fact that people volunteered to join JRRP despite often vague expectations of what it could offer, suggests that there is a gap in services available and that many people on sick leave are keen to look for help.

- Most survey respondents were satisfied with the explanation they received from the Contact Centre and from the video that was shown at the consent interview. Most understood that the trial was voluntary and that they could withdraw at any time and almost all recalled giving their consent to take part.

- The concept of randomisation was not always understood or believed, which highlights how difficult it can be to communicate complex concepts to participants.

- The trial design has successfully prevented any significant contamination of the Control Group.

- Most of the Control Group were quite disappointed at their allocation. A forthcoming qualitative focused study of Control Group members will help to provide further information on the reasons for these reactions and possible effects on behaviour.
- Panel study respondents were not always aware of the full range of services available to them through JRRP or what individual services are involved, and service providers should not assume that they are. Providers would need to communicate more of this type of information if clients are to be more actively involved in decision making.

- Impressions of service providers tended to be good, especially at the beginning. There were some reports of dissatisfaction with the way in which some services were delivered as participation continued, but the evidence may suggest that some early problems were ironed out as JRRP developed.

- Contamination between the Work and Health groups seems to be at reasonably low levels in terms of actual treatments received, but higher in terms of advice. This is not surprising given the conflict experienced by many provider staff which tended to lead to them putting their perceived legal and professional obligations before those of the trial. Ways of reducing conflict between existing professional codes and the requirements of a randomised control trial need to be considered in any future trial, for example, more consultation with provider staff at the beginning of the trial, and having a bedding-in period of a few months, after which conflicting definitions could be revised in consultation with staff.

- The role of case managers in providing practical and emotional support was very important to some JRRP clients. It is important for providers to maintain regular contact with clients and not expect participants to make contact themselves. Communicating the end of service provision to the client should be made clearer.
1 Introduction

This report contains early findings of participants’ experiences of taking part in a randomised control trial, the Job Retention and Rehabilitation Pilot (JRRP). This trial is being evaluated by the National Centre for Social Research (NatCen), in collaboration with the Social Policy Research Unit (SPRU) at the University of York, and the Urban Institute (Washington DC). The objectives of the trial are outlined in Section 1.1, and the main features of its design in Section 1.2. The objectives of this report are described in Section 1.3, and the sources of data used throughout are documented in Section 1.4.

1.1 Objectives of the Job Retention and Rehabilitation Pilot

The Job Retention and Rehabilitation research trial was developed to test interventions which might decrease the length of sickness absence and increase job retention for people with a health condition or impairment. In the UK since the early 1980s, the number of people on incapacity benefits has been increasing and this cannot be explained by any worsening of the health of the population. There is also concern over the incidence of sickness absence, particularly those on longer term absence, who are more likely to be at risk of losing their job or their business because of their illness, injury or impairment and many of whom do not work again.

For some people, long term sickness absence leads to a claim for incapacity benefits. Currently 7.6 per cent of the working age population are on incapacity benefits because of a health condition or impairment. When people start claiming these benefits, around 90 per cent say that they expect to return to work, but in fact more than 40 per cent will still be in receipt of these benefits a year later1. Just over 50 per cent of current recipients of incapacity benefits have a claim that has lasted five years or more.

Although not all those on certificated sickness absence or incapacity benefits would define themselves as disabled, evidence shows that employment rates fall with the onset of a disability and continue to fall the longer the disability spell lasts (Jenkins

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and Rigg, 2004). Labour Force Survey data show that in Spring 2003, approximately 6.9 million people of working age reported being long-term disabled and approximately 5.4 million declared a work limiting disability (Tibble 2004). The unemployment rate for disabled people in spring 2004 was about seven per cent compared to an unemployment rate amongst non-disabled people of around four per cent. Disabled people are very much more likely to be economically inactive (around 46 per cent compared to approximately 16 per cent of non-disabled people).

Such statistics reinforce concern with difficulties in both maintaining employment and improving labour market outcomes for people with health conditions and for disabled people. The Government’s concern to prevent long-term incapacity, improve return to work rates for people on sickness absence, and increase their employment retention was the basis for the JRRP.

Thus the purpose of this trial is to evaluate the impact of intervening early among the target population of people who have been off work due to sickness or disability for six weeks or more and who are at risk of losing their job or business as a result. The pilot aims to demonstrate whether one of three types of boost to existing services affects the rate of return to work and job retention. The outcome of the pilot will guide future policy priorities.

Along with one other recent trial, JRRP is unique amongst UK welfare to work initiatives, as it was designed from the start to be run as a research project, with evaluation fully integrated into the design. To ensure the evaluation is as robust as is possible, the pilot used random assignment, the first time this had been attempted on a large-scale voluntary labour market programme in the UK.

The design is also unique in that three models of intervention are being tested (see next section).

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2 The unemployed are still considered to be economically active. DWP in-house analysis Labour Force Survey Spring 2004.


4 The Employment Retention and Advancement Scheme (ERAS), another randomised control trial which is piloting services for lone parents and the long-term unemployed.

5 ERAS was launched shortly after JRRP.
1.2 Design of the trial

The basic features of the trial are as follows:

- the trial was run in six areas of the UK;
- it was aimed at those in employment of 16 hours or more a week who had been off work because of sickness or disability between six and 26 weeks;
- those interested in taking part volunteered by calling a central Contact Centre;
- those eligible were screened, and only those ‘likely’ to lose their job were accepted onto the trial;
- those eligible and screened-in were randomised to one of four equally sized groups: a Workplace intervention; a Health intervention; a Combined intervention and a Control Group;
- the impact of the interventions will be measured by comparing subsequent return-to-work rates for the four groups.

1.2.1 The areas

JRRP was run in Greater Glasgow, Newcastle and North Tyneside, Teesside, Sheffield, Birmingham and West Kent and these six areas were covered by four service providers. The actual areas covered were much larger than the area names suggest. For example, the Glasgow area covered not only the city of Glasgow, but extended into surrounding counties, such as Lanarkshire, Dumbartonshire and Renfrewshire. A single provider covered each area, although two service providers each covered two areas. In every area all three interventions were offered. In Birmingham and West Kent, the three interventions were each provided by a separate organisation through a sub-contracting arrangement.

1.2.2 Eligibility

To be eligible for JRRP several conditions needed to be satisfied. A client must:

- have been employed or self-employed and working for 16 hours a week or more;
- have been off work sick for between six and 26 weeks;
- have been living and, in most cases, working within one of the pilot areas;
- not be within 18 weeks of planned retirement.

However, to be entered onto the trial, clients had to be both eligible and to be ‘screened-in’. The ‘screening in’ process was designed to identify those with (on average) a greater than 50 per cent chance of losing their job if they received no intervention.
1.2.3 Marketing
There are no centrally held lists of those absent from work because of sickness or disability, so direct marketing to the eligible population was not possible. Instead, service providers implemented a variety of methods of marketing the pilot, including recruitment via General Practitioners (GPs) and employers, and general advertising (posters, radio, etc.). Potential participants needed to self-refer by calling a Contact Centre (or sending a freepost slip as described below).

Part-way through the trial some new marketing methods were implemented. ‘Field Advisers’ from an independent organisation were employed in each area during April 2004, to promote the pilot in GP surgeries selected by providers. They were given restricted information to give to, or discuss with, interested people, and encouraged people to call the Contact Centre. Some providers continued with this method of marketing for the rest of the trial. Around the same time, a central marketing organisation representing all providers conducted a mailshot of employers to raise awareness.

Freepost slips were used in all areas, where a volunteer could send their details to the Contact Centre using a slip rather than calling themselves. The Centre would then get in touch to provide more information and take the volunteer through the screening if appropriate. In addition, branded MED3 forms (which are used by GPs when completing sick notes for patients) with detachable slips to send to the Contact Centre were circulated to GPs from around the end of June 2004.

1.2.4 Entering the trial
To enter the trial, potential clients called a central telephone Contact Centre, where:

- they were given a brief explanation of the trial;
- eligibility for the trial was checked;
- those eligible were asked a series of questions from which an ‘at risk’ score was determined, and those who scored above a threshold value were invited to enter the trial;
- names and addresses of those ‘screened-in’ who wished to enter the trial were passed to NatCen for randomisation.

Volunteers were screened to reduce the number of people in the trial who would return to work irrespective of whether they received an intervention. Screening out such people will increase the power of the impact estimates to allow an effective measure of relative net impact of each of the three types of intervention with a smaller sample size than would otherwise be required. The screening was implemented as a computer-assisted telephone interview conducted when people contacted the Contact Centre to volunteer for the trial. A risk score was calculated from their answers and those achieving a score greater than a cut off were not considered at risk of job loss and were ‘screened out’.6

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6 For more detail on the screening tool, see Natarajan L., Smethurst L., Stratford N., and Taylor R. The implementation of a randomised control trial: improving the measurement of impact in the Job Retention and Rehabilitation Pilot using a screening tool developed for the Department for Work and Pensions, UK.
The tool carried out a number of tasks in addition to calculating the risk of job loss and eligibility for the pilot. It collected information to identify uniquely each volunteer and check whether a caller has put themselves forward at an earlier date, to prevent participants who do not have an outcome record from entering the pilot again and being randomised to another group. Also it is a source of standard information about the trial which forms part of the ethical obligations, for example to confirm that participants were not being coerced into the trial, that they understood that it was a randomised control trial and were given enough information to be able to give informed consent to randomisation.

Screening (and randomisation) took place for a period of 21 months in total, from April 2003 to December 2004. During this time, a total of two thousand, eight hundred and forty five people were screened and randomised into the JRRP trial.

1.2.5 Randomisation

Those who were screened-in and agreed to enter the trial were randomised to one of the four groups in equal numbers. This was done by a small team based at NatCen’s Telephone Unit in Brentwood. The randomisation was carried out using block randomisation separately for each pilot area, which ensured an almost exact 25 per cent allocation per group, both by area and over time. Randomisation occurred as quickly as possible after clients agreed to enter the trial, the maximum lag being 48 hours.

The design of the trial and the different pathways that volunteers could take through it is summarised in Figure 1.1 below.

Figure 1.1 JRRP Trial Design
1.2.6 Notifying clients and providers

All clients were notified of the randomisation outcome by post, although those randomised to an intervention were not yet told to which of the three groups they had been allocated. To minimise withdrawals from the service, the letters were sent out on the same day as randomisation, and explained to people that they were part of the trial, that they were free to use all normal services, and that NatCen would like to interview them in several months time. Clients were also given a freephone number to call (at NatCen) for further information.

In addition, service providers were notified of anybody allocated to an intervention on the same day as the letter was sent. All those randomised to one of the three interventions went through four additional stages before their plan of treatment (‘action plan’) was drawn up:

- they watched a short video that described the three way randomisation, and the written consent procedure;
- they were notified to which of the three groups they had been allocated;
- they were given an explanation of what their intervention might look like;
- they were asked to give written ‘consent’ that they had been given a full explanation of the trial, that they had had a chance to ask questions, that they consented to data being shared across the research team, and that they understood they could withdraw from the trial, or any component of the intervention, at any time.

In most instances this process took place during a face-to-face meeting between the client and a member of the service provider staff. Clients were allowed time to consider whether they would like to take part. Those giving written consent could then go straight to the assessment stage. In West Kent and Birmingham, the procedures for Health intervention clients were different because this was a telephone service; these clients were sent information about the consent procedures by post and asked to watch the video and sign the consent form at home and then post it back. However, these procedures changed half-way through the trial to become more similar to other areas, due to the higher levels of attrition which seemed to be resulting from this method.

1.2.7 The interventions

Those allocated to an Intervention Group and giving written consent were assessed and an individual action plan was drawn up. The interventions had to be appropriate for the group to which the client was allocated, and had to adhere to the following ‘rules’:

- there were major differences in the Health and Workplace interventions (even if there were some common elements);
- elements that featured under one of these interventions for one provider should not be under the other for another provider.
The Health intervention was defined in the following way:

- must be delivered away from the workplace;
- must deliver a treatment to the mind or body of the recipient;
- must not contact or seek to influence the employer or the workplace;
- could not be delivered by an Occupational Health Nurse;
- advice could only be about the health condition and focus on the physical body/mind.

The Workplace intervention was defined in the following way:

- could be delivered in any location;
- must be delivered by an appropriately qualified professional or organisation;
- could involve contact with the recipient’s employer;
- must focus on bringing about some degree of change within the individual’s workplace environment;
- advice could only be about the workplace or how people work.

The Combined intervention could be any or all of the above.

1.2.8 The service providers

The four service providers and the areas they were responsible for were:

Table 1.1 JRRP service providers, areas and brand names

<table>
<thead>
<tr>
<th>Lead organisation</th>
<th>Service name</th>
<th>Area</th>
<th>Area abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Glasgow, Public Health Department</td>
<td>HealthyReturn</td>
<td>Greater Glasgow</td>
<td>GL</td>
</tr>
<tr>
<td>Northumbria University</td>
<td>RouteBack</td>
<td>Newcastle &amp; Tyneside, Teesside</td>
<td>TY, TE</td>
</tr>
<tr>
<td>Sheffield Occupational Health Advisory Service (SOHAS)</td>
<td>WorkCare</td>
<td>Sheffield and surrounding district</td>
<td>SH</td>
</tr>
<tr>
<td>Human Focus*</td>
<td>WorkCare</td>
<td>Birmingham</td>
<td>BI, WK</td>
</tr>
<tr>
<td></td>
<td></td>
<td>West Kent</td>
<td></td>
</tr>
</tbody>
</table>

* Human Focus sub-contracted delivery of the health and Workplace interventions to Health First and Atos respectively (formerly known as First Assist and Schlumberger).

The screening tool was delivered at a national Contact Centre based in Glasgow. This centre was based at Call Point Europe under the management of the consortium delivering the JRRP service in Glasgow.
1.3 Objectives of this report and future publications

This report aims to give an early account of taking part in this randomised control trial, from the participants’ point of view. It explores participants’ experiences of contacting JRRP and receiving services, based on data from two partially-completed surveys (an Outcome Survey and a Survey of Controls and Screened-outs), and two out of three cohorts of the qualitative panel study. First, we describe the characteristics of participants (Chapter 2), and then consider their motivations for, and experiences of, volunteering for and entering the trial (Chapter 3). Chapter 4 describes volunteers’ first impressions of the service providers themselves and their experiences and views on the treatment and advice they received are covered in Chapter 5.

Measures have been taken to preserve the anonymity of all respondents. In the qualitative reporting, which gives detailed accounts of individual circumstances, this involves removing additional information, such as gender, which could potentially lead to identification.

Full reporting of the completed panel study and Outcome Survey will provide a richer set of findings than the preliminary results from partial samples reported here. Moreover, this report does not give any findings on the outcome of the trial, in terms of the impact of the interventions on return-to-work outcomes. These require careful analysis of the comprehensive data collected within the JRRP evaluation. Hence, more detailed reports presenting analysis of JRRP delivery, participants’ characteristics, motivations and experiences, outcomes and impacts, together with cost-benefit analysis, are scheduled for publication later in 2005 or early 2006. These reports will be preceded by a methodological assessment of the running of the randomised trial itself which will draw mainly on the research advice work and elements of the process evaluation.7

In addition, the following publication from the trial is due to be published in Spring 2005:

- *GP’s management of patients’ sickness absence from work*, (Mowlam and Lewis)

Finally, the following outputs from the evaluation have already been published:


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7 To receive notification when the reports are published and/or a copy of any of these reports, email Paul.Noakes@dwp.gsi.gov.uk. DWP research reports can also be found at www.dwp.gov.uk/asd/.
1.4 Brief description of data sources for this report

The data on which this report is based is derived from several different strands of the JRRP evaluation, which are described below. (A complete description of all the elements of the evaluation can be found in Appendix A).

1.4.1 Panel study aims and design

This section briefly describes the aims and design of the panel study. A more detailed discussion of how participants were recruited to the panel and a sample profile of the participants across all three cohorts of the study is given in Appendix B.

The panel study is one part of the process evaluation of JRRP. Its purpose is to interview a panel of participants at regular intervals over six months to collect information about experiences and events close to their actual occurrence, when recall is expected to be good. It is designed to provide detailed descriptive data about clients’ experiences to explore their participation as they use the service and to observe any changes in their feelings, views and intentions as they occur. Once complete, it will provide a rich understanding of how clients use the service, what they think of it, and what type of help is more or less useful at different stages.

