

Flinders University
Australian Industrial
Transformation
Institute

Revisiting Return to Work Coordinators

BUILDING BRIDGES 2010 TO 2016



Ann-Louise Hordacre
Australian Industrial Transformation Institute
March 2017



Revisiting Return to
Work Coordinators
BUILDING BRIDGES 2010 TO 2016

Australian Industrial Transformation Institute

Flinders Business School
Faculty of Social & Behavioural Sciences
Flinders University of South Australia

1284 South Road
Clovelly Park
South Australia 5042

www.flinders.edu.au/aiti

Published 2017.

URL: <http://www.flinders.edu.au/aiti/>

ISBN: 978-0-9945741-3-8

CAT: AIT201706

Suggested citation:

Hordacre A.L. (2017) *Revisiting Return to Work Coordinators. Building bridges 2010-2016*. Adelaide: Australian Industrial Transformation Institute, Flinders University of South Australia.

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Key findings 2016

PARTICIPANTS

In total, 345 (13%) of 2,639 invited Coordinators participated in the survey in 2016. They were mainly female (63%) and were an average age of 49 years having been in the role for almost five years, on average.



HOURS

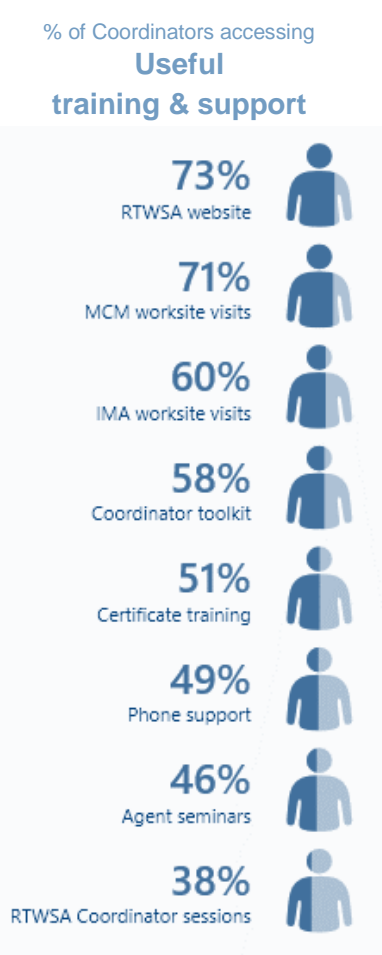
Coordinators worked:

- an average of 39 hours in the business per week
- an average of 6 hours in the Coordinator role.

Only 7% were exclusively employed by the business as Coordinators - with most of these working in a part-time capacity.

TRAINING

All Coordinators are required to participate in core training for the role with 89% indicating training received in 2016 had been effective or very effective. Additional training activities were available to ensure Coordinators remained up-to-date with legislative requirements of the role and were aware of the support available to help them fulfil their role. Eight activities were considered useful to very useful (on average). However, there was considerable variation in their uptake amongst Coordinators.



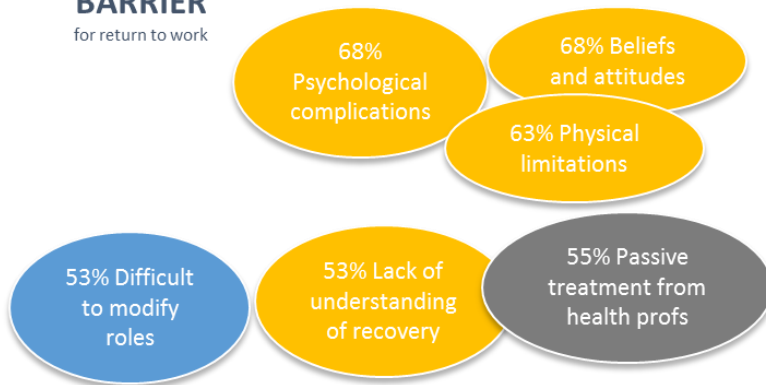
“Our workers trust me and I trust them.”

VALUE

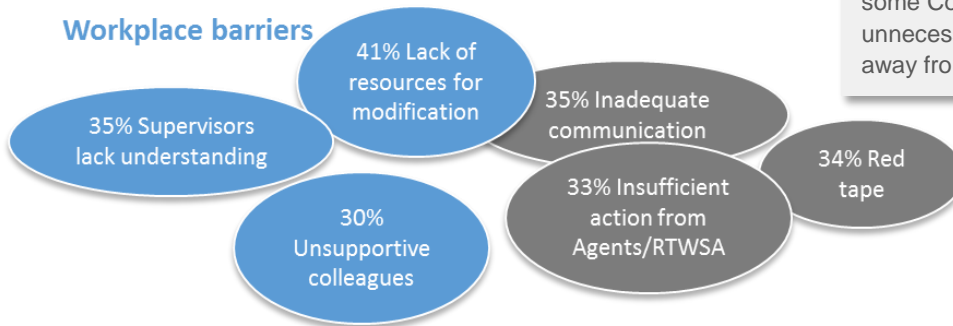
Coordinators agreed or strongly agreed that their role was valued by colleagues and the business’s management, but most strongly felt they were valued by persons with a work injury. While only around one in twenty disagreed and believed they were not valued in the workplace.

% reporting factor as quite or very significant
BARRIER
for return to work

Personal barriers



RTW process barriers



Workplace barriers

BARRIERS

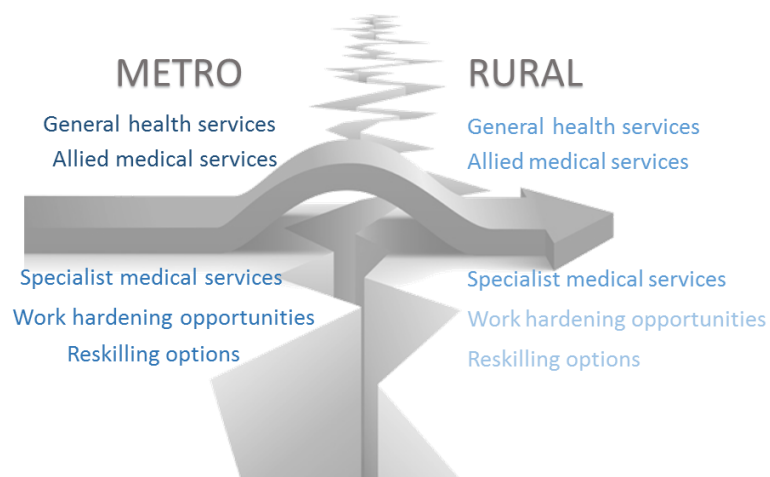
Personal factors such as psychological complications, challenges, beliefs and attitudes remain the most commonly cited barriers to return to work. Workplace and RTW process factors are also considered significant barriers – but to a lesser degree.

The introduction of mobile case managers has been successful measure and well received by Coordinators. The role of health professionals remains contentious with GPs held responsible by some Coordinators for unnecessary extension of time away from work.

REGIONS

Coordinators in rural regions, particularly in the farthest reaches of the state, were more likely to experience service gaps for injured workers thereby limiting their ability to function in the role when compared with Coordinators in metropolitan regions.

- **Health and medical services** were readily available in the metropolitan area, but more difficult to access in rural areas – particularly specialist services.
- **Return to work services** were also more difficult to access in rural areas, with Yorke Mid North and Eyre Western least able to provide these services.



Contents

KEY FINDINGS 2016	I
ACKNOWLEDGEMENTS	VIII
DISCLAIMER	VIII
SUMMARY	IX
RESPONDENT CHARACTERISTICS.....	IX
BUSINESS CHARACTERISTICS	IX
COORDINATOR EXPERIENCE	IX
<i>Coordinators valued</i>	<i>ix</i>
COORDINATOR TRAINING & SUPPORTS.....	X
<i>View of required training</i>	<i>x</i>
<i>View of additional training</i>	<i>x</i>
<i>View of ReturnToWorkSA inputs</i>	<i>x</i>
<i>View of available tools</i>	<i>x</i>
BARRIERS TO RETURN TO WORK	XI
<i>Personal barriers</i>	<i>xi</i>
<i>Workplace barriers</i>	<i>xi</i>
<i>Process factors – claims agents</i>	<i>xi</i>
<i>Process factors – role of health professionals</i>	<i>xii</i>
REGIONAL GAPS	XII
KEY STRATEGIES TO ASSIST RTW	XII
<i>Contact with workers</i>	<i>xii</i>
<i>Return to Work Plans</i>	<i>xii</i>
<i>Role clarity</i>	<i>xiii</i>
RTWSA PROGRAMS AND SERVICES	XIII
1 BACKGROUND	1
2 APPROACH	1
3 RESULTS	2
3.1 RESPONDENT CHARACTERISTICS	2
3.2 BUSINESS CHARACTERISTICS	5
3.3 COORDINATOR EXPERIENCE	9
3.4 REQUIRED COORDINATOR TRAINING.....	16
3.5 ADDITIONAL TRAINING AND SUPPORT ACTIVITIES	19
3.5.1 <i>Training activities</i>	19
3.5.2 <i>Support services</i>	21
3.5.3 <i>Tools</i>	23
3.5.4 <i>RTW Matters resources</i>	25
3.5.5 <i>Professional development activities</i>	27
3.6 BARRIERS TO RTW	28
3.6.1 <i>Personal barriers</i>	28
3.6.2 <i>Workplace barriers</i>	32
3.6.3 <i>RTW Process barriers</i>	36
3.6.4 <i>Comments</i>	40
3.7 REGIONAL SERVICE AND SUPPORT GAPS.....	41
3.8 KEY STRATEGIES TO ASSIST RTW	43
3.8.1 <i>Communication and support strategies</i>	43
3.8.2 <i>Workplace policy and process strategies</i>	48
3.8.3 <i>Strategies to help Coordinators perform role</i>	54

3.9	RTWSA PROGRAMS AND SERVICES	58
	REFERENCES.....	61
	APPENDIX A: VALUING THE RTW ROLE, 2016.....	62
	APPENDIX B: ADDITIONAL COMMENTS – BARRIERS 2016	68
	APPENDIX C: IDEAS TO IMPROVE RTW OUTCOMES IN THE WORKPLACE, 2016	73

List of Tables

TABLE 1: INJURED WORKER SERVICE GAPS IN REGION IMPACTING ON COORDINATOR FUNCTION BY REGION, 2016	42
TABLE 2: COORDINATOR SUPPORT GAPS IN REGION IMPACTING THEIR FUNCTION BY LOCATION, 2016	43

List of Figures

FIGURE 1: PARTICIPATION AND RESPONSE RATE, 2010 & 2016	3
FIGURE 2: GENDER OF COORDINATORS, 2010 & 2016.....	3
FIGURE 3: AGE OF COORDINATORS, 2010 & 2016	4
FIGURE 4: HIGHEST LEVEL OF COMPLETED EDUCATION REPORTED BY COORDINATORS, 2010 & 2016	4
FIGURE 5: COORDINATORS WITH ENGLISH AS FIRST LANGUAGE, 2010 & 2016	5
FIGURE 6: LOCATION OF COORDINATOR DUTIES, 2016.....	5
FIGURE 7: DISTRIBUTION OF COORDINATORS BY INDUSTRY, 2010 & 2016	6
FIGURE 8: EMPLOYMENT OF COORDINATORS BY BUSINESS SIZE, 2010 & 2016.....	7
FIGURE 9: LOCATION OF RTW COORDINATOR’S MAIN PLACE OF WORK, 2016.....	8
FIGURE 10: WORK INJURY INSURANCE TYPE REPORTED BY COORDINATORS, 2016.....	9
FIGURE 11: YEARS IN COORDINATOR ROLE, 2010 & 2016.....	10
FIGURE 12: NUMBER OF CLAIMS AND WORKERS ASSISTED REPORTED BY COORDINATORS, 2010 & 2016	10
FIGURE 13: RELATIONSHIP BETWEEN INJURED WORKERS AND CLAIMS ASSISTED, 2010.....	11
FIGURE 14: RELATIONSHIP BETWEEN INJURED WORKERS AND CLAIMS ASSISTED, 2016.....	11
FIGURE 15: HOURS ENGAGED IN COORDINATOR ROLE, 2010 & 2016.....	12
FIGURE 16: OTHER MAIN ROLES IN ADDITION TO COORDINATOR, 2016.....	13
FIGURE 17: METHOD OF ASSIGNMENT TO COORDINATOR ROLE, 2010 & 2016	13
FIGURE 18: DETAILED METHOD OF ASSIGNMENT TO ROLE, 2016	14
FIGURE 19: PERCEPTIONS OF HOW MUCH THE COORDINATOR ROLE IS VALUED IN THE WORKPLACE, 2010 & 2016	15
FIGURE 20: PERCEPTIONS (%) OF HOW MUCH THE COORDINATOR ROLE IS VALUED IN THE WORKPLACE, 2010 & 2016	15
FIGURE 21: COORDINATORS COMPLETING REQUIRED RTWSA TRAINING, 2010 & 2016	17
FIGURE 22: YEAR COORDINATOR COMPLETED REQUIRED TRAINING, 2016	17
FIGURE 23: EFFECTIVENESS OF COORDINATOR REQUIRED TRAINING, 2010 & 2016.....	18
FIGURE 24: EFFECTIVENESS OF COORDINATOR REQUIRED TRAINING BY YEAR OF TRAINING, 2016.....	18



FIGURE 25: ADDITIONAL TRAINING ACTIVITIES USED BY COORDINATORS, 2016.....	19
FIGURE 26: REGULARITY OF ADDITIONAL TRAINING USED BY COORDINATORS, 2016	20
FIGURE 27: ADDITIONAL TRAINING ACTIVITIES CONSIDERED USEFUL BY COORDINATORS, 2016	20
FIGURE 28: PROPORTION CONSIDER ADDITIONAL TRAINING ACTIVITIES USEFUL, 2016.....	21
FIGURE 29: SUPPORT SERVICES USED BY COORDINATORS, 2016	21
FIGURE 30: REGULARITY OF SUPPORT USED BY COORDINATORS, 2016	22
FIGURE 31: SUPPORT ACTIVITIES CONSIDERED USEFUL BY COORDINATORS, 2016	22
FIGURE 32: PROPORTION CONSIDER SUPPORT ACTIVITIES USEFUL, 2016.....	23
FIGURE 33: TOOLS USED BY COORDINATORS, 2016.....	23
FIGURE 34: REGULARITY OF TOOLS USED BY COORDINATORS, 2016	24
FIGURE 35: TOOLS CONSIDERED USEFUL BY COORDINATORS, 2016	24
FIGURE 36: PROPORTION CONSIDER TOOLS USEFUL, 2016	25
FIGURE 37: RTW MATTERS RESOURCES USED BY COORDINATORS, 2016.....	25
FIGURE 38: REGULARITY OF OTHER RESOURCES USED BY COORDINATORS, 2016	26
FIGURE 39: OTHER RESOURCES CONSIDERED USEFUL BY COORDINATORS, 2016.....	26
FIGURE 40: PROPORTION CONSIDER OTHER RESOURCES USEFUL, 2016	27
FIGURE 41: OTHER USEFUL PROFESSIONAL DEVELOPMENT ACTIVITIES FOR COORDINATORS, 2010 & 2016	28
FIGURE 42: SIGNIFICANCE OF PERSONAL BARRIERS FOR INJURED WORKERS ACCORDING TO COORDINATORS, 2010 & 2016.....	29
FIGURE 43: PERSONAL BARRIERS: PHYSICAL LIMITATIONS AND INJURY TYPE, 2010 & 2016.....	29
FIGURE 44: PERSONAL BARRIERS: PSYCHOLOGICAL COMPLICATIONS, 2010 & 2016	30
FIGURE 45: PERSONAL BARRIERS: CHALLENGES, 2010 & 2016.....	30
FIGURE 46: PERSONAL BARRIERS: LACK OF UNDERSTANDING OF RECOVERY/ RTW PROCESS, 2010 & 2016.....	31
FIGURE 47: PERSONAL BARRIERS: BELIEFS AND ATTITUDES, 2016.....	31
FIGURE 48: WORKPLACE BARRIERS FOR INJURED WORKERS ACCORDING TO COORDINATORS, 2010 & 2016.....	32
FIGURE 49: WORKPLACE BARRIERS: INSUFFICIENT KNOWLEDGE OF INJURY & MANAGEMENT, 2010 & 2016	33
FIGURE 50: WORKPLACE BARRIERS: ROLES/ CONDITIONS THAT ARE DIFFICULT TO MODIFY, 2010 & 2016	33
FIGURE 51: WORKPLACE BARRIERS: LACK OF RESOURCES TO PAY FOR MODIFICATIONS, 2010 & 2016	34
FIGURE 52: WORKPLACE BARRIERS: UNDERSTAFFING/LIMITED STAFF RESOURCES, 2010 & 2016	34
FIGURE 53: WORKPLACE BARRIERS: UNSUPPORTIVE COLLEAGUE, 2010 & 2016	35
FIGURE 54: WORKPLACE BARRIERS: SUPERVISORS/ MANAGERS LACK UNDERSTANDING, 2010 & 2016	35
FIGURE 55: WORKPLACE BARRIERS: ENCOURAGED TO RETURN BEFORE PHYSICALLY ABLE, 2010 & 2016	36
FIGURE 56: WORKPLACE BARRIERS: INABILITY TO PROVIDE MODIFIED/ALTERNATIVE DUTIES, 2016	36
FIGURE 57: RTW PROCESS BARRIERS, 2010 & 2016.....	37
FIGURE 58: RTW PROCESS BARRIERS: ENCOURAGED TO RTW BEFORE PHYSICALLY ABLE, 2010 & 2016	37
FIGURE 59: RTW PROCESS BARRIERS: CONFLICT OR INADEQUATE COMMUNICATION WITH OTHERS IN RTW PROCESS, 2010 & 2016	38

FIGURE 60: RTW PROCESS BARRIERS: INSUFFICIENT ACTION FROM CM, MCM OR RTWSA, 2010 & 2016	38
FIGURE 61: RTW PROCESS BARRIERS: RED TAPE ASSOCIATED WITH FORMAL CLAIM, 2010 & 2016	39
FIGURE 62: RTW PROCESS BARRIERS: INSUFFICIENT ACTION FROM RTW SERVICE PROVIDERS, 2016	39
FIGURE 63: RTW PROCESS BARRIERS: PASSIVE TREATMENT BY MEDICAL/ HEALTH CARE PROVIDERS, 2016.....	40
FIGURE 64: INJURED WORKER SERVICE GAPS IN REGION IMPACTING COORDINATOR FUNCTION, METROPOLITAN & RURAL, 2016	41
FIGURE 65: COORDINATOR SUPPORT GAPS IN REGION IMPACTING THEIR FUNCTION, METROPOLITAN & RURAL, 2016	43
FIGURE 66: USEFULNESS OF COMMUNICATION AND SUPPORT STRATEGIES (PART 1), 2010 & 2016	44
FIGURE 67: USEFUL COMMUNICATION/SUPPORT STRATEGIES: MAINTAINING REGULAR CONTACT WITH IW, 2010 & 2016	44
FIGURE 68: USEFUL COMMUNICATION/SUPPORT STRATEGIES: WORKING CLOSELY WITH CMS & MCMs, 2010 & 2016.....	45
FIGURE 69: USEFUL COMMUNICATION/SUPPORT STRATEGIES: WORKING CLOSELY WITH MEDICAL OR TREATMENT PROVIDERS, 2010 & 2016	45
FIGURE 70: USEFUL COMMUNICATION/SUPPORT STRATEGIES: WORKING CLOSELY WITH RTW SERVICE PROVIDERS, 2010 & 2016	46
FIGURE 71: USEFULNESS OF COMMUNICATION AND SUPPORT STRATEGIES (PART 2), 2010 & 2016	46
FIGURE 72: USEFUL COMMUNICATION/SUPPORT STRATEGIES: INVOLVING OTs AND PHYSIOS IN JOBS ANALYSIS OR WORK SITE ASSESSMENTS, 2010 & 2016.....	47
FIGURE 73: USEFUL COMMUNICATION/SUPPORT STRATEGIES: ARRANGING/ATTENDING CASE CONFERENCES, 2010 & 2016.....	47
FIGURE 74: USEFUL COMMUNICATION/SUPPORT STRATEGIES: CONTACT WITH IW COLLEAGUES TO ENCOURAGE SUPPORT, 2010 & 2016.....	47
FIGURE 75: USEFUL COMMUNICATION/SUPPORT STRATEGIES: ENCOURAGING SUPERVISORS TO BE MORE SUPPORTIVE/ACCOMMODATING, 2010 & 2016.....	48
FIGURE 76: USEFUL COMMUNICATION/SUPPORT STRATEGIES: ENSURING FAMILY AND SUPPORTS ARE AWARE OF RTW ACTIONS, 2010 & 2016	48
FIGURE 77: USEFULNESS OF POLICY & PROCESS STRATEGIES (PART 1), 2010 & 2016	49
FIGURE 78: USEFUL POLICY/PROCESS STRATEGIES: WHS POLICY,2010 & 2016	49
FIGURE 79: USEFUL POLICY/PROCESS STRATEGIES: RTW POLICIES & PROCEDURES,2010 & 2016	50
FIGURE 80: USEFUL POLICY/PROCESS STRATEGIES: EARLY CONTACT WITH EMPLOYEE, 2010 & 2016	50
FIGURE 81: USEFUL POLICY/PROCESS STRATEGIES: DEVELOPING & UPDATING RECOVERY & RTW PLANS, 2010 & 2016	50
FIGURE 82: USEFUL POLICY/PROCESS STRATEGIES: IMPLEMENTING RECOVERY AND RTW PLANS, 2010 & 2016.....	51
FIGURE 83: USEFULNESS OF POLICY & PROCESS STRATEGIES (PART 2), 2010 & 2016	51
FIGURE 84: USEFUL POLICY/PROCESS STRATEGIES: CHANGING WORK HOURS TO ACCOMMODATE INJURY, 2010 & 2016	52



FIGURE 85: USEFUL POLICY/PROCESS STRATEGIES: REDESIGNING ROLES AND DUTIES TO ACCOMMODATE INJURY, 2010 & 2016.....	52
FIGURE 86: USEFUL POLICY/PROCESS STRATEGIES: MODIFYING WORKPLACE TO ACCOMMODATE INJURY, 2010 & 2016	53
FIGURE 87: USEFUL POLICY/PROCESS STRATEGIES: BEING MORE FLEXIBLE TO ACCOMMODATE INJURED WORKER NEEDS, 2010 & 2016.....	53
FIGURE 88: USEFUL POLICY/PROCESS STRATEGIES: INCREASING MONITORING WHEN INJURED WORKER RTW, 2010 & 2016	53
FIGURE 89: USEFULNESS OF STRATEGIES HELPING COORDINATORS TO PERFORM ROLE (1), 2010 & 2016	54
FIGURE 90: USEFUL TO RTWC: CLARIFYING WHO AT SITE IS IN CHARGE OF MANAGING RTW, 2010 & 2016	54
FIGURE 91: USEFUL TO RTWC: IMPROVE TRAINING FOR COORDINATOR, 2010 & 2016.....	55
FIGURE 92: USEFUL TO RTWC: IMPROVE TRAINING FOR EMPLOYEES ON INJURY & MANAGEMENT, 2010 & 2016.....	55
FIGURE 93: USEFUL TO RTWC: INCREASE TIME FOR COORDINATOR ROLE, 2010 & 2016	56
FIGURE 94: USEFULNESS OF STRATEGIES HELPING COORDINATORS TO PERFORM ROLE (2), 2010 & 2016	56
FIGURE 95: USEFUL TO RTWC: MORE ADMIN ASSISTANCE FOR RTW TASKS, 2010 & 2016	57
FIGURE 96: USEFUL TO RTWC: HAVING MORE EFFECTIVE DIARY MANAGEMENT SKILLS, 2010 & 2016	57
FIGURE 97: USEFUL TO RTWC: INCREASE FINANCIAL RESOURCES FOR COORDINATOR ROLE, 2010 & 2016.....	57
FIGURE 98: USEFUL TO RTWC: ENHANCE SUPERVISOR UNDERSTANDING OF RTW PROCESS/ROLE, 2016.....	58
FIGURE 99: AWARENESS OF RTWSA SERVICES AND PROGRAMS, 2016.....	59

Acknowledgements

This project was developed as a collaboration between ReturnToWorkSA (RTWSA) and the Australian Industrial Transformation Institute (AITI) at Flinders University. In particular we would like to acknowledge Margaret Swincer, Graham Dewhurst and Lucy D'Aloia from RTWSA for their consideration and contributions to the development of the 2016 survey and for feedback on the final report.

