Finding a Dutch Program for HIV-Specific Employment Services

Betty Kohlenberg

A new program in Amsterdam offers return to work services to people living with HIV/AIDS. Referrals start from the disability evaluator in the national agency that provides financial support to people with disabilities. With services currently offered only in Amsterdam, a career counselor in private practice advises individuals and a counselor with a rehabilitation services agency works with groups. Both sets of services are limited in time and resources. Comparisons of the Dutch program with San Francisco's Positive Resource Center's Employment Services program show similarities in client concerns and counselor approaches. Sick leave and disability benefits are integrated in the Netherlands; unlike in the United States, rehabilitation services may be mandated by the disability evaluator who identifies a potential for employment in the beneficiary.

As a vocational rehabilitation counselor, I have worked with people with a wide range of disabilities, and have been privileged to provide direct services and program consultation to people with HIV/AIDS since 1995 through Positive Resource Center in San Francisco.

One of the most extensive American employment service agencies for people living with HIV/AIDS, Positive Resource Center (PRC), (www.positiveresource.org) often reaches out to other HIV-specific rehabilitation services. Mark Misrok, Director of Client Services and Community Programs in PRC's Employment Services Program, has drawn together in a new American organization, the National Working Positive Coalition (NWPC) (www.workingpositive.net), a varied group of people – service providers, policy and program planners, academic researchers, trainers, consultants and government funding planners – who are interested in expanding the intersection of AIDS service organizations and vocational rehabilitation. The goals of both PRC and the NWPC include offering technical assistance to develop HIV-specific employment programs and sharing the information they have gathered about this new and focused area of rehabilitation.

With this outreach orientation in mind while planning a visit to Amsterdam in the spring of 2006, I searched the Internet for professionals in the Netherlands with whom I could exchange information about the NWPC and PRC, where I have been a consultant since 1995. I hoped to hear whether employment was a topic of concern in the HIV community as it is in the U.S. and how Dutch programs compared with those in America. The kind responses to my stumbling through the Dutch websites allowed me to learn about an integrated program started in 2004 providing HIV-specific return-to-work services for people living with HIV in the Netherlands. The information that Karin de Graaff, a self-employed career counselor, and Robert Loose, a counselor at a rehabilitation agency, and Paul Kerssens, a disability benefits evaluator, shared not only provided a description of their program but offered a glimpse into how differing social support systems and cultures influence the structure of employment services and how professionals working with HIV/AIDS issues develop similar approaches.

With the ubiquitous Dutch language skills, de Graaff, Loose, and Kerssens spoke to me in English, and we all searched for words that would allow us to understand each others' programs and the cultural systems in which they are anchored. I learned that *reintegratie* (literally "reintegration") is the Dutch for rehabilitation, and they explained Dutch attitudes toward gays and lesbians (general acceptance), the legality of prostitution, how people with disability are supported, and how services are funded.

The HIV Community's Request for Employment Services

In a pattern similar to the way many HIV-specific employment services arose in the U.S., the Dutch rehabilitation program for people with HIV/AIDS (PWAs) started with a request from the HIV community. HIV-specific rehabilitation services were initiated by Ronald Brands, of the *Hiv Vereniging Nederland* (Netherlands HIV Association), who asked the disability insurance coordinating agency (UWV) to create rehabilitation services with a different approach for HIV-positive clients with the objectives of preventing people from dropping out of work, creating an accepting work environment, and providing step-by-step counseling to prepare people with HIV for employment.

UWV did not respond immediately to this request, but authorized the development of these services in November 2003. The first letter sent to all the members of the Netherlands HIV Association informing them of the services did not produce much of a response. By October 2004 when the rules governing benefits eligibility had been tightened and some people who were being reevaluated were losing their benefits, more PWAs receiving disability insurance or unemployment insurance benefits were motivated to investigate the new program. Paul Kerssens was designated to be the UWV representative referring all HIV-positive people in the Netherlands seeking employment services, regardless of their locale or prior professions.

As part of a four-agency effort, HIV-specific rehabilitation services were created by Karin de Graaff, working independently as De Graaff Training & Coaching, and Robert Loose, a counselor who works for Agens, a rehabilitation services company. Agens cooperates in this program with de Graaff, the Netherlands HIV Association which supports outreach to its members, and with UWV, which provides funding for the program to the service providers.

People receiving disability insurance benefits in the Netherlands may have their income linked to mandatory participation in rehabilitation programs if the disability evaluator feels that they could benefit from return-to-work services. General rehabilitation services, or *reintegratie,* are offered by more than 500 organizations in the Netherlands. UWV has contracts with about 25 private organizations to which it will refer clients, including Agens, a company which serves people with all kinds of disabilities, or clients may find services on their own. UWV funds the mandatory rehabilitation services.