The panel comprises a total of 36 people, in three cohorts, purposively selected to ensure coverage of the three Intervention Groups, the six different providers (but avoiding duplication for the two providers which operated in two areas\(^8\)), duration of the trial, diversity in sex, age, ethnicity, occupation, employer size and activity, industry sector, length of time off sick when people first contacted the service, type of employment contract (full or part-time; permanent or fixed term), self-employment and health condition.

The sample is divided into three cohorts to allow differences in experiences as services developed and matured to be included. In addition, this strategy allows interim feedback. However the panel study is designed as a sample of 36 cases to be reported together at the end of the study.

Each cohort follows 12 JRRP clients over a six-month period beginning as soon as possible after their first contact with the provider. The first interview takes place in the participant’s home in order to build rapport and because of the detail and length of this interview. Participants are then interviewed approximately every four weeks by telephone to examine any developments in their health, any movements towards a return-to-work and any impact JRRP may have had on these. Clients continue to be interviewed regardless of whether they are still in contact with a JRRP provider.

At the time of writing, the first two cohorts had been completed (fieldwork periods ended in January 2004 and October 2004 respectively) and the findings are integrated in this report. Fieldwork for the third and final cohort began in October 2004 and finished in May 2005.

\(^8\) The areas chosen were West Kent (WorkCare), Tyneside (Routeback), Glasgow (HealthyReturn) and Sheffield (WorkCare).
It should be noted that the qualitative data presented in the remainder of this report are based on the 24 participants who took part in the first two cohorts, and focuses on experiences rather than impacts and outcomes. Readers should also be aware that any comparisons made between the two cohorts are based on small samples and therefore may not be more widely generalisable. The third cohort of the panel study has yet to be analysed and full findings from all three cohorts will be reported at a later date.

1.4.2 SoSOC aims and design

The Survey of Screened-Outs and Controls (SoSOC) is a telephone survey lasting about 20 minutes, conducted by NatCen among trial entrants who were randomised to the Control Group and people who had called up to join the trial but were screened-out as not at risk of losing their job. The latter group did not include those who were ineligible to take part in the trial.

The survey’s main aim is to provide an estimate of the deadweight rate of the trial, to give an early indication of the effectiveness of the screening tool. The deadweight measured by the survey is a return to work (of any length) amongst the Controls at 28 weeks after first going off sick from work. The survey also collects information on respondents’ experiences of entering the trial, which provides some of the data used in this report.

The SoSOC data used in this report is based on a partial sample, as fieldwork was almost, but not quite complete at the time of writing. The full sample will be analysed in a forthcoming report which will evaluate how the trial operated. More detail on this survey including response rates are given in Appendix B.

1.4.3 Outcome Survey aims and design

The Outcome Survey (OCS) is a face-to-face10 survey conducted at home with all those randomised into the JRRP trial, whether they be in any of the Intervention Groups or the Control Group. The main aim is to collect comprehensive outcome data on the four randomisation groups. This interview lasts an average of just over an hour.

The main outcome measure is collected via a detailed work history, covering the period between first going on sick leave and the week before the OCS interview. Various secondary outcomes are measured such as mental and physical health.

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9 That is those who did not live and work within the designated areas, or who were within 18 months of planned retirement, or had not been off work for between 6 and 26 weeks.

10 The survey was conducted face-to-face with the exception of a small number of interviews with respondents who also participated in the panel study. The OCS was conducted as a shortened telephone interview with these cases to reduce the burden of the evaluation.
(using a computer-assisted self-completion section), attitudes to work, and financial situation. There are also questions about participants’ experiences of taking part in the trial, and their views on providers and the services they received.

Interviewers are given a ‘target date’ to help them time the interview correctly, either 44 weeks after the respondent first went off sick from work (for those who were off work sick for between six and 22 weeks at the time of calling the Contact Centre) or 48 weeks after this date (for those who were off work between 23 and 26 weeks). Interviewers are instructed to interview no earlier than one week before the target date, and to aim for an interview no later than one week later (although the latter rule is flexible, as it is preferable to have a late interview than none at all). The reason for this timing and more detail on the survey including response rates are given in Appendix B.

The OCS is not yet complete – interviewing will continue into summer 2005, as the last entrants to the trial will not reach their target dates for interview until then. This report contains preliminary findings of participants’ views and experiences of JRRP, based on the first 1,545 cases to be interviewed and edited (about 70 per cent of the total number of cases expected to be interviewed once the survey is complete).

The survey data are reported unweighted (see Appendix B for further detail).

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11 This does not include the cases from the pilot, who due to the data model being different, have not yet been coded and edited. They will be included in the final dataset as it will be important to include as many clients as possible in the impact analysis to maximise the statistical power of the sample.
2 Characteristics of respondents

The first part of this chapter draws on the data collected from participants during the Outcome Survey (OCS). The data describes the characteristics of respondents, the purpose being to provide some background on the types of people who entered the trial (Section 2.1), and on their housing (2.2), qualifications and employment (2.3) and health (2.4). Section 2.5 uses data from the first panel study interview to give some background into participants’ situation with regard to returning to work at that time.

2.1 Demographic characteristics

Fifty seven per cent of OCS respondents were female, the same proportion as were randomised into the trial (so this does not represent a response bias). Most respondents were in their 30s (25 per cent), 40s (33 per cent) or 50s (30 per cent) at the time they were interviewed. Seven per cent were under 30 and five per cent were over 60. Nine in ten were White, with the largest ethnic minority groups being Indian and Caribbean (both two per cent).

2.2 Household and housing

Two-thirds of OCS respondents were married or living with a partner, 40 per cent without any dependant children living at home, and 27 per cent with children. Sixteen per cent were living alone, and seven per cent were single parents. Ten per cent were living in some other type of household.

Most were buying their home with a mortgage (58 per cent) or already owned it outright (15 per cent). Eleven per cent were renting from a Local Authority, five per cent from a Housing Association and four per cent were renting privately. Five per cent were living in the home of their partner, parents or relatives. Very few had any other arrangement for their housing.
2.3 Qualifications and employment

As would be expected of a group of people who were recently in work, most respondents held some qualifications. Twenty per cent had a degree or equivalent, 27 per cent A levels or similar, and 32 per cent qualifications below this level. Three per cent had qualifications where the level was not classified. Only 17 per cent had no qualifications at all.

Almost all OCS respondents have had a very stable working life. When asked to choose a statement from a card which best summed up their experience between leaving school or college and now, 88 per cent said that they had spent most of this time in steady jobs (Table 2.1). A small proportion (four per cent) had spent a lot of their adult life looking after their family or home, and a similar number (three per cent) had been in and out of work several times. Only one per cent had spent a lot of time out of work because of a health condition. This strongly suggests that for most respondents, taking time off work due to ill-health was a fairly recent event and not one that had characterised the majority of their working life.

Table 2.1 Summary of working life of JRRP Outcome Survey respondents

<table>
<thead>
<tr>
<th>Statement</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>... spent most of my working life in steady jobs</td>
<td>88</td>
</tr>
<tr>
<td>... spent most of my working life self-employed</td>
<td>1</td>
</tr>
<tr>
<td>... mainly done casual or short term work</td>
<td>1</td>
</tr>
<tr>
<td>... spent a lot of time out of work because of a health condition</td>
<td>1</td>
</tr>
<tr>
<td>... spent more time unemployed than in work</td>
<td>*</td>
</tr>
<tr>
<td>... spent a lot of my adult life looking after family or the home</td>
<td>4</td>
</tr>
<tr>
<td>... spent a lot of my adult life caring for a sick or disabled adult/child</td>
<td>1</td>
</tr>
<tr>
<td>... been in and out of work several times</td>
<td>3</td>
</tr>
<tr>
<td>None of these apply to me</td>
<td>1</td>
</tr>
</tbody>
</table>

Unweighted base (all respondents) 1545

2.4 Health

OCS respondents were asked to describe the health condition(s) or disability(ies) that was/were affecting them at the time they went off sick from work. These conditions were coded according to the International Classification of Diseases (ICD-10) coding system and the results are shown in Table 2.2 below. Two types of condition stand out: 42 per cent mentioned diseases of the musculoskeletal system and connective tissue (for example, back and neck problems), and 41 per cent mental and behavioural disorders (for example, stress, depression or anxiety). No other single type of condition was nearly as common, with the next most prevalent being injury, poisoning and other consequences of external causes (21 per cent) and diseases of the circulatory system (ten per cent).
Table 2.2  Health conditions of JRRP Outcome Survey respondents at the time they went off sick from work

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Preliminary Outcome Survey %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>42</td>
</tr>
<tr>
<td>Mental and behavioural disorders</td>
<td>41</td>
</tr>
<tr>
<td>Injury, poisoning and certain other consequences of external causes</td>
<td>21</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>10</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>7</td>
</tr>
<tr>
<td>Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified</td>
<td>7</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>6</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>5</td>
</tr>
<tr>
<td>Endocrine, nutritional and metabolic diseases</td>
<td>4</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>3</td>
</tr>
<tr>
<td>Certain infectious and parasitic diseases</td>
<td>2</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>2</td>
</tr>
<tr>
<td>Factor influencing health status and contact with health services</td>
<td>2</td>
</tr>
<tr>
<td>Diseases of blood &amp; blood-forming organs and certain disorders involving immune mechanism</td>
<td>1</td>
</tr>
<tr>
<td>Diseases of the eye and adnexa</td>
<td>1</td>
</tr>
<tr>
<td>Diseases of the ear and mastoid process</td>
<td>1</td>
</tr>
<tr>
<td>Diseases of the skin and subcutaneous tissue</td>
<td>1</td>
</tr>
<tr>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>1</td>
</tr>
</tbody>
</table>

Unweighted base (All respondents except five who refused to give details of their health condition) 1540

Note: columns do not sum to 100 as more than one health condition could be given

2.5  Position in relation to a return to work at the first panel interview

This sub-section draws on data collected at the first panel interview with participants about their position in relation to a return-to-work at that time. It also explores whether any steps had been taken by employers, healthcare professionals or any other relevant parties to encourage a return-to-work.

At the first panel interview, two respondents were no longer employed, four had already returned to their existing jobs, and the remainder were all still on sick leave. These different positions are discussed in turn below. The first panel interview was conducted early on during peoples’ participation in the Job Retention and Rehabilitation Pilot (JRRP) and there was no evidence of any impact of JRRP on these early outcomes. Thus we report the situations of respondents here to provide background on their position before JRRP intervened.
2.5.1 Those who were no longer employed

Both respondents no longer employed had become unemployed shortly after getting in contact with JRRP, having been dismissed on the grounds of ill-health. In one case, an employer was described as having been quite supportive prior to the point of dismissal; the line manager had kept in regular telephone contact with the employee and had also investigated the possibilities of redeployment or of making adjustments but found no alternatives that suited the employee’s condition. In contrast, in the second case, a respondent reported no employer support with regard to remaining in work.

In both cases, healthcare services (outside JRRP) seemed to have had little impact on improving respondents’ fitness for work. In one case, despite a number of referrals to specialists and for scans, a participant was still without a definitive diagnosis of their condition. In the other case, a respondent reflected that a lack of progress might have been due to the insufficient length of time spent with their GP during appointments.

2.5.2 Those who were already back at work

The four clients who had already returned to work before the first panel interview had some very similar characteristics; their medical conditions were all recurrent and they had all made a graduated return-to-work. However, they differed in their perceptions of how supportive their employers had been in helping them get back to work. In three of the cases, employers did appear to have been supportive. This involved tangible support like regular contact (in the form of home visits and telephone calls) from line managers to check on employees’ progress and discussions of graduated return plans with occupational health staff. It also involved more intangible forms of support, such as a generally positive attitude towards the employee, which included showing concern for their condition and encouraging a return-to-work only when fit and ready. This level of support appeared to be associated with the recurrent nature of this group of respondents’ conditions. For example, in one case, both manager and employee were accustomed to a pattern of recurrent sickness absence over a number of years during which time the employer had become flexible, allowing the employee to work when health allowed and to take time off when it did not. In another case, a respondent described how their employer had told them not to return to work until they felt fit enough. This attitude was, they felt, the result of the manager having learned from a previous absence period, when the employee had returned to work too soon and become ill again. In the third case, the employer was described as having been very understanding about the employee’s need for time off for treatment for a condition that had developed following an accident in the workplace. This employer’s supportive attitude continued once the employee was back in work; new equipment had been provided.

In the fourth case, the respondent’s employer was described as having been supportive in the beginning, with home visits initially and then follow-up telephone calls. However, the tone of this contact soon started to change and the respondent
began to feel under pressure from the employer rather than supported. This person felt under pressure to return to work before they were fully recovered or risk being dismissed. Ultimately the fear of dismissal pushed this person back to work sooner than they would have planned. Once back in work, support was still felt to be lacking. In particular, the respondent was disappointed about not having been consulted about a change in duties.

The healthcare services, outside of JRRP, that this group of participants were receiving also had a role to play in their returns-to-work. GPs, in particular, played an important part in the rehabilitation process. It is possible to identify two distinct, but linked, roles: providing healthcare support and providing return-to-work support. In terms of healthcare support, GPs prescribed medication but had also encouraged their patients not to go back to work before they were sufficiently fit. Given that the health conditions of these four people were all recurrent, their GPs had often had direct experience of how detrimental a premature return-to-work could be for their recovery. Once respondents were in a position to return to work, some GPs provided an important source of return-to-work support. This took the form of acting as someone to talk to once in work or as an advocate—in one case a GP had negotiated with an employer to reduce one participant’s working hours which had proved too demanding following the return-to-work. It also involved making referrals to specialists to help with the psychological impacts of being back at work. Other healthcare professionals were also involved in helping people remain in work following a return. For example, a physiotherapist continued to provide treatment once the patient was back in work.

2.5.3 Those who remained off sick

The remaining participants were all absent from work when they were interviewed at the beginning of the panel study. The involvement of employers, GPs and other healthcare professionals in helping people move closer to a return-to-work was varied.

Contact with employers, which included both line managers and occupational health staff, appeared to be largely driven by the approach the employer took to the employee. It is possible to identify two extremes in employer attitudes. At one extreme, there were those employers who wanted their staff to return to work but only when the employee was physically and mentally ready. This more supportive attitude from employers was illustrated by a number of different reported behaviours:

- Line managers or supervisors maintained regular informal contact. This more commonly involved weekly phone calls but also regular informal meetings and home visits in some cases. Employees described these encounters as friendly and did not appear to feel pressured by them. Additionally, there was often contact with colleagues and friends from work which ranged from colleagues sending cards and telephoning to the absent employee visiting the office to provide sickness certificates, keep up-to-date with any changes or take part in social events where their health condition allowed.
It was also common among more supportive employers for there to have been some discussion with the employee concerning how he or she might come back to work. One example was where a participant talked about how their manager had offered to extend a training period (in a new job) and had discussed a number of possible redeployment options with them. In another case, a respondent reported that a provisional target date for a return-to-work had been agreed with a line manager, but with a caveat that the return could be delayed if recovery had been slower than expected.

Some respondents also talked about how they had received support from occupational health staff during their sickness absence. In one example, a participant was relieved when an occupational health doctor confirmed that a return-to-work should only be attempted when the employee was ready. In another example, an employee had been referred by their employer’s occupational health service to one of the JRRP service providers.

Finally, there was one case of an employer agreeing to fund private healthcare treatment for an employee.

At the other extreme were those employers who were thought to have demonstrated a lack of flexibility when considering their employees’ returns-to-work. This less supportive attitude was indicated by the following reported behaviours:

- Compared to the more supportive employers described above, contact with management or occupational health staff was much less frequent, or non existent in very extreme cases. Where it did occur it tended to be on a formal basis and consist of the employee attending meetings to update management when sick notes were extended, to discuss return-to-work dates, or to have medical assessments carried out by occupational health staff. Participants’ descriptions of contact with employers tended be very negative, especially with regard to occupational health staff. One respondent, for example, described the occupational health nurse they had met as ‘cold and unsympathetic’ in the way she questioned the seriousness of the respondent’s condition. Management were also sometimes the subject of negative comments. Some respondents felt that their employers showed no interest in their health and general wellbeing and that the only support they received of this kind was from colleagues. A more extreme example of an unsupportive employer was where a boss was reported as having told an employee that she was not interested in the respondent working for her if they were incapacitated in any way.