However, our biggest thanks are reserved for the RTW Coordinators (“Coordinators”) who gave generously of their time and insights in completing the survey.

With thanks

Dr Ann-Louise Hordacre

Australian Industrial Transformation Institute (AITI)

Flinders University

Disclaimer

The views presented here are the views of survey respondents only. In this report we are seeking to represent the views of the Coordinators accurately. We do not seek to comment on, critique, endorse or condone these views or the suggestions contained therein.



Summary

Respondent characteristics

Almost one in eight (13.1%) Coordinators participated in the 2016 survey - half the response rate of the 2010 survey when one in four (26.4%) of Coordinators participated. The reasons for the decline in response is unknown. Differences between the respondents were found with regard to age and education. Participants in 2016 were an average of 4 years older than those in 2010, they were more likely to have a diploma or an associate diploma and less likely to have qualifications at Certificate III to IV. Neither of these findings are surprising as Coordinators in 2016 had been in the role longer than those in 2010. Almost all Coordinators at both surveys spoke English as their first language, however, there was an increase in the proportion with another first language which increased from 1.9% in 2010 to 5.1% in 2016.

Business characteristics

Businesses from all key industries were represented in both 2010 and 2016, with around one in five Coordinators working in manufacturing businesses – by far the largest industry represented. Statistically more Coordinators responded from mining, public administration and defence in 2010 and from communication in 2016 – but numbers in these industries were low at both times. Although not a legislative requirement it is interesting to note that statistically more micro (1-4 employees) and small (5-9 employees) businesses were represented in the 2016 survey. While reasons for them having Coordinators are not known, it may be the business recognises the value of the Coordinator role or it could be the business was previously required to have a Coordinator, but it has since contracted.

Coordinator experience

Coordinators from the 2016 survey reported they had been in the role for statistically longer (Mean = 4.9 years) compared with those completing the survey in 2010 (1.4 years). This is unsurprising given the legislative requirement for businesses to have Coordinators was introduced in 2009.

On average Coordinators spent around one sixth (16%) of their work time on Coordinator duties with the remainder of their week spent on duties relating to their main work role – most commonly as WHS or HR managers or officers. However in 2016, there was an increase in the proportion of Coordinators who worked exclusively in this role, albeit usually in a part-time capacity.

There was a strong relationship between the number of injured workers and claims assisted at both times. However, the strength of the relationship reduced from 2010 to 2016 suggesting a decline in the number of claims activated per injured worker assisted. There are a number of possible reasons for this - Coordinators may have improved their support and management of minor injuries or perhaps changes to the legislative framework may have reduced the number of low level or vexatious claims. Although, under the new premium model medical costs do not impact on an employer's premium, so medical only claims may not have decreased.

Coordinators valued

Generally, in both 2010 and 2016, Coordinators agreed their roles were valued in the workplace by both management and colleagues. Although around one in five were unsure about the value placed in their role, only 5% to 8% felt they were not valued. Coordinators in 2016 believed persons with a work injury valued their role statistically more than either managers and executive

staff or other staff and workers with around four in five (79.7%) agreeing or strongly agreeing their role was valued by injured workers.

Coordinator training & supports

Statistically fewer Coordinators in 2016 (87.4%) compared with 2010 (95.0%) had completed required RTWSA training. However, much of this differential can be accounted for by exemptions, with a number of Coordinators having completed appropriate qualifications or interstate training. More than one in twenty Coordinators were unaware of the requirement to be trained or didn't feel it was necessary. Although this proportion was low, there is a need to ensure all workplaces and Coordinators are advised of the legislative requirements of the role.

View of required training

It is positive to note, that Coordinators in 2016 rated the effectiveness of the training required by RTWSA statistically higher than in 2010. Of particular interest, one quarter of 2016 participants reported training was extremely effective, compared with just over one eighth of 2010 participants. Ratings of required training have trended upward over the last five years with 13.8% of Coordinators reporting this training was extremely effective in 2012 climbing to 36.4% of those who completing training in 2016. In the last couple of years, Coordinators reported sessions were informative and the trainers and guest speakers were knowledgeable. Importantly, participation in these training sessions meant Coordinators knew where to go for resources and who to get help from.

View of additional training

A range of additional training and support activities have been made available in recent years to help Coordinators keep up-to-date with legislative requirements and responsibilities and to ensure they know how to access tools and support when required. With regard to training activities around half had accessed Coordinator certificate training and a similar proportion had attended seminars or workshops run by the Agents. Coordinators using these considered them useful. Although the events calendar and RTW Matters e-learning portal could be accessed from a computer, only one third (32.9% and 34.6%, respectively) reported using these. Most of those who had not accessed the training had interest in doing so – although around 15-20% of Coordinators did not.

View of ReturnToWorkSA inputs

For those completing the 2016 survey, almost half had received worksite visits from a ReturnToWorkSA injury management advisor (IMA), three in five accessed phone support services, and seven of ten Coordinators had received a worksite visit from a mobile case manager (MCM). All three services were considered useful, however, MCM site visits were reported to be very useful by more than half the Coordinators who had received them. Most of those who hadn't accessed these supports were interested in visits from an IMA and the phone support service – however, there was less interest in MCM site visits, noting it was already well subscribed.

View of available tools

With regard to tools available to Coordinators in 2016, almost three quarters had accessed the ReturnToWorkSA website finding it useful overall. Whilst only one in five Coordinators had accessed the *Managing Psychiatric Injuries Guide*, three in five expressed interest in using it in the future. While not un-useful, the guide was considered the



least useful of the tools. It is not known whether the lack of usefulness stems from Coordinators accessing it when it wasn't required - or the guide itself proving less useful.

RTW Matters resources were considered amongst the least useful support. However, it should be noted that for these and the aforementioned training and support activities, very few indicated they were not useful. Around half the Coordinators accessed the RTW Matters website, two in five the newsletters and one in five the webinars. However, there is much scope and interest in utilising these more. Notably more than half of Coordinators were interested in the webinars which suggests further promotion could enhance their uptake.

Barriers to return to work

A range of the acknowledged barriers to return to work were explored spanning personal, workplace and RTW process factors. All areas with a statistical differences between 2010 and 2016 had a reduction in the Coordinators' perception that the factor was a barrier.

In 2010, personal barriers including psychological complications, challenges, physical limitations, and to a lesser extent lack of understanding about recovery and the RTW process were considered the biggest obstacles to return to work, with workplace and RTW process barriers considered important but to a lesser degree. Similar results were found in the 2016 survey.

Personal barriers

From 2010 to 2016 there was a general downward trend (often indicating statistical difference) in ratings of the significance of all listed barriers. This trend was less evident for personal barriers, with statistical difference found only in relation to psychological issues and personal challenges. While it is positive that these personal barriers were considered less inhibiting in 2016 compared to 2010, the decline is minimal and ratings for personal barriers exceed those for almost all workplace and return to work process barriers. This finding reaffirms previous perceptions of how individual factors of the injured worker impact return to work outcomes and aligns with the literature that focuses predominantly on how injured workers themselves contribute to positive or negative return to work outcomes.

Workplace barriers

Six of seven workplace barriers reduced significantly from 2010 to 2016, with average ratings falling by up to 0.6 points. Of note, Coordinators reported unsupportive colleagues, lack of understanding from management and insufficient knowledge about injury and its management were a reduced barrier to returning injured workers to work. This is a positive finding and points to a better understanding of RTW and injury in the workplace.

Process factors – claims agents

The impact of RTW process factors also reduced from 2010 to 2016. Notably, insufficient action from claims managers rated poorly in 2010, with more than one quarter (28.9%) indicating this was a very significant issue impacting their ability to manage a work injury. Since then, another agent was introduced to manage work injury claims from employers registered with ReturnToWorkSA. Probably of greater impact was the *Return to Work Act 2014* which introduced structural changes to claims management. Mobile case managers (MCMs) are a feature of this new environment and one Coordinators perceive as working effectively. In 2016, only 16.5% reported insufficient action from claims managers or MCMs as posing a very significant barrier to successful RTW.

Process factors – role of health professionals

More than half (54.0%) reported that passive treatment by health professionals was a ‘quite’ or ‘very’ significant barrier. Health professionals being a process barrier was also nominated under the other significant personal or workforce barriers category. This finding accords with the 2010 survey and other work exploring GPs’ interaction with non-medical sectors.

Coordinators continued to call for improved training of GPs and other health specialists specifically in regard to providing care to injured workers. Several Coordinators cited examples of GPs advocacy for injured workers to extend their claims and time off work when they were not deemed to be necessary by the Coordinator. This is a vexed issue - and one not easily solved.

Clearly, many Coordinators assign a level of responsibility to injured workers and see them as creating barriers to RTW. This is most evident in the two thirds of Coordinators who reported worker fear-avoidance behavior and attitude toward the workplace as ‘quite’ or ‘very’ significant barriers to RTW, with another quarter believing this was a ‘somewhat’ significant barrier.

Regional gaps

While numbers of Coordinators responding from rural areas was low, it is clear the further one is from Adelaide the more problematic some of these issue are. Coordinators were least likely to identify gaps in general health services. Gaps for specialist services were rated the same as general health services in metropolitan areas, but were markedly less accessible in rural areas.

Options for reskilling were reasonable in metropolitan areas, but significantly less in rural areas. Gaps between metro and rural areas with regard to access to support and services for Coordinators were small, with the only statistical difference relating to decreased opportunities for training.

Key strategies to assist RTW

Coordinators rated the usefulness of key communication and support and workplace policy and process strategies for returning injured workers to work. Communication and support strategies were rated quite to very useful by most Coordinators.

Contact with workers

Of note, more than two thirds of Coordinators found maintaining regular contact with the injured worker and working closely with the claims agent or MCM very useful. No statistical differences were found between 2010 and 2016, with responses approaching the ‘ceiling’ (maximum possible scores).

Policy and process strategies were main viewed as very useful. Notably, more than three quarters of Coordinators reported it was very useful to have early contact with injured employees. The literature points to early and considerate contact with workers as promoting positive attitudes toward the workplace, increasing RTW outcomes and reducing the cost of lost time claims (Butler, 2007).

Return to Work Plans

Developing and implementing Recovery and RTW plans were also identified by three in five Coordinators as very useful in helping them to perform their role. Under the 2010 policy arrangements Coordinators could not prepare Plans. Changes to that policy now enables Coordinators to prepare their Plans and it is feasible that Coordinators could value a process in which they have more control.



Only one statistical difference was found, with Coordinators in 2016 increasingly likely to recognise the usefulness of changing work hours to accommodate an injury.

Role clarity

Coordinators also provided perspectives on how the strategies assisted them in their role. The most useful strategy related to clarifying who at the site was in charge of managing the RTW process. Given the Coordinators central role in this process, it is not surprising clarity around this issue is seen as particularly useful. While this is clearly considered a useful strategy, we suggest the reduction in barriers relating to unsupportive colleagues and understanding about RTW, injury and its management suggest clarity around this issue is improving. Less than three in five Coordinators believed increasing the time available to perform the Coordinator role would be useful to some extent (see Figure 93), with Coordinators working more hours in the role more likely to report this strategy was useful.

RTWSA programs and services

Coordinators were asked about their awareness and interest in five programs and services administered by RTWSA. For the most part Coordinators were aware about MCM and telephone reporting for a new claim and interested in it. However, there was a small but significant proportion (12.1% and 17.4%, respectively) who indicated no interest in these services.

Around two thirds of Coordinators were aware of the Reemployment Incentive Scheme for Employers (RISE) but only half of these were interested in the service. There was considerable interest in the recently released job dictionaries and the Reskilling pilot – however, with almost one quarter and one third, respectively, of Coordinators unaware of them there is considerable scope for providing additional information about how and when to access them.

1 Background

Effective from 1 January 2009, employers with 30 employees or more were legislatively required to appoint rehabilitation and return to work (RTW) coordinators (“Coordinators”) in South Australia. This decision followed the *Clayton Review* of the worker’s compensation system with Coordinators responsible for the organisation’s internal management of work-related injuries and the rehabilitation and return to work of injured employees.

The year following the implementation of the legislation, in 2010, the team from the Australian Industrial Transformation Institute (AITI)¹ conducted a survey of 570 Coordinators for RTWSA² (Hordacre, Katterl, Chiveralls, Barnett, & Spoehr, 2010). The online survey explored the demographic and workplace characteristics of Coordinators, the perceived efficacy of their training and professional development activities, the value placed on the role by organisations, barriers to RTW, and usefulness of strategies to promote RTW in the workplace.

Six years on RTWSA sought to repeat the survey in order to

- Compare the characteristics and perceptions of Coordinators in 2010 and 2016;
- Understand their experiences, organisational role and the way they engage with injured workers;
- Examine what has worked in the six years since their inception;
- Explore other challenges that have emerged over this time; and
- Clarify how the new RTW Act will impact on the function of Coordinators in the workplace and within the scheme.

2 Approach

The 2010 Coordinator survey was used as the starting point in developing a survey for 2016 Coordinators. Where possible, questions from the 2010 survey were retained in 2016 to enable comparisons across time. However, a number of changes were unavoidable to ensure the contents were up-to-date with the current roles and responsibilities of today’s Coordinators. The required modifications and new additions to the survey were made in consultation with key RTWSA staff and piloted with a small number of RTWSA staff and Coordinators. No issues were raised regarding the content, clarity and comprehension of the survey. AITI sought and was granted Flinders University Social and Behavioural Research Ethics Committee approval for administration of the survey³.

In both 2010 and 2016, data collection was undertaken using AITI’s secure, encrypted online survey facility. In brief, administration involved emails to a list of Coordinators via Survey Monkey:

- All Coordinators were advised by RTWSA via email about the forthcoming survey.
- Personalised email invitations were sent to all potential participants (based on a list provided by RTWSA).
- The email included a unique web-link (one for each potential participant). Once the survey was complete the web-link closed (preventing individuals responding multiple times to the survey).

¹ Then at Australian Institute for Social Research.

² At that time known as WorkCoverSA.

³ Project number 7417.

- The unique web-link facilitates the reminder process. Providing the ability to produce targeted email reminders only to those who have not completed the survey (i.e. those who complete the survey do not get 'bothered' by further reminders).
- This process helped AITI to determine exact response rates, manage email bounces and error messages, along with 'out of office' responses.
- All potential participants are able to opt out of the specific survey (or for all future surveys from Survey Monkey) by selecting the online option or by contacting AITI.

In 2016⁴, the survey was conducted in two waves⁵. Wave 1 was launched on 16 November 2016, with a reminder sent around two weeks later. Wave 2 was launched on 5 December 2016 with a reminder sent a week later.

After the data collection period was closed a complete electronic dataset was generated and downloaded to SPSS⁶. This dataset was then subject to thorough checking and a data cleaning process, to assess and resolve potential data quality issues such as completeness of responses, validity of responses and consistency of responses.

Quantitative data was analysed using SPSS statistical software. Data are presented as either proportions, as counts or as results on a Likert (rating) scale from 1 through 5 (the Likert scales used are shown in the figures). Statistical testing was undertaken where relevant and appropriate with reference to the sample size and characteristics of the data. Data and findings that may lead to the identification of individuals was not released (i.e. crosstab data with small cell sizes were not presented). Analyses typically involved descriptive statistics and some parametric tests (e.g. t-tests and analysis of variance). Statistical significance indicates whether data points or 'observations' reflect a pattern or have occurred by chance. Some results have reached *statistical significance*⁷ indicating, for example, a difference between two or more groups. Where this has occurred we have commented on it.

3 Results

3.1 Respondent characteristics

In total, 345 (13.1%) of 2,639 invited Coordinators participated in the survey (see Figure 1). This can be compared to a response rate of 26.4% in 2010, when 570 Coordinators participated. The gender distribution of survey respondents was (statistically) the same (see Figure 2). There was an age difference⁸ between the two cohorts with respondents in 2010 statistically younger (44.3 years) than those participating in 2016 (48.6 years) – this is not unexpected as Coordinators were new to the role in 2010 whereas 2016 respondents had been in the role for a number of

⁴ Details about the method for the 2010 survey can be found in Hordacre et al. (2010).

⁵ Wave 2 was comprised of a second smaller cohort of Coordinators whose details were provided by RTWSA a couple of weeks after Wave 1 was sent.

⁶ The statistical package used for analysis.

⁷ The probability (p) values or limits of what is considered statistically significant are conventionally set at 'p<.05' (significant), 'p<.01' or p<.001'(highly significant). The former means there is only a 5 in 100 (5%) chance of this result being a coincidence and the latter meaning only a 1 in a thousand (0.1% chance) of the result being a coincidence.

⁸ t (817) = -5.8, p<.001.



years. Participants in 2010 were more likely to be aged in their 20s and 40s, with 2016 participants almost four times more likely to be aged 60 years and over (see Figure 3).

Figure 1: Participation and response rate, 2010 & 2016

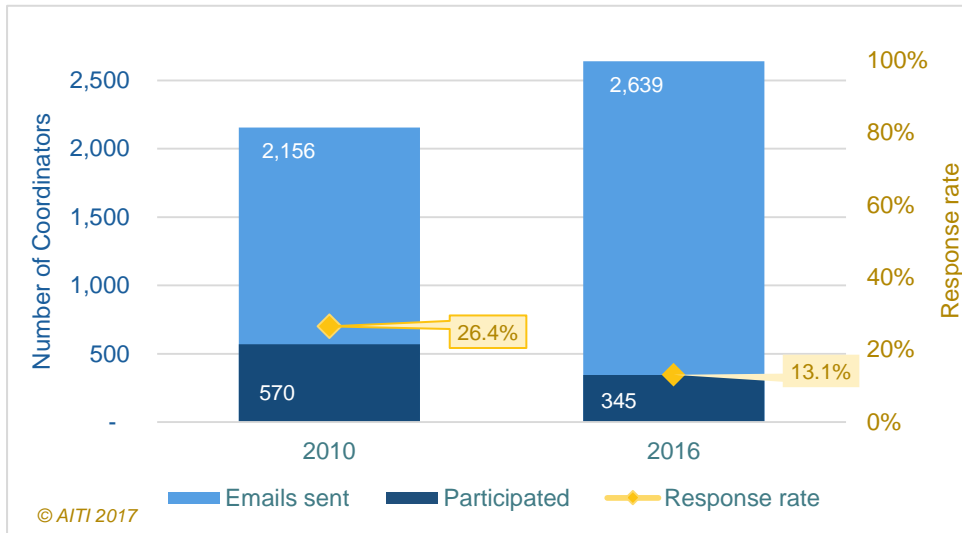


Figure 2: Gender of Coordinators, 2010 & 2016

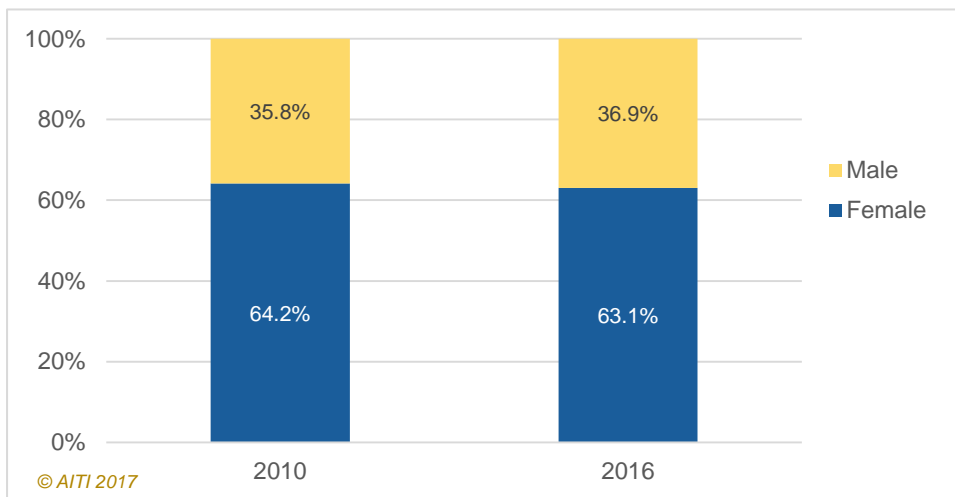
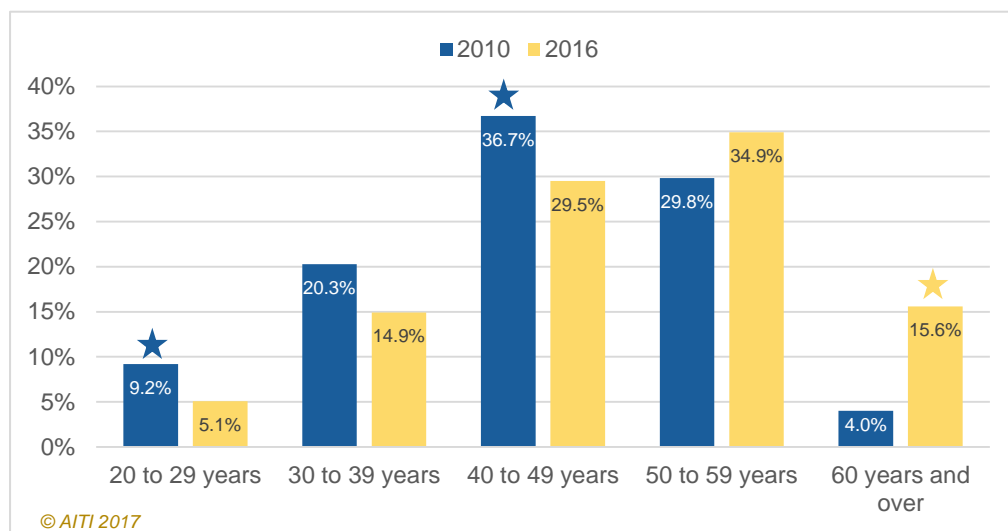


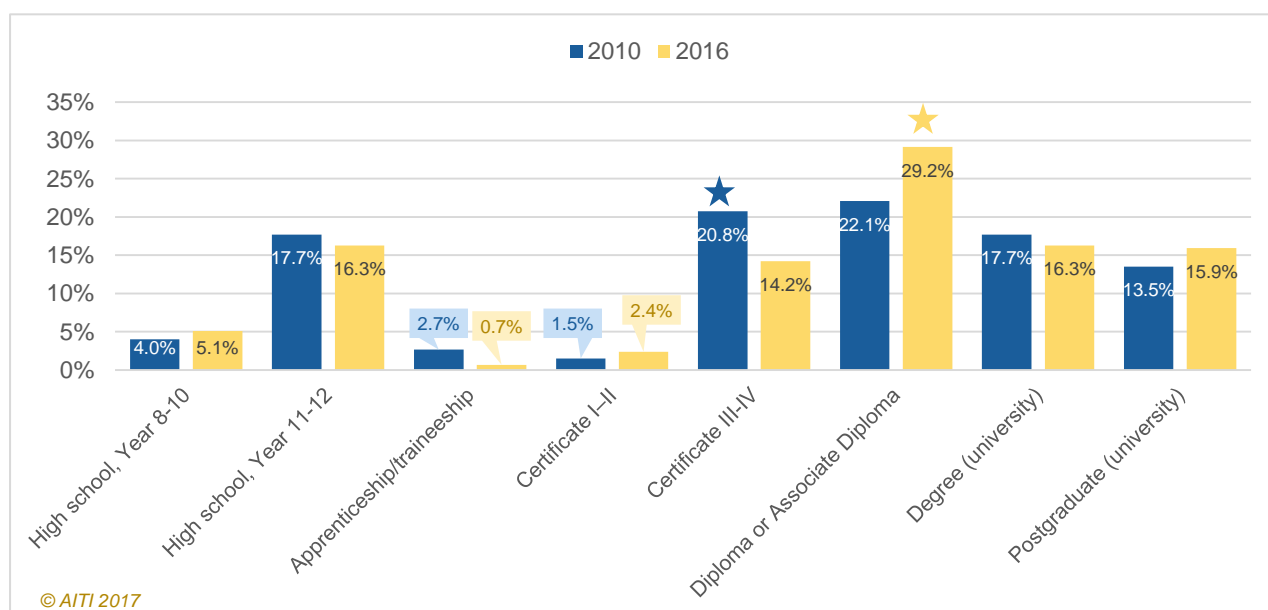
Figure 3: Age of Coordinators, 2010 & 2016



★ Indicates statistical differences were found (with the colour denoting the group with the higher proportion).