Dutch Vocational Rehabilitation Services for People Living with HIV/AIDS

Individual Services

Karin de Graaff is a self-employed career counselor who lives and works near Haarlem, about 12 miles west and north of Amsterdam. De Graaff has worked with people with HIV/AIDS (PWAs) since about 1998, first funded through grants and now paid by the government for each individual she sees. A nurse for many years, she trained to be a career counselor (*loopbaanadvisering).* Although she used to counsel clients during the full rehabilitation process from plan formulation through the implementation of their plans, her work now with PWAs is concentrated on pre-vocational activities called the Social Activation Process. She advises PWAs on topics like budgeting and financial management, organizing their lives, mediating conflicts with employers and getting ready to work. As Ronald Brands noted in the announcement of the program on the Netherlands HIV Association's web site (Brands, 2005), de Graaff's extensive experience with PWAs has earned her "the fullest trust of the HIV Association."

De Graaff sees her clients once every week or two for 1½ hour appointments, about four to ten or twelve times depending on the individual for a period of three to four months before they join Robert Loose's program. In a program she designed to fit the clients' needs, her work seems similar to Positive Resource Center's approach of helping clients manage or lessen work barriers in all four areas of life related to considering work while living with HIV: medical issues, legal and financial issues, psychological and social support issues, and vocational issues. De Graaff focuses on the first three of these domains in individual counseling sessions. For the vocational decision-making, she refers clients to Loose's group program at Agens.

Group Services

Agens ("ah-chhens") provides vocational rehab services all over the Netherlands for people with all disabilities. Formerly a government agency and now a private company, Agens has hired the government vocational rehabilitation workers so the company currently has about 1000-1400 employees. Robert Loose, the only person at Agens focusing on HIV-specific clients now, will soon be training a group of about 20 employees who have volunteered to learn HIV issues to work with this population.

A work trainer (*arbeidstrainer*) who specializes in what is called "reintegration" or vocational rehabilitation, Loose worked as a nurse for 10 years, then moved

to corporate middle management before becoming a quality manager. His auditing of rehabilitation agency performance led him to wanting to teach people how to improve performance and he became a trainer. He also learned neuro-linguistic programming (NLP) as part of his interest in counseling.

Robert Loose's program includes four stages. The first is a 6-week training program called *Working with HIV*, a closed counseling group with a maximum of 10 participants who meet twice a week for 4-5 hour sessions. He focuses on psychological exercises emphasizing self-esteem and self-understanding but also spends one session discussing disclosure issues. He has conducted four groups so far, in which participants are mostly gay men with a wide range of vocational backgrounds. Only two women have participated.

The second stage is the afternoon meeting once per month when participants return as a group to discuss their progress. In the third stage, participants attend their choice of a number of recurring workshops offered to people with disabilities and conducted by another Agens employee. The workshops cover topics like understanding want ads ("vacancy analysis"), writing resumes and cover letters, interviewing, assertiveness, networking, and workshops for people who are over 50 or who have higher education. At this stage, the PWAs attend workshops with people with many different disabilities. The fourth stage consists of implementing the plan: usually searching for work, volunteering, or going to school.

Loose created the program in Amsterdam to help people with HIV with employment issues about 2 years ago. Of the 60 people who have gone through his intake process, about 40 people have participated in his program; of those 40, 10-15 have returned to work. Clients are given a maximum of 1½ years in his program, including six months of services after they have returned to work. Agens is paid according to the number of people who go through milestones - first, intake, then completing his training. Agens receives a big bonus if clients go to work. Milestones for return to work are marked at 9, 12 and 15 months of employment, with at least 6 months at work indicating success.

Financial Support for People with Disabilities in the Netherlands

Two of the main differences between the Dutch and American programs are the involvement of the Netherlands disability benefits agency in referral for rehabilitation services and the mandatory nature of their rehabilitation referrals. In the U.S., vocational rehabilitation is a voluntary benefit. While the Ticket to Work and other new pilot programs from the Social Security Administration are exploring ways of increasing rehabilitation services and possible return to work for people receiving disability payments, the Social Security Administration does not mandate rehabilitation participation.

Kerssens explained that UWV is the main insurance company in the Netherlands covering employees who are sick, become disabled or who have lost their jobs. In 2002, five private companies that insured different industry sectors united as UWV, a governmental agency. UWV has since become an independent agency with government support but is self-determining in creating its own programs. Dutch employees who are too sick to work are covered for the first two years off work by employer-paid insurance as sick leave. After that two-year period, the UWV-administered coverage begins. These programs are roughly equivalent to American benefits of sick leave, Social Security Disability Insurance (SSDI) and Unemployment Insurance.