- Discussions of a return-to-work typically focused on setting a return-to-work date but did not include any conversations about how the process of returning to work could be facilitated, such as through redeployment, graduated returns or by making appropriate adaptations to the workplace. Return-to-work dates were either set directly by the employer or employees were required to provide a fixed return-to-work date themselves. This was difficult for those who had made little progress health wise towards a return-to-work. Regardless of who set the date, this process put pressure on some employees to return to work...
sooner than they were ready. For example, one person who was unable to provide their employer with a return-to-work date regularly received requests from work to take on jobs as if the respondent were still working. Having to call and remind the employer that they were still off sick added to the pressure this employee was already feeling from the employer to get back to work as soon as possible. Where employees could not demonstrate that they could return to work by the required date, some employer discussions turned to the subject of termination of employment. In one example, someone nearing retirement age was encouraged to consider taking early retirement.

- As options like redeployment or graduated returns were rarely suggested by this group of employers, it was up to the employee to make a specific request. However, such requests were generally turned down because management would not allow it on the grounds that it would be impractical within the working environment or for other reasons not specified. In one example, someone had requested to return to work on a part-time basis as it was felt that the condition would not allow them to work full-time. However, all the employer would allow was a graduated return to full-time working hours which ultimately failed and so the respondent was signed off sick again in a matter of days.

- Whilst employees were expected to keep their employers updated about health conditions and sick notes, there appeared to be no reciprocal updating of employees about what was happening with their jobs during their absence. One person had heard rumours about restructuring at their work which could have meant that they no longer had a job to go back to. This was neither confirmed nor denied by the employer. As a consequence, employees tended to be suspicious of the motives of any contact with their employer. Some talked about how some contacts with their manager had made them feel as though they were being checked up on to see if their absence was legitimate. Similarly, the involvement of occupational health staff was perceived by some respondents as a means for their employer to gather the necessary evidence – by means of a medical examination for example – to allow them to dismiss the employee.

Contact with healthcare professionals and their involvement in people’s progress back to work was also varied. Typically, General Practitioners (GPs) had the most contact with participants but hospital consultants and community psychiatric nurses (CPNs) were also involved in some instances. The breadth and frequency of this contact varied, and this variation was often associated with how supportive healthcare professionals were perceived by their patients. Participants found it more supportive where GP (and in one case a CPN) contact was more regular, where sick notes were regularly reviewed (e.g. every two weeks), where referrals were made not only within the National Health Service (NHS) but also to outside services including JRRP, and where GPs raised the subject of returning to work with their patients. Approaches that people saw as less supportive were infrequent contact with GPs as a result of longer term sick notes (of four weeks or more) being issued, inadequate explanations about their conditions, and a lack of referrals to specialists.
or other services. However, the referral process was also criticised, where there was
delay and a larger number of specialists involved. One respondent, for example,
described having felt like a piece of paper being passed between different
consultants trying to decide on the correct form of treatment by what seemed like a
process of elimination.
3 Participants’ experiences of entering the trial

This chapter explores the process of joining the Job Retention and Rehabilitation Pilot (JRRP) trial from the participants’ point of view, including where they heard about the trial (Section 3.1), their reasons for joining (3.2), and the views of their family, employer and General Practitioner (GP) about this (3.3). It also provides feedback on participants’ experiences of screening (3.4.1), including how well they felt that the trial was explained to them (Section 3.4.2), their reactions to being randomised and their understanding of the randomisation process (3.4.3). The chapter draws on early findings from the first two cohorts of the qualitative panel study, and data from the partially completed Outcome Survey (OCS) and Survey of Controls and Screened-Outs (SoSOC).

3.1 How and what participants first heard about JRRP

The survey findings reported in this section are based on an amalgamation of data from the two surveys (the OCS and SoSOC)\(^{12}\). Evidence from both surveys combined shows that a very high percentage of volunteers found out about the trial through their GP or employer (Table 3.1). Just over one third (36 per cent) heard about it from a GP or other medical/health care professional, 28 per cent from their employer or through work, and 14 per cent from adverts at the GP’s surgery. Other less common ways of finding out about the project had been word-of-mouth through friends or relatives (five per cent), adverts in a newspaper/magazine (four per cent), and on the radio (three per cent).

\(^{12}\) All those in the Control Group were approached for SoSOC (see Section 1.4.2 for more detail). Those who responded were asked, among other things, about how they heard about the trial, and their experience of screening and being randomised. All Controls (except for a few who refused re-contact) were subsequently approached for the OCS. If they had already completed SoSOC, they were not asked these questions again. For the Control Group, the data is from SoSOC if the respondent completed this survey and from the OCS if they did not. For the Intervention Groups, the data is all from the OCS.
Among panel study participants, the most common source of initial information about JRRP also appeared to be respondents’ GPs. In some cases, GPs strongly encouraged their patients to get in touch with JRRP whereas others had just passed on leaflets or telephone numbers. The GP’s surgery was also a source of information for some: clients had sometimes picked up a leaflet about JRRP in the waiting room or seen a poster rather than hear about the service from their GP. Other healthcare professionals – occupational health doctors and nurses and a National Health Service (NHS) physiotherapist – were also a source of information about JRRP. In the remaining cases some people had been motivated to find out more following a radio advertisement, some had heard about the service through their employer (a leaflet passed on by a manager and a recommendation from a union), one person had received a leaflet through their letterbox, and another person was unable to recall how they had found out about the service.

**Table 3.1 How participants heard about the trial (from Outcome Survey and Survey of Screened-outs and Controls)**

<table>
<thead>
<tr>
<th>Source of Information</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>From a GP or other medical/health care professional</td>
<td>36</td>
</tr>
<tr>
<td>From my employer/through my work</td>
<td>28</td>
</tr>
<tr>
<td>Adverts at the GPs</td>
<td>14</td>
</tr>
<tr>
<td>From a friend or relative</td>
<td>5</td>
</tr>
<tr>
<td>In a newspaper or magazine</td>
<td>4</td>
</tr>
<tr>
<td>On the radio</td>
<td>3</td>
</tr>
<tr>
<td>From a leaflet delivered to my door</td>
<td>2</td>
</tr>
<tr>
<td>Leaflet from other source</td>
<td>2</td>
</tr>
<tr>
<td>Poster/advert in other location</td>
<td>1</td>
</tr>
<tr>
<td>On the Internet</td>
<td>*</td>
</tr>
<tr>
<td>On the television</td>
<td>*</td>
</tr>
<tr>
<td>From someone who works for Routeback/WorkCare/HealthyReturn</td>
<td>*</td>
</tr>
<tr>
<td>Some other way</td>
<td>4</td>
</tr>
</tbody>
</table>

*Base (all Control and Intervention Group respondents to the OCS and SOSOC) 1,722*

An important part of the trial design was to avoid the service providers having any contact with volunteers before they were randomised into the Intervention Groups. This was to prevent any contamination of the Control Group. For this reason, although providers were responsible for marketing the trial in their areas, they were not allowed to have any direct contact with potential clients and screening was conducted by a central Contact Centre. Table 3.1 provides evidence that this approach was successful, as only six survey respondents (0.3 per cent) claimed to have heard about the project direct from a member of Routeback, WorkCare, or HealthyReturn staff.
As noted above, employers were a common source of initial information about the trial. During the Research Advice visits, some provider staff expressed their suspicions that certain clients had been coerced into volunteering for the trial by their employers. Evidence from the OCS suggests that although this did sometimes happen, it was uncommon. Only 18 respondents (one per cent overall) said that their employer informed them about the trial and instructed them to take part. Twelve per cent were informed and encouraged to take part by their employer, and nine per cent were simply informed about it without either encouragement or coercion.

3.2 Reasons for contacting the JRRP trial

This section reports on panel study respondents’ reasons for contacting the JRRP trial and their early expectations, based on a combination of what they had heard about the service before making any contact and also what they learnt from the Contact Centre. How these expectations changed once participants had made contact with service providers is covered in Chapter 4.

Some people did not appear to have clear or explicit reasons for joining. Instead they said that their motivation had been that participation was free, voluntary and ‘could do no harm’. Some said they would be willing to try anything that might help them get back to work. One person talked about how they had initially joined the service as they thought it would show their employer that they were being proactive about trying to get back to work.

Panel study participants found it difficult to recall specifically what they had understood about JRRP before joining. Often they found it impossible to distinguish between what they had known about the service before making contact and what they had subsequently learnt from the Contact Centre and the providers. However, it did appear that everyone understood that the service was designed to help them return to work (among survey respondents, 84 per cent thought that the services offered would help them get back to work). In addition, there was a common perception that the service would focus on improving health, which is perhaps not surprising given that the most common route to JRRP was via the health service.

Given that some clients knew very little about the service, other than it was designed to help them get back to work, they tended to have quite limited expectations of what JRRP could do for them. This was also sometimes a reaction to poor experiences of existing services, for example long waiting lists for NHS treatment. Nevertheless, there were some respondents who had more definite reasons for joining: they were looking for specific services. Most commonly people were looking to receive health treatments, and had sometimes been recommended to contact JRRP by their GP (or other healthcare professional) at a point where their treatment was not progressing as fast as they would have liked on the NHS, due to waiting lists.

13 See Appendix A for an explanation of the Research Advice role in the trial evaluation.
for scans or consultations for example. JRRP was perceived as being able to provide such treatments sooner, either through private treatment or by speeding up existing NHS services.

It was less common for people to have expectations concerning workplace services. The only examples were two respondents who hoped that JRRP would be able to mediate with their employers and agree a return-to-work plan, and another respondent who thought that JRRP might be able to help with finding another job.

3.3 Views of family, employers, GPs about joining

Nine in ten respondents to the OCS had told their friends and/or family about taking part in the trial, of and these, 72 per cent had found their reactions to be positive (Table 3.2). Very few had encountered negative reactions (two per cent), with the remainder (23 per cent) neutral about it.

It was less likely that respondents’ GPs knew about their participation, but still a majority were aware of this (72 per cent). Most GPs who knew about it were reported to be positive (75 per cent), 18 per cent neutral and only three per cent negative. On the whole, GPs’ (and some occupational health staff) reactions to JRRP were also described as being positive by those panel study respondents who had discussed taking part with them. This is not surprising given that GPs had often recommended the provider to participants in the first place. However, reactions were also positive where GPs had not been aware of JRRP prior to being told about it by their patients.

Sixty-eight per cent of OCS respondents said that their employer knew that they were taking part in the trial. Employers’ reactions were reported as being a little less positive than the other groups, though still a clear majority (60 per cent) felt that it had been positive. Only nine per cent had received a negative reaction, though this is a much higher level than among friends/family or GPs. Most respondents were not able to be very specific about why their employers had reacted negatively, but the most common specific reason (given by a quarter) was that the employer resented the involvement of a third party. There was no evidence from the panel study to suggest whether employers had expressed any views about people taking part.

Table 3.2 Reactions of family/friends, GP and employer to participation in the trial, from the Outcome Survey

<table>
<thead>
<tr>
<th></th>
<th>Friends/family</th>
<th>Employer</th>
<th>GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>72%</td>
<td>60%</td>
<td>75%</td>
</tr>
<tr>
<td>Neutral</td>
<td>23%</td>
<td>26%</td>
<td>18%</td>
</tr>
<tr>
<td>Negative</td>
<td>2%</td>
<td>9%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Unweighted base (all those whose family, employer, GP were aware of participation) 1,392 1,050 1,108
3.4 Recall of the process of joining JRRP

This section explores clients’ reactions to being screened by the Contact Centre when they volunteered to join the trial, including their recall of, and views on, the explanation they were given. It also considers their understanding of the randomisation process and their reactions to being allocated to one of the four groups.

3.4.1 Awareness and understanding of the Contact Centre and screening process

Clients who took part in the panel study found it difficult to recall what took place before their first meeting with the service providers, as it was difficult to distinguish between dealings with the Contact Centre and service providers. Spontaneous references to the Contact Centre were rare. The only concrete examples were references to a ‘call centre’, a free phone number and speaking to someone with an unfamiliar accent. Some people were able to recall elements of the conversation they had, such as being asked for details of employment histories and medical conditions, an explanation of the randomisation process, assurances that participation was voluntary, and one person recalled having given their consent to being randomised and for their details to be shared within the trial consortium. On the whole however, people found it difficult to remember much about this stage of the process.

3.4.2 Adequacy of explanation given at screening

When prompted, most survey respondents (97 per cent) did recall having phoned the Contact Centre to join the trial. Most of those who remembered this contact also remembered being given an explanation of the project (96 per cent) and said that the explanation was clear and easy to understand (89 per cent). Overall, three per cent found the explanation confusing and seven per cent said it was partly clear/partly confusing. Most (88 per cent) of those who remembered getting an explanation of the project said that it was clear that there was a chance that they might not receive any extra help. Almost one in ten (9 per cent) would have liked more information about the project (Table 3.3).

There is evidence that having been allocated to the Control Group affected respondents’ recall or perception of the screening process. A higher proportion found the explanation confusing (seven per cent of Controls, compared to two per cent of the Intervention Groups). The proportion wanting more information was much higher for Controls (15 per cent) than for the Intervention Groups (seven per cent). The most likely reason for these differences is that the Intervention Groups’ answers were affected by further explanations of the trial from providers.
Table 3.3  Adequacy of explanation of the trial, from the Outcome Survey and Survey of Screened-outs and Controls

<table>
<thead>
<tr>
<th>When you heard the explanation of the project …</th>
<th>Intervention Group</th>
<th>Control Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>...was the explanation clear &amp; easy to understand?</td>
<td>% saying yes</td>
<td>% saying yes</td>
<td>% saying yes</td>
</tr>
<tr>
<td>90</td>
<td>86</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td>...was it clear that there was a chance you might <strong>not</strong> receive any extra help to return to work?</td>
<td>87</td>
<td>89</td>
<td>88</td>
</tr>
<tr>
<td>...did you think you would be eligible for the service?</td>
<td>74</td>
<td>74</td>
<td>74</td>
</tr>
<tr>
<td>...were you given all the information that you wanted?</td>
<td>93</td>
<td>85</td>
<td>91</td>
</tr>
<tr>
<td>...did you think that the types of services offered would help you get back to work?</td>
<td>84</td>
<td>85</td>
<td>84</td>
</tr>
</tbody>
</table>

Base (all Control & Intervention Group respondents to the OCS and SoSOC) 1

<table>
<thead>
<tr>
<th>Base (all Control &amp; Intervention Group respondents to the OCS and SoSOC) 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,138</td>
</tr>
<tr>
<td>427-455</td>
</tr>
<tr>
<td>1,565-1,593</td>
</tr>
</tbody>
</table>

1 Bases vary due to differing levels of missing data.

3.4.3  Awareness, understanding of and reactions to randomisation process

Once screened-in by the Contact Centre, details of volunteers were sent to the National Centre for Social Research (NatCen) to be randomised into one of the four groups. Volunteers were sent a letter informing them of the outcome, and most OCS respondents remembered receiving this letter (90 per cent).

At this stage, volunteers were only told whether they were in an Intervention Group (i.e. not which of the three groups) or the Control Group. As might be expected, those allocated to the Control Group were on the whole, quite disappointed about this. Asked to rate from 0 (very disappointed) to 10 (very happy) how they had felt when they had found out which group they were in, the mean score given by this group (combining data from both surveys) was just 3.1. Over a third (36 per cent) gave the most disappointed score of zero.

By contrast, those assigned to the Intervention Groups felt much happier about their group when they found out which one they were in (which happened when they first met with the provider). The mean score was highest for those in the Combined group (9.4). Indeed, 57 per cent of those assigned to this group gave the maximum score of 10. Those in the Health intervention were a little less happy about this (mean score 8.3), with fewer giving the maximum score (40 per cent). Among the Intervention Groups, Workplace clients were the least happy about their group (a mean score of 6.7), and only 15 per cent gave a score of 10. However, the average score was still significantly higher than that given by the Control Group.

There was little spontaneous discussion of what panel study respondents thought about the Intervention Groups to which they had been assigned. When asked what they thought, people tended to say they were just grateful to be getting any help at
all, or they were pleased they had been allocated to the group they had hoped for. However, there were some people who were disappointed by the outcome of the assignment process. Disappointment was most common among those people who had been assigned to the Workplace group, but had contacted JRRP to receive a specific health treatment, in some cases on the recommendation of their GP. There was no evidence of disappointment among those who were assigned to the Health or Combined Intervention Groups. This reinforces the findings reported above from the OCS.

There was very little spontaneous discussion of the concept of randomisation among panel study respondents, so most of the data reported here was the result of direct questioning. Also, it should be noted that in what follows, respondents found it difficult to distinguish between what information was provided by the Contact Centre and what was discussed during the first meeting with service providers.