Educational differences were also evident between the cohorts, with participants statistically more likely to have Certificate III-IV level qualifications in 2010, but statistically⁹ more likely to have Diploma or Associate Diploma qualifications in 2016 (see Figure 4). While numbers were low, respondents in 2016 were statistically¹⁰ more likely to have a first language other than English (5.1%) compared with those completing the survey in 2010 (1.9%, see Figure 5).

Figure 4: Highest level of completed education reported by Coordinators, 2010 & 2016



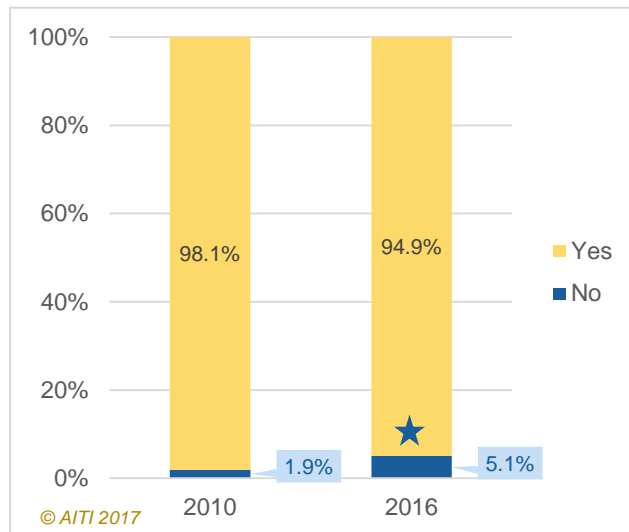
★ Indicates statistical differences were found (with the colour denoting the group with the higher proportion).

⁹ $\chi^2 (7, N=820)=14.5, p<.05.$

¹⁰ $\chi^2 (1, N=820)=6.5, p<.05.$



Figure 5: Coordinators with English as first language, 2010 & 2016

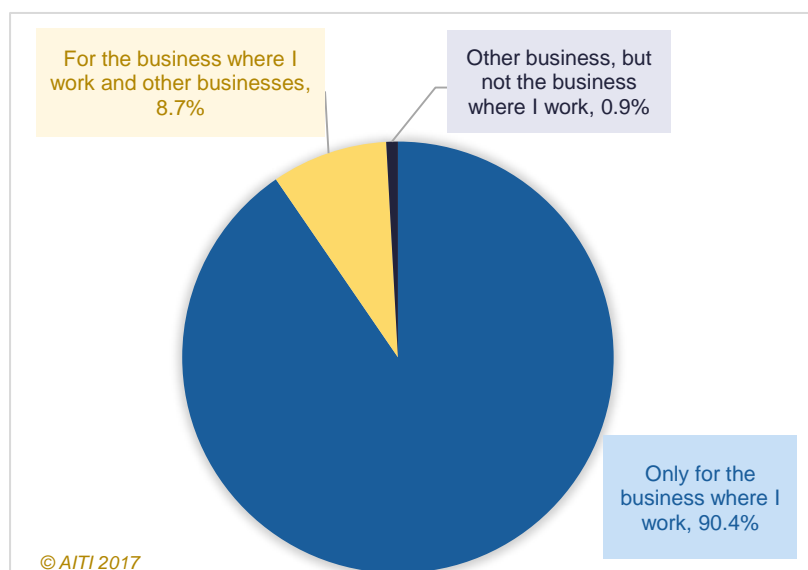


★ Indicates statistical differences were found (with the colour denoting the group with the higher proportion).

3.2 Business characteristics

All South Australian businesses that employ 30 or more workers must have a Coordinator. However, the Coordinator can be a staff member or someone engaged externally to provide the required functions for the business. In 2016, nine out of ten respondents (90.4%) reported they conducted their Coordinator functions only for the business in which they worked (see Figure 6). Almost all others (8.7%) reported they acted as Coordinator for the business they worked in and for other businesses, these respondents tended to work in large organisations and were likely to provide the function across multiple sites. For the purpose of this survey, they were asked to answer questions for their business only. The remaining small number (0.9%) indicated they were engaged externally to provide Coordinator functions for a business they did not work directly in. As this latter group may perform the Coordinator function for many different businesses they were asked to provide responses for the main business where they performed these duties.

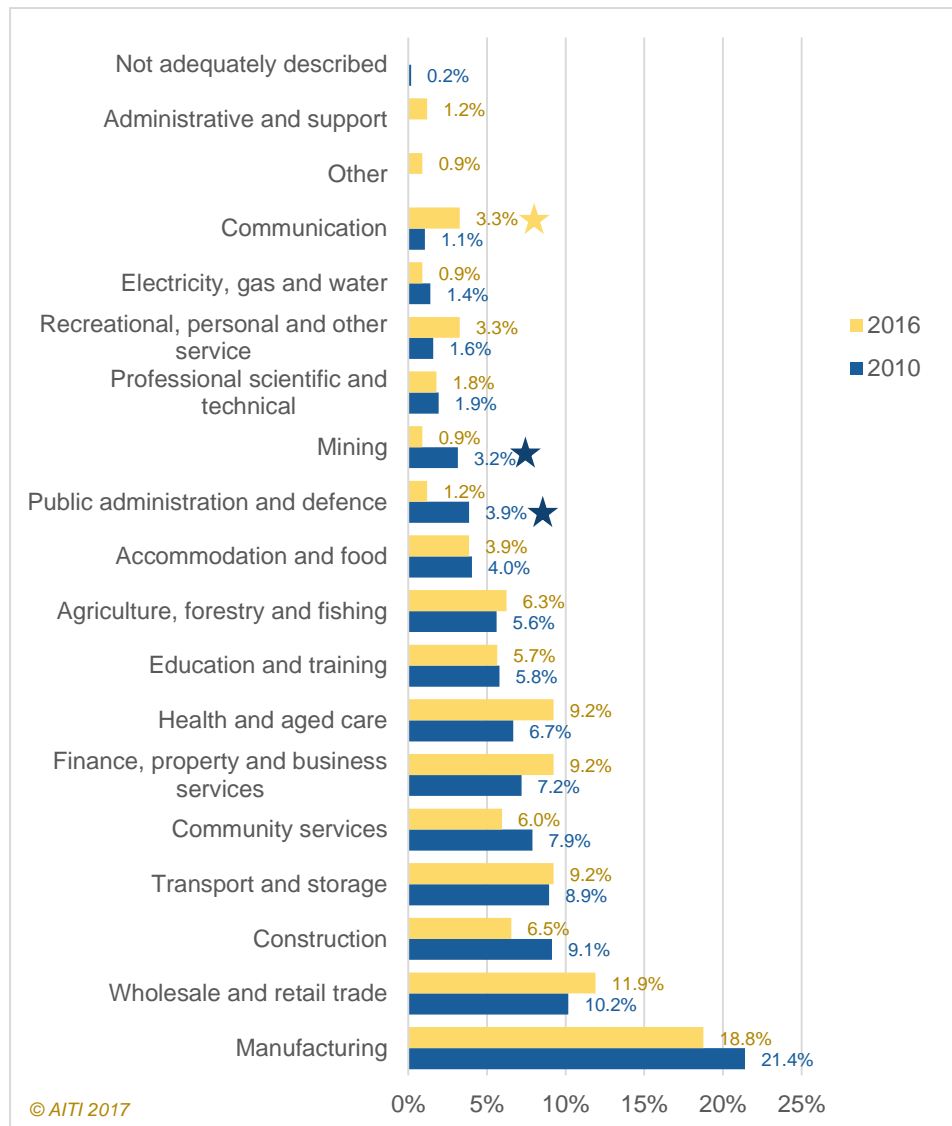
Figure 6: Location of Coordinator duties, 2016



Note, question not asked in 2010.

Coordinators from all key industries¹¹ were represented in both 2010 and 2016. Around one in five survey respondents were from manufacturing businesses (see Figure 7) – by far the largest industry represented. This was followed by wholesale and retail trade which contributed around one in ten responses at both times. Different proportions of responses between each survey were noted with Coordinators from public administration and defence, and mining statistically less likely to have contributed in 2016, while Coordinators from the communication industry were statistically more likely have responded in 2016¹² - noting that the number of businesses from any of these industries was low and didn't exceed 22 in any year.

Figure 7: Distribution of Coordinators by Industry, 2010 & 2016



★ Indicates statistical differences were found (with the colour denoting the group with the higher proportion).

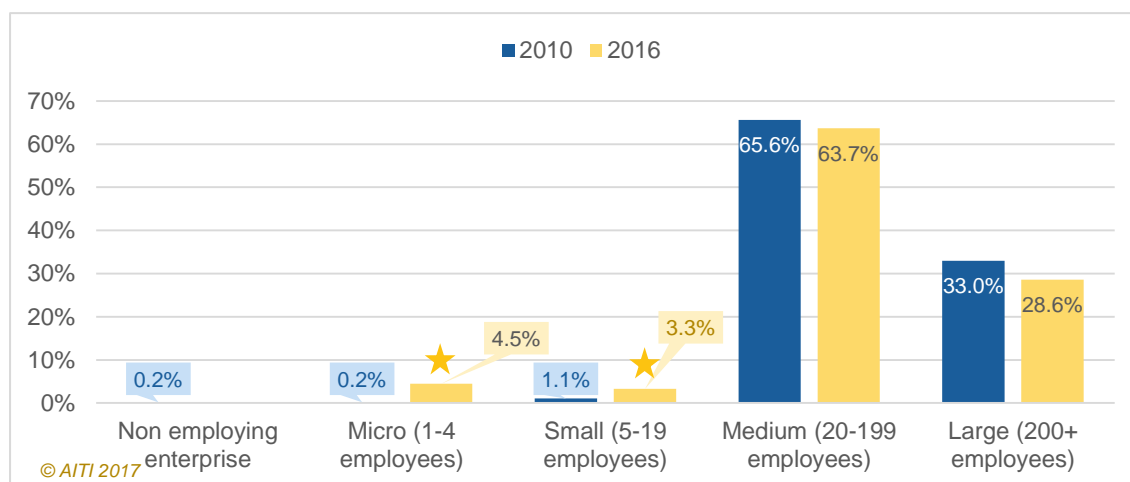
¹¹ Industries were allocated to align with twelve common South Australian Industry Classifications (SAIC). Where Coordinators provided an 'other' response they were coded into the classification of best fit, with results presented for 18 industries.

¹² $\chi^2 (18, N=906)=38.4, p<.01$.



The distribution of businesses in terms of employee numbers¹³ was broadly similar for medium (20-199 employees) and large (200+ employees) businesses across both surveys (see Figure 8). However in 2016, statistically ¹⁴ more micro (1-4 employees) and small (5-19 employees) business Coordinators responded. While there is no legislative requirement for businesses of this size to have a Coordinator, this is an increase from seven (in 2010) to 26 businesses in 2016 responding in these combined categories. Micro and small businesses were well spread across twelve of the eighteen industry categories, they were proportionally more like to be from the communication (17.6%) or electricity, gas and water (18.2%) industries – each of which had fewer than seventeen businesses.

Figure 8: Employment of Coordinators by business size, 2010 & 2016



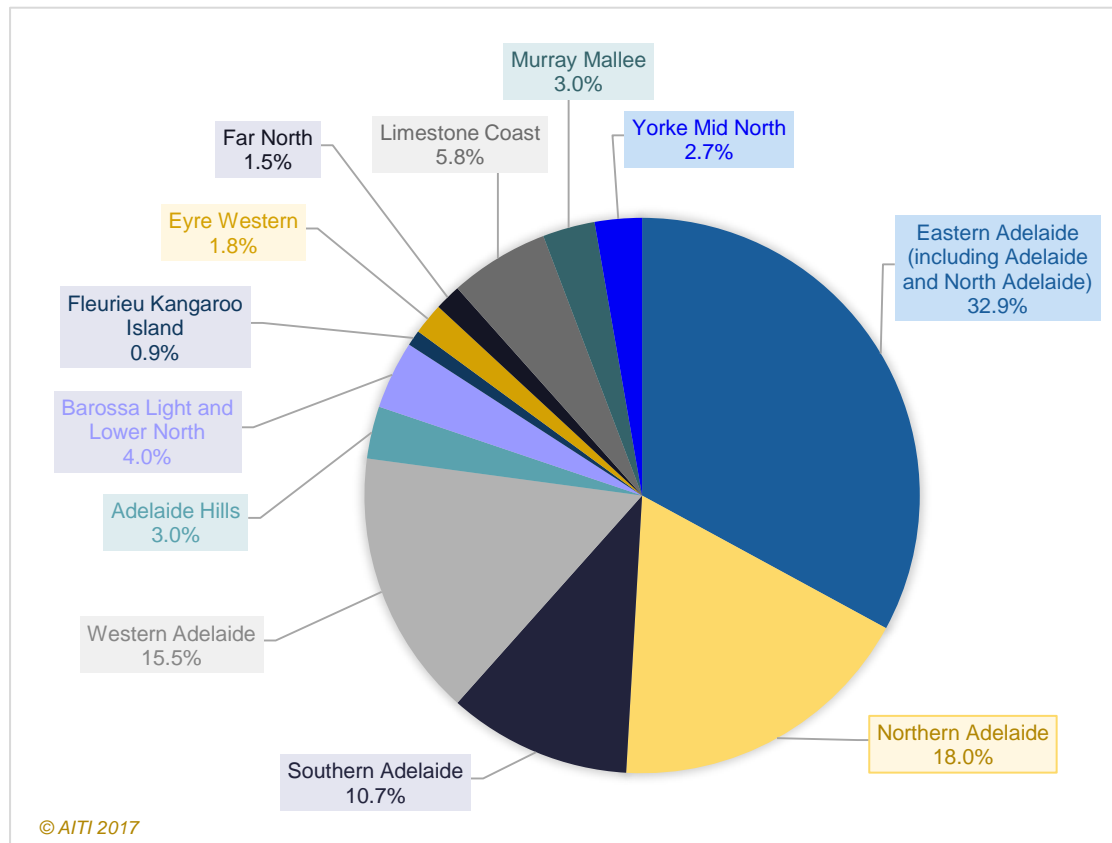
★ Indicates statistical differences were found (with the colour denoting the group with the higher proportion).

The South Australian Government uses a consistent set of twelve regions as administrative boundaries for the delivery of government services. Four of these (Eastern, Northern, Western & Southern Adelaide) comprise greater Adelaide with the remaining eight distributed across the state. With most (77.5%) of the South Australian population living in greater Adelaide it is reassuring that the same proportion (77.1%) of businesses are similarly located (see Figure 9). Almost one third of responding Coordinators worked in the Eastern Adelaide region comprising Adelaide and North Adelaide along with the eastern suburbs.

¹³ Business size groupings used standard classifications as per Swanepoel and Harrison (2015).

¹⁴ $\chi^2 (4, N=906)=29.6, p<.001$.

Figure 9: Location of RTW Coordinator's main place of work, 2016

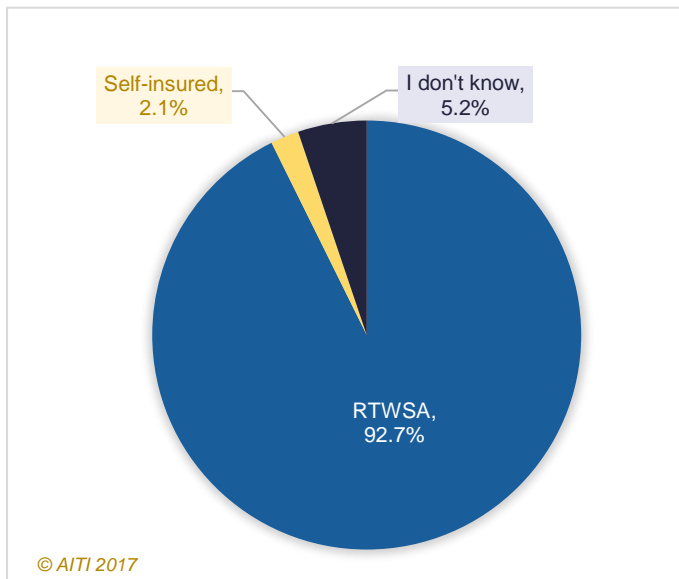


Note, this geographic information was not available for 2010.

Self-insurance for work injuries is available to large businesses operating in South Australia as an alternative to insurance with RTWSA – providing they meet the legislative and code of conduct requirements and can demonstrate effective work health and safety management and appropriate work injury management. As of January 2017 there were 71 private self-insured employers registered in South Australia, with Coordinators from seven (10%) of these participating in this survey. In most cases (92.7%) Coordinators understood their business to be insured through RTWSA (see Figure 10), with a small proportion unsure of their insurance arrangements.



Figure 10: Work injury insurance type reported by Coordinators, 2016



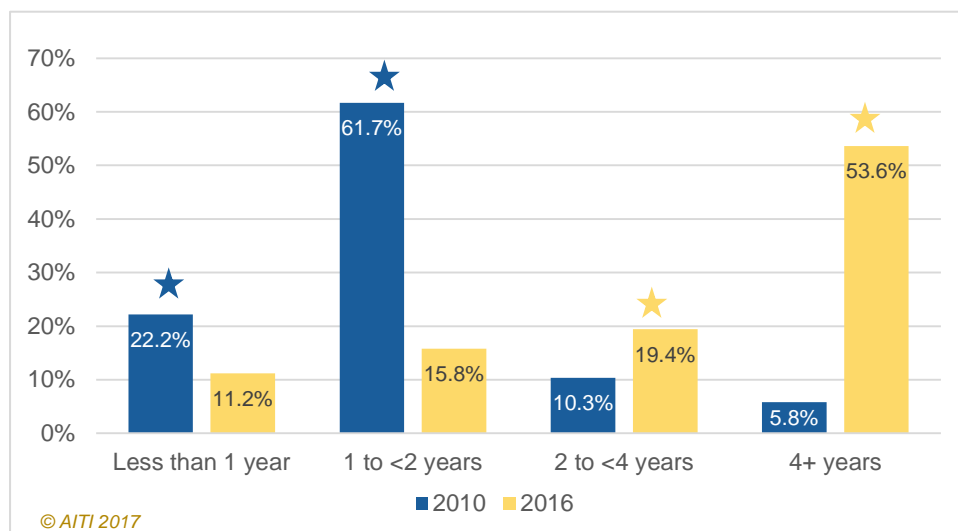
Note, this insurance information was not available for 2010.

3.3 Coordinator experience

From 1 January 2009, employers with 30 or more employees were required to appoint a Coordinator. Eighteen months later, the 2010 Coordinator survey was administered. While employers may have had Coordinators in situ predating the legislative requirement, it is not surprising that in 2016, Coordinators had been in the role statistically¹⁵ longer than those from 2010, an average of 4.9 years compared with 1.4 years, respectively. Figure 11 presents more detail. In 2010, around three in five Coordinators had been in the role between one and two years – aligning with the legislated introduction of the role. Only 16.1% of Coordinators had been in the role longer than two years. In 2016, these findings had all but reversed – three quarters (73.0%) of Coordinators had been in the role for more than two years, with most of these acting as Coordinators for more than four years.

¹⁵ $t(329) = -14.2, p < .001$.

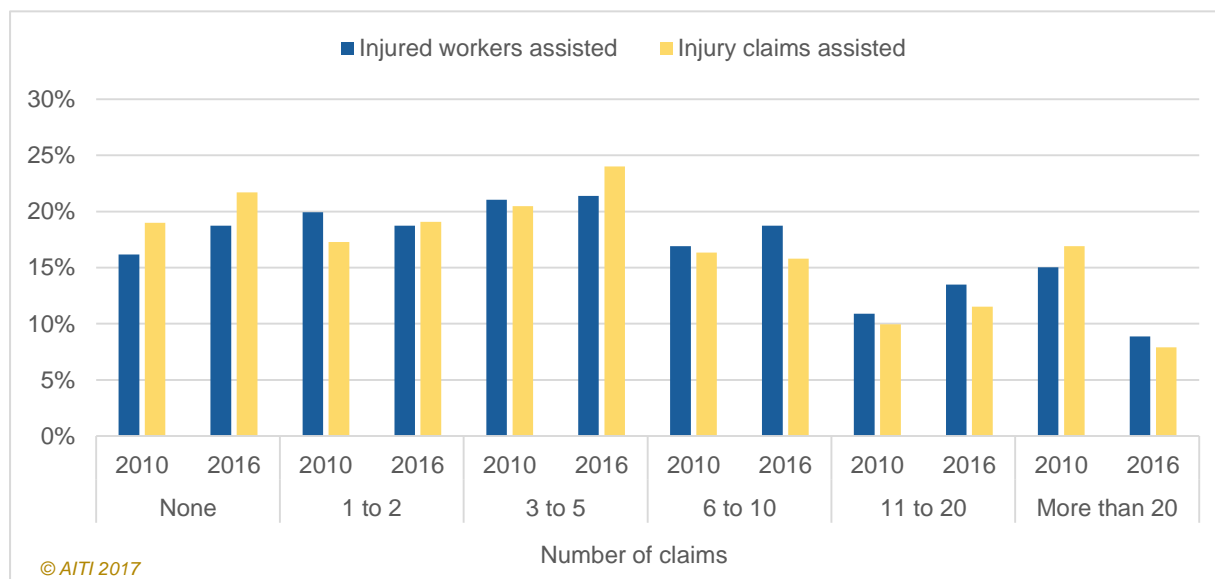
Figure 11: Years in Coordinator role, 2010 & 2016



★ Indicates statistical differences were found (with the colour denoting the group with the higher proportion).