Historically, the Netherlands had the highest percentage (1 million of the population of 17 million or almost 6%) of employees receiving disability and unemployment benefits among all the European countries. At about 70% of the previous wage up to a maximum, the benefits were high enough that there was little incentive for recipients, known as claimants, to return to work. The country has made major changes in the benefits structure in the last five years and more recently has tightened the eligibility requirements to the point that many people are losing benefits. As of October 2004, the UWV started re-evaluating everyone under the age of 50 who is getting disability payments and this is motivating more people with HIV to seek employment services.

Disability Evaluation and Mandatory Rehabilitation

An *arbeideskundige* ("work ability evaluator") like Paul Kerssens evaluates a person's eligibility for the UWV-administered benefit called the WAO. A new law as of January 1, 2006 created a newly named benefit, the WIA, which will replace the WAO. Kerssens is one of 20 disability evaluators in the Amsterdam area, though the only one working with HIV-positive clients.

The eligibility evaluation procedure (*functieduiding* or "interpretation of function") is essentially a transferable skills analysis. From an individual interview, the UWV evaluator combines information about the person's job history, medical situation as evaluated by a UWV physician, and education. Work experience is classified according to the requirements of the job they used to perform. Education is classified at levels 1 to 7[1]. The evaluator compares the individual's work experience, physical or mental capacity, and education with requirements listed in computerized job analyses. So far, analyses for 8000 occupations in the Netherlands have been completed by a team of 20 an-

alysts nationally who visit Dutch employers and speak to human resource representatives and employees to determine job requirements along 55 parameters. The eligibility evaluator tries to identify at least three jobs the claimant might be able to perform with his or her level of physical and mental capacity. A partial disability resulting in projected earnings of the identified jobs no greater than 80% of the claimant's former wages will allow the claimant to receive the full benefit (70% of former wages up to a maximum). If the jobs identified as within the applicant's capacity pay at least 85% of prior earnings, the person is not eligible at all for benefits. If the loss of earnings is between 15% and 80%, the client may get a proportion of the benefit.

Once the UWV evaluators determine the eligibility for disability benefits, they may also mandate that the recipients participate in activities to help them get back to work. Paul Kerssens writes a rehabilitation plan *(reintegratie visie)* to outline what services he recommends to help in this process. UWV pays for the rehabilitation services.

Those people no longer considered eligible after the evaluation receive a final two months of benefits during which they can apply for unemployment benefits for up to 3.25 years if they qualify, or take advantage of the rehabilitation services offered by private agencies to help them find a job.

Program Eligibility

If a person does not have a sufficient work history to qualify for the insurance benefit, he/she gets *Sociale Deinst,* (roughly equivalent to the American SSI benefits), which pays much less than the UWV-administered benefit and has stricter rules. *Sociale Dienst* pays about €1200 per month for 2 people, €800-€900 for one person, who must be living alone or with another person eligible for the benefit. UWV does not administer the *Sociale Dienst* benefit, but Paul Kerssens requested that recipients of this benefit also be allowed to participate in the HIV-specific rehabilitation services program.

Comparing Dutch and American Programs

Many similarities with Positive Resource Center's programs in San Francisco were clear: de Graaf's counseling addresses similar issues to those covered by PRC's service coordinators; Loose's closed counseling group has many parallels with the *Making A Plan (MAP)* career counseling program; the Agens workshops resemble many of PRC's workshops: the rotating series for job seeking skills called *Mondays at Ten*, the local labor market information series called *Career Compass*, and the workshop for older employees, *45+ and Positive*. The Dutch program does not include the job search assistance provided by PRC.

Amsterdam's population of 713,400 is very close to San Francisco's 734,676, and both cities function as a hub of services for much larger populations: Amsterdam as the capital of the Netherlands, and San Francisco as a magnet city in Northern California's Bay Area. Many San Franciscans have moved to the city from other parts of the U.S. or abroad and thus need to recreate communities for social support and employment networking. Amsterdam as the capital of a much smaller country (population about 16.4 million) may have more people who can rely on family and friends as they explore the possibility of working while living with HIV. These differences may change the job search experience in terms of difficulty and duration for Dutch and American job seekers with HIV.

Loose has distributed the article on Disclosure from my website (Kohlenberg, 1998) to his clients as this is a significant area of concern to his clients. Dutch laws similar to American disability non-discrimination laws protect PWAs in the Netherlands from employer inquiries about medical issues or HIV status. Loose has seen client concern about HIV stigmatization and has heard PWAs express low self-esteem because of the disease. Many of his participants are as afraid to disclose their serostatus to employers or others as their American counterparts.

After outlining the Client-Focused Model for Considering Work for people with HIV/AIDS (Goldblum & Kohlenberg, 2005, pp 115-124) which describes the service structure used by Positive Resource Center in San Francisco, I asked Loose about outcome pressures. Funding that rewards the rehabilitation agency for client progress might tend to influence counselors unduly to push people into employment who were not really able to work. Loose acknowledged that this financial structure could produce pressure on the counselor to force people back to work even if they are not ready, but he has not felt that he is under such pressure. He has, however, felt the effect of the funding timing for Agens, which occurs in one- and two-year cycles, making long-term program planning difficult and resulting in frequent expansions and contractions in the size of the agency.

