ASORC

The Australian Society of Rehabilitation Counsellors Ltd (ASORC)

Submission to the Hon John Mansfield AM QC

Regarding the

Independent Review of the Return to Work Act 2014 and its Administration and Operation

February 2018

Emailed to: RTWreview@sa.gov.au

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Introduction

The Australian Society of Rehabilitation Counsellors Ltd (ASORC) thanks the Hon John Mansfield AM QC for the opportunity to make a submission to the *Independent review of the Return to Work Act 2014 and its Administration and Operation* that he has been tasked to undertake pursuant to Section 203 of the *Return to Work Act 2014.*

In line with the published Terms of Reference, ASORC understands that the Hon John Mansfield AM QC is being asked in his independent review to consider, assess and advise upon, including by way of research and consultation with relevant Return to Work Corporation of South Australia (RTWSA) members and staff, South Australian Employment Tribunal (SAET) members and staff, other interested persons and the general public, the following matters in respect of the 3 year period commencing on 4 December 2014:

1. the extent to which the scheme established by the Act and the dispute resolution processes under the Act and the *South Australian Employment Tribunal Act 2014* have achieved a reduction in the number of disputed matters and a decrease in the time taken to resolve disputes (especially when compared to the scheme and processes applying under the repealed Act);

2. without limiting paragraph (1), whether the jurisdiction of the SAET under the Act should be transferred to the South Australian Civil and Administrative Tribunal;

3. the extent to which there has been an improvement in the determination or resolution of medical questions arising under the Act (especially when compared to the system applying under the repealed Act);

4. the performance of RTWSA in managing claims including RTWSA's outcomes in reducing instances of work injury;

5. the performance of self-insured employers including outcomes in reducing instances of work injury;

6. changes in return to work rates at key milestones outlining factors influencing any improvement or deterioration;

7. factors contributing to non-seriously injured workers failing to achieve a return to work within two years;

8. any additional recommendations regarding reskilling services to assist return to work outcomes;

9. whether the scheme has yet achieved financial stability and if not when the scheme will be likely to be mature and stable;

10. any other recommendations based on your review of the administration and operation of the Act which you consider appropriate and consistent with the objects of the Act.

This ASORC submission provides responses to 5 of the above Terms of Reference (TORs), namely TORs 4, 6, 7, 8 and 10 and offers 20 Recommendations.

Information on ASORC

To provide the review team with some context on ASORC we provide you with the information below.

ASORC is the peak professional body representing Rehabilitation Counsellors throughout Australasia. Established in 1976, ASORC is a non-party political, non-sectarian and not for profit organisation. The mission of ASORC is to promote the profession of rehabilitation counselling and to foster the professional capability of members.

ASORC provides:

- A long standing and respected voice for the profession (over 30 years since inception).
- Resources, education, mentoring and supervision necessary for members to achieve career advancement and enhanced credibility in the profession and in the community.
- A robust set of core competencies and code of ethics
- Access to latest research and academic commentary through the ASORC ® Journal (AJRC).
- Access to a network of similarly skilled and minded professionals across Australia.

Rehabilitation Counsellors are Allied Health Professionals who work within a counselling and case management framework to assist people who are experiencing disability, a health condition or social disadvantage to participate in employment or education, or to live independently and access services in the community.

It is important to note especially in the SA context, where this has been an ongoing source of confusion, that the occupation of **Rehabilitation Counsellors should not be confused with Rehabilitation Consultants.**

Rehabilitation Counsellors belong to the specific allied health profession of Rehabilitation Counselling, whilst Rehabilitation Consultant is a generic title that covers a range of professionals and non-professionals.

Rehabilitation Counselling is an independent allied health profession that has been recognised in Australia since the mid1970s and internationally since the 1950s. University courses in Rehabilitation Counselling commenced at Sydney University in 1974 and are now delivered at universities across Australia.

The Heads of Worker's Compensation Authorities (HWCA), to which the majority of Worker's Compensation schemes in Australia and New Zealand are bound, lists ten health and allied health professions that meet the requirements for delivering return-to-work services. One of these is the profession of Rehabilitation Counselling.

Rehabilitation Counsellors:

- belong to a professional body – ASORC being the peak professional body
- have fulfilled specific tertiary academic requirements,
- possess well defined professional competencies
- are qualified to deliver more than just Return to Work and associated services
- and are bound by a specific Code of Ethics.

Rehabilitation Consultants on the other hand:

- do not necessarily belong to a professional body
- in some cases do not have a university degree
- may or may not be qualified to deliver Return to Work and associated services
- and are not necessarily bound by a specific Code of Ethics

The title Rehabilitation Consultant is a generic description that is sometimes used by Work Injury insurers and authorities to describe anyone who delivers return-to-work and associated services within these systems. As there is no restriction on the use of this title, persons with limited or no qualifications who work in the wider social services field may also call themselves Rehabilitation Consultants and equally persons with other qualifications can use this title (eg Physiotherapists, Speech Pathologists, and Psychologists).