Understanding of the concept of randomisation was varied. Some people appeared to be clear about how the process worked. They talked about how it was similar to a lottery or like names being picked out of a hat, and others were aware that the assignment was done by computer. There was also some awareness of there being a Control Group, for example where one person was able to recall being told that one in four people would receive no treatment.

In contrast there were others who had either misunderstood the explanation they were given, such as a person who also recalled the one in four statistic but thought that it related to the likelihood of being accepted into the trial altogether, or could not recall how the groups were assigned. Even where people did appear to understand the concept, there was often some scepticism or disbelief that the group they had been assigned to was the result of such a process. Instead, they believed that they had been assigned by the service providers according to their circumstances. Others were unaware of the randomisation process and also thought that they had been assigned to an Intervention Group according to their situation. Some talked about how they believed that the group allocation was based on the questionnaires they had completed in their initial assessment.

There was also a large degree of uncertainty among OCS respondents as to how they had been put into their group. Fifty per cent knew that it had been a random assignment, but 36 per cent were unsure how it had been chosen and 11 per cent thought that the service provider staff had chosen it for them.

Some panel study respondents questioned the fairness of the randomisation process, and in particular the possibility of ending up with no help, even where they understood why the Control Group was necessary for research purposes.
4 Participants’ first impressions of providers

This chapter looks at the next stage of participation in the trial for those assigned to one of the Intervention Groups. Details of members of these groups were passed to service providers usually within one or two working days after randomisation, and the provider then made contact to arrange an initial meeting. This chapter draws on the partial data from the panel study and the partially-completed Outcome Survey (OCS) to give feedback from participants on this first meeting. This includes their first impressions of provider staff (Section 4.1), awareness of their Intervention Group (4.2.1), the consent procedures (4.2.2), initial assessments (4.2.3) and action plans (4.2.4). Section 4.3 looks at how their understanding and expectations changed over time.

4.1 First impressions of the providers

On the whole, panel study participants had very positive first impressions of service providers, which were, for the most part, based on their dealings with provider staff. The comments made about staff tended to relate either to their interpersonal skills or their professional skills. The way staff spoke to volunteers was commonly described as ‘friendly’, but also ‘courteous’ and ‘charming’. Participants also talked about how they were made to feel at ease by the ‘relaxed’ and ‘reassuring’ demeanour of provider staff, and they also felt that staff were ‘sympathetic’, ‘caring’ and genuinely ‘interested’ in their cases. People also talked about how they did not feel under any pressure from provider staff whether that concerned thinking about a return-to-work or more generally. One respondent described how they felt able to take the lead in terms of what they wanted to do next. This person’s perception of the role of the Job Retention and Rehabilitation Pilot (JRRP) was that it was there to try and help them achieve what they wanted to do.

Staff were also often referred to as being ‘professional’ for a number of reasons. One person, for example, was very impressed by their providers’ organisational skills in assessing and managing cases. Other people made direct comparisons with services outside JRRP. One talked about how, compared to past experiences of National
Health Service (NHS)-provided physiotherapy, the JRRP-funded physiotherapist was more committed to and enthusiastic about the case. Another was impressed by the knowledge of provider staff about a health condition, and how, unlike a General Practitioner (GP), they were willing to spend time explaining how the illness would develop; and a third person thought that the individual attention available through JRRP must be similar to how private healthcare services would operate.

OCS respondents were also asked about their first impressions of their case manager at the consent interview. Generally these were also very positive – 83 per cent felt that he or she had listened to what they had to say ‘very well’ and 13 per cent ‘quite well’.

4.2 Recall and understanding of first meeting with the service provider

The first meeting between clients and service providers usually involved: watching a video about the randomisation process; a consent procedure involving gaining written consent to take part in the trial, to allow providers access to medical records, to permit the transfer of personal details between different members of the JRRP consortium, and to take part in the various research elements; an assessment; and the design and agreement of an action plan. As part of the panel study and the OCS, respondents were asked about this first meeting. The details of what was recalled are discussed below.

Most OCS respondents had their first meeting face-to-face at the provider’s premises (74 per cent). For 12 per cent, this was conducted over the telephone, eight per cent had the meeting in their own home and one per cent somewhere else. The remaining five per cent said that they withdrew before this first meeting. Most (77 per cent) did not have any practical difficulties with travelling to the meeting. However, 13 per cent had problems getting to the venue, five per cent had problems getting into the building, and four per cent with the cost of transport.

The panel study found that these meetings were more commonly conducted face-to-face in provider offices although they were conducted by telephone by one of the service providers. Often they were carried out by the person who would later become the respondent’s case manager (see Section 5.1) but not always. The length of time reportedly spent in these sessions ranged from 20 minutes up to one and a half hours. There was no mention of any physical examination as part of the meetings, although some people did say that they were subsequently assessed by a physician or other healthcare worker. In the case of one respondent, the assessment process took the form of a series of appointments with a number of different medical and occupational health professionals and took up most of the day.

This meeting most commonly took place within two weeks after respondents phoned the Contact Centre to join the project. Of those who did not withdraw from the service before the meeting, 29 per cent had it within one week and 49 per cent
between one and two weeks. Fifteen per cent did not have the meeting until after a gap of three to four weeks, three per cent waited five weeks or longer, and five per cent could not remember how long they waited. These delays tended to arise both from problems providers had in contacting clients quickly, but also from clients’ other commitments. Even if contact was made quickly, the date that the client wanted to come in could be quite far in advance, often due to a holiday or operation they had booked. Also, for one or two providers, the consent interviews were only held on specific days of the week which may have prolonged the delay if that day was difficult for the client.

An important part of this first consent interview was the showing of a ten minute video which explained the research trial and the client’s role within it. Few panel study respondents spontaneously mentioned watching a video. They remembered it when they were asked about it but their recall of its content was limited. Among those who could recall the video, it was said to cover randomisation and a description of the different intervention groups. People also commented that the video was relatively short (between five and 20 minutes in length), informative, easy to follow and reiterated most of what had already been explained by service provider staff. When prompted, most OCS respondents (87 per cent) remembered being offered the video to watch, and of these, 97 per cent had watched it. Most found it clear and easy to understand (87 per cent), and only four per cent found it confusing to any extent.

4.2.1 Awareness of the Intervention Groups

One of the purposes of the initial interview was to tell clients for the first time to which of the three Intervention Groups they had been assigned. The letter sent to inform them they were in the group that would receive extra services did not specify which group they were in, to minimise withdrawals for those who did not like their assigned group. Of those OCS respondents who did not withdraw from the service before the consent interview, 80 per cent recalled being told which type of service they would receive at this interview (Workplace, Health or a combination of the two). Ten per cent said that they were told about this on another occasion, and six per cent that they were never told about this.

Among those who did recall being told which group they were in, about eight in ten accurately named their group, although a sizeable minority did not. About one in ten of all groups were not sure which one they were in. Seven per cent of Workplace and six per cent of Health group respondents thought they were in the Combined group. Five per cent of those in the Combined group thought they were in the Health group (Table 4.1).

Those who received contaminatory treatment (that is treatment that was supposed to be restricted to another Intervention Group – see Section 5.4) in both the Health and Workplace groups were more likely to think they were in the Combined group (18 per cent and 10 per cent respectively) than those in these groups who received uncontaminated treatment (five and six per cent).
Table 4.1  Intervention Group that respondents thought they were in, by actual group, from Outcome Survey

<table>
<thead>
<tr>
<th>Actual group:</th>
<th>Health</th>
<th>Workplace</th>
<th>Combined</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group according to respondent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Health</td>
<td>85</td>
<td>2</td>
<td>5</td>
<td>33</td>
</tr>
<tr>
<td>Workplace</td>
<td>1</td>
<td>78</td>
<td>1</td>
<td>25</td>
</tr>
<tr>
<td>Combined</td>
<td>6</td>
<td>7</td>
<td>83</td>
<td>32</td>
</tr>
<tr>
<td>Not sure/can’t remember</td>
<td>8</td>
<td>12</td>
<td>10</td>
<td>10</td>
</tr>
</tbody>
</table>

Unweighted base (Intervention Group who recalled being told their group) 381 334 359 1,074

Awareness of the different Intervention Groups also varied among panel study respondents. Some people, for example, were unaware that they were in a group at all, like the person who thought their service provider was just a counselling service. Or they were very vague about the group they were in, like one person who talked about being in “one of the categories that got help”. The concept of a specific Intervention Group seemed unimportant to these people: they were just grateful that they were receiving any help at all.

Among those who were aware of there being different Intervention Groups, or ‘categories’, ‘packages’ or ‘pathways’ as they were sometimes referred to, levels of understanding were varied. People were generally aware of three groups. However, whilst some people referred to the three Intervention Groups (Health, Workplace and Combined), others made reference to the two single Intervention Groups (Health and Workplace) and the Control Group in place of the Combined Group.

How people referred to the different groups also varied. Few people used the terminology used by JRRP service providers. Instead people often had their own distinct ways of referring to the different Intervention Groups. The Workplace group was either given a name such as ‘work path’, ‘workforce group’ or ‘return to work group’ or detailed references were made to the purpose of the group for example ‘the group providing help to return to work, or find a new job’. The ‘medical group’ was one way the Health group was referred to, as were more detailed descriptions such as ‘supporting me healthwise’ or ‘help with health problems’. Similarly, the Combined Intervention Group was also known as the ‘middle group’, the ‘occupational group’, the ‘therapy group’ and the ‘intensive group’. The Control Group was rarely referred to by name. The ‘group where people received no help’ was a more typical way of describing it.

4.2.2 Consent procedure

As one of the purposes of this initial meeting was to gain written consent, it is reassuring that almost all OCS respondents who attended (93 per cent) recalled, when prompted, discussing giving their consent to take part. Some form of consent
procedure was also generally recalled by panel study respondents, but people’s memories of what they had given consent for were sometimes vague. Clients most commonly recalled having consented to allowing their service provider to have access to their medical records, although this was not actually part of the JRRP consent procedure itself. There was also some recollection of having consented to take part in the research trial, to allow service providers to contact their employers and to demonstrate their understanding of the confidential and voluntary nature of the trial. There were few references to consenting to being randomised. Some people talked about having signed a number of documents but could not recall what they had specifically consented to. One person could not recall having signed anything, but did remember having verbally agreed to the service provider having access to medical records.

The different levels of recall evident here between panel study and OCS respondents is likely to be caused by methodological factors. OCS respondents were generally prompted with specific questions which often contained information designed to jog their memory. The information collected from Panel study respondents tended to be less prompted and more spontaneous, hence the lower levels of recall observed.

Almost all (96 per cent) of those OCS respondents who attended the initial interview gave their consent to join the trial at this time. Three per cent declined. Of those who agreed to join, 93 per cent recalled signing a form to give their consent to take part. Two per cent said they did not sign a form and five per cent could not remember.

The most common reason given for deciding to take part at this stage was to get back to work (43 per cent). 38 per cent said that it was to get general help or support, 11 per cent to get medical treatment or counselling, and six per cent simply to get better.

Although no specific concerns were raised about the consent procedure by panel study respondents (which may also have been because no-one recalled any spontaneously), it may be a cause for concern that there were wide variations in understanding reported. Nevertheless it was very clear to people that participation in the trial was voluntary and that they could withdraw at any time. Most (90 per cent) OCS respondents who gave consent realised that they did not have to do so if they did not want to, although eight per cent thought they had to continue at this stage and two per cent did not know.

4.2.3 Assessments

It was clear from panel study respondents’ accounts that some form of assessment took place at the initial interview, although how this was described varied. The term ‘assessment’ was rarely used by those who were interviewed. Instead it was more common for people to refer to a ‘meeting’, ‘interview’, ‘induction’ or ‘a quick talk’ involving a series of questions about health and work circumstances – in some cases using a paper or computer based questionnaire – followed by a discussion of what services were planned.
Most OCS respondents recalled discussing their health (94 per cent) and work (90 per cent) at the initial interview. Almost as many recalled discussing the services or treatment they might get, but far fewer (15 per cent) discussed the issue of benefits or tax credits (Table 4.2). This is likely to be because not all providers offered help with these issues. Most respondents (91 per cent) were happy with the topics covered and did not have any outstanding issues that they would have liked to discuss at the interview. Eight per cent felt that there were things they did not get the opportunity to discuss, the most common being benefits and tax credits (31 per cent), and more explanation of the services/treatments they would get (26 per cent).

The Intervention Group did not make a large difference to the topics that respondents remembered discussing. Those in the Health group were slightly less likely to have discussed benefits/tax credits (12 per cent compared to 17 per cent in the other two groups), but there were no significant differences between the groups in the proportions stating they would have liked to discuss these issues.

It was not always evident how involved participants were in the initial discussions about what services were planned for them. Few panel study respondents spontaneously mentioned having been asked what they wanted from JRRP, and those that were asked tended to have given a very general reply. One person said they just wanted any extra help they could get; another said they wanted help to get back to work. Among the remaining cases, there was a strong impression that suggestions were made by provider staff and that the only participant involvement in discussions was when they were asked if they had any opinions on or objections to what was planned. In fact one person used the phrase ‘they decided I should have…’ to describe how the treatment plan was discussed. Despite this, people, on the whole, said they were happy with this level of consultation and did not feel under any pressure to agree to anything they did not want. One respondent said that they ‘trusted [the service providers] to know what they were doing’. Another talked about feeling ‘in charge’ of what was happening in their case, in terms of treatments and when and how they might return to work. They saw the role of their service provider as ‘just providing the help’.
Table 4.2  Topics discussed at the initial consent interview with service providers, from Outcome Survey

<table>
<thead>
<tr>
<th>Topic</th>
<th>Preliminary Outcome Survey data</th>
</tr>
</thead>
<tbody>
<tr>
<td>My health</td>
<td>94 %</td>
</tr>
<tr>
<td>Giving my consent to take part</td>
<td>93 %</td>
</tr>
<tr>
<td>My work</td>
<td>90 %</td>
</tr>
<tr>
<td>Services or treatments I might get</td>
<td>86 %</td>
</tr>
<tr>
<td>Benefits/Tax Credits</td>
<td>15 %</td>
</tr>
<tr>
<td>Personal life and issues</td>
<td>4 %</td>
</tr>
<tr>
<td>Other issues</td>
<td>3 %</td>
</tr>
<tr>
<td>Nothing was discussed</td>
<td>1 %</td>
</tr>
<tr>
<td>Can’t remember</td>
<td>1 %</td>
</tr>
<tr>
<td>Health care previously received</td>
<td>1 %</td>
</tr>
<tr>
<td>Training</td>
<td>*</td>
</tr>
<tr>
<td>Transport</td>
<td>*</td>
</tr>
</tbody>
</table>

Unweighted base (Intervention Groups who did not withdraw before consent interview) 1,140

However, it was clear from respondents’ accounts that some people lacked the knowledge about what services were available or about what individual services involved to play a strong role in deciding what services they wanted. One example of this was someone who appeared content to accept a course of aromatherapy despite not knowing what it was. This lack of knowledge of the services available through JRRP became more evident as the panel study continued. Discussions in subsequent interviews highlighted how some clients, in the Combined Intervention Group in particular, were unaware of the full range of services available to them. For example one person, after having received a variety of health-related support, assumed that there would be no workplace support because it had not been mentioned.

People’s reflections, at the final panel interview, about whether JRRP had met their expectations or not, also gave some insight into clients’ knowledge of what JRRP had to offer. Some said that they had not had specific expectations as they did not have a clear idea of the range of services on offer. One person, for example, talked about how they were only able to accept or decline the suggestions made to them by provider staff rather than be able to choose from a list of the services available which would have made them feel more ‘involved’ in the decision making process.

There was also an underlying impression that some people were willing to accept the service or treatment being offered to them even where they had reservations. This is perhaps not surprising given the strong feelings of gratitude people tended to have towards JRRP at this point in their contact. An example here was someone offered cognitive behavioural therapy who, in their panel study interview, talked about how they had been ‘happy to go along’ with the service provider’s suggestion despite being unsure as to its appropriateness in their case.
Regardless of participants’ perceived level of involvement in the discussions that took place during assessments, impressions were on the whole positive, especially when compared to the NHS. For example, someone talked about how they felt provider staff had taken the time to really understand their problems unlike the NHS which they described as ‘in and out and cheerio’. In another example, the quality of a secondary assessment that was more medical in nature was described by one respondent as being more thorough than anything experienced elsewhere. The only real criticisms of JRRP, at this stage, came from those clients who were disappointed with the Intervention Group they had been assigned to.