Exploring the similarities and differences in our respective countries, Kerssens and I discussed the Dutch program and Positive Resource Center's program.

- The Dutch program is explicitly aimed at helping reduce the number of people eligible for disability benefits and is funded by the government through UWV with this focus. PRC's focus is expressed in their mission statement: to assist PWAs in making informed choices that maximize available benefits and employment opportunities.

- Participation is voluntary at this time for Dutch PWAs, although disability benefits recipients without HIV may be mandated to take part in other rehabilitation programs. Participation in PRC's programs is also voluntary.
- A special request from UWV was needed to include recipients of the non-insurance-based benefits in the HIV-specific service program, which was expanded in 2005 from covering Amsterdam residents to those in the more rural parts of the Netherlands. In contrast, anyone with HIV, even those who are working or who are not eligible for government benefits, may participate in PRC's programs, which are mostly available to people without consideration of residence or benefits source.
- Both countries provide rehabilitation services without cost to the participants. Kerssens expressed surprise that American government agencies would support rehabilitation programs.
- The Dutch program is time- and resource-limited for participants. PRC clients have access to services during an unlimited period and may repeat programs and return for further services when needed or if circumstances occur that alter the factors that affect how they consider employment.
- Both programs emphasize emotional support and other holistic approaches while focusing on employment services.

An Opportunity for Cooperation and Comparison

De Graaf, Loose and Kerssens all told me that as far as they know, they are the only European country providing HIV-specific employment services, although a program called AIDS Hilfen may be starting in Berlin. De Graaf and Loose were consulted that same week by a British delegation looking at the Dutch experience with tightening disability benefits and seeking guidance in creating a similar program in England.

It was clear that the new Dutch program devised by experienced rehabilitation and career professionals is proving successful. With the support from the disability benefits administrator, participants are voluntarily starting to consider work and about 25%-37% of those who have gone through the program have returned to work. Though small, the program is expanding from Amsterdam to be available to rural residents, and more rehabilitation specialists are being trained to run the programs. With different financial structures and cultural norms, people with HIV in both America and the Netherlands still fear discrimination and stigmatization and worry about disclosing their health status.

It seems that many of the employment concerns of people living with HIV cross oceans and national borders, and the programs created to help them use similar approaches to address the multiplicity of their concerns. It will be fascinating to compare Dutch and American experiences as both programs grow.

Footnote

[1] See "Dutch-American Comparisons" appendix for description of the educational levels.

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Biography

Betty Kohlenberg, M.S., B.A., CRC, ABVE-D, has a private vocational counseling and forensic practice in San Francisco. She focuses mainly on family law including collaborative practice, personal injury, employment law and LTD appeals cases. She recently wrapped up 12 years of consulting work in HIV and employment, including counseling people living with HIV/AIDS, teaching, researching, writing and developing a theoretical model as well as co-founding a national organization.

Acknowledgements

The author gratefully acknowledges the Dutch translation support from Jacob Boas, Ph.D, and the generous cooperation of Karin de Graaff, Robert Loose, and Paul Kerssens. This article is dedicated to Philip Kohlenberg (1942- 2006).

Appendix
Dutch-American Comparisons

Euro-dollar conversion

The Euro is currently worth approximately $1.20. Therefore, €1000 = $1200; $1000 = €833.

Salary Comparisons

For comparison's sake, some typical wages in the Netherlands are

- €1880/month for a truck driver
- €1500/month for a secretary
- €1550-€1600/month for a nurse
- €2300-€2400/month for a high school teacher with experience
- €80,000-€100,000 per year for a successful corporate sales representative

Lawyers typically charge €200 per hour, psychiatrists charge €150 per hour.

Education System

The Dutch education system includes high school (*gymnasium*), after which the person can opt for studies at the following vocational levels. A student does not have to finish high school to enter these programs.

- LBO (berup = profession; onderwys = education) or Lower Professional Education
- MBO or Middle Professional Education
- HBO or Higher Professional Education

These are practical study areas, separate from university studies which are more theoretical. The university degree is Doctorate. The LBO/MBO/HBO studies take 2-4 years normally. The HBO and a Master's degree together are roughly equivalent to a university degree. An example: nursing studies are at the HBO level.

For disability evaluations, an applicant's education level, from 1 to 7, is compared to that required by the employer to perform a particular job.

- Level 1 = No basic schooling
- Level 3 = LBO
- Levels 4/5 = MBO
- Level 6 = HBO
- Level 7 = university

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