Slightly different questions were asked in 2010 and 2016 with regard to the number of claims and workers the Coordinator had assisted, with the difference principally related to specifying a temporal dimension in 2016 – with Coordinators asked to indicate numbers in the last two years¹⁶. While Coordinators reported far more outliers (i.e. more than 20 workers or claims assisted) in 2010, when viewed by category as in Figure 12, responses from Coordinators in 2010 were broadly similar to those in 2016.

Figure 12: Number of claims and workers assisted reported by Coordinators, 2010 & 2016

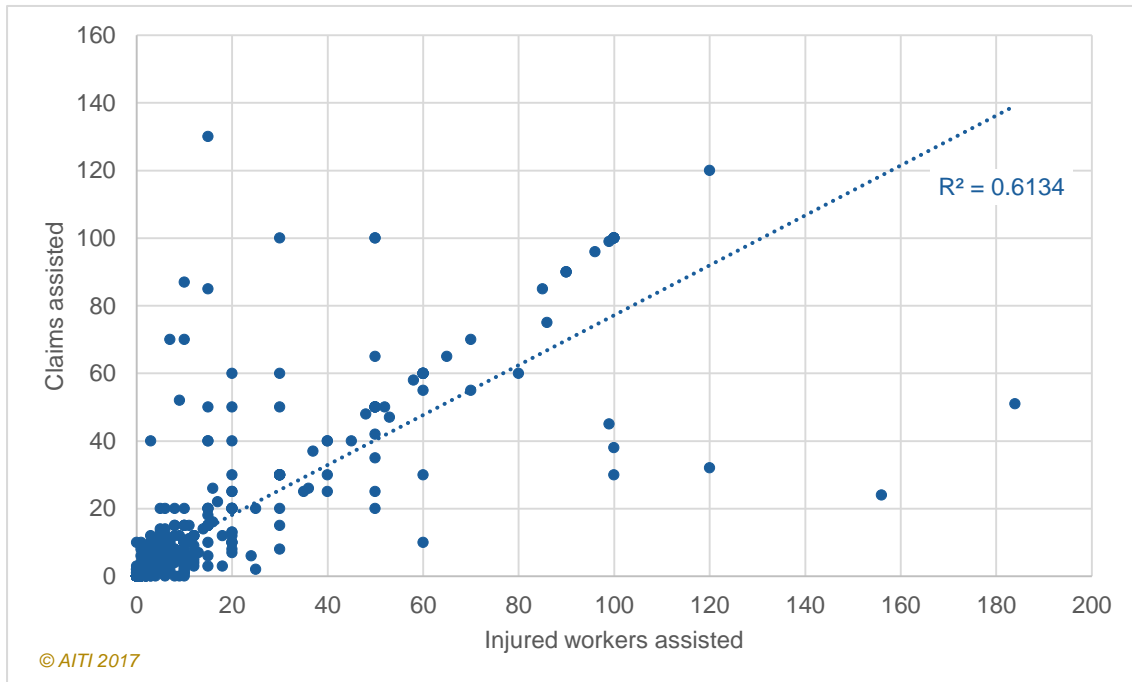


¹⁶ Two years was selected as a reasonable approximation of the timeframe addressed in 2010.



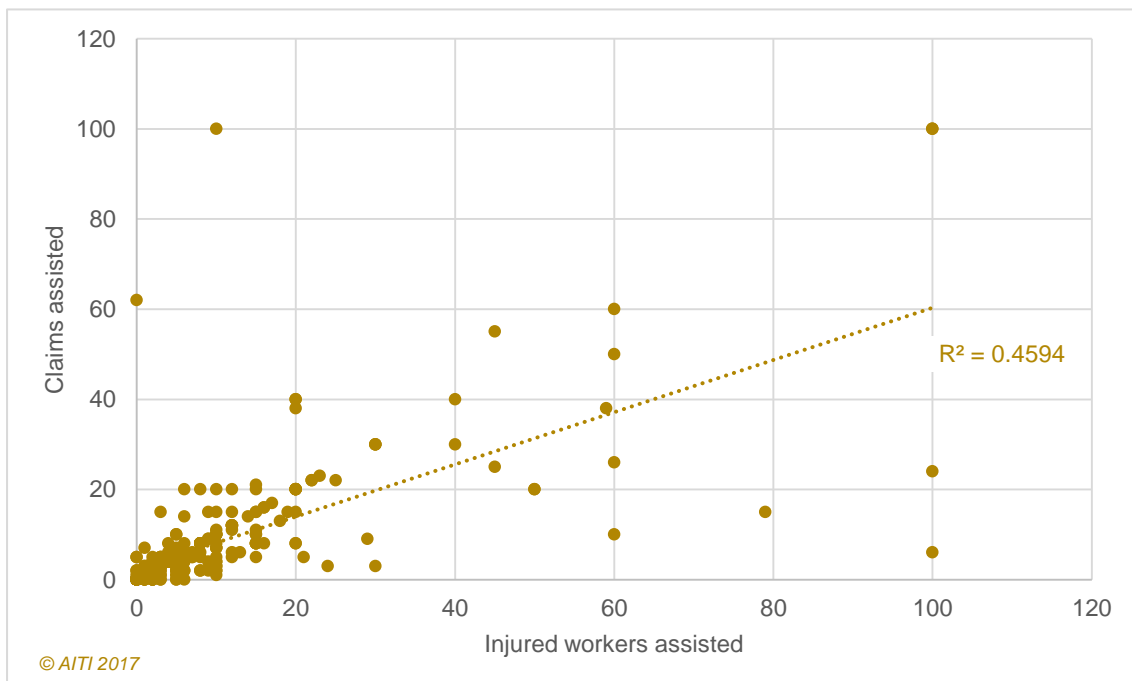
Correlations between the number of injured workers and claims assisted were positive and strong at both times. In 2010, 61% of the variance in one variable was accounted for by the other (see Figure 13). However, in 2016, the strength of the relationship was reduced - and only accounted for 46% of the variance (see Figure 14). While the reason for this is not known, it is interesting to note that this suggests a decline in the number of claims activated per injured worker assisted.

Figure 13: Relationship between injured workers and claims assisted, 2010



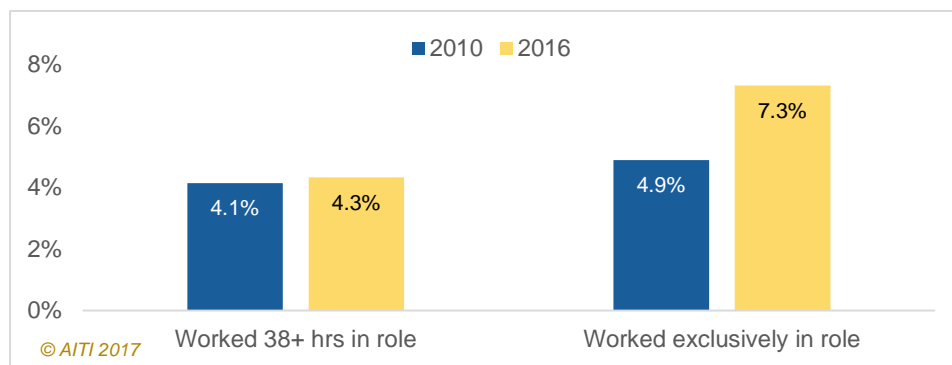
Note, 8 cases were outliers and removed from this analysis.

Figure 14: Relationship between injured workers and claims assisted, 2016



Coordinators in both 2010 and 2016 worked an average of 39 hours in the business per week and an average of 6 hours (around 16% of their time) in the Coordinator role. Only 4.1% of Coordinators in 2010 worked in the role more than 38 hours a week, with only 4.9% reporting this was their only role in the business (noting most of these were in part-time positions). Little had changed in 2016 – 4.3% worked as Coordinators for more than 38 hours a week. However in 2016, a higher proportion (7.3%) were exclusively employed by the business as Coordinators - with this again predominantly in a part-time capacity.

Figure 15: Hours engaged in Coordinator role, 2010 & 2016

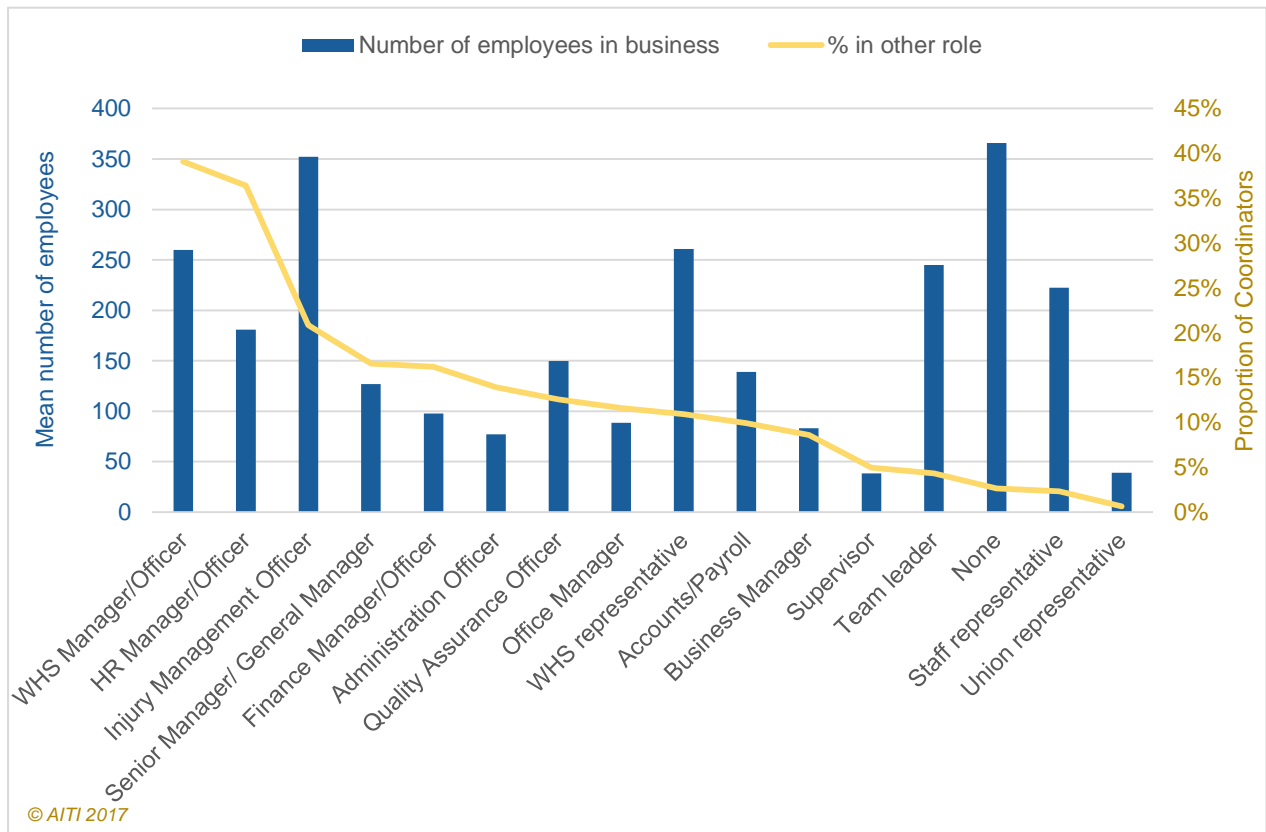


In 2016, Coordinators were asked to indicate the other main roles they undertook in addition to Coordinator¹⁷. Almost one in four (39.1%) indicated they were also engaged as Work Health and Safety (WHS) Managers or Officers, with slightly fewer (36.4%) filling the role of Human Resources (HR) Managers or Officers (see Figure 16). Coordinators who had no other role in the business or were engaged as Injury Management Officers worked in large businesses averaging around 350 employees. At the other end of the spectrum when the Coordinator's other role was supervisor or union representative their business size was on the small-end of medium with an average of just under 40 employees.

¹⁷ In 2010, Coordinators were asked to indicate only one other role, therefore results aren't comparable.



Figure 16: Other main roles in addition to Coordinator, 2016



Note, multiple responses possible. This question was not asked in 2010.

A similar proportion of Coordinators in 2010 and 2016 applied, volunteered or were appointed to the role (see Figure 17). Most of those appointed to the role indicated they were either told to do it or were given the option (see Figure 18). For the rest of those appointed, most reported it was part of the role, or it was a good fit for them as they were already providing similar functions or because it was aligned with their existing responsibilities.

Figure 17: Method of assignment to Coordinator role, 2010 & 2016

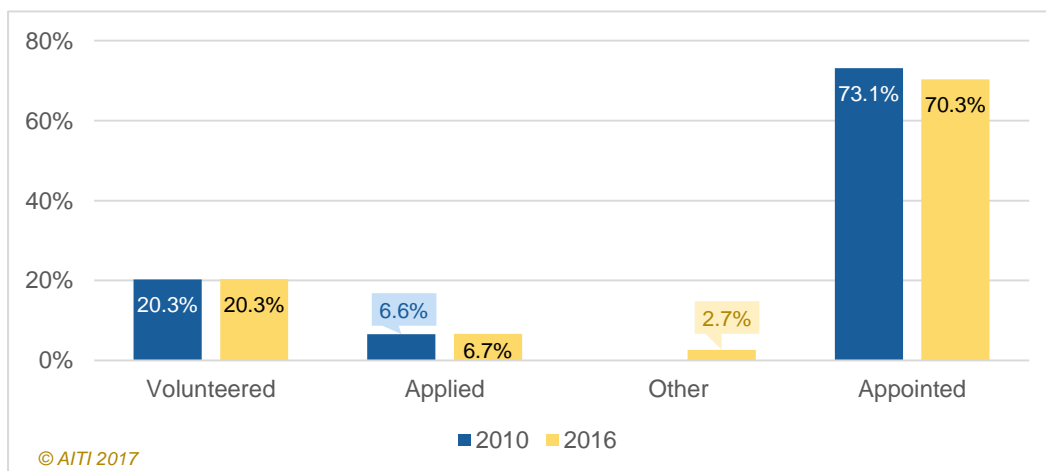
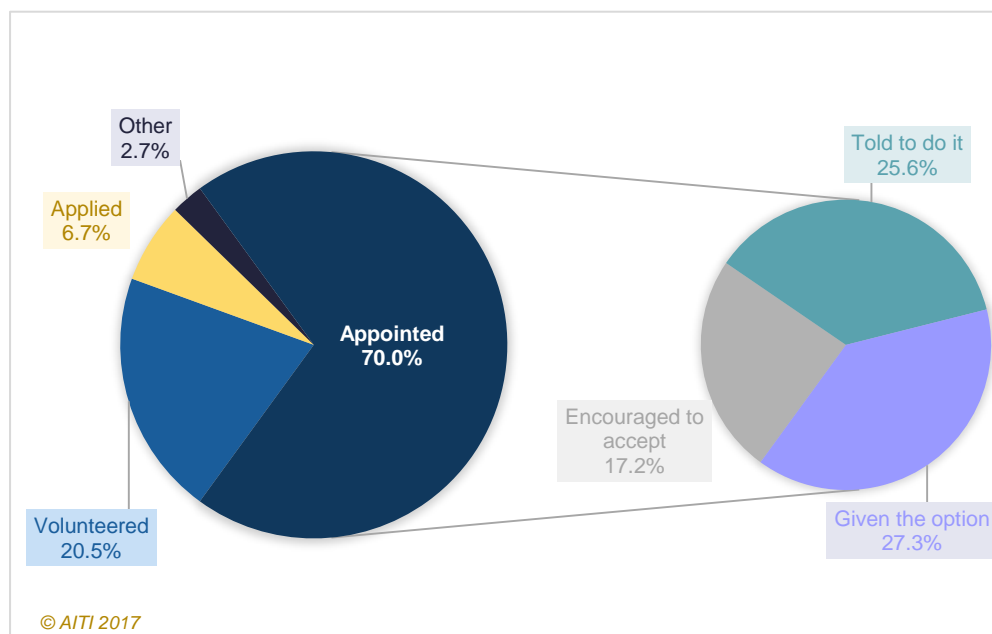


Figure 18: Detailed method of assignment to role, 2016



Note, details about method of assignment to role not available from 2010 survey.

In 2010 and 2016 Coordinators were asked whether they agreed their role was valued in the workplace by managers and executive staff and by other staff and workers. Perceptions about how persons with a work injury valued the role was asked in 2016 only. There were no statistical differences between perceptions about role value in 2010 and 2016 (see Figure 19). However in 2016, it was believed persons with a work injury valued the role statistically more than either managers and executive staff¹⁸ or other staff and workers.¹⁹ Reflecting this, around four in five (79.7%) Coordinators agreed or strongly agreed their role was valued by injured workers (see Figure 20). Fewer (70.4% and 72.5% in 2010 and 2016, respectively), believed their roles were valued by managers and executives while only 64.6% to 71.5% believed the same of other staff and workers. The principal difference lay in Coordinator perspectives about managers and executive staff in 2016 with 35.9% of Coordinators indicating management strongly valued their roles. Although there was some ambiguity, less than 8.2% believed their roles were not valued by colleagues or management – and only 4.4% believed injured workers didn't value what they did.

¹⁸ $t(282) = -7.1, p < .001$.

¹⁹ $t(282) = -4.0, p < .001$.



Figure 19: Perceptions of how much the Coordinator role is valued in the workplace, 2010 & 2016

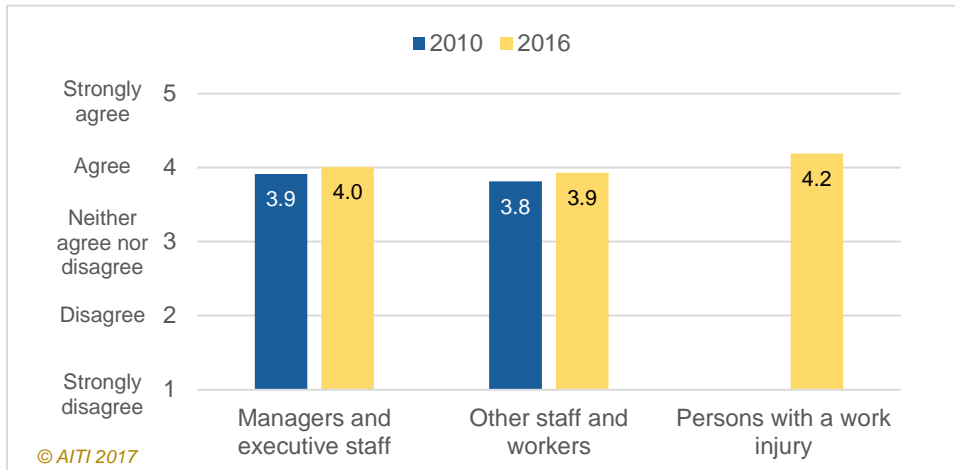
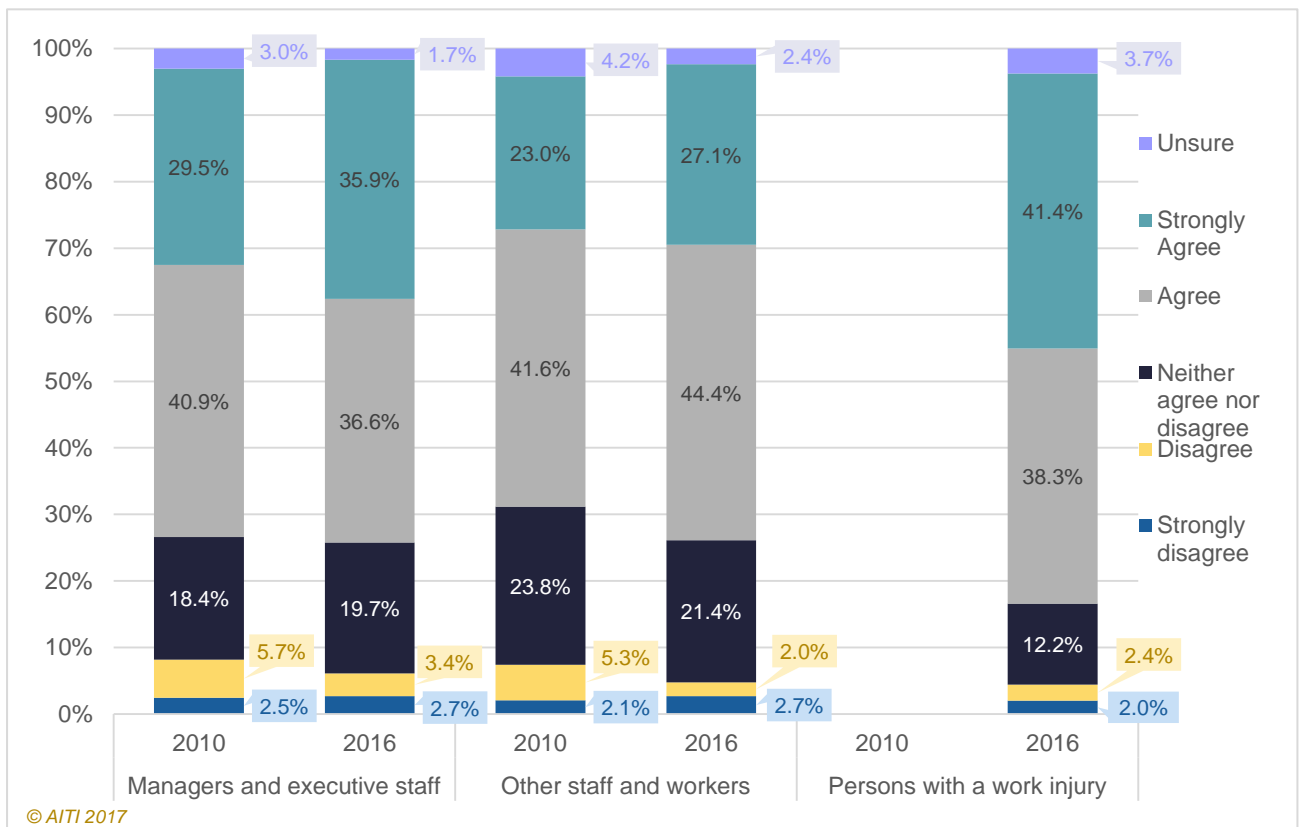


Figure 20: Perceptions (%) of how much the Coordinator role is valued in the workplace, 2010 & 2016



Almost half the 2016 participants provided a comment about how the Coordinator role was valued in their workplace (see Appendix A:). Many discussed organisation benefits including having “one point of contact” and their role as an experienced “interpreter” who acts as a link between workers, organisation, medical professional and insurer. But while Coordinators attempt to keep all workers informed about their role, the general perception is that the value of the role is most derived through management and those who need their services -

Certainly it is appreciated by people who need to use it including employees and managers, as it provides a single point of contact where they can get simple advice and assistance, and takes away from the manager needing to perform in this area where they may use the skills frequently and feel adequately qualified.