There were no reports of any participant involvement in any ongoing assessments of their cases. However, it was evident that the services offered to clients developed over time as circumstances changed. In some cases, existing services, for example exercise plans or the intensity of treatments like physiotherapy, were adapted in accordance with changes to people’s health conditions. In other cases, new services were introduced when others had either run their course or when they had not had the desired outcome. In one example, a respondent was offered help with finding alternative employment when negotiations with their employer were not progressing as planned.

4.2.4 Action plans

The action plan was an obligatory part of the assessment procedure, whereby a plan detailing the services and treatments to be provided was agreed with the volunteer. The client then signed the plan and was given a copy. However, there was no spontaneous mention of action plans during the panel study interviews (although when prompted, 81 per cent of OCS respondents did remember agreeing such a plan). Once prompted, some sort of written document – ranging from a document clearly entitled ‘action plan’, through a brief statement of future plans to a letter documenting the content of the initial meeting with the service provider – was recalled by some, although few could definitely recall having signed this document or having received their own copy. Others did not recall any formal record of what was talked about, but were clear that a plan had been discussed. Regardless of whether people could recall the action plan or not, participants appeared to be content with the services proposed for them at this early stage, and with their own involvement in any decisions taken.

Revisions to action plans as the trial progressed were seldom reported, but there was a common perception that plans could be changed and that they would develop as time went on. However, whether any changes would involve the participants themselves was not clear. For most OCS respondents who recalled having an action plan, their help or treatment followed this plan exactly (45 per cent), or a great deal (29 per cent). However, changes to the planned treatment occurred for a sizeable minority, as the action plan was only followed to some extent for 14 per cent, not much for five per cent and not at all for seven per cent.
4.3 How understanding and expectations changed over time

Panel study respondents’ expectations and understanding of what JRRP could offer them often began to change soon after they had had their initial meetings with providers. On the whole, expectations were higher at this point, as people were told about the help they would receive, but also because of their positive first impressions of providers. Raised expectations were particularly common among those who had not known what to expect when they initially contacted JRRP. For example, one participant had not expected to be offered physiotherapy prior to joining up, but was very pleased that it was available.

However, there was a group of people whose initial expectations were lowered once they had learned about what the service provider had planned for them, such as one person who, having taken part with the intention of receiving some specific medical help quicker than was available on the NHS, was disappointed when allocated to the Workplace group.
5 Participants’ experiences of treatments

This chapter examines the types of help, treatment and advice received by participants in the Intervention Groups, the extent to which they had finished receiving help or were expecting any further help (5.2), and their views on the help received (5.3), as well as their views on the case management which was an integral part of the intervention for most (5.1). It also takes a preliminary look at the possible extent of contamination in terms of treatment and advice between the three treatment groups, and also of the Control Group (5.4). Section 5.5 looks at respondents’ general impressions of providers’ services. Finally, Section 5.6 explores reasons for turning down treatments and 5.7 at how contact with the Job Retention and Rehabilitation Pilot (JRRP) ended and reasons for withdrawing from the service.

5.1 Contact with a case manager

This section explores participants’ relationships with their case manager, the type and frequency of contact, the reported nature of the case management role, and what aspects of the role were most appreciated by clients.

Regular contact with a single member of service provider staff was a common feature of the experiences of panel study respondents, in addition to any contact with case workers providing specific services. There were some cases, however, where it was not possible to identify a single point of contact. One respondent, for example, described contact with the service provider as a team approach. Another person appeared to have regular contact with two different case workers. In two cases, respondents talked about how their contact person had changed part way through the panel study due to staff turnover.

Although this main contact was most likely to be, in JRRP terms, a ‘case manager’ this term was rarely used by those in the panel study. On the whole, people either referred to their contact person by name or by their professional specialism (e.g. ‘the physio’). Other people described this person as ‘the lady who did the induction’, ‘the person who keeps in touch with me’, ‘my case worker’, ‘an administrator’ or ‘a
facilitator’. In some cases the case manager was the same person who had conducted the first meeting and assessments.

Contact with people who appeared to be case managers varied in how often it took place, how it was conducted and what it involved. Contact was more regular where clients were in receipt of services, and ranged from once a week to once a month. Contact was much less regular, and in some cases intermittent, where there were long intervals between services being delivered, where services had ended or where no services had been delivered.

During the first few weeks, contact tended to be face-to-face, but subsequent contact tended to be conducted by telephone. Regardless of the method of contact, it was nearly always initiated by the service provider. It is difficult to be conclusive about why this was the case, but there was an underlying impression that participants were reluctant to make contact themselves. This is discussed in more detail in Section 5.7.

The reported role of the case manager was also varied: it ranged from duties such as checking up on progress made, making recommendations and referrals, to delivering services and providing emotional and practical support to clients. Client support appeared to be very important to respondents across the sample as it was consistently talked about in very positive terms. It was possible to identify a number of different benefits derived from this support:

- A dedicated contact person. People recurrently talked about how they took comfort from knowing that there was ‘someone there thinking about [them]’.

- A listening ear. Participants also appreciated having someone who would listen to them regardless of whether they had good or bad things to say. Some said that they found their case manager easier to talk to than their employer, General Practitioner (GP) or family members as they did not judge what clients said and were seen as being ‘on [their] side’. Others talked about how they particularly valued being able to talk to their case manager when they were stressed or angry, as they knew that their case manager would be able to calm them down and provide any necessary reassurance.

- A motivator. Case managers were an important source of encouragement and moral support for some volunteers. Some gave examples of how they relied on encouragement from case managers to complete courses of treatment such as home exercise programmes. Others talked about how the positive attitude of their case managers had made them feel more confident when dealing with difficult situations such as meetings with employers. One person summed up the effect their case manager had on their motivation: ‘if they can be bothered then it makes you bothered’.

- Someone to answer questions. Others saw their case manager as a useful source of advice. The advice received ranged from the general, for example ideas about alternative employment, to the specific, such as an explanation of the Disability Discrimination Act.
5.2 Services and advice received

This section examines the types of services and advice that the Outcome Survey (OCS) Intervention Group and panel study respondents said they received from service providers. Among OCS respondents, it focuses on those who did not withdraw from services before the first consent interview (five per cent did so at this point), and who had some further contact with providers after the consent interview (nine per cent did not have any further contact).

In addition to the 14 per cent who terminated contact at these two stages, a further 15 per cent of the Intervention Groups had not received any treatment or advice by the time of the OCS interview, although they had had some form of further contact with the provider. Only one in ten of these were expecting to receive any services at some point in the future. Twelve per cent of respondents in the Intervention Groups had received some advice from the provider but no actual practical help or treatment (although 16 per cent of these were expecting to receive some in the future). The remaining 58 per cent of those in the Intervention Groups had received some practical help or treatment (Table 5.1).

The Intervention Groups differed in their rate of withdrawal and treatment. The Workplace group were more likely to withdraw than the other two groups, especially after the consent interview, when they would have found out for the first time which group they were in. They were also much less likely to have received any treatment by the time of the OCS interview. Only 32 per cent mentioned any treatment received, compared to 67 per cent of the Combined and 74 per cent of the Health group. The Workplace group were much more likely to have received only advice (or to have perceived their treatment as advice rather than practical support), or to have received no advice or treatment at all.

Table 5.1 Rate of withdrawal and receipt of treatment and advice (Outcome Survey)

<table>
<thead>
<tr>
<th>Section</th>
<th>Health %</th>
<th>Workplace %</th>
<th>Combined %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrew before consent interview</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Withdrew after consent interview, but before treatment</td>
<td>7</td>
<td>14</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Did not withdraw, but no treatment or advice received</td>
<td>11</td>
<td>25</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Received some advice, no treatment</td>
<td>5</td>
<td>23</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Received some treatment, no advice</td>
<td>42</td>
<td>15</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>Received both treatment and advice</td>
<td>32</td>
<td>17</td>
<td>47</td>
<td>32</td>
</tr>
</tbody>
</table>

*Unweighted base (all Intervention Group respondents)*

<table>
<thead>
<tr>
<th></th>
<th>Health</th>
<th>Workplace</th>
<th>Combined</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>418</td>
<td>386</td>
<td>402</td>
<td>1,206</td>
</tr>
</tbody>
</table>
There was some evidence that the Combined group were taking longer to complete their treatments. Among those who had received, or were expecting to receive, any services (either practical help or advice), 71 per cent of the Health and 70 per cent of the Workplace group had completed their treatments, compared to 58 per cent of the Combined group. Forty two per cent of this group were still receiving services or expecting to receive them in the future.

Of those Intervention Group members who did not withdraw, 23 per cent overall said that they had received ‘any support in any job, either at [their] place of work or anywhere else. This could be arranging changes to [their] job, or training, or other support’. More than twice as many (58 per cent) said that they had received ‘any help with [their] health condition or disability, either at a hospital, at the service provider’s office, or anywhere else’.

The most common work-related practical help or support was with arranging some change in working hours or conditions. Of those who received workplace help, 54 per cent received help with arranging a gradual return to work; 18 per cent help with arranging more flexible hours; 19 per cent help with arranging a reduction in physical tasks; 16 per cent help with arranging a reduction in workload; and 13 per cent received help with arranging a different job with the same employer. The other common type of help was equipment to help respondents do their job, which was received by 23 per cent (Table 5.2).

Most of those who received this type of help mentioned only one (58 per cent) or two (23 per cent) different kinds of help (the mean number of workplace treatments mentioned was 1.8).

With reference to workplace interventions, panel study respondents described service providers accompanying them to meetings with employers, case workers negotiating return-to-work plans with employers, the conduct of workstation assessments and functional capacity assessments, and medical reports demonstrating employees’ ability to work being provided to employers at the participant’s request.

Other services that had been received by panel study respondents were debt and benefit advice and help with benefit claim form filling, advice on college courses, psychometric and other tests to identify job options, help in updating a CV, and help with job applications – involving both help with filling in forms and accompaniment at interviews. Individual cases of referrals to services provided by Jobcentre Plus, job brokers, careers and occupational advice services and other work-related schemes designed to help with the funding of assisted returns-to-work were also reported. In addition, some people known to be in the Workplace Intervention Group talked about having received a medical examination, sessions with a counsellor and an offer of discounted medical treatment.
Table 5.2  Type of workplace support received from providers (Outcome Survey)

<table>
<thead>
<tr>
<th>Support Provided</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help with arranging a gradual return to work</td>
<td>54</td>
</tr>
<tr>
<td>Other special equipment to help me to do my job</td>
<td>23</td>
</tr>
<tr>
<td>Help with arranging a reduction in physical tasks</td>
<td>19</td>
</tr>
<tr>
<td>Help with arranging more flexible hours</td>
<td>18</td>
</tr>
<tr>
<td>Help with arranging a reduction in my workload</td>
<td>16</td>
</tr>
<tr>
<td>Help with arranging a different job with my employer</td>
<td>13</td>
</tr>
<tr>
<td>Someone to support me at work</td>
<td>7</td>
</tr>
<tr>
<td>Training so I could do a different job</td>
<td>4</td>
</tr>
<tr>
<td>Equipment to allow me to work at home</td>
<td>3</td>
</tr>
<tr>
<td>Help with jobsearch</td>
<td>3</td>
</tr>
<tr>
<td>Payment for (adapted) transport to and from work</td>
<td>2</td>
</tr>
<tr>
<td>Help with arranging home working</td>
<td>1</td>
</tr>
<tr>
<td>Other work-related practical help</td>
<td>13</td>
</tr>
</tbody>
</table>

Unweighted base (Intervention Groups who received any workplace support)       240

Just a few different types of health treatment accounted for most of the health-related support that OCS respondents remembered receiving. Of those who received any health treatments, 50 per cent received physiotherapy or therapeutic exercise; 34 per cent some form of counselling, cognitive behavioural therapy or psychotherapy; 26 per cent were referred to a consultant, specialist or surgeon; and 25 per cent were given complementary or alternative therapies (Table 5.3). No other type of support was received by more than ten per cent. As with workplace help, most mentioned only one (51 per cent) or two (29 per cent) different types of health treatment, and the mean number mentioned by those who received any health treatment was 1.8.

Panel study participants in the Health and Combined groups received a range of health support. Some form of psychological therapy (typically cognitive behavioural therapy (CBT)) and physiotherapy were mentioned recurrently by clients in receipt of healthcare services from JRRP. The latter involved home exercise regimes and, in one case, accompanied swimming sessions and the use of a pain management machine as well as more standard physiotherapy sessions. Hypnotherapy and relaxation sessions, pain management, breathing exercises, aromatherapy, acupuncture, Pilates, a JRRP funded gym membership, referrals to consultants and for scans, a suggestion for a change in medication, an attempt to expedite National Health Service (NHS) scan results and surgery were also reported. Finally, occupational therapy was a service received both in the context of healthcare and the workplace, but in different service provider organisations.
Table 5.3  Type of health support received from providers  
(Outcome Survey)

<table>
<thead>
<tr>
<th>Service</th>
<th>Preliminary Outcome Survey data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapy/therapeutic exercise</td>
<td>50%</td>
</tr>
<tr>
<td>Counselling, cognitive/behavioural therapy/psychotherapy</td>
<td>34%</td>
</tr>
<tr>
<td>Referral to a Consultant/Specialist/Surgeon</td>
<td>26%</td>
</tr>
<tr>
<td>Complementary/alternative therapies</td>
<td>25%</td>
</tr>
<tr>
<td>Personal coaching, stress management</td>
<td>9%</td>
</tr>
<tr>
<td>Gym facilities/membership</td>
<td>9%</td>
</tr>
<tr>
<td>Referral to psychiatrist/psychologist</td>
<td>6%</td>
</tr>
<tr>
<td>Pain management programme/pain clinic</td>
<td>5%</td>
</tr>
<tr>
<td>Training in activities of daily living/coping skills</td>
<td>5%</td>
</tr>
<tr>
<td>Back School/Classes, Postural advice</td>
<td>4%</td>
</tr>
<tr>
<td>Providing adaptations/equipment for the home</td>
<td>2%</td>
</tr>
<tr>
<td>Other adaptations/equipment</td>
<td>1%</td>
</tr>
<tr>
<td>Cardiac/coronary rehabilitation course</td>
<td>*</td>
</tr>
<tr>
<td>Other health-related practical help</td>
<td>5%</td>
</tr>
</tbody>
</table>

*Unweighted base (Intervention Groups who received any health support)  596

Just over half (52 per cent) of OCS respondents who had further contact with providers after the consent interview, said that they had received advice (as opposed to practical help or treatment) from or through the provider. The most commonly-mentioned advice was on how to improve their health (63 per cent) and how to return to work (55 per cent). Twenty-three per cent received advice on benefits, debts or their financial situation. Legal advice (for example on employment or disability rights) was recalled by nine per cent, and five per cent recalled some other type of advice. In most cases (92 per cent), this advice was received from a member of the provider staff, whilst ten per cent remembered getting this advice from someone from another organisation (this is likely to be providers’ sub-contractors).

5.3 Appropriateness of services and advice

This section reports clients’ views on the support they received, whether they found it helpful and whether there were any particular treatments that they did not consider helpful or appropriate. It also explores whether participants perceived any gaps in the treatment that was offered and what additional treatment they would have liked.

Where either work- or health–related support was received, OCS respondents were generally very positive about this help. Almost three-quarters said that both types of support were ‘very helpful’, and most of the remainder found them ‘fairly helpful’. Only three per cent found the support unhelpful to any degree and three per cent felt that some of it had been helpful, but some unhelpful. There were no differences
in how work- and health-related support were perceived — both were viewed as equally helpful (Table 5.4).

Respondents were slightly less likely to have found the advice very helpful than they did any practical support received: 66 per cent found the advice ‘very helpful’ and 25 per cent ‘fairly helpful’. Very few found it unhelpful (two per cent).

Table 5.4 Helpfulness of work- and health-related support and advice, rated by Outcome Survey respondents

<table>
<thead>
<tr>
<th></th>
<th>Work help</th>
<th>Health help</th>
<th>Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very helpful</td>
<td>70%</td>
<td>74%</td>
<td>66%</td>
</tr>
<tr>
<td>Fairly helpful</td>
<td>18%</td>
<td>16%</td>
<td>25%</td>
</tr>
<tr>
<td>Neither helpful nor unhelpful</td>
<td>6%</td>
<td>5%</td>
<td>6%</td>
</tr>
<tr>
<td>Fairly unhelpful</td>
<td>1%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Very unhelpful</td>
<td>2%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Some helpful, some unhelpful</td>
<td>3%</td>
<td>3%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Unweighted base (Intervention Groups who received each type of help) 240 596 536

However, there was much variation in panel study participants’ views about the services they received. With one exception, respondent experiences of physiotherapy, and related services such as home exercise routines and accompanied swimming sessions, were very positive, as they had often had a noticeable impact on health. People were also generally positive about sessions with occupational therapists, a case of expedited surgery, a referral for medical tests which led to a much needed diagnosis, aromatherapy sessions, acupuncture, Pilates, a free gym membership, help with job applications and updating a CV and benefits advice.