Whereas a Rehabilitation Counsellor may be employed as a Rehabilitation Consultant, Rehabilitation Consultants are often not Rehabilitation Counsellors. Hence it is very important that Rehabilitation Counsellors are not confused with Rehabilitation Consultants as the titles are not necessarily interchangeable.

Please note that in this submission the acronym RC refers to Rehabilitation Counsellor and NOT Rehabilitation Consultant.

Term of Reference 4: The performance of RTWSA in managing claims including RTWSA's outcomes in reducing instances of work injury

Based on the Public Tableau data website it does not appear that there has been a significant change in claim numbers. Since the implementation of the new Act, the number of claims lodged each financial year has been relatively consistent from year to year with a small reduction over the 4 financial year periods (RTWSA, 2018a).

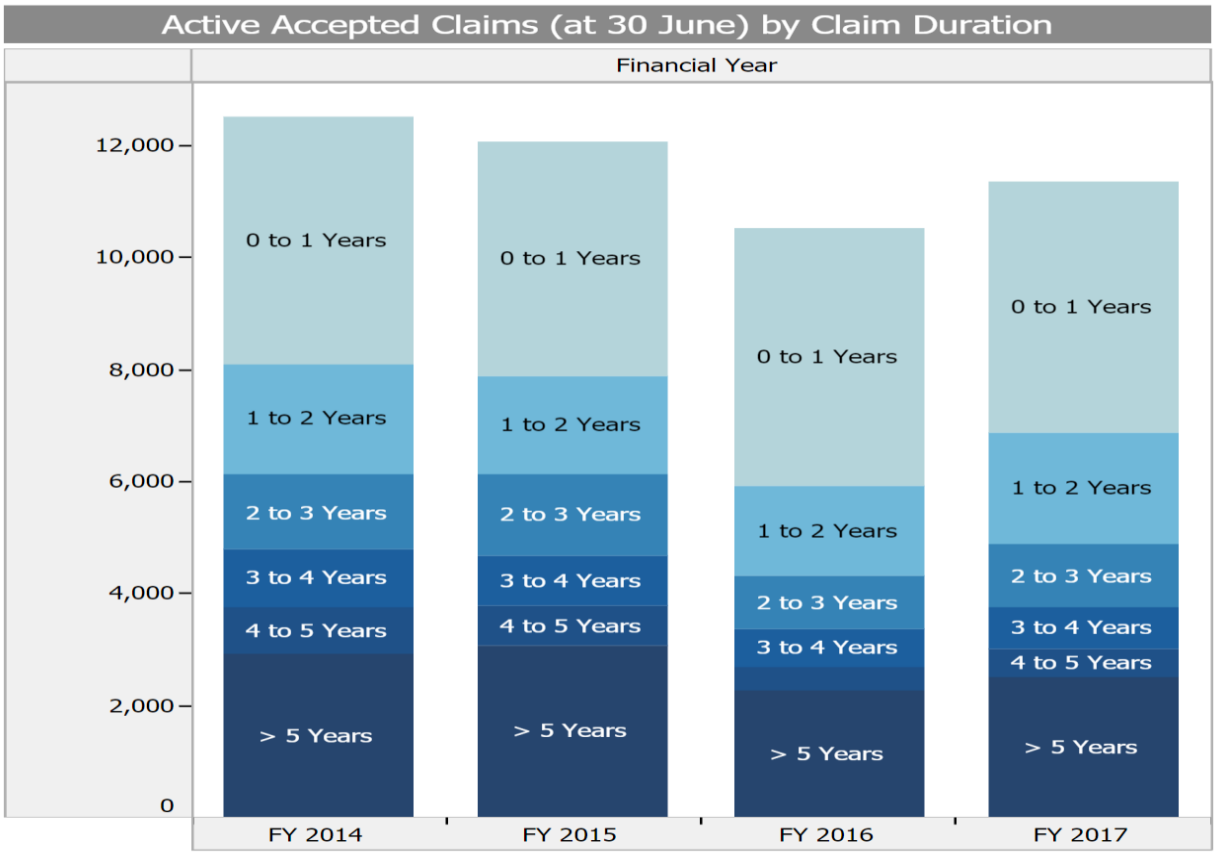

Figure 1 – Active accepted claims by Duration, shows a total number of claims in FY2014 of 12,507, FY2015 of 12052, FY2016 of 10,504 and FY2017 11,359. Source: https://public.tableau.com/profile/rtwsa#!/vizhome/ReturnToWorkSA-InsurerStatisticsFY2017/ReturnToWorkSA-InsurerStatisticsFY2017. According to the notes for this table the reduction in claim in FY 2015 and FY 2016 are due to redemption payments.