In addition, value was also seen as a consequence of business savings including premium savings and reductions in lost time from work due to injuries -

Decrease in premiums, supported workers, returning to work in some capacity sooner than before we had a RTW Coordinator.

The value of this role has become apparent after the successful RTW outcomes have financially impacted the bottom line.

The role of Coordinator differed between organisations. A number of Coordinators indicated their involvement commenced when there was an injury and ended when this was resolved. During these times it was valued, but at other times they did not contribute in a meaningful way. Others saw their role as intrinsic to safety and well-being within their organisation, with trust and confidentiality important considerations -

RTW Coordinators are a pivotal inclusion to the safety and wellbeing of all employees throughout the workplace.

Our workers trust me and I trust them.

3.4 Required Coordinator training

Coordinators were asked whether they had completed training required by RTWSA. A statistically lower²⁰ proportion (87.4%) of Coordinators in 2016 (compared to 95.0% in 2010) indicated they had participated in a required training course (see Figure 21). We note that as the requirement for businesses to have Coordinators was legislated in 2009 it is likely that there was a high number of courses available at this time to accommodate the new role - this may account for some of the difference. Figure 22 presents the proportion of Coordinators completing training in a given year.

Coordinators who hadn't completed training in 2016 were asked why. Of these 32% indicated they had an exemption as they either had appropriate qualifications or had received interstate training. Twelve Coordinators (35.3%) reported they were unaware this was a requirement (noting these had been employed in the role an average of just under three years, with all but three not having had the responsibility of managing an injured worker). Another eleven either didn't think it was necessary, didn't have time or hadn't been able to avail themselves of a suitable course. While the actual proportion who were unaware of or didn't think the training was necessary was low, there is a need to ensure all Coordinators are advised of the legislative requirements of the role.

²⁰ $\chi^2 (1, N=802)=15.2, p<.001$.



Figure 21: Coordinators completing required RTWSA training, 2010 & 2016

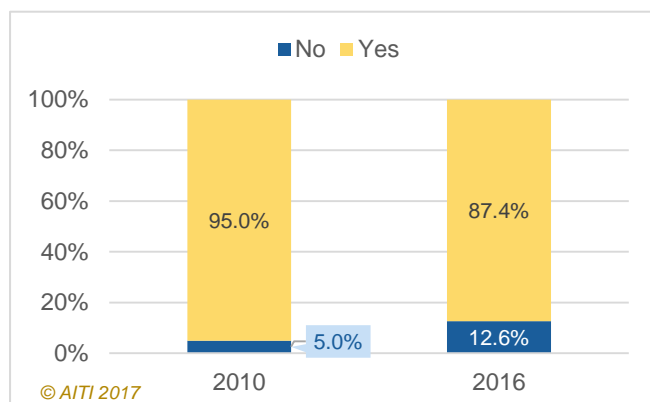
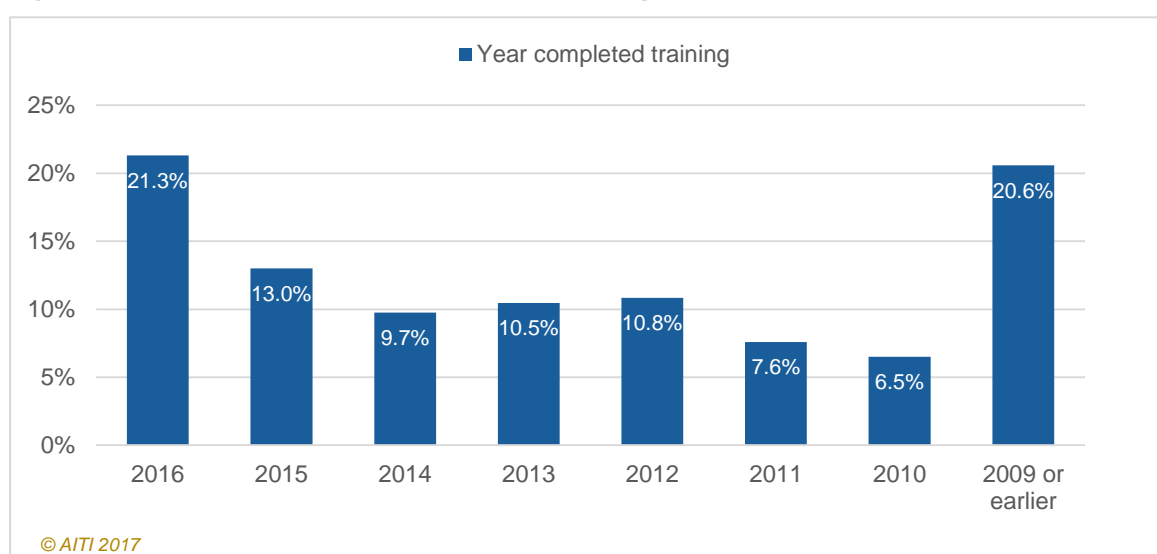


Figure 22: Year Coordinator completed required training, 2016



Note, year of training was not asked in 2010.

Coordinators were asked to rate the effectiveness of the required training they received on a five point scale (1=extremely ineffective through to 5=extremely effective). Coordinators who participated in the 2016 survey rated the effectiveness statistically higher (Mean=4.0)²¹ than Coordinators from the 2010 survey (Mean=3.8).²² This difference can also be seen in Figure 23. Of particular note, one quarter of 2016 participants reported training was extremely effective, compared with just over one eighth of 2010 participants. When considering the effectiveness of training delivered over the last five years (since 2012), it is evident from Figure 24 that around 90% of Coordinators rated the training as effective to some degree. Critically over this time, Coordinators have increasingly rated the training they received as extremely effective – with 36% providing this rating in the last two years (2015 and 2016).

²¹ Mean refers to the arithmetic average.

²² $t(540) = -3.9, p < .001$.

Figure 23: Effectiveness of Coordinator required training, 2010 & 2016

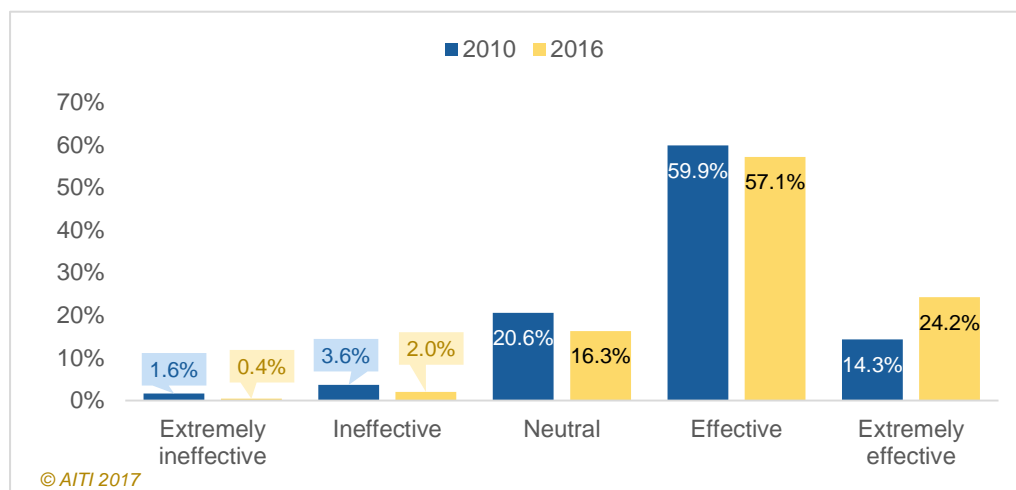
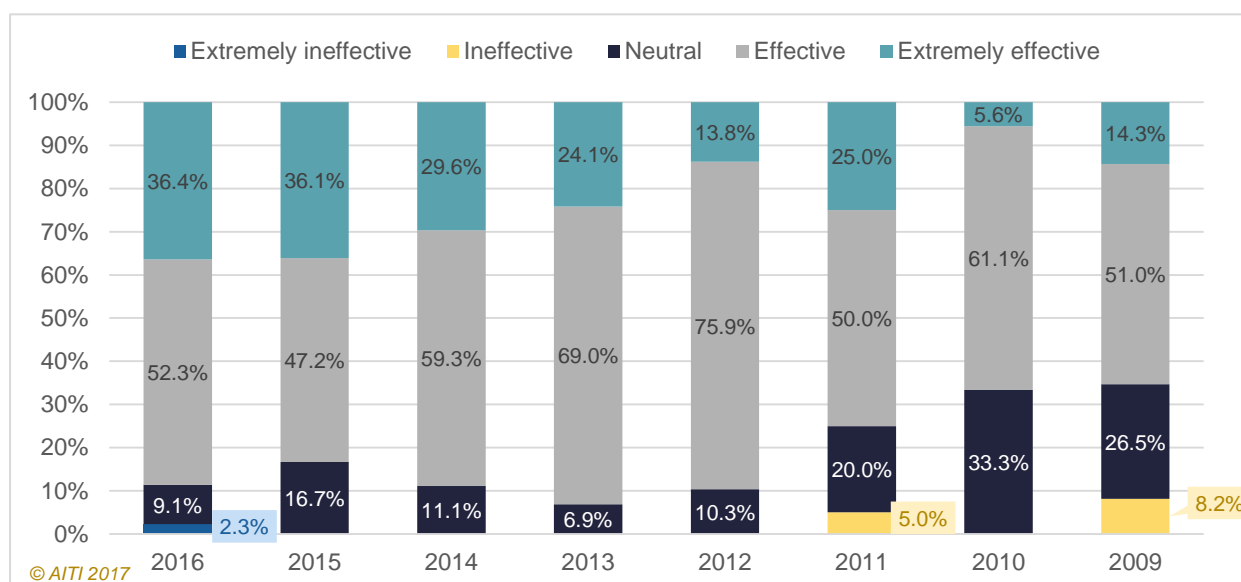


Figure 24: Effectiveness of Coordinator required training by year of training, 2016



Note, year of training not asked in 2010.

As indicated above, training was generally seen as effective or extremely effective. Focusing on Coordinators who completed training in the last couple of years, most felt the sessions were informative and the trainers and guest speakers were knowledgeable. Importantly, participation in these training sessions meant Coordinators knew where to go for resources and who to get help from.

It was very informative training and RTWSA have been in contact and very supportive since.

As someone who has ZERO exposure at the time of the training/course, there were still a few blank spots, however the support has been great.

The training was very informative and well organised. They provided useful information and links to templates and guides.

I believe that without the training and with the case I had to deal with first up there would of been a very different outcome. I would also like to say that without the support of the RTW staff and trainers I would have struggled to obtain the outcome that I did.



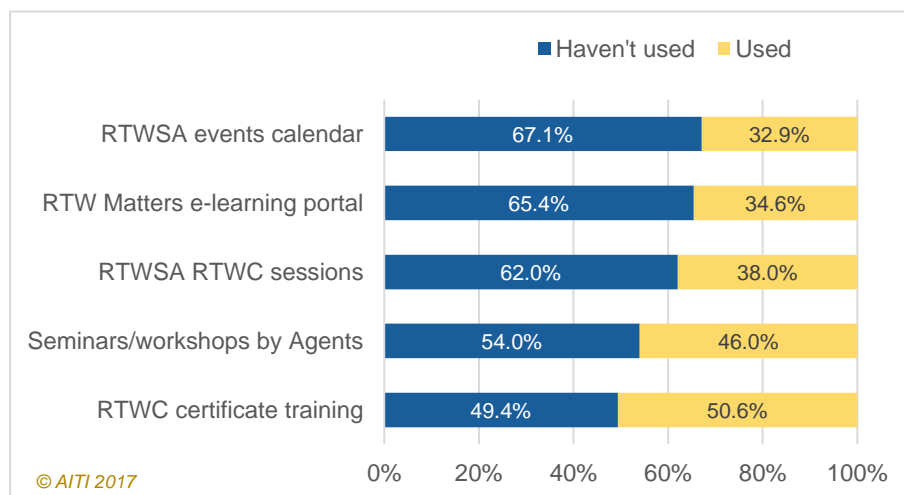
3.5 Additional training and support activities

3.5.1 Training activities

In 2016, a range of additional training²³ and support activities were available to Coordinators. These were usually delivered by RTWSA and were provided to ensure Coordinators were up-to-date with the legislative requirements of their roles and aware of the support available to them to fulfil their obligations to the organisation, employees (injured and otherwise), Agents and RTWSA.

In 2016, Coordinators were asked if they had used five specific training activities in the previous two years. Around half (50.6%) had attended RTW Certificate training with just under a half (46.0%) indicating they had attended seminars or workshops held by Agents (see Figure 25). RTWSA Coordinator sessions were less popular with 38.0% availing themselves of this training opportunity. Although the events calendar and RTW Matters e-learning portal are accessible from a computer, only one third (32.9% and 34.6%, respectively) reported using these.

Figure 25: Additional training activities used by Coordinators, 2016

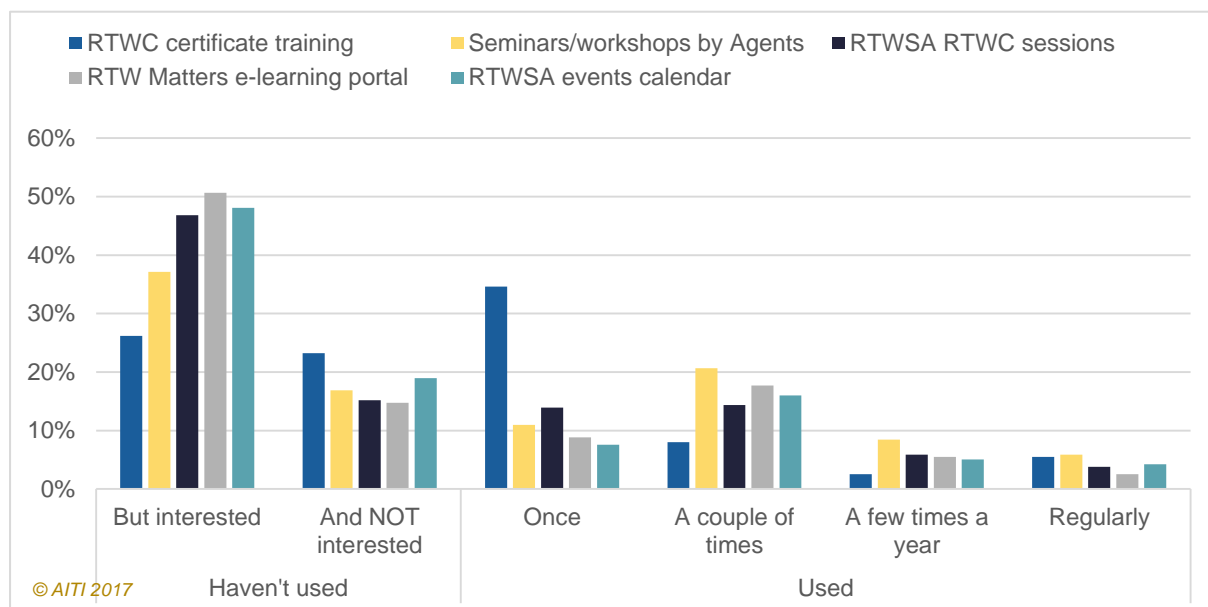


Note, question was not asked in 2010.

Unsurprisingly, most (34.6%) accessing Coordinator Certificate training used it once, while Coordinators accessing other training activities were more inclined to access them a couple of times (see Figure 26). Around 15-20% of Coordinators hadn't used and had no interest in any of the additional training activities. However, there was a significant proportion who hadn't used them to date, but were interested in doing so. This was most common for the RTW Matters e-learning portal (50.6%), RTWSA events calendar (48.1%) and RTWSA Coordinator sessions (46.8%).

²³ Activities referred to here exclude the required training discussed in Section 3.4.

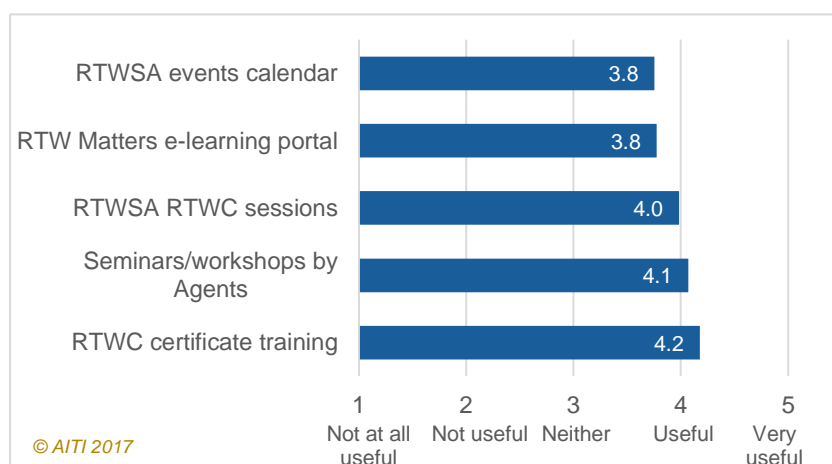
Figure 26: Regularity of additional training used by Coordinators, 2016



Note, question was not asked in 2010.

Coordinators accessing each training activity were asked to rate their usefulness (see Figure 27). Most useful in this category were Coordinator Certificate training (Mean=4.2), seminars or workshops delivered by Agents (Mean=4.1) and RTWSA Coordinator sessions (4.0). From Figure 28 it is evident that very few who accessed the training options felt they weren't useful, with around half indicating each of the training activities were 'useful', the difference usually lay in the proportions ranking the training as either 'very useful' or 'neither'.

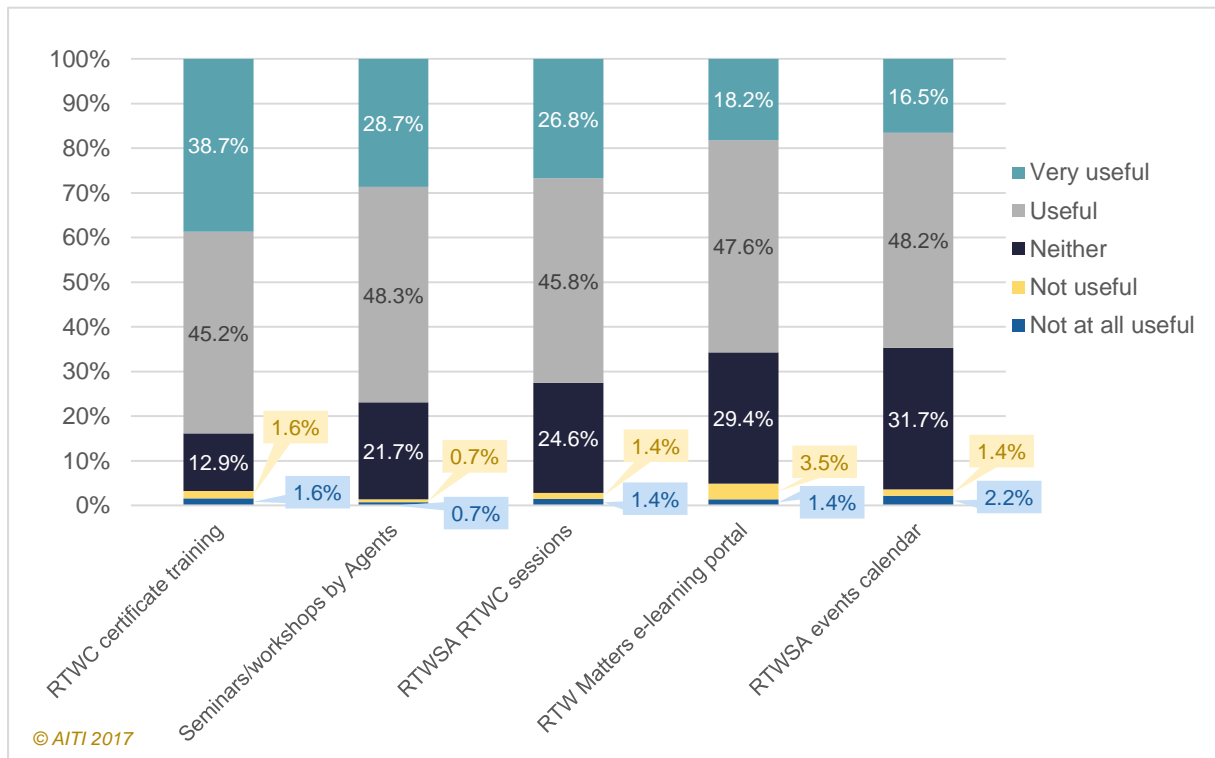
Figure 27: Additional training activities considered useful by Coordinators, 2016



Note, question was not asked in 2010.



Figure 28: Proportion consider additional training activities useful, 2016

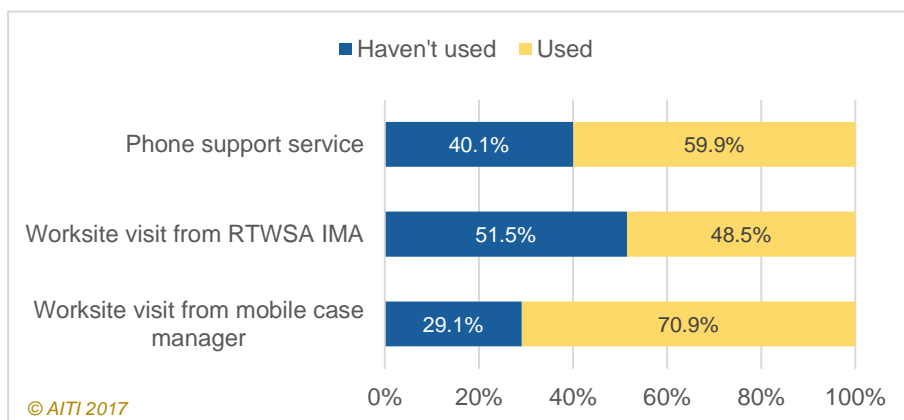


Note, question was not asked in 2010.

3.5.2 Support services

In addition to training, Coordinators were able to access support services involving one-on-one support and site visits from RTWSA and the Agents (see Figure 29). For those completing the 2016 survey, almost half (48.5%) reported they had received worksite visits from a RTWSA injury management advisor (IMA) when they needed assistance. Three in five (59.9%) had accessed phone support services, and approaching three quarters (70.9%) had received a worksite visit from a mobile case manager (MCM).