There were a number of services, however, that received more mixed reactions from participants. This was particularly true of psychological therapy. In the first cohort of the panel study, dissatisfaction with this type of therapy was more common, such as that expressed by someone who spoke of being ‘emotionally damaged’ by the experience or the person who felt that their counselling sessions were inappropriate. In contrast, reactions among those interviewed as part of the second cohort of the study, including some people receiving therapy services from the same providers as those in the first cohort, were, on the whole, much more positive. Someone thought the counselling they had received had been instrumental in helping them return to work. A possible explanation for the difference in perceptions between the two cohorts could be that there was an improvement over time in how this type of treatment was explained and delivered by case workers. This is supported by the fact that complaints about poor explanations of what the different forms of psychological therapy would involve were only mentioned by those dissatisfied respondents in the first cohort.
Hypnotherapy was another service that received both good and bad reactions from participants: in one case it was described as relaxing and a boost to confidence; in others it was criticised for having been conducted without client consent as part of another form of treatment.

Feedback from participants was also mixed where service provider liaison with employers was concerned. Respondents were positive about provider input where it was seen to have achieved a successful outcome, for example where mediation with employers had led to a reduction in working hours for a client who had recently returned to work but was finding the work tiring. Feedback was more negative where the provider intervention had had a negative impact on return-to-work plans. An example of this was where a negotiation had led to a graduated return-to-work plan that was too fast a pace for the respondent to manage.

Some of the other services delivered by JRRP received negative comments from respondents. Careers advice and some of the associated tests, for example, were described as ineffective in helping people move any closer to work, as were some of the other workplace related services. One person also talked about how they had been unable to understand why their provider had funded some minor surgery for a condition that had no direct link to their sickness absence.

5.3.1 Perceived gaps in service provision

Given that panel study respondents tended to be unaware of what services were available through JRRP beyond what they had already received or been offered, it was difficult for them to report gaps in service provision. Nonetheless, some gaps in services were perceived, such as where people were unable to receive the services they wanted as they had not been allocated to the appropriate Intervention Group, or because some services, for example MRI scans, were said to be unavailable due to lack of funding. There were also cases of services being promised but then not delivered. According to what respondents said they had been told by their providers, this was sometimes due to a lack of funding, as in the case of an offer of dental treatment that was later withdrawn.

On other occasions, services were said to have been withdrawn because they duplicated services available outside JRRP. An example of this was a respondent who had some planned sessions with a clinical psychologist cancelled when the provider realised that the client was already in receipt of similar treatment elsewhere. Another reason for a planned service not being delivered was where it was not considered appropriate at the time, for example a workstation assessment was put on hold following a client’s dismissal. Finally, some services that were promised to participants, such as debt advice, were never delivered. This was often perceived by respondents to have been due an error on the part of the providers, rather than the result of a clear decision to withdraw the service in question.

The OCS evidence suggests that quite a large minority of Intervention Group respondents perceived a gap in services. Among those who did not withdraw before or immediately after giving consent, 30 per cent said that there were services they would have liked to receive which were not offered to them. Workplace group clients were more likely to have perceived such a gap (42 per cent), than those in either the Health (27 per cent) or Combined (21 per cent) groups.
The services most commonly desired by the Workplace group were medical – 27 per cent of those who wanted additional services named physiotherapy, 26 per cent wanted a referral to a consultant or specialist, 24 per cent counselling or CBT, and 12 per cent complementary or alternative therapies. However, 12 per cent wanted help with arranging a gradual return to work, and 12 per cent training so they could do a different job. This suggests that a minority of Workplace clients were not offered services that were appropriate to their group.

Health group members who wanted additional services most commonly desired help that could only be given to the Workplace group, such as arranging a gradual return to work (23 per cent), liaison with their employer (20 per cent), help with arranging a different job with their employer (15 per cent), or training to do a different job (10 per cent). However, they too named some treatments which could have been offered as part of their intervention (17 per cent wanted referral to a specialist and 14 per cent counselling or CBT). The Combined group were more likely to mention health than workplace treatments (18 per cent counselling, 16 per cent a referral, and 12 per cent physiotherapy).

5.4 Contamination

This section considers the evidence available so far from the two surveys as to the extent of contamination between the four groups, and explores some possible reasons for contamination occurring. As described in Section 5.2, Intervention Group OCS respondents were asked what types of treatment and advice they had received from service providers. If any respondents in the Health group say that they received help or advice with their job/workplace, or conversely, any of those in the Workplace group claim to have received medical treatment or advice, then it must be suspected that their treatment was contaminated. It is important to estimate the extent of contamination as it will be necessary to take such cross-over between treatments into account when estimating the impact of the trial, which will be the subject of a later report. It should be stressed that this is only a preliminary analysis of contamination, and that further evidence from providers’ records will be required to determine which cases have actually been contaminated.

The evidence from the OCS suggests that contamination in terms of actual treatment or practical help/support did occur for a minority of participants, but at reasonably low levels. Looking just at those who did not withdraw from services before the consent interview, and who had some further contact with providers, eight per cent of the Health Group said that they had received ‘any support in any job, either at [their] place of work or anywhere else’, and 13 per cent of the Workplace Group claimed to have received ‘any help with [their] health condition or disability, either at a hospital, at the service provider’s office, or anywhere else’. As a percentage of all members of these Intervention Groups, ten per cent of Workplace and seven per cent of Health group members received contaminated treatment according to this self-report measure.
The most common contaminatory workplace treatment in the Health Intervention Group was help with arranging a gradual return to work (received by about half of those whose treatment was contaminated in this way). It might be hoped that those receiving contaminatory treatment were exposed to fewer such treatments than those receiving them correctly, but this was not the case for workplace treatment. The mean number of treatments mentioned by those who received workplace help was similar among the Health (1.6), Workplace (1.7) and Combined (1.9) groups.

Workplace group respondents who had received contaminatory health treatment most commonly mentioned counselling or CBT (about a third) or a referral to a consultant or specialist (about a quarter). The mean number of health treatments mentioned was similar among the Workplace (1.4) and Health (1.6) groups, but somewhat higher among the Combined group (2.1).

Contamination in terms of advice rather than practical help/treatment was more common, according to evidence from the OCS (Table 5.5). Among those who had received any advice through the provider, over a third (35 per cent) of the Health group said that they had been given advice about how to return to work. Similarly, 40 per cent of the Workplace group had been advised about how to improve their health. As a percentage of all members of these Intervention Groups, 16 per cent of Workplace and 13 per cent of Health group members received contaminatory advice.

Table 5.5 Types of advice received from providers, by Intervention Group (Outcome Survey)

<table>
<thead>
<tr>
<th>Expected for Workplace/Combined only:</th>
<th>Health</th>
<th>Workplace</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice on how to return to work</td>
<td>35</td>
<td>63</td>
<td>62</td>
</tr>
<tr>
<td>Advice on benefits/debts/financial situation</td>
<td>15</td>
<td>27</td>
<td>25</td>
</tr>
<tr>
<td>Legal advice (employment/disability rights)</td>
<td>3</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Advice on how to deal with work situations</td>
<td>1</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Advice on training</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Expected for Health/Combined only:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advice on how to improve health</td>
<td>75</td>
<td>40</td>
<td>70</td>
</tr>
<tr>
<td>Expected for any group:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional/moral support</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>

Unweighted base (Intervention Groups who received any advice) 153 154 229

The difficulty experienced by provider staff in limiting advice to that allowed under each Intervention Group has been a recurring theme throughout the Research Advice visits to provider premises. Thus it is not surprising to find evidence from the

14 See Appendix A for an explanation of the Research Advice role in the evaluation.
OCS of fairly sizeable levels of contamination in terms of advice. The Research Advice visits unearthed the following issues which explain why this type of contamination has occurred:

- **Service provider staff experienced difficulties in interpreting the guidelines on advice-giving in an ‘on the spot’ situation.** For example, deciding what can and cannot be discussed in the Health group where a client was suffering from work-related stress. If someone was off work because their manager was bullying them and they told the caseworker all about the situation, it was unclear whether the caseworker could then discuss the specific relationship with the individual manager, or whether they had to stick to general strategies for increasing assertiveness and stress management.

- **Staff perceived conflicts of interest between the trial guidelines and the ethical and professional guidelines under which they worked.** An example was that of someone in the Workplace group who had had a stroke and worked with power tools. It may not have been safe from a health point of view for them to return to work, but as case managers could not advise on or talk about the client’s health, they could not find out whether it was safe.

- **Whereas it was relatively easy to monitor whether treatments provided or referrals made to other agencies are ‘contaminatory’, this was almost impossible for advice and signposting.** Consequently it was impossible to be sure whether interventions are or are not ‘contaminated’, particularly where services were being delivered by sub-contractors, whose activities were less readily monitored and controlled.

- **Provider staff had difficulty in understanding why debt and benefits advice was allowed in the Workplace group but not in the Health group** – it did not logically appear to sit in one group better than the other.

- **Advice on the workplace was seen as an integral part of some health treatments,** for example, a physiotherapist’s normal way of working could cover a discussion of how to cope at work.

Another possible type of contamination is that of the Control Group, which could have happened if providers (or any other organisations involved) gave this group any help or advice which led them to change their behaviour in any way. The opportunities for this to occur were limited in the following ways by the design of the trial:

1. service providers were not allowed to have any direct contact with potential recruits before they were randomised to an Intervention Group;

2. volunteers were screened by a central Contact Centre whose advisers had been trained to build a rapport with callers without giving any help or advice that could lead to contamination;

3. volunteers were notified of allocation to the Control Group by a letter from National Centre for Social Research (NatCen) and were given a helpline number to call if they wanted to discuss it with anyone. The helpline was staffed by NatCen advisers also trained not to give any contaminatory help or advice;
4. providers were never given details of the Control Group members, and the Control Group were never given the phone number or any other contact details of service providers (the only numbers given on marketing materials were of the central Contact Centre).

The success of the first safeguard against contamination has already been discussed in Section 3.1, in that less than one per cent of survey respondents heard about the trial directly from providers. The second was assessed as part of an exercise conducted by the Research Advisers from NatCen, which involved listening to a random sample of screening interviews. There was only slight evidence of potentially contaminatory information being given out. This was most likely to occur when callers asked about specific medical treatments, for example sometimes specific treatments such as physiotherapy were discussed.

Provision of the NatCen helpline was felt to be ethically necessary to provide some form of support to the Control Group who might be disappointed/upset at their allocation to this group. In the event, the helpline was used more frequently by the Intervention Groups, 15 per cent of whom said they called or tried to call, compared to only six per cent of Controls. As the proportion calling was small, it is highly unlikely that this contact was a significant source of Control Group contamination.

An evaluation of the fourth safeguard was attempted by asking OCS respondents in the Control Group if ‘other than the initial call, have you had any other contact with the WorkCare/Routeback/HealthyReturn project?’. Overall, 22 per cent said that they had had further contact with the project. However, when asked what this contact had consisted of, it was evident that the vast majority were referring to further contacts with either the Contact Centre, the NatCen helpline15 or NatCen letters or phone calls to do with one of the surveys. There was very little evidence indeed of any real contamination, which is the expected outcome given the measures taken to keep Controls and providers separate throughout the trial.

5.5 General impressions of providers’ services

This section explores panel study and OCS participants’ perceptions of how service provider staff operated in general, how provider staff liaised with other parties involved in client cases, the pace at which services were delivered and how accessible they found provider premises.

After the consent interview, most further contacts for OCS respondents took place in person at the provider’s premises (72 per cent of respondents who had further contact) or over the telephone (38 per cent). Seven per cent had contact in person in

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15 About half of the Control Group’s calls to the helpline were because they were disappointed at their allocation to this group. Other reasons for calling included giving new contact details, wanting clarification of the letter sent to notify them of their group, wanting to withdraw from the trial, or not having received the letter.
their own home, three per cent in person at their workplace, two per cent by email and one per cent in person somewhere else. Most (82 per cent) did not have practical difficulties with these contacts, but 11 per cent had difficulty getting to the venue, five per cent with the cost of transport, four per cent had trouble getting into the building, one per cent had difficulty with car parking, and one per cent with other things.

Accessibility did not appear to have been very problematic for panel study respondents. No one said that they experienced any difficulties in locating provider offices. All locations appeared to be easily accessed by car or by bus. There were, though, occasional parking problems due to insufficient spaces in one location, and sometimes bus journeys were described as long. People with mobility problems as a result of their conditions tended to be provided with taxis, at the provider’s expense, and often without asking which was very well received. The OCS shows that this was quite common – 46 per cent had been offered a taxi to get to the first interview, of whom 57 per cent accepted. Some people were very pleased to receive home visits where travelling was particularly difficult.

However, some panel study respondents did go on to talk about the potential problems they perceived about provider offices. Someone reported that their provider’s office was on the first floor, which meant climbing a set of stairs, which, according to the respondent, might not be accessible for everybody. In the respondent’s own experience, climbing the stairs had proved useful to the case worker assessing the participant’s level of fitness as it highlighted how exercise could lead to breathlessness. The same respondent also felt that the provider’s exercise room could have been bigger, as it could only really fit two people comfortably. The cost of getting to the offices was a concern for some. One person thought that maybe the cost of bus fares might be a problem for other people, especially as the provider in question had not offered to pay them. However, another respondent thought that one service provider wasted money by providing taxis when they were not really needed.

Impressions of service provider staff and those delivering services on their behalf were more positive among those who took part in the second cohort of the panel study than the first, although it should be noted that this observation is based on a small sample size. Clients in the second cohort said they had developed good relationships with provider staff, and felt sufficiently involved in the decisions taken concerning the services they received. In contrast, some respondents from the first cohort felt they had been badly treated by service provider staff. In one example, someone reported having been ‘verbally abused’ and told they were not welcome after missing one of the sessions of a particular treatment programme. Another person felt their psychotherapist had ‘played psychological games’ with them.

Respondents’ accounts of how provider staff communicated with them were also varied. On the whole, communication was described as good where it concerned case managers, although there were some criticisms that related to how contact with service providers ended, which is discussed in more detail in Section 5.7. There
were also some examples of poor communication whilst people were still in contact with providers. One example was a provider who had not told a client that a further session of psychotherapy had been arranged. The person only became aware when a taxi, booked to take them to the session, arrived at their house. A more recurrent problem was where provider staff did not follow-up plans to organise referrals or new services, such as where someone was promised a referral to a benefits adviser but was never contacted by the adviser.

On the whole, people had not been directly involved in how service provider staff communicated with each other and with sub-contractors, employers and GPs, so the discussion of this was limited. Where people had been involved, views on how well liaison between different parties had been managed varied. Liaison with employers, for example, which was a common feature of workplace interventions, was generally considered to be effective. In contrast, clients’ perceptions of communication between service providers and GPs, which typically consisted of the passing of medical reports and results, were more mixed. This type of communication was seen to work more effectively where participants were involved in the passing of information between the two parties, or where they were clear about what information was being shared. Problems were more common where people were less involved, like in the example of a respondent who was angry to discover that their GP had received a letter from their estranged service provider questioning the state of the patient’s mental health.

Other problems included a copy of a report of the results of a consultation arranged through JRRP not being sent to a client’s GP, and an initial letter gaining a GP’s consent to medical records not being followed up by a provider when there had been no response from the GP. There were also mixed views about how well service provider staff communicated with each other and with their sub-contractors where this was discussed in the panel interviews.

Perceptions of the pace at which JRRP services were delivered was also varied. In considering pace, it is necessary to distinguish between the pace at which services were set up as well as the pace at which services were delivered. Some respondents were very impressed at the speed at which their providers arranged treatment packages for them. This is perhaps not surprising considering some people’s experiences of long waits for NHS services, such as physiotherapy. One person, for example, was amazed at how quickly their case manager had responded to their request to have some hypnotherapy sessions, as recommended by an NHS healthcare professional. There were also cases where the pace was considered to be slow, such as the person whose provider had made no progress in arranging appropriate treatments due to a delay in gaining GP consent for access to the respondent’s medical records.