Face to face service delivery appears to have improved service provision for the most part. Employers and Workers generally indicate that they have more meaningful contact with the claims agent and questions/ concerns are addressed in a timelier manner. However, recently our members have communicated to us that face-to-face interactions of claims managers has reduced. This was, in part, attributed to increased administration, case numbers and complexities associated with new referral processes to vocational rehabilitation. In addition, our members report that injured workers have reported ongoing frustrations with changes in their Mobile Case Managers (MCM)/claims owners.

Because of the mobile nature of the MCM role, some workers report that it is difficult to reach their MCM, however, the Net Promoter Scores (NPS) reported in the Annual General Report for 2016/2017 indicate that, overall, the service has improved (RTWSA, 2018b). This is consistent across Annual reports for 2014/2015 and 2015/2016. The latter needs to be considered carefully

and the question to ask is whether the improvement in the NPS actually reflects true and meaningful satisfaction for injured workers. For example, is the sample size and distribution correct? What is less clear is at what point the NPS data reported on is drawn and is the data the same for claims as they move through the continuum or do they deteriorate?

Injured workers often report that the services provided by MCM's, prior to them being referred to vocational rehabilitation, do not always meet their requirements or expectations, due to a lack of clarity about what the expectations of the services are. We believe that since the implementation of the Act and the MCM role, there has been an added expectation that MCM's can manage what can be a complex biopsychosocial series of problems, without a Rehabilitation Counsellor's expertise. Furthermore, there seems to be a sentiment that a MCM makes the role of a well-qualified and experienced Rehabilitation Counsellor redundant to a degree. In some cases this has led to injured worker behaviour becoming more entrenched because issues were not adequately assessed and managed. MCM's are not suitably qualified to undertake complex biopsychosocial assessments and provide recommendations, career counselling, job seeking support and vocational rehabilitation referrals. Too often our members report that they receive referrals too late in the claim when unhelpful thinking, such as catastrophising, fear, injustice and perceptions of disability, have either not been addressed or, worst case scenario, reinforced by repeated unsuccessful return to work plans or being certified unfit for extensive periods of time. It is not hard to see that it is only a small leap to those people genuinely believing that they cannot achieve work in the foreseeable future.

There can be a perception from injured workers that the MCM only has their employers' interests at heart. While we are aware that this is not the role of the MCM, this culture remains and adds to the challenges and complexities to the return to work activities, when they are planned by the MCM. Our members report that in some situations despite the advice from MCM's regarding returns to work being appropriate, some injured workers (particularly with high levels of perceived injustice or psychological injuries arising out of situations like harassment) will not follow MCM advice, because they conclude that it is not in their best interest to do so.

We are aware that the agents have committed to ongoing professional development around some of these issues, however, for some scheme participants it will be difficult to shift the belief/ culture that insurance companies are only interested in their bottom line, which in their minds is what they protect by rejecting claims and paying out the minimum possible. This is not completely isolated to Return to Work insurance, but the insurance industry as a whole. This attitude from some participants has prevailed despite the scheme increasing benefits in the front end of the claims package. From the injured workers perspective, time is of the essence because of the 2 year income support cap. Therefore, it is now more important than ever that timely, quality proactive services are provided to injured workers in the scheme. ASORC believes that appropriate assistance from a suitably qualified Rehabilitation Counsellor is critical to achieving timely, safe and durable return to work outcomes and promotes the health benefits of good work.

Following on from the above point, research suggests that perceptions of injustice commonly arise out of the work injury claimants' mistrust in either their employer or the insurance provider. In addition, Australian research found that in three states the stress related to the experience of making a claim was prevalent. Claimants with stressful experiences had poor long-term recovery (Grant, O'Donnell, Spittal, Creamer, & Studdert, 2014). Many qualitative studies of claimant's experience with compensation systems have identified the stressful nature of the claims process as a contributor to enduring ill-health. For those participants who present with increased perception of injustice, they are less likely to trust the agent/ employer and more likely to trust their treating doctor or allied health practitioners. They are less likely to engage easily with services that have been arranged/ promoted by the agents. They are less likely to fully engage in a return to work plan that is developed and supervised by the agent or their employer.

The Work Injury Screening & Early Intervention (WISE) study (Nicholas, M: 2017) evaluated the implementation of an early risk screening and psychosocial management intervention instituted for employees with acute soft tissue injuries within a large hospital network in Australia. In the study, they found the abbreviated OMPSQ-SF (questionnaire) was effective in predicting who is likely to have more days lost from work and that the intervention resulted in increased return to work rates. They also noted that the role of the Return to Work Coordinator was **essential** and they were the **key link** between Injured Worker, workplace, treatment providers and Insurance claims manager. Essentially, in the Return to Work SA system and, in terms of function only, the role of Rehabilitation Counsellor is very closely related to the role of the Return to Work Coordinator.