Figure 29: Support services used by Coordinators, 2016

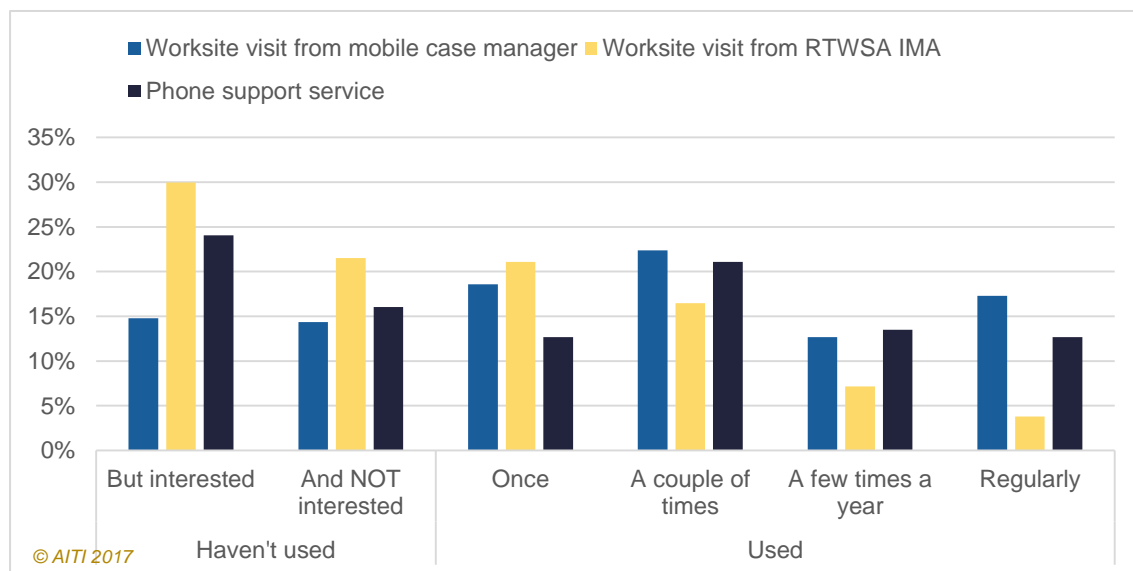


Note, question was not asked in 2010.

Three out of five Coordinators who had not currently received the service were open to RTWSA extending its IMA worksite visits to them, with a further 24.1% interested in the phone support

service (see Figure 30). Most Coordinators accessing support services had used them a couple of times. Not surprisingly Coordinators using mobile case managers two or more times assisted statistically more injured workers (Mean=15.3 workers compared with 5.0); and were involved with statistically more injury claims (Mean=12.7 claims compared with 4.3)²⁴. Similarly, Coordinators accessing IMA visits a couple of times also dealt with statistically more injured workers (Mean=15.0 workers compared with 8.7) and claims (Mean=13.2 claims compared with 7.0)²⁵. There was no difference on these measures with regard to phone support.

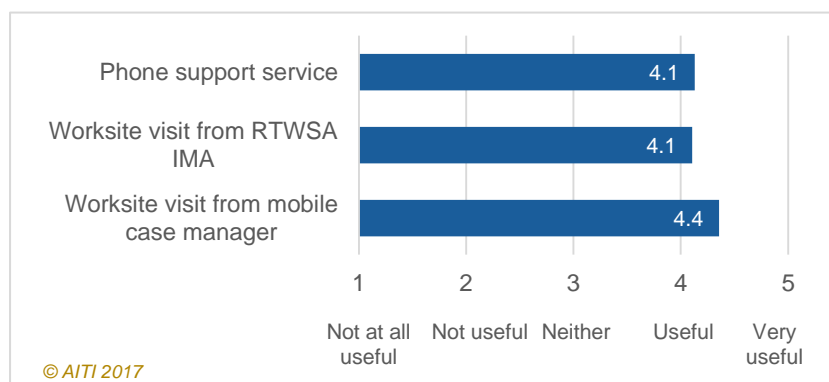
Figure 30: Regularity of support used by Coordinators, 2016



Note, question was not asked in 2010.

Perceptions about the support services accessed were very favourable, particularly with regard to worksite visits from MCMs (Mean=4.4; see Figure 31). This is also evident in Figure 32, with more than half of those receiving MCM visits reporting they were ‘very useful’.

Figure 31: Support activities considered useful by Coordinators, 2016



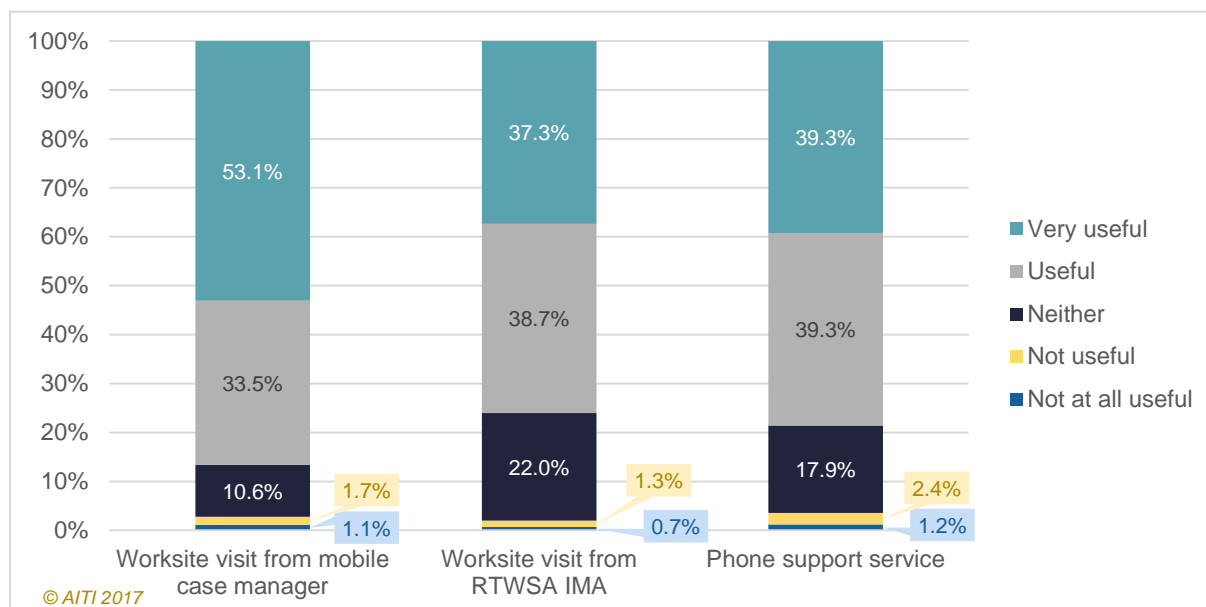
Note, question was not asked in 2010.

²⁴ t (207.4) = -5.2, p<.001; t (210.3) = -4.9, p<.001.

²⁵ t (235) = -2.7, p<.01; t (99.6) = -2.8, p<.01.



Figure 32: Proportion consider support activities useful, 2016

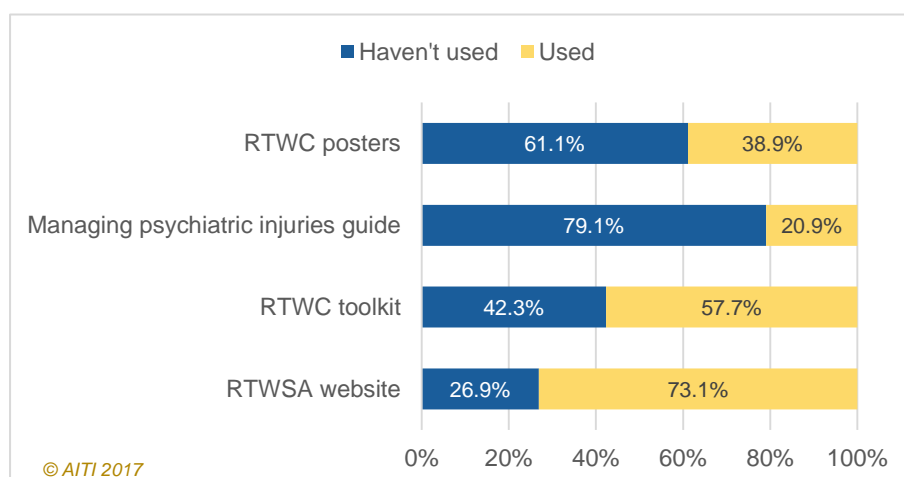


Note, question was not asked in 2010.

3.5.3 Tools

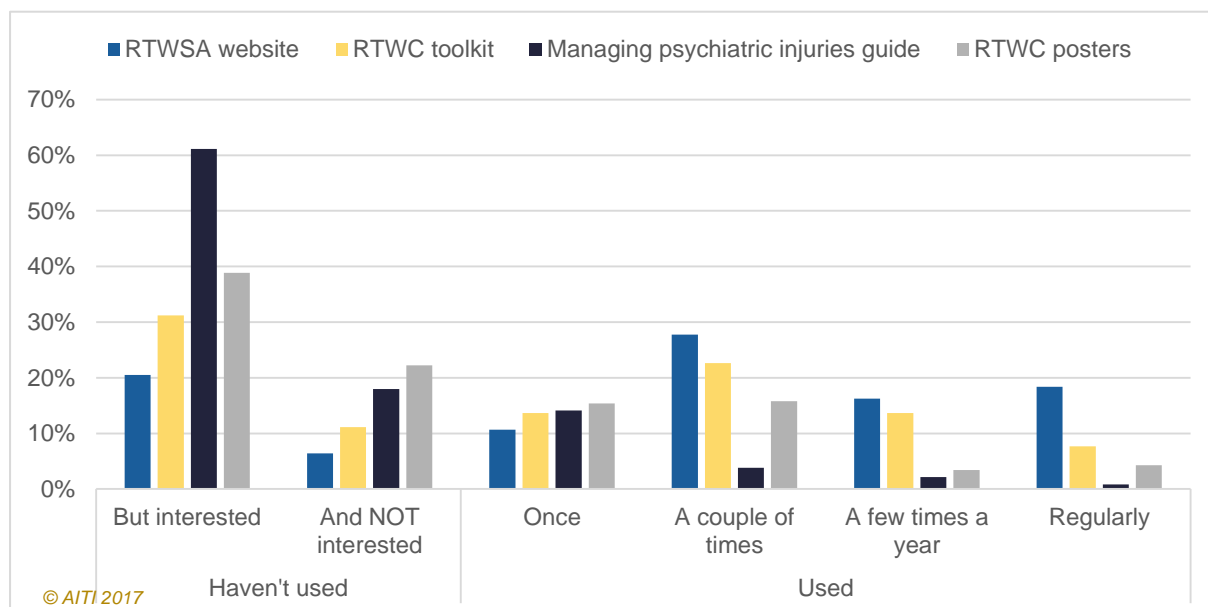
Tool use ranged from almost three quarters (73.1%) using the RTWSA website through to only one in five (20.9%) accessing the *Managing Psychiatric Injuries Guide* (see Figure 33) in 2016. However, there was considerable interest in using the *Managing Psychiatric Injuries Guide* and those not already accessing the Coordinator Toolkit and RTWSA website expressed an interest in doing so (see Figure 34). Not surprisingly, the website was used the most (85.4% used it a couple of times in the last two years). However, once accessed the toolkit proved popular with repeat use by most.

Figure 33: Tools used by Coordinators, 2016



Note, question was not asked in 2010.

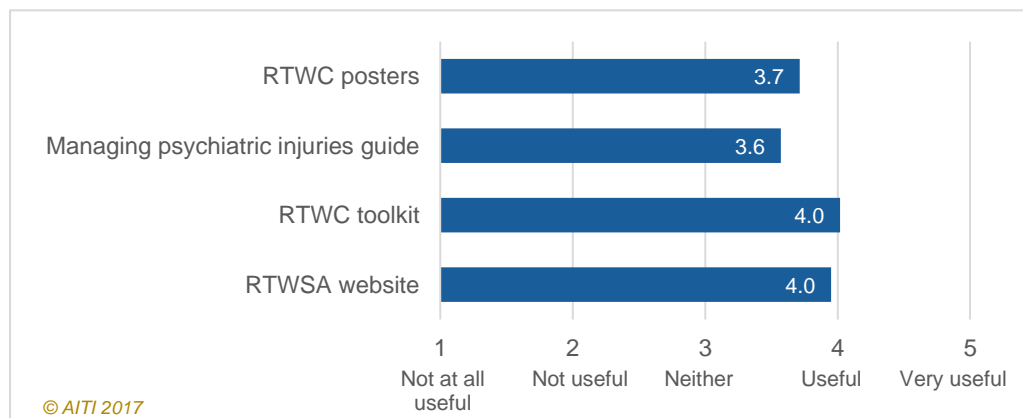
Figure 34: Regularity of tools used by Coordinators, 2016



Note, question was not asked in 2010.

The Coordinator Toolkit and RTWSA website were considered the most useful of the tools (see Figure 35), with over one quarter accessing the Toolkit considering it 'very useful' (see Figure 36). The *Managing Psychiatric Injuries Guide* rated poorly in comparison – however, almost half (45.6%) the Coordinators expressed ambivalence about its usefulness, which could stem from the fact that psychiatric injuries are not commonly encountered by Coordinators.

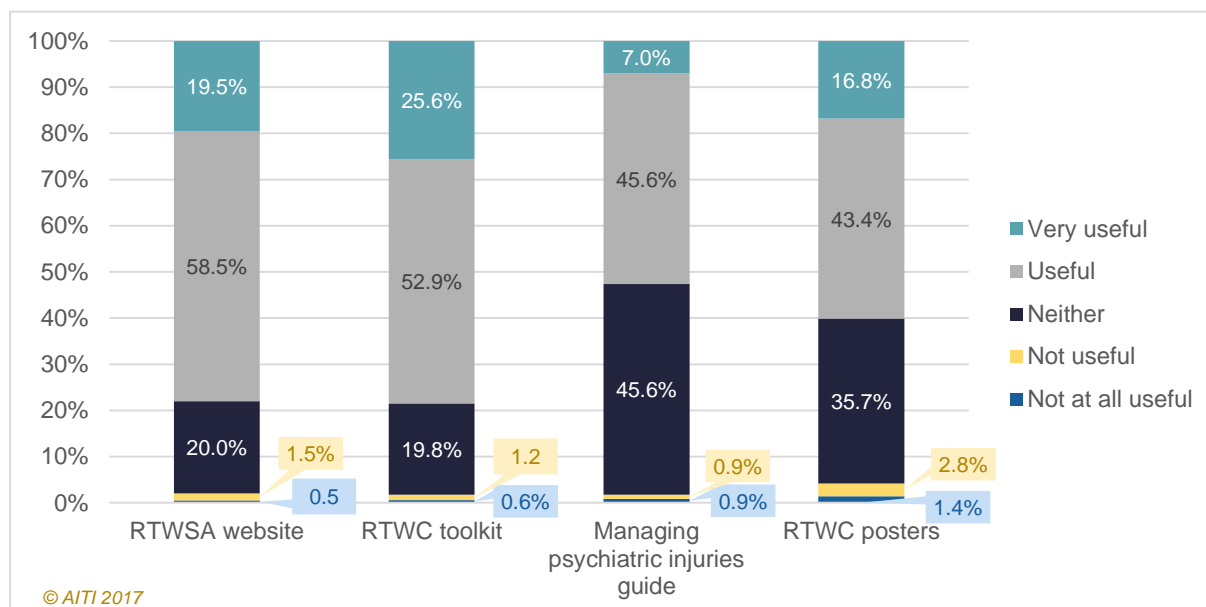
Figure 35: Tools considered useful by Coordinators, 2016



Note, question was not asked in 2010.



Figure 36: Proportion consider tools useful, 2016

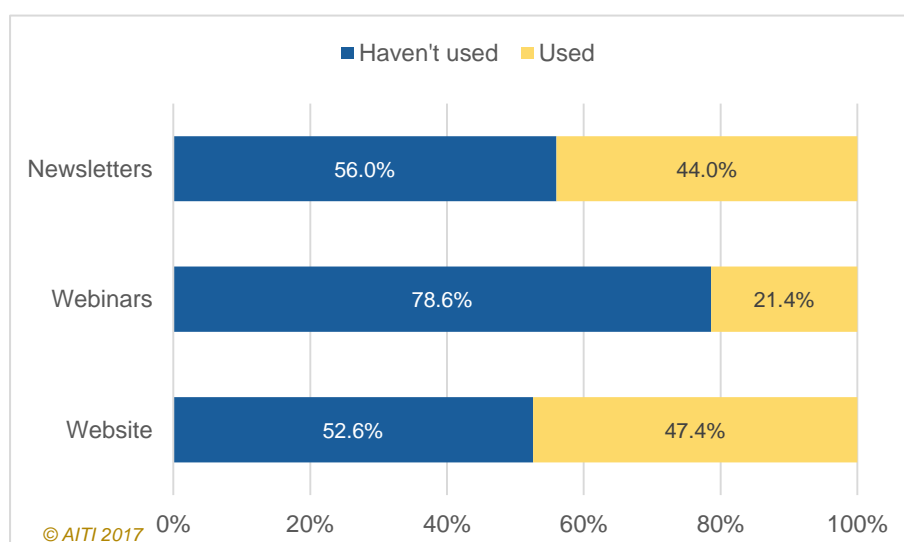


Note, question was not asked in 2010.

3.5.4 RTW Matters resources

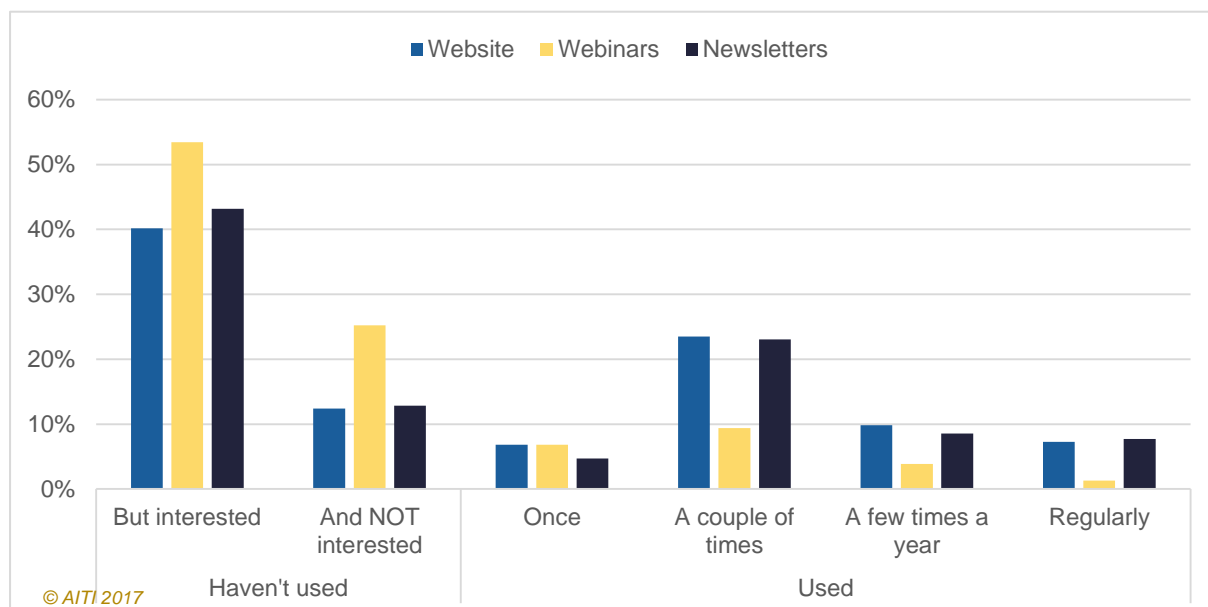
Coordinators have a range of RTW Matters resources available for their use. Of these resources half (47.4%) the Coordinators indicated they had accessed the online portal (see Figure 37) – with this resource providing them with access to relevant articles, blogs, handbooks, tools, templates and learning opportunities. One in five (21.4%) had accessed the webinars, while 44.0% accessed the newsletters. Of note, three quarters not currently accessing the website and newsletters are interested in doing so – with two thirds of those not partaking of webinars also interested (see Figure 38). Coordinators accessing the RTW Matters resources were most likely to have done so a couple of times.

Figure 37: RTW Matters resources used by Coordinators, 2016



Note, question was not asked in 2010.

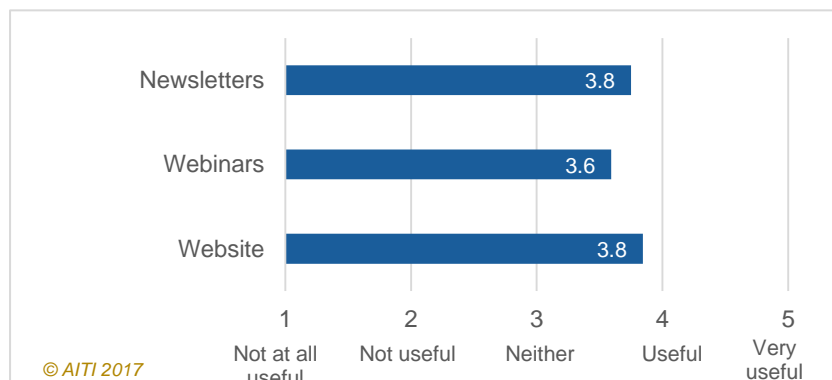
Figure 38: Regularity of other resources used by Coordinators, 2016



Note, question was not asked in 2010.

RTW Matters resources were considered amongst the least useful (see Figure 39). However, it should be noted that for these and the aforementioned training and support activities, very few indicated they were 'not useful' or 'not at all useful'. The main differential in those with lower usefulness ratings was that more Coordinators rated them 'neither' useful nor unuseful. This was the case for 45.0% of Coordinators accessing webinars (see Figure 40).

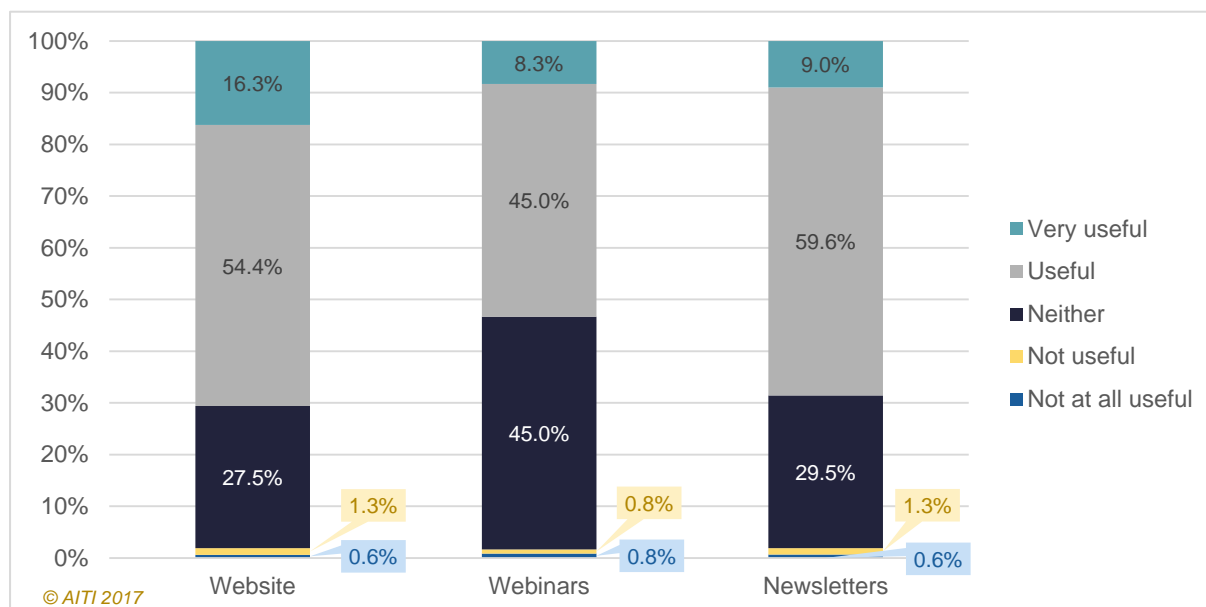
Figure 39: Other resources considered useful by Coordinators, 2016



Note, question was not asked in 2010.