These findings are supported by the OCS, where most respondents (93 per cent) felt that the pace of the process of joining the trial was about right. Six per cent felt it was too slow and only one per cent that it was too quick. The most common reason for feeling it was too slow was the long time between the first contact with the project
and the consent interview (44 per cent). A quarter thought it was too slow because they were impatient to recover their health quickly (25 per cent) or to return to work quickly (24 per cent). Thirteen per cent felt that the service provider had been inefficient (Table 5.6).

On the whole, panel study respondents were satisfied with the pace at which services were delivered in terms of the frequency of sessions. However, some people considered their treatment was too intense which led them to feel pressurised and exhausted, such as the person who found their twice weekly sessions of CBT too much. The duration of courses of treatment was also generally perceived as adequate. However, the manner in which a course of treatment ended was sometimes criticised. This is discussed in more detail in Section 5.7.

The evidence from the OCS suggests that providers struck the right balance with the pace of further contacts to organise help. Ninety-four per cent felt that the pace was about right, and only four per cent found it too slow and one per cent too fast. The number who found it too slow is too small for detailed analysis of the reasons for this, but the most common reasons were impatience to return to work or recover health, a view that the provider staff were inefficient, and a long gap between being screened and getting help organised.

Any comments made by panel study respondents about service provider premises were, on the whole, positive. When talking specifically about the offices in which providers operated, one person commented on how the building where their provider’s offices were situated was much more attractive than the NHS buildings they were used to. This participant went on to say that inside the offices there was a relaxed atmosphere that made one feel more comfortable about ‘opening up’ about one’s circumstances. Another respondent praised the reception staff and area of their provider for making them feel at ease.

### Table 5.6 Reasons respondents felt pace of joining the trial was too slow (Outcome Survey)

<table>
<thead>
<tr>
<th>Preliminary Outcome Survey data</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long time between first contact and first interview</td>
<td>44</td>
</tr>
<tr>
<td>Wanted to recover my health quickly</td>
<td>25</td>
</tr>
<tr>
<td>Wanted to return to work quickly</td>
<td>24</td>
</tr>
<tr>
<td>They were inefficient</td>
<td>13</td>
</tr>
<tr>
<td>Called up when had been off sick for less than six weeks so had to wait to become eligible</td>
<td>8</td>
</tr>
<tr>
<td>Too many members of staff dealing with case</td>
<td>6</td>
</tr>
<tr>
<td>Had to wait for medical treatment to finish before receiving help</td>
<td>6</td>
</tr>
<tr>
<td>Too much paperwork/admin</td>
<td>5</td>
</tr>
<tr>
<td>Too many questions</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>21</td>
</tr>
</tbody>
</table>

*Unweighted base (Intervention Groups who felt pace of joining too slow) 63*
5.6 Reasons for turning down treatment

During the consent process, it was stressed to participants that they did not have to accept any treatment that they did not want, even if they consented to take part in the trial. This section looks at those who turned down treatment, what they turned down and their reasons for doing so.

Among those OCS respondents who had further contact with providers after the consent interview, 12 per cent turned down some help, service or part of a service offered to them. The most commonly-refused treatment was counselling, CBT or psychotherapy (25 per cent of those who refused something refused this). Fifteen per cent refused to give the provider permission to contact their employer at all. Thirteen per cent refused physiotherapy/therapeutic exercise, and 12 per cent complementary/alternative therapies. The various other treatments were turned down by smaller proportions, the largest of these being the seven per cent who turned down a gradual return to work, and six per cent who refused gym facilities. Thirteen per cent refused some other unspecified treatment.

Among panel study respondents, there were few cases of clients rejecting specific services that they had been offered. Where they did it was for a number of different reasons. In some cases it was because the services on offer were seen as inappropriate (in the OCS, 32 per cent of those who turned down a treatment said that this was because they did not think they would benefit from it). Examples included a person who did not want to receive any of the workplace services they were eligible for because they had joined the trial in the hope of getting health treatments, and someone who declined their provider’s offer of a course on bullying as they did not want to relive their own traumatic experiences. Services were also not taken up where there was a lack of time or desire among respondents already back at work, to take up the offer and where the services on offer were a duplication of similar provision outside JRRP (21 per cent of OCS respondents who refused a service said it was because they could get it elsewhere). One respondent, for example, declined an offer of some counselling as they were already in receipt of a similar service on the NHS. There were also cases of people withdrawing from services already in operation. An example of this was someone who asked a provider to stop some physiotherapy sessions due to dissatisfaction with how they were progressing. Another reason mentioned by 11 per cent of OCS respondents who refused a service was that they did not feel well enough to take up the offer.

5.7 How contact with JRRP ended and its implications

As already mentioned, five per cent of OCS respondents withdrew from the services before attending the first consent interview, and a further nine per cent ceased contact after this interview but before they had any further contact with the provider. This section looks at these participants’ reasons for withdrawing early, and at how contact ended for all participants.

The withdrawal rate was slightly higher for Workplace respondents (at seven per cent before consent and 14 per cent afterwards), than for Health (four and seven per...
cent) or Combined (six and seven per cent) respondents (Table 5.1). Twenty per cent of respondents who left the pilot early did so simply because the provider had either not contacted them or had not offered them any treatment. A similar proportion (17 per cent) had other treatment organised. Sixteen per cent withdrew because they had already or were about to return to work, and 12 per cent because they did not feel well enough to return to work. Only eight per cent withdrew because they did not like the treatment on offer, and seven per cent because they thought they were going to get better anyway. Seventeen per cent gave other unclassified reasons (Table 5.7).

Whilst some people were still in contact with JRRP at the final panel study interview, including some who were back at work, for others dealings appeared to have already ceased. Where contact continued, the motivations behind it varied. In some cases people were still in receipt of services. There were also some cases of people in the Workplace group who were planning to get in touch with their providers once they were in a position to attempt a return-to-work in order to discuss how their provider might be able to help.

Where participants perceived that contact had ended or was about to end it was rare for them to have received any formal notification of this. Typically, contact with service providers had become less and less frequent to a point where it was assumed by the respondent that it had ended. In some of these cases, contact was resumed at a later date by a telephone call, postcard or letter requesting an update of client progress. In other cases, contact ended more abruptly. For example, one person was not given prior warning that their most recent CBT session had been the last. This respondent did not mind that the sessions had run their course but was disappointed at not having been forewarned.

Table 5.7  Reasons for withdrawing before receiving any services (Outcome Survey)

<table>
<thead>
<tr>
<th>Reason</th>
<th>Preliminary Outcome Survey data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact not made by provider/no help offered</td>
<td>20</td>
</tr>
<tr>
<td>Had other treatment organised</td>
<td>17</td>
</tr>
<tr>
<td>Returned to work/about to return to work</td>
<td>16</td>
</tr>
<tr>
<td>Not well enough to return to work</td>
<td>12</td>
</tr>
<tr>
<td>Didn’t like the treatment offered</td>
<td>8</td>
</tr>
<tr>
<td>Thought I was going to get better anyway</td>
<td>7</td>
</tr>
<tr>
<td>Not well enough to attend meetings</td>
<td>4</td>
</tr>
<tr>
<td>Decided didn’t want to return to work</td>
<td>2</td>
</tr>
<tr>
<td>Given external advice not to continue with treatment</td>
<td>1</td>
</tr>
<tr>
<td>Caring responsibilities</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
</tr>
</tbody>
</table>

Unweighted base (intervention groups who withdrew before receiving any services) 172
The only cases where it was clear that contact had definitely ended were where the client had withdrawn from receiving services and where the service provider notified the participant that he or she was no longer eligible to receive services through JRRP. There were three cases of complete withdrawal from JRRP among panel study respondents. Dissatisfaction with services received was the reason in each case. In the first case, someone was unhappy with the pace of the graduated return-to-work plan a service provider had agreed with an employer. This person withdrew from JRRP when they realised they could get their employer’s occupational health department to agree a more gradual return. In the second case, a participant withdrew after the way they had been treated by provider staff following a missed appointment. And in the third case, a client withdrew from JRRP because they felt that the course of CBT that they were receiving was inappropriate to their needs as they could not understand how it would help them get back to work. There were two cases where contact had been formally ended by a service provider. Both received written notification that their service providers were no longer able to provide any more services for them.

Where contact had ended, the reactions of participants were varied. Where people felt that JRRP had nothing left to offer them, it was generally accepted. However, there was a group of respondents who were clearly disappointed that contact had ended as they felt that they could still benefit from JRRP’s help in getting them back to work. Much of this disappointment was concerned with the ending of contact with case managers. Some people described how they had become reliant on the practical and emotional support they received from their case managers. An example of this was someone who talked throughout their panel interviews about how the regular contact with a case manager was what gave them the motivation to ‘get out of bed in the morning’. This person talked about needing their case manager to ‘do the driving’. Some other people, however, were disappointed that their service provider had not done more to explore other services available to help them get back to work. One example of this was a person who said they would have liked some help with applying for courses to develop new skills but was not sure that this was within the provider’s remit.

Participants recurrently talked about how their service providers had told them they could make contact with them whenever they needed. However, as mentioned at the beginning of this chapter, there was little evidence of clients making any contact themselves. The only examples were where clients had called to cancel or rearrange appointments or to ask for advice or information about other services. Where people were looking for continued emotional support from case managers there was a widespread reluctance among participants to make contact with providers. The reasons behind this reluctance were not always discussed, but there was some evidence to suggest that some people felt they would be wasting their case managers’ time. Their perception was that if their case managers had not been in contact with them it was because they were no longer interested in their case, which made clients reluctant to make contact.
To sum up, this chapter has shown that of the one in four who received Workplace support and six in ten who got Health support, almost all found it helpful. The half who received advice found this slightly less helpful than the practical support. Some treatments were considered more helpful than others – experiences of physiotherapy, occupational therapists, surgery, referral for medical tests, aromatherapy, acupuncture, Pilates, gym membership, help with job applications and benefits were all very positive. Some received more mixed reactions, such as hypnotherapy, liaison with employers and in particular psychological therapy (but this may have improved over time). Careers advice and some other workplace services were seen as ineffective. Some gaps were perceived, where services were not available in the Intervention Group, or were outside JRRP’s remit. Most clients were positive about provider premises and accessibility, although some had transport, access or parking problems.

Most clients had regular contact with a case manager, whose support was talked about very positively (although some had become reliant on it). Case managers’ communication with clients and employers was seen as good, but perceptions of communication with GPs, other provider staff and their sub-contractors were more mixed. Participants were generally reluctant to make contact with case managers themselves, feeling they would be wasting their time.

Some Intervention Group participants were more satisfied with their treatments than others; four in ten Workplace clients wanted services that were not offered, most commonly medical. The level of unmet demand for treatment was lower among the Health and Combined groups. Workplace clients were also more likely to withdraw, less likely to receive treatment and more likely to receive just advice or nothing at all.

Most clients did not receive ‘contaminated’ treatment, although contamination in terms of advice was somewhat more common. The evidence is that very little contamination of the Control Group occurred.
6 Concluding remarks

The picture emerging from these preliminary analyses is that participants allocated to the Job Retention and Rehabilitation Pilot (JRRP) Intervention Groups had, on the whole, a positive experience of taking part in the trial. They felt that they received clear explanations about the trial both at screening and from providers. They were generally pleased to be assigned to the Intervention Groups, and had positive initial impressions of provider staff and premises. In general, participants were impressed with the speed with which treatments were arranged and felt that the treatments and advice received were helpful. The practical and emotional support provided by case managers was particularly appreciated. However, there were some problems: according to the survey some experienced delays in meeting with providers for the first time and a small proportion never met with them or received any treatment (although this was by choice for many). Some had problems getting to or into the provider’s premises. Client involvement in deciding on their treatment appeared to be limited, and some clients were unhappy with the treatment received. Workplace clients in particular were likely to feel they had not received the treatment they wanted.

As Control Group clients were not included in the panel study, the evidence for their experiences is more limited, but it is clear that they experienced disappointment with their group. However, they were on the whole satisfied with the explanation they received about the trial when applying to join, and most had realised that there was a chance that they would not receive any help.

As indicated in the opening chapter, this is an introductory report. As such, it would be premature to draw detailed conclusions about JRRP at this stage. Nevertheless, this is an opportunity to highlight a selection of key findings that have emerged from the first two cohorts of the panel study and the early survey interviews which may have policy implications.
Section 2.5 details people’s initial positions in relation to a return-to-work, as explored in their first panel study interview. This describes the roles played by General Practitioners (GPs) and employers in helping people back to work before they contact JRRP. Clearly a more positive attitude towards returning to work among employers and GPs was important in the cases of those participants who had gone back to work shortly after contacting JRRP. In contrast, some of the people who remained off sick when they were interviewed at the beginning of the panel study described a much less supportive attitude among their employers and GPs with regard to returning-to-work.

The fact that people volunteered to join JRRP despite often vague expectations of what the service could offer them, suggests that there is a gap in services available to help people back to work and that many people on sick leave are keen to look for ways to help them get back to work. It also suggests that volunteers needed to know more about what services JRRP could offer.

Given that panel study respondents often found it difficult to recall much about the process of making contact with and joining JRRP, it is not possible to be conclusive from this data about how well consent, action plans and randomisation were explained and handled by service providers. However, most survey respondents were satisfied with the explanation they received from the Contact Centre and from the video that was shown at the consent interview. Most understood that the trial was voluntary and that they could withdraw at any time. And almost all recalled giving their consent to take part. The reason for the differences in recall levels between these two data sources lies in the different methodologies used in asking questions.

There was evidence from both the panel study and the surveys that showed that the concept of randomisation was not always understood or believed, although respondent understanding may have been better at the point when the concepts were explained than at the point of the research. Whilst this seemed to have little noticeable influence on panel study respondents’ opinions and experiences of JRRP, it does highlight how difficult it can be to communicate often complex concepts to participants.

From the evidence available so far, it appears that the trial design has successfully prevented any significant contamination of the Control Group. Repeating these elements of the design should therefore be considered in any future trial of this nature.

Most of the Control Group were quite disappointed at their allocation to this group, but only a small proportion used the helpline that had been set up to allow them to vent their feelings. Their disappointment may have been quite mild and not severe enough to need to talk to anyone. Alternatively, this could reflect successful recruitment, screening and notification procedures which prepared people adequately and enabled them to accept their disappointment. Or, they may have been very disappointed, but not felt able to phone to discuss it. The reactions of this group are important to the evaluation, both because
they may have experienced real distress and because extreme disappointment might affect their subsequent behaviour compared to someone who had not taken part in the trial. The forthcoming focused study of Control Group members will provide some information about this, but earlier feedback would be preferable in any future evaluation of a similar trial.

- Panel study respondents’ accounts of the assessment that commonly took place during the initial meetings with service providers, coupled with their often limited expectations of JRRP suggested that people were not always aware of the full range of services available to them through JRRP or what individual services involved. This lack of knowledge meant that participants were not in a position to have a dialogue with their service provider about what services they would like or need. It also made it difficult for them to identify gaps in service provision. This finding highlights how service providers should not assume that their clients are aware of the range of services available to them or understand what individual services involve. It also suggests that service providers would need to communicate more of this type of information if clients are to be more actively involved in decision making.

- Among those who took part in the panel study, impressions of service providers tended to be good, especially at the beginning of their participation in the trial. When compared with existing services like the National Health Service (NHS), respondents’ opinions of the providers were particularly favourable. Most survey respondents found the premises accessible and rated their case manager highly. However, the reactions of panel study respondents to providers and the services they delivered became more mixed over time. Among those who took part in the first cohort of the panel study there were some reports of dissatisfaction with the way in which some services were delivered. However, fewer comments of this nature were made during the second cohort. Although the small sample size makes it difficult to compare the two cohorts in any meaningful way this difference between the cohorts might suggest that some early problems were ironed out as JRRP developed.

- Contamination between the Work and Health Intervention Groups seems to be at reasonably low levels in terms of actual treatments received, but higher in terms of advice. This finding is not surprising given the reluctance on the part of many provider staff to withhold advice that could be of benefit to clients and the fact that they felt bound by their obligations to professional bodies and their ‘duty of care’ to clients to deliver appropriate help. They perceived failure to give advice about existing services as not only going against their own ethos and training but possibly damaging their professional reputation and the participants themselves. There was also a perception that they could be deemed culpable in a court of law if they had deliberately withheld information they knew could help a client. Staff therefore experienced conflict which tended to lead to them putting their perceived legal and professional obligations before those of the trial. Ways of reducing conflict between existing professional codes and the requirements of a randomised control trial, and of reducing the concerns of
provider staff that the trial restrictions could damage participants, need to be considered in any future trial of this kind. Feedback from provider staff suggested that more consultation with them and listening to their concerns at the beginning of the trial might have helped prevent the interventions being defined in a way that contradicted their everyday understanding of their ethical obligations. Also, it may have helped to have a bedding-in period of a few months, after which the various players meet to discuss the issues arising. The conflicting definitions would be revised if possible, and feedback if changes could not be made would then help to ensure that provider staff sign up to the definitions.