Recommendations:

1. The approach so far from RTWSA to promote one claim owner for the life of the claim is beneficial. While there will be changes because of variations in staff retention and resources, it has reduced the shifting of cases between case managers, which can then delay services and result in inefficiencies.
2. Continue with the face to face service model and the behavioural principles.
3. Consider further review of Return to Work Service (RTWS) fee schedule. Some options for consideration include:
    a. Review of who can make referrals. For example, consider allowing treatment providers to make referrals for RTWS. This occurs in other states and often because it is a referral made by their treating doctor, workers are more willing to accept the service. Rapport with providers is built faster and communication between the GP, RC and MCM is improved. This is not to say that agents are to be excluded from this process.
    b. The implementation of the current MCM model has been positioned as improving service provision, not to attempt to provide expert services. Therefore, it seems sensible to continue to use expert services such as Rehabilitation Counselling where there is a protracted return to work that is outside of what is considered biomedically reasonable. It is likely that if recovery and return to work exceeds these timeframes, that there are psychosocial risk factors which are likely to complicate returning to work. Therefore, using timely expert services to identify these barriers and implement strategies to remediate them makes sense and is consistent with scheme reform.
    c. Consider the value of the current RTWS schedule of fees. It is convoluted and, in fact, often MCM's end up needing to seek advice from our members regarding which service is most suitable for the situation. Often this results in the referral being made based on how much work is involved, leading to the goal of the referral not always being consistent with the desired outcome set by RTWSA. This makes it difficult for the agent to make referrals and for the regulator to measure performance. Some examples of other models that could be useful to consider are:

        i. When a referral is made to a RTWS, the provider assesses what is required and then provides a plan (with costs) to the Agent to review and approve. This is not dissimilar to what happened prior to the existing model. However, often plans were very long documents and highly generic. Using the behavioural principles, the expectation for RTWS providers would be that the plan be tailored to the person and stakeholders involved. This would mean that the RTWS provider and the injured worker would need to discuss the expected outcome and use SMART (Specific, Measurable, Attainable, Relevant, Timely) goal setting principles.

ii. Using NDIS as a model. Whilst this is still in the implementation phase, it could provide some interesting ideas to improve services and worker engagement in that workers could work with the MCM to determine which services are going to be beneficial for them and then the worker is placed at the centre of choosing those services. They can then select services that suit their needs and desired outcome, subsequently creating their own self-care plan. The self-care plan would be reviewed with their GP and MCM, whilst it places the worker in a position where they are accountable for the decisions they make and services they use. The potential limitation to this service may be that workers may need some education regarding the benefit of RTW service providers. It would also potentially indicate to the MCM where the worker felt they were in regards to their return to work.

Term of Reference 6: Changes in return to work rates at key milestones outlining factors influencing any improvement or deterioration

RTW rates have not significantly improved since the inception of the Job Placement Service provision. Currently, job seeking services are tendered to a few job placement providers only (and only one vocational rehabilitation provider), thus narrowing opportunities for injured workers to access providers that may be better positioned to fit the injured worker's needs.

Only one threshold is needed to refer injured workers to a Job Placement Service provider and that is 15 hours of more of capacity. This is fundamentally flawed, as it does not consider a person's readiness for work. Therefore, injured workers are referred prematurely for services that are not equipped to deliver appropriate career counselling or training to manage the psychosocial risk factors that are, in many cases, not resolved and thus the job seeking can fail. The injured workers then become further discouraged towards the vocational rehabilitation, it reinforces injured workers fears that they will not find suitable employment and leads to psychosocial factors increasing and ultimately they tend to fail to return to work.

Currently, we see significant vacancies being generated as a result of injured workers being unable to return to their pre injury role. Employers are then needing to replace injured workers using the open labour market. Removal of secondary coding has negatively impacted employer willingness to hire injured workers, fearing reaggravation and impact to their premiums.

The Re-employment Incentive Scheme for Employers (RISE) scheme has been available in the scheme for a number of years; since the implementation of the RTW Act the incentive has been changed from a 12 month incentive to a 6 month incentive. It was promoted as a better financial incentive because the wage reimbursements were higher than the old scheme. But that just does not stack up, based on earnings of $52,000 pa:

Old Scheme at 40% for 12 months = $20,800
New Scheme at 100% for 4 weeks = $4000, plus 22 weeks at 50% = $11,000,
making a best case total of = $15,000.