Figure 40: Proportion consider other resources useful, 2016



Note, question was not asked in 2010.

3.5.5 Professional development activities

Coordinators were asked in the 2016 survey if other professional development activities would be useful for them to fulfil the requirements of their role (a few of these questions were asked in 2010).

Refresher training was viewed as useful by three in five (57.9%) Coordinators, making this the most selected item (see Figure 41). Two in five felt workshops with guest speakers (40.4%) and/or e-learning modules (42.1%) would be useful. Other professional development activities were seen as useful by fewer Coordinators – however, with one to two in five Coordinators seeing value in workshops with guest speakers (40.4%), structured programs run by training providers (31.9%), personalised guidance and support (25.5%) and webinars (23.8%), these are definitely worth exploring further.

Requests made here, for professional development opportunities may not acknowledge that these opportunities are already being delivered. For example, almost two thirds of those who sought webinars for professional development had not accessed them – although most had indicated an interest in using them. This points to a gap in knowledge and the potential benefit of promoting the availability of existing tools more broadly - acknowledging that promotion works best when well targeted.

In asking Coordinators about other professional development activities, there was some recognition that people can't always be trained for what's needed -

Each case differs, I don't believe you can train people for the unexpected way some claims go, its best to be on the front foot and control the claim from the start.

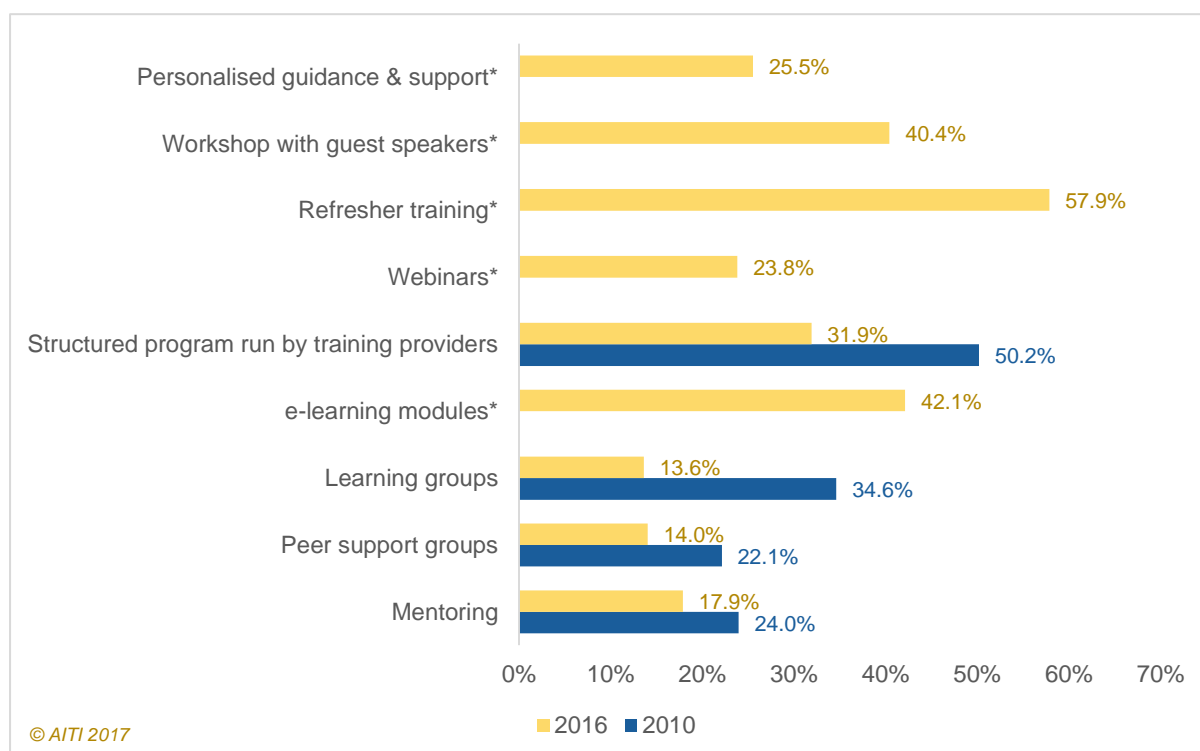
Some Coordinators indicated the currently available professional development activities were sufficient and they had limited capacity in an already busy job to partake further. Others called for access to refresher courses, with one suggesting this should be regular and mandated to ensure they were up to date with changes to their role.

Compulsory training for any changes that occur which effect RTW or WorkCover claims - even if held only 6 monthly or yearly

Mentoring, mentioned by almost one in five (17.9%) Coordinators, was seen as a valuable approach both internally within the business and externally through another organisation. Although recognising the need for any intensive activity it is likely to be limited to large organisations with a strong role required for injury management. One Coordinator suggested their role could be enhanced by:

Being assigned to a Rehab Provider as a mentor in the initial phase of a new RRTW Coordinator Role. I have found the Rehab Provider chosen to assist in a few claims invaluable to my learning and best outcomes for the employee and organisation.

Figure 41: Other useful professional development activities for Coordinators, 2010 & 2016



* Indicates question not asked in 2010. Note, multiple responses possible.

3.6 Barriers to RTW

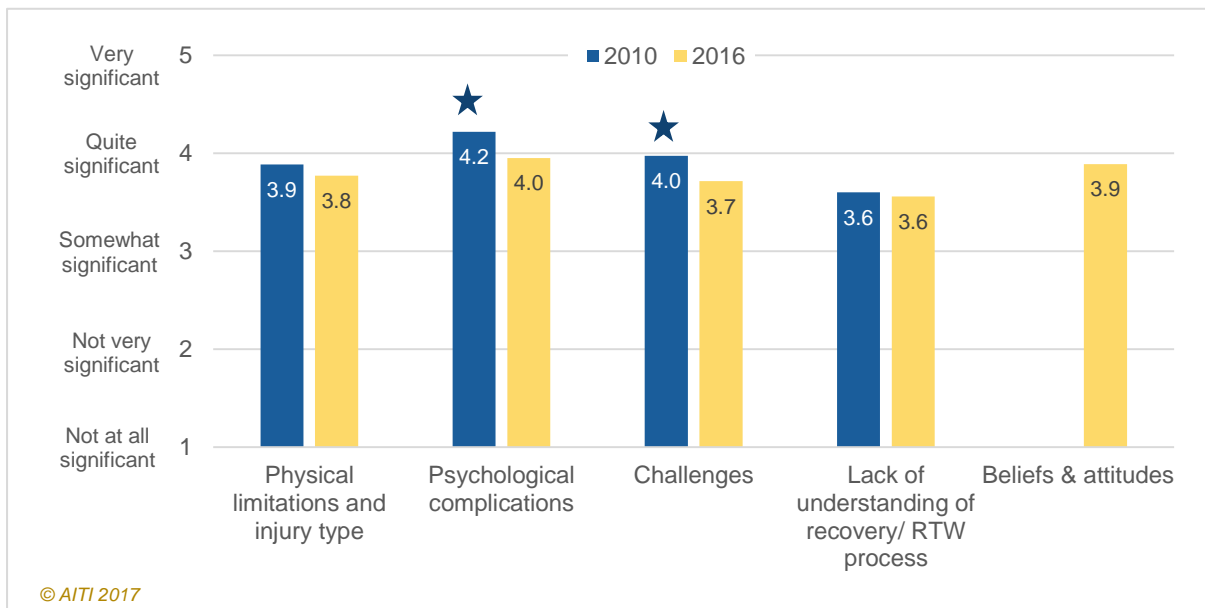
3.6.1 Personal barriers

Coordinators were asked about the significance of personal barriers for injured workers when returning to work. In 2016, on average, Coordinator responses ranged from a low of 3.6 relating to Coordinator experience regarding the significance of an injured worker’s lack of understanding of the recovery or return to work process (see Figure 42) through to a high of 4.0 relating to psychological complications (i.e. depression, anxiety) for the worker. Statistical differences between 2010 and 2016 were found, with Coordinators in 2010 more likely to report



psychological issues²⁶ and personal challenges²⁷ (i.e. fears, distress, frustrations, isolation, relationship problems) were barriers to return to work.

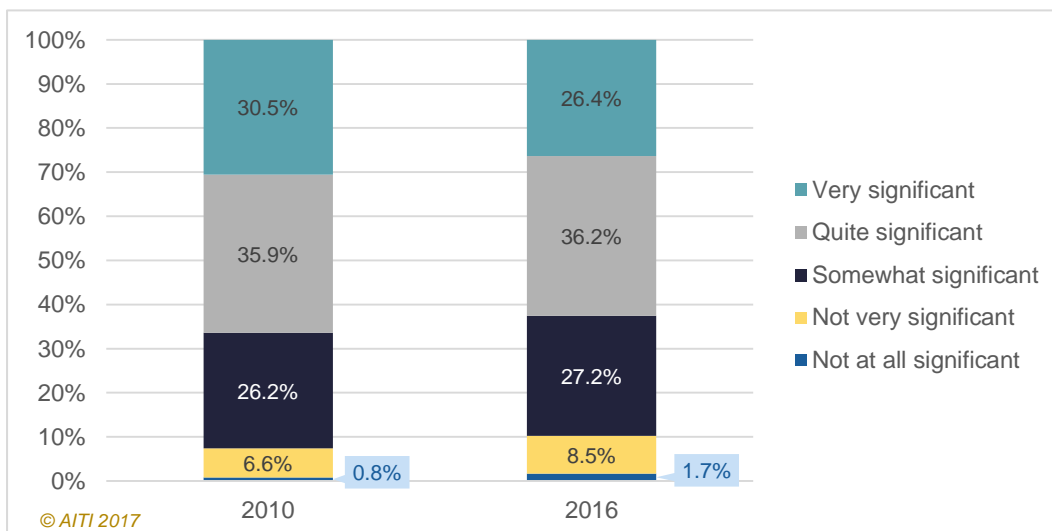
Figure 42: Significance of personal barriers for injured workers according to Coordinators, 2010 & 2016



★ Indicates statistical differences were found (with the colour denoting the group with the higher value).

Average perceptions about the role of physical limitations and the type of injury (e.g. medical or practical limitations) were not statistically different in 2010 and 2016 (see Figure 42). However, Figure 43 reveals a slight reduction in the proportion who reported this was ‘very significant’ with a corresponding slight increase in the proportion indicating this did not play a significant role.

Figure 43: Personal barriers: Physical limitations and injury type, 2010 & 2016



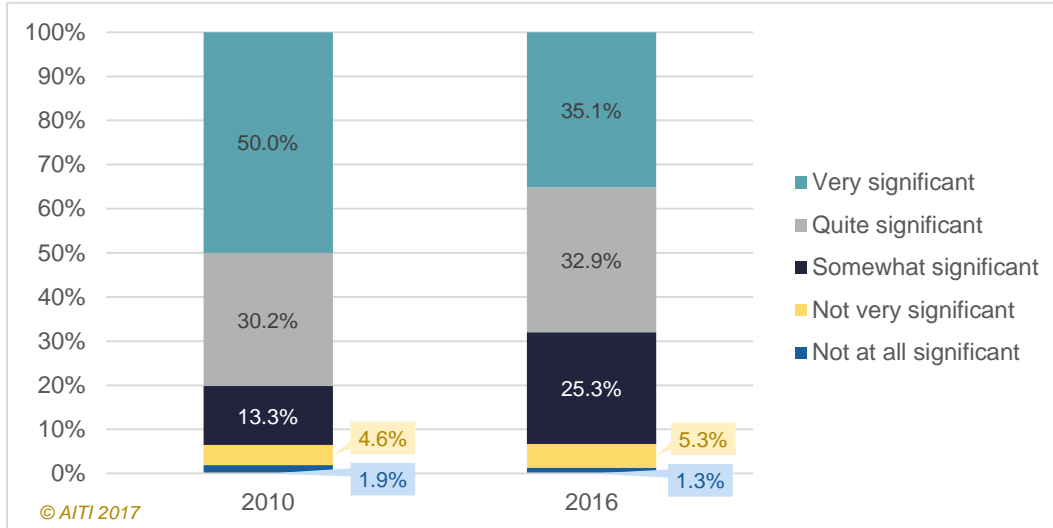
As mentioned, there was a statistical decline between 2010 (Mean=4.2) and 2016 (Mean=4.0) with regard to Coordinator perceptions about the role played by psychological complications for

²⁶ t (703) = 3.4, p=.001.

²⁷ t (709) = 3.3, p=.001.

the worker (i.e. depression, anxiety). Figure 44 shows the considerable variation in the way responses were distributed across the two time frames. In 2010, half (50.0%) the Coordinators reported psychological complications was a 'very significant' barrier to return to work, with just over one-third (35.1%) responding in this way in 2016.

Figure 44: Personal barriers: Psychological complications, 2010 & 2016



As identified in Figure 42, Coordinators in 2016 were statistically less likely to cite personal challenges such as fear, distress, frustrations, isolation and relationship problems as a barrier for injured workers getting back to work than Coordinators in 2010. This is further evident in Figure 45 which shows more than one-third (35.1%) of 2010 Coordinators believed challenges such as these were 'very' significant compared with less than one quarter (22.5%) in 2016. Most of this differential is now captured in the 'somewhat' significant category, which has increased in 2016. Around 10-11% reported personal challenges were not significant (at both times).

Figure 45: Personal barriers: Challenges, 2010 & 2016

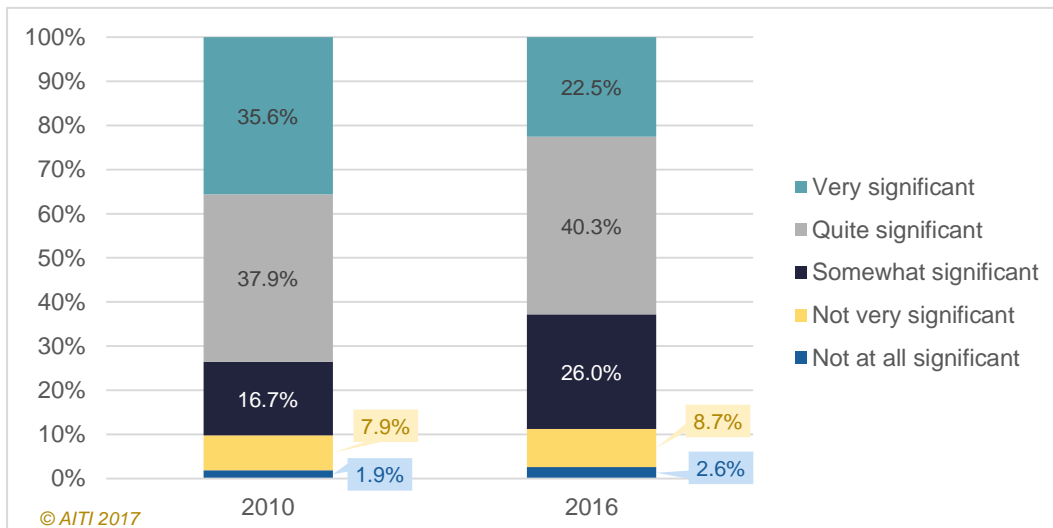
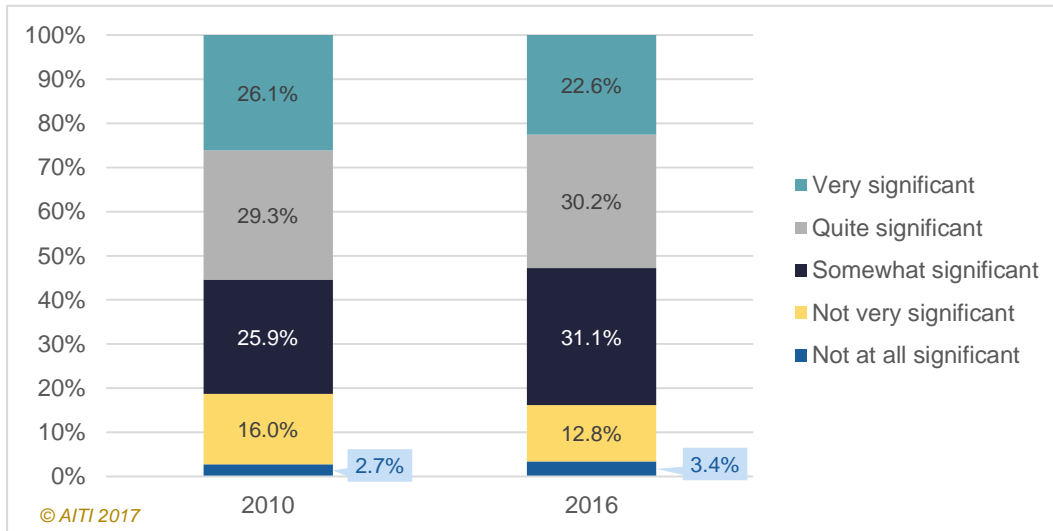


Figure 46 addresses Coordinators' perceptions about the barrier to RTW caused by a lack of understanding of recovery and the return to work processes. There was no statistical difference found between 2010 and 2016 survey recipients (see Figure 42), and with



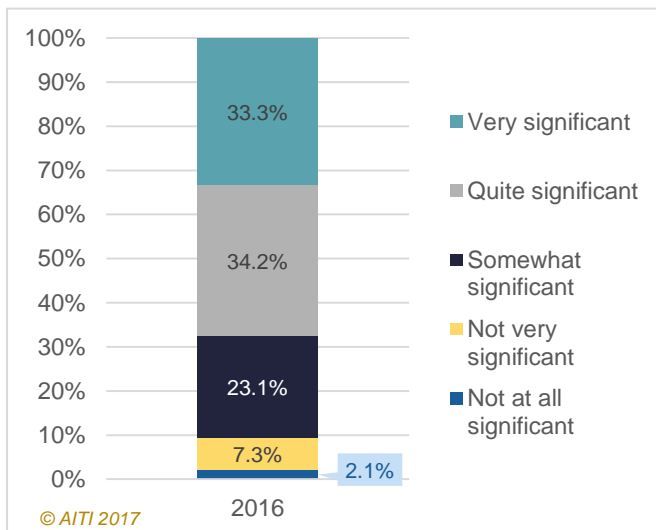
a Mean rating of 3.6 it was considered the least significant personal barrier impacting return to work outcomes.

Figure 46: Personal barriers: Lack of understanding of recovery/ RTW process, 2010 & 2016



Coordinators were asked about the impact of injured worker’s beliefs and attitudes, such as fear avoidance behaviour and attitude toward the workplace, for the first time in 2016 (see Figure 47). This was deemed to be ‘very’ significant by one-third (33.3%) of Coordinators and ‘quite’ significant by another third (34.2%). Again few felt it had limited significance.

Figure 47: Personal barriers: Beliefs and attitudes, 2016



Note, question not asked in 2010.

When asked to identify other personal barriers impeding a return to work outcome, a few Coordinators in 2016 responded with most of these citing the doctor acted as a barrier. Few specific details were provided of how they acted as a barrier in this context, however, in 2010 doctors were not viewed as having an understanding of the worker’s compensation system and did not seek information about how a work injury can be managed at work, for example -

Unwillingness of the medical profession to consult with employers prior to issuing restrictive or ‘unfit’ certificates. Few doctors have or attempt to have any knowledge of available suitable duties which will meet the restrictions of a workplace injury. There is no guideline in place to limit the

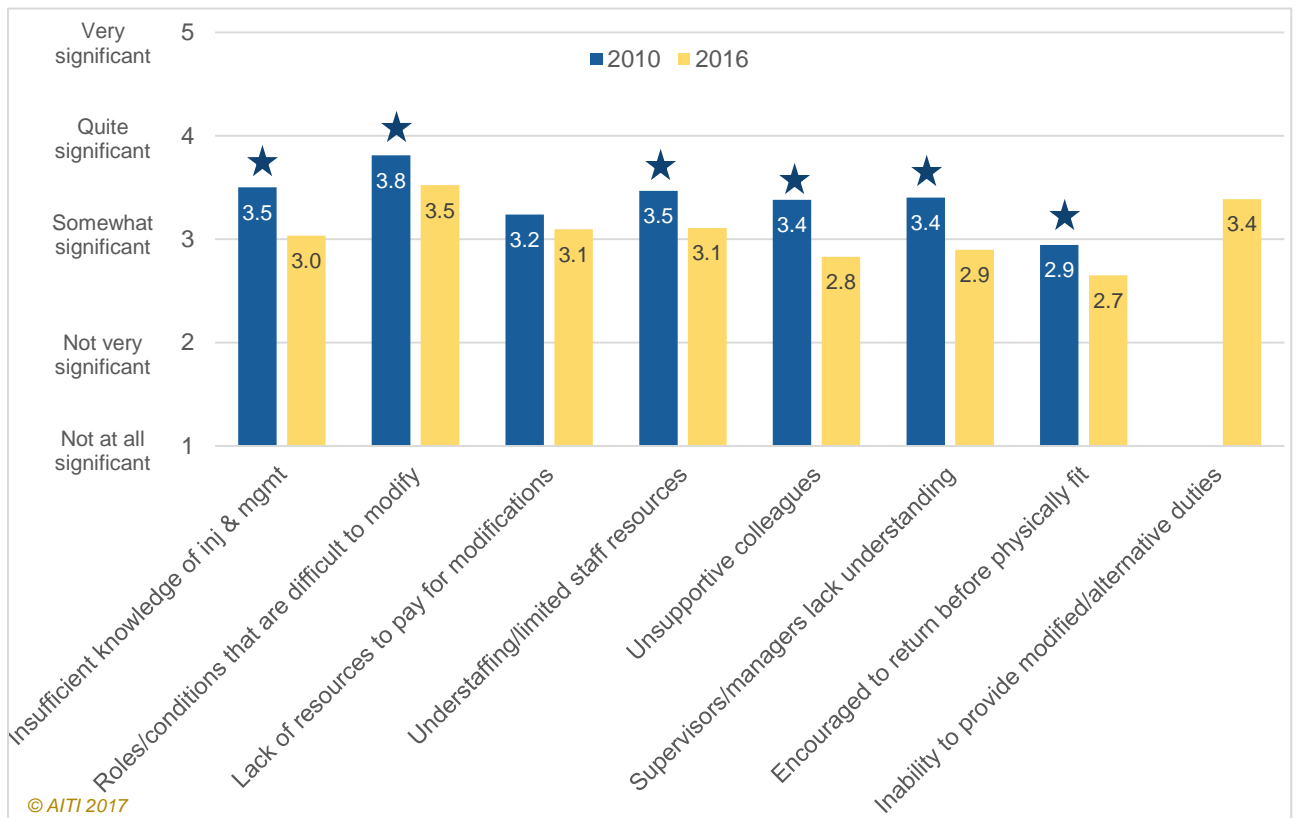
ability of a doctor to certify a worker off work for long periods despite a capacity to return to work on restricted duties without discussing alternatives with a RTW Coordinator or Rehabilitation Provider.