• The role of case managers in providing practical and emotional support was very important to some JRRP clients who took part in the panel study. People particularly appreciated having a dedicated contact person who was willing to listen to their concerns as well as provide them with moral support and advice. The importance of this role was further highlighted in later discussions by some respondents’ palpable disappointment that contact with case managers had ended.

• It was often easy for these participants to assume that, where it seemed that contact had ended, their service provider was either unable to provide any more services for them or that their case was no longer considered a priority. Consequently respondents were reluctant to make contact with provider staff, even where they had been invited to. This highlights how important it is for providers to maintain regular contact with their clients and to not expect participants to make contact themselves. It also suggests that negotiating the end of service provision to the client should be made clearer.
Appendix A
The JRRP evaluation

The evaluation of the Job Retention and Rehabilitation Pilot (JRRP) has two main strands: an evaluation of job retention services; and an evaluation of the trial itself. These strands are being evaluated via an impact assessment (including a cost-benefit analysis), a process evaluation and a research advice component.

Evaluation objectives

The main objective of the evaluation of job retention services is to measure and compare the impact on return to work rates and job retention between the three Intervention Groups, and between the three groups and the Control Group. A successful outcome is defined as a return to work (to either the same job or a different one) of 16 hours or more for 13 consecutive weeks.

Return-to-work is the primary outcome for the trial, but data will be collected on a large range of secondary outcomes, such as other work outcomes (for example, hours worked per week, attitudes to work, perceived barriers to work); health outcomes such as self-assessed general health, attitudes towards health, use of health services; and economic well-being of client households.

The evaluation of job retention services also aims to explore in detail clients’ experiences, and decision-making as they use the service and to witness change in their feelings, views and intentions as it occurs. It will provide a rich understanding of how clients use the service, what they think of it, and what type of help is more or less useful to them at different stages.

A further objective of this aspect of the evaluation is to examine the cost-effectiveness of the scheme and who gains and who loses from the services.
Appendices – The JRRP evaluation

The main objectives of the research into the trial procedures is to allow us to report on and respond to the following:

- that those entering the trial have understood the trial procedures (including the need for a Control Group);
- that the trial will have sufficient statistical power to determine the impact of the three interventions on return to work rates;
- that the measures of impact derived from the trial are unbiased, or at least very close to unbiased.

Evaluation design

Research advice

A key element of the evaluation was to observe the operation of the pilot to ensure that the procedures were working well and to help providers whenever possible on areas that related to the running of the trial (as opposed to delivering the interventions). This involved giving guidance to new staff on the consent procedures, talking over data collection and recording issues with providers and providing training.

The main issues were to see how well the screening tool worked; whether there were lessons in marketing that could be passed between providers; whether there were ways to ensure that losses to the trial through attrition and ‘no-shows’ were minimised; and ensuring that contamination between the Health and Workplace groups was minimised.

The main elements of the research advice role were:

- site visits to service provider offices and the Contact Centre to observe working practices and to provide support and advice;
- analysis of routine administrative data to identify problems relating to sample numbers and attrition;
- small sample telephone surveys with clients to assess reasons for drop-out/non-participation;
- desk assessments of action plans and interventions to check adherence to the randomised allocation;
- assessment of the screening tool via an early telephone survey to compare the deadweight rates\(^ {16} \) of Controls and those screened-out.

\(^ {16} \) The ‘deadweight rate’ refers to the proportion of clients who would have returned to work anyway, without any additional help from JRRP services.
Impact assessment

This element of the evaluation aims to measure the impact of the pilot via a face-to-face survey of all randomised clients, including the Control Group. This survey is called the Outcome Survey (OCS).

The impact assessment also includes a cost-benefit analysis, to show the return on investment of the funds committed to the pilot intervention. Simply having the intended impact on clients is not enough, if that comes at great cost in terms of public funds that might have been used in other ways. Once costs are considered, the net balance may not be favourable. The cost-benefit analysis will also inform the question of incidence and fairness that surround any public intervention: who gains and who loses from the scheme. The analysis will compare the costs of the interventions, derived from cost data collected directly from service providers and from the OCS, to their benefits in terms of any impact on return-to-work rates, use of health services and benefits.

Process evaluation

The components of this element are:

- a panel study of clients who will be interviewed at regular intervals over a period of six months to collect ‘real time’ data about their experiences of the service.

- a series of focused, research question-led studies which:
  - explore the operation of the service
  - explain how people return to work.

Evaluation database

At the end of each monthly reporting period, every organisation (Contact Centre, National Centre for Social Research (NatCen) randomisation and each service provider), sent an extract of their data to be merged together centrally at ORC, the organisation contracted to create and manage the database. The merged extract became the Management Information and Evaluation Database, which contains screening information, details of services received from providers and outcomes for pilot participants. The original content of the database is defined in detail in a document known as the Data Catalogue. The database is held by the Information Analysis Directorate at the Department for Work and Pensions (DWP).

There were some difficulties with the extracts sent to ORC. The Contact Centre data extracts did not contain all the necessary data items. This was resolved when a new data capture system was set-up by SDA. Also, some providers experienced difficulties exporting their data so that their extracts were formatted incorrectly, had missing data items or were not being populated correctly. A newly formatted database was designed by SDA to improve the data extracts from providers.
The change to the Contact Centre data extracts had a further impact on the merged extract produced by ORC. The merged extracts only contained the newly formatted cases because the two types of extract are not directly comparable. Work was needed to allow the screening data from both types of extract to be viewed simultaneously.

Evaluation organisation

The evaluation of JRRP is managed by officials from DWP’s Health and Work Division in consultation with other colleagues from DWP strategy teams, Jobcentre Plus (who managed service delivery), DWP Contract Management Group and the Department of Health (DH). The pilot is supervised by a project management board with officials from DWP, DH, the Health and Safety Executive and the Scottish Executive.

The evaluation is being carried out by NatCen in collaboration with the Social Policy Research Unit (SPRU) at the University of York, and the Urban Institute (Washington DC).
Appendix B
Methodological appendix

Survey of Screened-Outs and Controls methodology

The Survey of Screened-Outs and Controls (SoSOC) is a telephone survey of trial entrants who were randomised to the Control Group and people who had called up to join the trial but were screened-out as not at risk of losing their job. The latter group did not include those who were ineligible to take part in the trial17.

The survey’s main aim is to provide an estimate of the deadweight rate of the trial, to give an early indication of the effectiveness of the screening tool. The deadweight measured by the survey is a return to work (of any length) amongst the Controls at 28 weeks after first going off sick from work. This is a proxy for the main outcome measure, which is recorded by the Outcome Survey (OCS) at a minimum of 44 weeks after first going off sick (see next section). The deadweight measure was collected via a week-by-week work history going back to the date that volunteers first went off sick before they phoned to join the trial. The survey also collected information about volunteers’ demographics, household, financial situation, health attitudes to work and their experiences of screening and randomisation.

At the time of writing, fieldwork was almost complete for this survey. As at 4 April 2005, 857 cases had been issued, consisting of 689 control and 168 screened-out volunteers. Productive interviews had been conducted with 79 per cent of Controls and 71 per cent of screened-outs. These figures include cases which had not yet been approached, because they had not reached their target dates for interview. The response rates amongst attempted cases gives a better indication of the actual response rate and the possible final response. Taking just those cases, the control response rate was 80 per cent and, amongst the screened-outs, 74 per cent.

17 That is those who did not live and work within the designated areas, or who were within 18 months of planned retirement, or had not been off work for between 6 and 26 weeks.
The average interview length was 16 minutes for Controls and 21 minutes for screened-outs, the difference being because the latter were asked some questions that the Controls would not be asked until the OCS (on attitudes, bridges and barriers to work and benefits).

Outcome Survey methodology

OCS is a face-to-face computer-assisted survey conducted at home with all those randomised into the Job Retention and Rehabilitation Pilot (JRRP) trial, whether they be in any of the Intervention Groups or the Control Group. The main aim is to collect comprehensive outcome data on the four randomisation groups.

The survey is ongoing at the time of writing, but as at 4 April 2005, 2,517 cases had been issued, out of which 1,769 interviews had taken place. This represents 70 per cent out of all those issued, but the final response is likely to be higher, as this includes cases not yet covered. A better indication of the response rate is gained by looking at the response for completed waves of fieldwork as shown in Table B.1 below. Taking just those waves which are complete (waves one through to eleven), the response rate is 80 per cent. The average interview length so far is 67 minutes.

The response rate of the Control Group (61 per cent so far out of all those issued) is lower than that of the Intervention Groups (73 per cent). This is understandable given that the former have received no additional help from providers. Those who have received an intervention are more likely to feel an obligation to complete the survey in return for the help that they received.
Table B.1  Outcome Survey response to date, by wave number

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<th>4</th>
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<td>174</td>
<td>2,517</td>
<td></td>
</tr>
</tbody>
</table>
The main outcome measure is collected via a detailed work history, covering the period between first going on sick leave and the week before the OCS interview. Various secondary outcomes are measured such as mental and physical health (using a computer-assisted self-completion (CASI) section), attitudes to work, and financial situation. The response rate to this has been very high, with 90 per cent completing it on the laptop, eight per cent allowing the interviewer to complete it for them (due to sight/reading problems or unwillingness to use the computer), two per cent completing a paper version, and less than one per cent refusing it altogether.

Interviews are conducted around a ‘target date’, which is either 44 weeks after the respondent first went off sick from work (for those who were off work sick for between six and 22 weeks at the time of calling the Contact Centre), or 48 weeks after this date (for those who were off work between 23 and 26 weeks). Interviewers are instructed to interview no earlier than one week before the target date, and to aim for an interview no later than one week later. However, the latter rule is flexible, as it is preferable to have a late interview than none at all.

The reason for this timing is the collection of the main outcome measure during the interview, which is defined as whether the respondent has returned to work of more than 16 hours for 13 consecutive weeks. The time interval allows for those who join the trial to receive their treatment from the provider and then to return to work for long enough for a successful outcome to be measured. Those who join the trial after a longer period off sick have their interview delayed by four weeks as otherwise they may not have sufficient time to get treatment and return to work before the interview.

The survey data are reported unweighted. There is some evidence of differential rates of response by sub-group which means the screened-in and interviewed samples are not strictly identical in their profiles. We considered the case for non-response weighting of the interview survey to bring the interview survey closer into line with the screened-in sample profile, but have elected not to use such weights on two grounds:

(a) the weights make only very small differences to the interview survey estimates and their use does not change the interpretation of the findings. Certainly the changes are too small to justify the increase in standard errors that weights would cause;

(b) neither the screened-in nor the interviewed samples are representative of ‘an external population’ in the sense that they are both self-selected (rather than randomly selected) groups. So, weighting the interviewed sample to the screened-in sample would not make it more ‘population representative’. The interviewed sample is best interpreted as it strictly is, namely a sample of people eligible for, and opting to take part in the trial who subsequently agree to an interview. With this interpretation no weighting is needed.
Qualitative panel study methodology

The panel study is one part of the process evaluation of JRRP. Its purpose is to interview a panel of participants at regular intervals over six months, to collect information about experiences and events close to their actual occurrence, when recall is expected to be good. It is designed to provide detailed descriptive data about clients’ experiences, to explore their participation as they use the service and to observe any changes in their feelings, views and intentions as they occur. Once complete, it will provide a rich understanding of how clients use the service, what they think of it, and what type of help is more or less useful at different stages.

The panel comprises 36 people, in three cohorts, purposively selected to ensure coverage of the following variables:

- Intervention group – 12 respondents from each of the three intervention groups;
- Service provider – nine respondents from four of the six locations, providing coverage of the six different providers but avoiding duplication for the two providers which operate in two areas\(^1\); \(^1\) The areas chosen were West Kent (WorkCare), Tyneside (Routeback), Glasgow (HealthyReturn) and Sheffield (WorkCare).
- Duration of the trial – the sample is divided into three cohorts to allow differences in experiences as services developed and matured to be included. In addition, this strategy allows interim feedback. However, the panel study is designed as a sample of 36 cases to be reported together at the end of the study;
- Participant characteristics – the sample is also designed to reflect diversity in sex, age, ethnicity, occupation, employer size and activity, industry sector, length of time off sick when people first contacted the service, type of employment contract (full or part-time; permanent or fixed term), self-employment and health condition.

Each cohort follows 12 JRRP clients over a six-month period beginning as soon as possible after their first contact with the provider. The first interview takes place in the participant’s home to build rapport and because of the detail and length of this interview. Participants are then interviewed approximately every four weeks by telephone to examine any developments in their health, any movements towards a return-to-work and any impact JRRP may have had on these. Clients continue to be interviewed regardless of whether they are still in contact with a JRRP provider.

At the time of writing, the first two cohorts had been completed (fieldwork periods ended in January 2004 and October 2004 respectively) and the findings are integrated in this report. Fieldwork for the third and final cohort began in October 2004 and finished in May 2005.
Recruitment and sampling

Table B.2 profiles the sample achieved for the panel study as a whole and for each of the three cohorts. Given the large number of variables present in the sample frame, it was necessary to prioritise certain criteria over others. Intervention group, gender, age, duration of sickness absence and main health condition were therefore established as the primary sampling criteria. The aim was to achieve a broadly even split across the dimensions of each criterion, where the sample frame allowed. However, some characteristics, for example lone parenthood, self-employment and minority ethnic backgrounds, were scarce within the available sample frame.

Within the sample of 36 there was a broadly even split across gender and age group. However, duration of sickness absence and main health condition reflect the composition of the JRRP database as a whole: more people had been off sick for between six and 12 weeks than for longer periods, and mental health and musculoskeletal conditions were the most common conditions in the database. (See Chapter 2)

In terms of secondary criteria, there was an equal split between those with dependent children and without, although there was only one lone parent. Four respondents were from a minority ethnic group. The majority had worked 35 hours or over per week which was consistent with the profile of all JRRP participants. The occupations of those interviewed were broadly balanced between the public and private sectors. Two respondents were self-employed, and one of these was also employed.

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19 Most of this information is derived from the JRRP evaluation database of participants from which respondents were sampled.
Table B.2  Panel Study sample

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Cohort 1</th>
<th>Cohort 2</th>
<th>Cohort 3</th>
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<tbody>
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<td>Male</td>
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<tr>
<td>Female</td>
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<td>8</td>
<td>5</td>
<td>4</td>
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<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16-35</td>
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<td>12</td>
<td>4</td>
<td>5</td>
<td>3</td>
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<tr>
<td><strong>Domestic situation</strong></td>
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<tr>
<td>Single people without children</td>
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<td>4</td>
<td>3</td>
</tr>
<tr>
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<td>1</td>
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<td>0</td>
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<tr>
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<td>6</td>
</tr>
<tr>
<td>Couples with dependent children</td>
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<td>6</td>
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<tr>
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<td><strong>Duration of sickness absence</strong></td>
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<tr>
<td>6-12 weeks</td>
<td>17</td>
<td>4</td>
<td>7</td>
<td>6</td>
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<td>13-19 weeks</td>
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<td>20-26 weeks</td>
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<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Part-time (16-34 hrs)</td>
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<td>3</td>
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</tbody>
</table>

The scope for purposive sampling was also affected by the following limitations:

- The sample frame for each cohort was deliberately restricted to protect the total sample frame available for the OCS. The idea behind this was that people who were contacted (by letter or telephone) but not subsequently recruited to take part in the panel study might be discouraged from taking part in the survey at a later date. With this in mind, letters were sent out to only 24 clients at first, and individuals in a reserve sample of another 12 clients were only contacted once the initial sample had been exhausted.
Small numbers entering the trial in some pilot areas also affected sampling. In the third cohort, for example, the numbers in one location were so low that in one of the intervention groups there was only one potential respondent. Widening the sample frame to include database extracts from previous months was avoided as much as possible because of the drawback that the first panel interview would have taken place much further from the point of first contact with JRRP and thus have implications for recall.
References


Prime Minister’s Strategy Unit (2004), Improving the Life Chances of Disabled People, London: Cabinet Office.