Meaning that new employers taking on an injured worker are $5800 worse off, in terms of financial incentive. We have provided a best case figure, because, the other factor is that employers only have access to this scheme while the worker remains in their income entitlement period. So in reality, for an injured worker to offer the full entitlement to a new employer they need to be in their new employment before the 18 month mark of their claim. Yet in some cases the goal is not even changed until this point, or they are still completing their retraining. The other issue is that this puts the injured worker in the position of having to inadvertently disclose potentially to an employer the length of their claim, once they are beyond the 18 month mark (which may diminish their chances further of employment). This may lead to the injured worker being less competitive either because of concerns regarding risk, or they can get more of an incentive with someone else. It is also the only employment incentive scheme we're aware of that decreases in value the longer a participant has been in the scheme. From our members experience this scheme provides some negotiating power in terms of turning work experience placements into real employment and preventing participants from exiting the scheme without an employment outcome.

Recommendations:

4. Opening up the Job Service Placement to all the providers currently registered with RTWSA and also engaging recruitment organisations. This will increase the chance of

finding appropriate placements for injured workers and incentivise other providers who are not currently tendered to engage in job seeking service provision. This, in turn, will lead to continuity of service provision.

5. Consider implementing a job placement fee for non-tendered providers with some sensible parameters so that people who have the vacancies are encouraged to place injured workers.
6. Engaging Industry bodies and employers to provide mentorships to injured workers. Currently ReSkilling providers have access to financial incentives to place workers into skills maintenance programs. Offering incentives to employers to facilitate skills maintenance placements could lead to more placements and potentially new employment outcomes if these could then be converted into RISE placements.
7. Encouraging employers that are in the process of "change of employment goal" and providing them with an incentive to recruit another injured worker from the scheme.
8. Incentivising employers who employing injured workers in terms of assurance against aggravation of pre-existing injuries. For example, allowing 12 months for any aggravation to be attributed to the original claim.
9. Review RISE, to at least allow for the wage incentives to be paid to an employer for the full 6 month period, as long as they have commenced prior to the end of the income entitlement period.
10. Consider other incentives for new employers, for example using the behavioural principles to explore the employers' needs in order to employ the injured worker and being able to tailor the package to them. Other options could be bonus premium discount.

Term of Reference 7: Factors contributing to non-seriously injured workers failing to achieve a return to work within two years

These are the factors that we've identified via our member network to have a negative impact on return to work outcomes.

a. Lack of clear understanding about the injured workers limitations and delay in making a decision about change of employment goal.
b. Comorbidities, particularly where they are not well managed, which generally occur at the beginning of the claim and in absence of RTWS Provider intervention.
c. Failure to provide access to services at the right time, i.e. inability to identify and manage psychosocial issues.
d. Quality of service provision and lack of accountability from within the spectrum of key stakeholders. Of note is that RTWS Providers were measured on return to work outcomes and "Star Rated", while no other profession that is involved in a person's recovery and return to work is measured in this way. This places Rehabilitation Counsellors in a position of being inadvertently perceived to be aligned to the Insurers. Clearly, this not only leads to lack of appropriate service within an appropriate time but also poor compliance towards the service that has been provided by the Insurers to the injured workers. Furthermore, it diminishes the concept of person centred service provision, because we then have to meet the criteria of the referral, rather than just doing what needs to be done to get the person back to work. As an example, in the current fee schedule under fit for work services, it states that RTWSA will not pay for "job search activities such as resume development", but one of the pathway services is arranging and monitoring a work placement. If an injured worker does not have a resume, then our members end up completing one, because host employers generally want to see their resume before agreeing to meet with the worker.
e. Lack of objective and appropriate approach to vocational rehabilitation referrals. For example, one threshold is needed only to refer injured workers to a Job Placement Service (JPS) provider and that is 15 hours of more of capacity. Merely meeting this requirement does not say anything about the person's readiness for work. Therefore, injured workers are referred prematurely for services, they wonder why they are being asked to get a job while they are only at 15 hours. The injured workers then become further discouraged towards their RTWS Provider and ultimately fail to return to work. Also, because not all providers can provide JPS, workers can be unhappy about having to change to a new service provider. There is limited scope for handovers between one service and the next.
f. Rehabilitation Counsellors have broad service offerings and hence Rehabilitation Counsellors are well equipped to prepare injured workers for independent career transition and job seeking. The role of the RCs outside the compensation setting is to empower clients to become independent, which works almost always. Currently, job seeking services are tendered to several providers (and only one vocational rehabilitation provider), thus narrowing opportunities for injured workers to access providers that may be better positioned to fit the injured workers' needs.
g. Because of the JPS fee structure there is more onus put on the JPS provider to locate paid work for the injured person. ASORC supports a model where workers are taught appropriate job seeking methods and are able to apply these independently.
h. Continuity of service provision is important. Vocational Rehabilitation referrals are capped and segmented based on their main intended focus. This leads to services being closed and injured workers being referred to a number of providers throughout their claim. Often, money is spent to collect background information, double up on services provided to date and build rapport. Therefore, where possible, consistency in service

provision should remain stable. Furthermore, rapport is often the key to the success of these services.

Recommendations:

11. Stronger emphasis to be placed updating the return to work goal. As soon as there is evidence which suggests we may need to consider alternative employment, the goal needs to be reviewed to reflect this. This might be utilising dual goals more readily so that the injured person has a plan B if returning to their pre injury work is not possible.
12. It would make sense to allow GPs and treatment providers to refer for RTWS when they feel it is appropriate. Often GPs welcome Rehabilitation Counsellors involvement because they then have support to manage the injured workers return to work. If this is not considered then MCM's should be using assessment tools to determine appropriateness of vocational rehabilitation referrals such as the OMPSQ-SF (questionnaire) for physical injuries and K10 for psychological injuries. This eliminates the subjective approach that currently exists when considering referral to a providers.
13. Eliminating recent complexities that surround making a referral to a RTW Provider. Apparently, the Agents, under the instruction from RTWSA, have been requested to undertake complex checklists (without use of any assessments or questionnaires) and justify referrals being made. This removes the MCM's decision making power as they now need to get approval for referrals.
14. In the Annual Report 2016 – 2017, and in other communications to RTWS Providers, RTW SA has stated that their mission is to provide a desirable, affordable and durable scheme. Yet our members – Rehabilitation Counsellors - are managed by capping services and potentially limiting service provision. In the last provider update the star rating system was abolished, because, reportedly, it was not achieving what it was set out to do, which was guiding referral patterns towards providers with better outcomes. One suggestion could be to implement an NPS rating for all stakeholders. If providers fail to meet the requirements then the provider should be asked to review and comment. The MCM can then decide if the referral should continue or not, based on the feedback of the worker and the provider, in a similar way to how the MCM's review service costs and effectiveness with workers at their reviews.
15. Opening up the Job Service Placement to all the providers currently registered with RTWSA. This will increase the chance of finding appropriate placements for injured workers and incentivise other providers who are not currently tendered to engage in job seeking service provision. This, in turn, will lead to continuity of service provision and ideally drive more employment opportunities for workers.

Term of Reference 8: Any additional recommendations regarding reskilling services to assist return to work outcomes

It would be great to see an improvement in services provided in regional locations. Thus, continue to explore services which can provide these opportunities.

Depending on the actual placement, a consideration could be to remunerate or reward employers for providing placements, at least in the initial stages, to help set up on the job training and increased supervision. Host employers who offer placements are not offered the same compensation for their time, despite them potentially providing a comparable benefit to the worker and scheme. It is often difficult to find a host employer due to the commitment from the employer and often investment required, however this is an important service to increase capacity, skills and confidence. In our experience, work placements can then lead to RISE opportunities, whereas these opportunities are limited in Reskilling. In order to prevent misuse of this provision, gaining employer and injured worker feedback upon completion will be important in order to determine the benefit of the learning outcomes.

There has been limited communication by RTWSA promoting Reskilling providers and their offerings. Improving collaboration is crucial for adequate service provision. Often MCM's do not know which training opportunities would be best suited for their injured workers, so knowing more about what can be provided would be beneficial to service planning.

Limitation of insurances by host employers are significant barriers that prevent injured workers being placed with a host employer. We often hear from host employers: "*our policy does not allow us to have injured workers on premises*". Current insurance offerings by RTWSA are not sufficient. Having a review of the Insurance policy for work trial purposes to be offered to host employers will be crucial to maximise the benefit that work trial placement can offer.

Term of Reference 10: Any other recommendations based on your review of the administration and operation of the Act which you consider appropriate and consistent with the objects of the Act.

ASORC supports the mission of RTW SA in achieving a desirable, affordable, durable scheme. We agree that this is critical to the health of the South Australian economy. For the most part the provisions under the Act are suitable. In this submission, we are not necessarily proposing changes to the Act. But we are strongly recommending that RTW SA reconsiders their approach to early intervention and access to Rehabilitation Counselling. RTW SA have a service standard to ensure that early and timely intervention occurs to improve recovery and return to work (RTWSA, Early and timely assistance, 2018). They met many of the points that relate to the MCM's, but we believe that there needs to be an improved focus on using qualified Rehabilitation Counsellors to assist where there are psychosocial risk factors to improve return to work outcomes and assist with the implementation of self-management strategies (Health Services Group - Transport Accident Commission and WorkSafe Victoria, 2018).

ASORC would like to continue to work collaboratively with RTWSA to support better scheme outcomes. In May 2015, and again in May 2017, ASORC met with RTWSA and expressed our interest in working with RTWSA and their Agents. ASORC are in a position to reach out to their members to address problem areas within the scheme. This could lead to innovative ideas to support scheme participants in achieving better health outcomes. Our members are concerned that referrals are no longer being made to Rehabilitation Counsellors. If there are concerns from RTWSA or the Agents, we would like to work together to resolve them. Our members have Continuing Professional Development (CPD) requirements that provide us with an opportunity to help RTWSA achieve scheme improvements.

The scheme continues to support prolonged treatment services often beyond what is reasonable because they are difficult to cease. However there is a sense that there is greater restriction on Rehabilitation Counselling which is aimed at addressing psychosocial risk factors and increasing capacity for return to work and community participation. There is voluminous literature challenging the validity of the biomedical model of disability and advocates for a social model or a social-psycho-bio model. There are indications that the biomedical model has the ability to further disable and marginalise people. Focusing on the social model is where allied health professionals are likely to achieve the best outcomes by restoring a sense of autonomy and self-mastery (Butler , 2011; Darlow, et al., 2012; Goggin & Newell, 2005; Mairs, 2002; Wand, 2012).

Contemporary chronic condition management best practice advocates for red, or medical, flags for persistent conditions to be excluded in the case of pain, for example. Once this is achieved, while convention remains that a medical treatment provider remains the head of multidisciplinary teams, the major inputs then come from allied health professionals who work holistically with the aim to reduce psychosocial risk factors including fear, catastrophic thinking, perceptions of injustice and disability, relationship breakdowns between parties, determining suitable employment options, negotiating with employers and other multifaceted issues. This is a Rehabilitation Counsellor's core role and it is achieved by improving participation in work, education and advocating for full participation in the community. The Australian and New Zealand College of Anaesthetists suggests that Rehabilitation Counselling included in multimodal therapy can help manage persistent pain (ANZCA Faculty of Pain, 2015).

In summary, we believe that Rehabilitation Counselling is underutilised in the RTWSA scheme. This has been an ongoing issue, from our perspective and one we have tried to remediate for some time. A further example, South Australia is the only scheme which does not allow a

qualified Rehabilitation Counsellor to complete a Vocational Assessment. To be a full member of ASORC you must demonstrate that you meet ASORC's core competencies which include Vocational Assessment and Counselling. But this has been brushed aside, by creating other assessments, which can be used, but people don't understand why they both exist or by commenting that it is more acceptable to the public to have this type of assessment completed by a Psychologist. Our members often hear of situations, where Vocational Assessments completed by Psychologists do not help the person determine suitable options to move forward. This then leads to further frustration because they feel that they are not being listened to or are then sent to vocational counselling for extra support.

Recommendations:

16. RTWSA should seek to significantly engage with ASORC and other relevant professional associations to continue to explore opportunities for improvement and provide feedback to members about issues. We feel that this is critical.
17. There needs to be a collaborative review of existing services, both treatment and RTWS, as well as development of programs that are based on objective and scientific data.
18. RTWSA should invest funds in research and development and open tenders to address gaps that are currently seen.
19. Implement systems that foster accountability across all providers and reduce unnecessary expenses. For example, better treatment management plans. One idea could be to compel the Provider to better articulate the likely outcome of treatment and how they anticipate it will help the injured worker return to work.
20. RTWSA should engage with ASORC to review how Rehabilitation Counselling can be best used to meet the needs of scheme participants.

ASORC Recommendations:

1. The approach so far from RTWSA to promote one claim owner for the life of the claim is beneficial. While there will be changes because of variations in staff retention and resources, it has reduced the shifting of cases between case managers, which can then delay services and result in inefficiencies.
2. Continue with the face to face service model and the behavioural principles.
3. Consider further review of Return to Work Service (RTWS) fee schedule. Some options for consideration include:
    a. Review of who can make referrals. For example, consider allowing treatment providers to make referrals for RTWS. This occurs in other states and often because it is a referral made by their treating doctor, workers are more willing to accept the service. Rapport with providers is built faster and communication between the GP, RC and MCM is improved. This is not to say that agents are to be excluded from this process.
    b. The implementation of the current MCM model has been positioned as improving service provision, not to attempt to provide expert services. Therefore, it seems sensible to continue to use expert services such as Rehabilitation Counselling where there is a protracted return to work that is outside of what is considered biomedically reasonable. It is likely that if recovery and return to work exceeds these timeframes, that there are psychosocial risk factors which are likely to complicate returning to work. Therefore, using timely expert services to identify these barriers and implement strategies to remediate them makes sense and is consistent with scheme reform.
    c. Consider the value of the current RTWS schedule of fees. It is convoluted and, in fact, often MCM's end up needing to seek advice from our members regarding which service is most suitable for the situation. Often this results in the referral being made based on how much work is involved, leading to the goal of the referral not always being consistent with the desired outcome set by RTWSA. This makes it difficult for the agent to make referrals and for the regulator to measure performance. Some examples of other models that could be useful to consider are:

        i. When a referral is made to a RTWS, the provider assesses what is required and then provides a plan (with costs) to the Agent to review and approve. This is not dissimilar to what happened prior to the existing model. However, often plans were very long documents and highly generic. Using the behavioural principles, the expectation for RTWS providers would be that the plan be tailored to the person and stakeholders involved. This would mean that the RTWS provider and the injured worker would need to discuss the expected outcome and use SMART (Specific, Measurable, Attainable, Relevant, Timely) goal setting principles.
        ii. Using NDIS as a model. Whilst this is still in the implementation phase, it could provide some interesting ideas to improve services and worker engagement in that workers could work with the MCM to determine which services are going to be beneficial for them and then the worker is placed at the centre of choosing those services. They can then select services that suit their needs and desired outcome, subsequently creating their own self-care plan. The self-care plan would be reviewed with their GP and MCM, whilst it places the worker in a position where they are accountable for the decisions they make and services they use. The

potential limitation to this service may be that workers may need some education regarding the benefit of RTW service providers. It would also potentially indicate to the MCM where the worker felt they were in regards to their return to work.

4. Opening up the Job Service Placement to all the providers currently registered with RTWSA and also engaging recruitment organisations. This will increase the chance of finding appropriate placements for injured workers and incentivise other providers who are not currently tendered to engage in job seeking service provision. This, in turn, will lead to continuity of service provision.
5. Consider implementing a job placement fee for non-tendered providers with some sensible parameters so that people who have the vacancies are encouraged to place injured workers.
6. Engaging Industry bodies and employers to provide mentorships to injured workers. Currently ReSkilling providers have access to financial incentives to place workers into skills maintenance programs. Offering incentives to employers to facilitate skills maintenance placements could lead to more placements and potentially new employment outcomes if these could then be converted into RISE placements.
7. Encouraging employers that are in the process of "change of employment goal" and providing them with an incentive to recruit another injured worker from the scheme.
8. Incentivising employers who employing injured workers in terms of assurance against aggravation of pre-existing injuries. For example, allowing 12 months for any aggravation to be attributed to the original claim.
9. Review RISE, to at least allow for the wage incentives to be paid to an employer for the full 6 month period, as long as they have commenced prior to the end of the income entitlement period.
10. Consider other incentives for new employers, for example using the behavioural principles to explore the employers' needs in order to employ the injured worker and being able to tailor the package to them. Other options could be bonus premium discount.
11. Stronger emphasis to be placed updating the return to work goal. As soon as there is evidence which suggests we may need to consider alternative employment, the goal needs to be reviewed to reflect this. This might be utilising dual goals more readily so that the injured person has a plan B if returning to their pre injury work is not possible.
12. It would make sense to allow GP's and treatment providers to refer for RTWS when they feel it is appropriate. Often GP's welcome Rehabilitation Counsellors involvement because they then have support to manage the injured workers return to work. If this is not considered then MCM's should be using assessment tools to determine appropriateness of vocational rehabilitation referrals such as the OMPSQ-SF (questionnaire) for physical injuries and K10 for psychological injuries. This eliminates the subjective approach that currently exists when considering referral to a providers.
13. Eliminating recent complexities that surround making a referral to a RTW Provider. Apparently, the Agents, under the instruction from RTWSA, have been requested to undertake complex checklists (without use of any assessments or questionnaires) and justify referrals being made. This removes the MCM's decision making power as they now need to get approval for referrals.
14. In the Annual Report 2016 – 2017, and in other communications to RTWS Providers, RTW SA has stated that their mission is to provide a desirable, affordable and durable scheme. Yet our members – Rehabilitation Counsellors - are managed by capping services and potentially limiting service provision. In the last provider update the star rating system was abolished, because, reportedly, it was not achieving what it was set out to do, which was guiding referral patterns towards providers with better outcomes. One suggestion could be to implement an NPS rating for all stakeholders. If providers fail to meet the requirements then the provider should be asked to review and comment. The MCM can then decide if the referral should continue or not, based on the feedback of the worker and the provider, in a similar way to how the MCM's review service costs and effectiveness with workers at their reviews.

15. Opening up the Job Service Placement to all the providers currently registered with RTWSA. This will increase the chance of finding appropriate placements for injured workers and incentivise other providers who are not currently tendered to engage in job seeking service provision. This, in turn, will lead to continuity of service provision and ideally drive more employment opportunities for workers.
16. RTWSA should seek to significantly engage with ASORC and other relevant professional associations to continue to explore opportunities for improvement and provide feedback to members about issues. We feel that this is critical.
17. There needs to be a collaborative review of existing services, both treatment and RTWS, as well as development of programs that are based on objective and scientific data.
18. RTWSA should invest funds in research and development and open tenders to address gaps that are currently seen.
19. Implement systems that foster accountability across all providers and reduce unnecessary expenses. For example, better treatment management plans. One idea could be to compel the Provider to better articulate the likely outcome of treatment and how they anticipate it will help the injured worker return to work.
20. RTWSA should engage with ASORC to review how Rehabilitation Counselling can be best used to meet the needs of scheme participants.

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