As we will see in future comments, these issues remained salient for 2016 Coordinators.

3.6.2 Workplace barriers

Workplace issues were considered to be more significant barriers by Coordinators in 2010 (compared to 2016) for six out of seven questions asked (see Figure 48). It is noteworthy that the specified workplace barriers were uniformly considered less significant than personal barriers (see Figure 42) – with the exception of responses to ‘work roles or conditions that are difficult to modify’ as answered in 2010.

Figure 48: Workplace barriers for injured workers according to Coordinators, 2010 & 2016



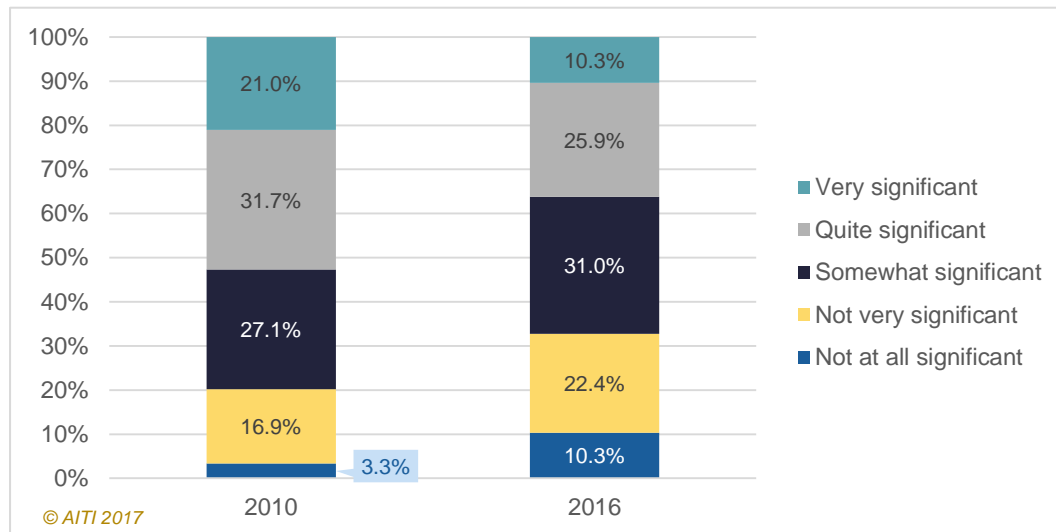
★ Indicates statistical differences were found (with the colour denoting the group with the higher value).

It is positive to note that Coordinators felt that insufficient knowledge of the injury and how to manage it in the workplace was statistically²⁸ lower in 2016 (Mean=3.0) than in 2010 (Mean=3.5, see Figure 48). Major changes related to a higher proportion of Coordinators who indicated this was ‘not at all’ or a ‘not very’ significant barrier in 2016 (10.3% and 22.4%, respectively, see Figure 49) compared to 2010 (3.3% and 16.9%, respectively). Correspondingly few 2016 Coordinators felt this was a very significant factor in 2016 (10.3%) compared with 21.0% in 2010.

²⁸ t (710) = 5.2, p<.001.

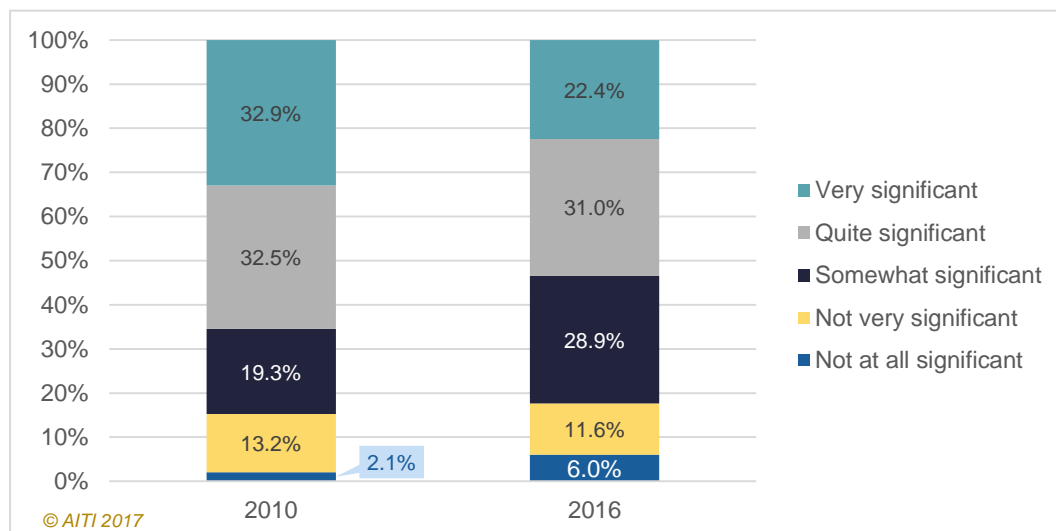


Figure 49: Workplace barriers: Insufficient knowledge of injury & management, 2010 & 2016



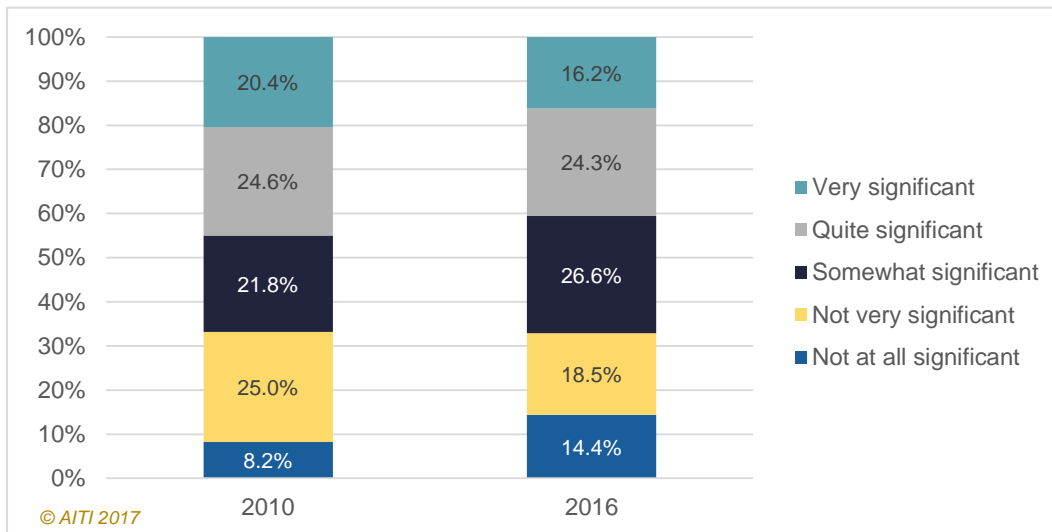
There was a statistical²⁹ decline in Coordinators' perceptions about the impact of work roles or conditions that are difficult to modify from 2010 (Mean=3.8) to 2016 (Mean=3.5) – although this remained the highest workplace barrier (see Figure 50). This is a positive finding as it suggests organisations are getting better at innovative solutions to work injury and/or they are improving the way they support their workers. There was no statistical difference between the years with regard to perceptions that there was a lack of resources to pay for workplace modifications, with mean responses between 3.1 and 3.2 (see Figure 51).

Figure 50: Workplace barriers: Roles/ conditions that are difficult to modify, 2010 & 2016



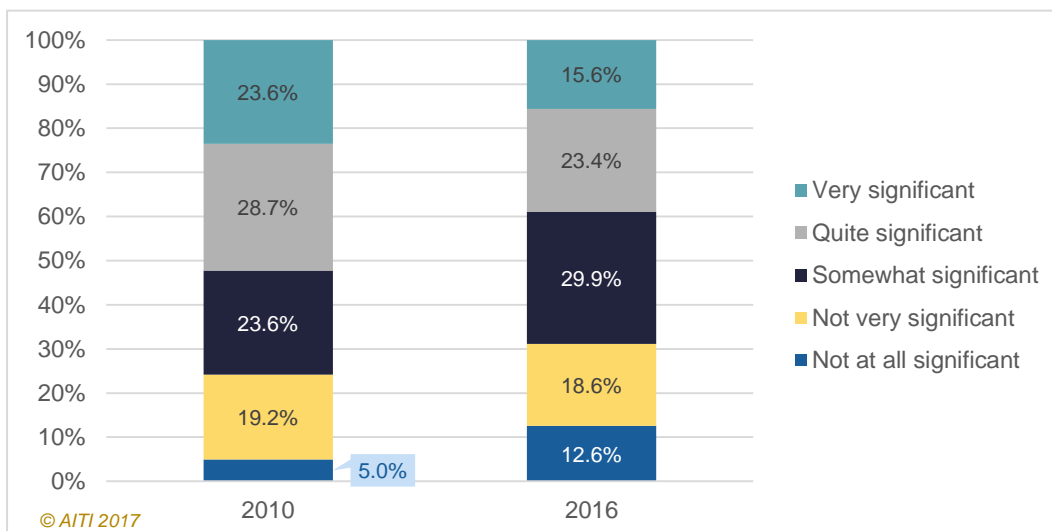
²⁹ $t(716) = 3.3, p = .001$.

Figure 51: Workplace barriers: Lack of resources to pay for modifications, 2010 & 2016



A statistical³⁰ difference was evident between the years with regard to the belief that understaffing or limited staff resources formed a barrier to return to work with 2010 Coordinators (Mean=3.5) believing this was a bigger issue than 2016 Coordinators (Mean=3.1, see Figure 48). The most apparent change being a reduction in those considering it was a 'very significant' barrier in 2016 and a corresponding increase in those who felt it was 'not at all significant' (see Figure 52).

Figure 52: Workplace barriers: Understaffing/limited staff resources, 2010 & 2016



Unsupportive colleagues of the injured worker were statistically³¹ more likely to be deemed a barrier in 2010 (Mean=3.4) compared with 2016 (Mean=2.8, see Figure 48) with almost half of

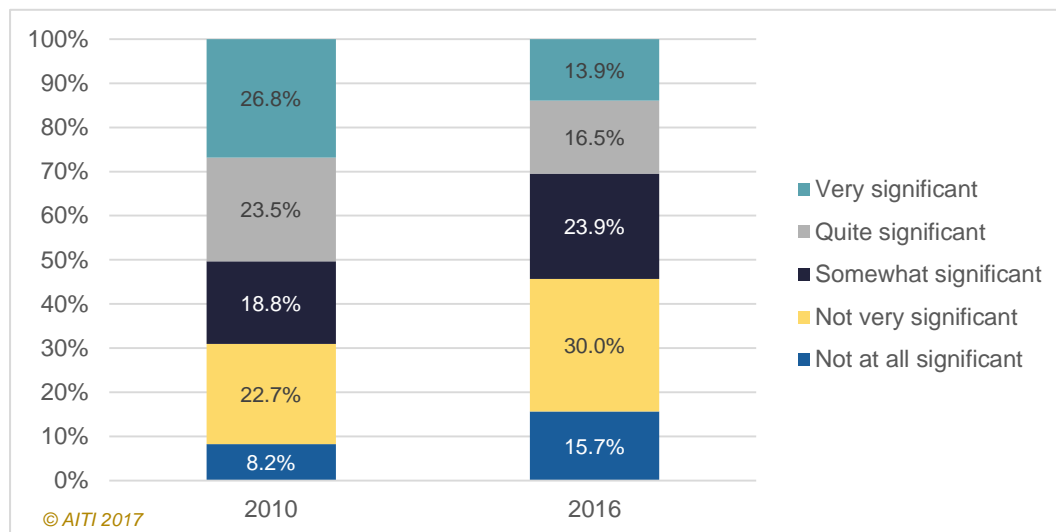
³⁰ t (713) = 3.7, p<.001.

³¹ t (713) = 5.3, p<.001.



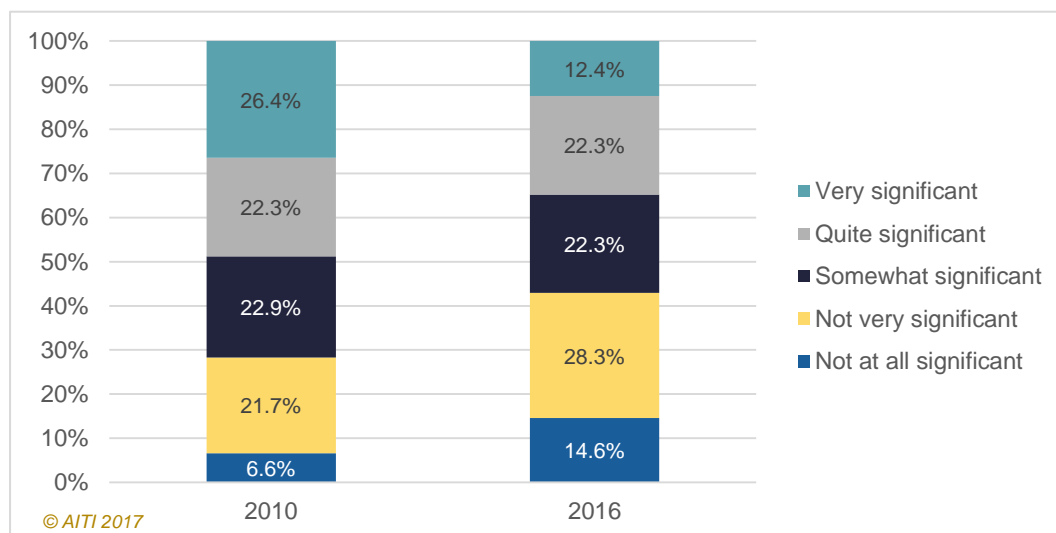
Coordinators reporting that unsupportive colleagues were not a significant barrier (see Figure 53). This is a positive finding as it points to an increased organisational awareness of processes around injured workers which is filtering down to all staff.

Figure 53: Workplace barriers: Unsupportive colleague, 2010 & 2016



There was a similar statistical³² decline from 2010 (Mean=3.4) to 2016 (Mean=2.9) in Coordinator perceptions regarding lack of understanding about return to work by supervisors and managers as a barrier for people returning to work (see Figure 48). In this case, only 34.7% of 2016 Coordinators felt it was a 'quite' or 'very' significant factor, compared with 48.7% in 2010 (see Figure 54).

Figure 54: Workplace barriers: Supervisors/ managers lack understanding, 2010 & 2016



Coordinators in 2010 (Mean=2.9) were statistically³³ more likely to consider workers being encouraged to return to work before they were physically able as a workplace barrier, than those in 2016 (Mean=2.7, see Figure 48). More than half the 2016 Coordinators felt this was either 'not

³² t (715) = 5.0, p<.001.

³³ t (711) = 2.7, p<.01.

very' or 'not at all' a barrier (see Figure 55), with this rating lower than all other workplace barriers. The inability of the workplace to provide modified or alternative duties was first asked in 2016 –with a mean rating of 3.4 (see Figure 48). Just under one quarter of Coordinators considered it was 'somewhat' significant (23.7%), a similar proportion reported it was 'quite' significant (24.1%) while just over a quarter felt it was a 'very' significant barrier to return to work (see Figure 56).

Figure 55: Workplace barriers: Encouraged to return before physically able, 2010 & 2016

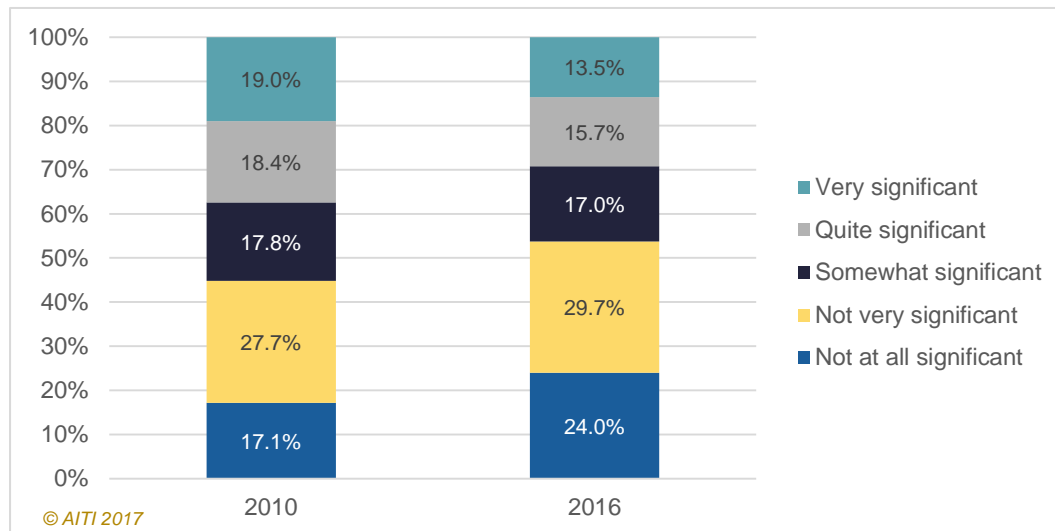
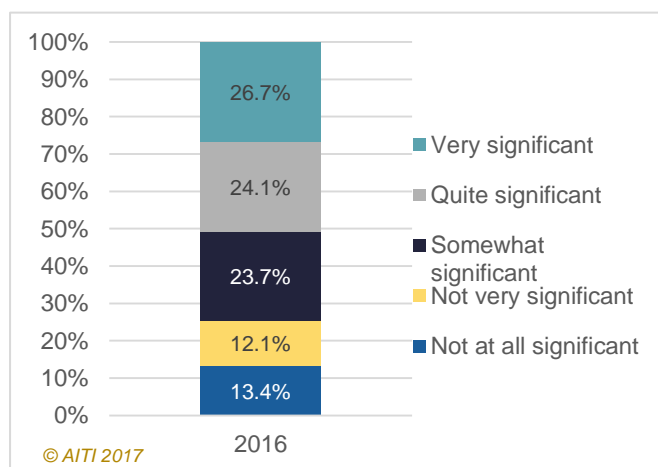


Figure 56: Workplace barriers: Inability to provide modified/alternative duties, 2016



Note, question not asked in 2010.

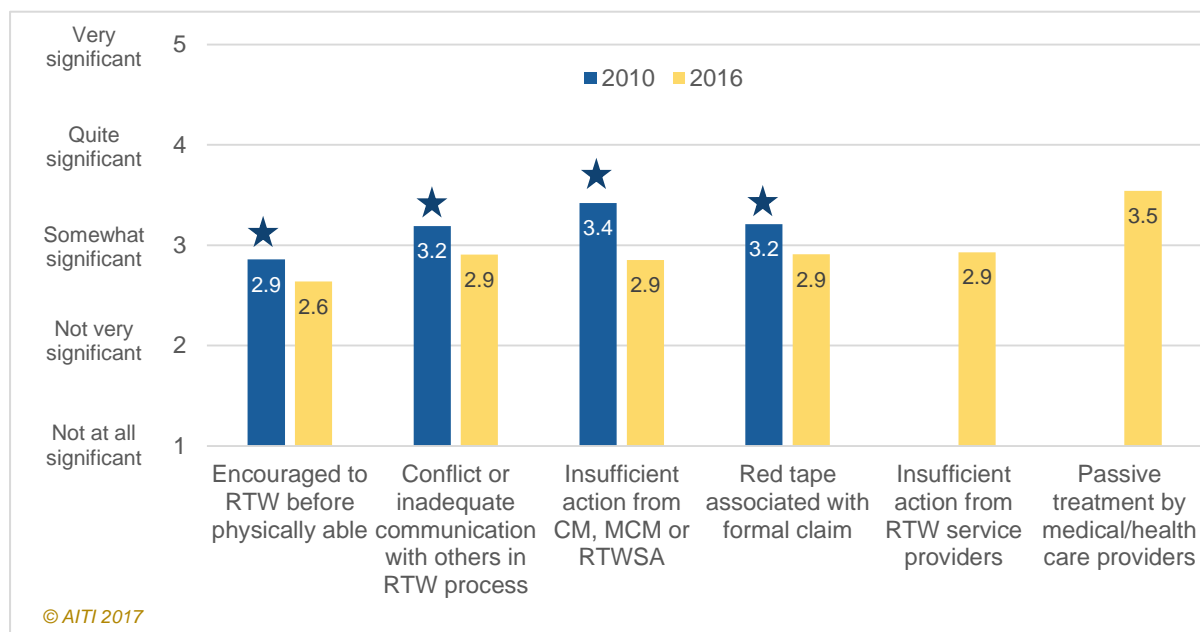
Five Coordinators responded to a question asking to identify other significant barriers with four of these indicating the doctor was the biggest barrier.

3.6.3 RTW Process barriers

Coordinators in 2016 were also less likely to perceive RTW process factors as barriers in returning to work than those in 2010, with statistical differences found for the four factors assessed at both times (see Figure 57) and discussed further on.



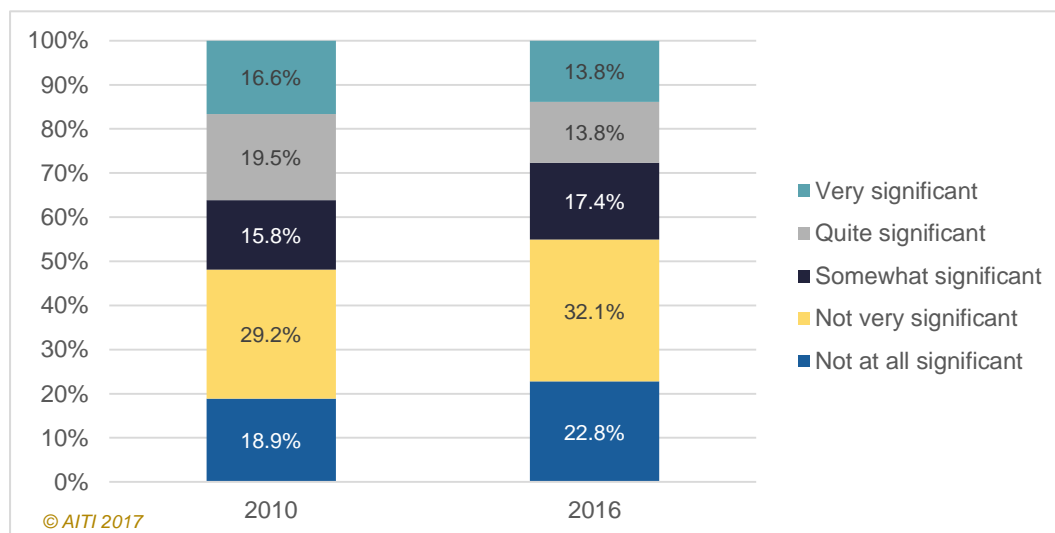
Figure 57: RTW process barriers, 2010 & 2016



★ Indicates statistical differences were found (with the colour denoting the group with the higher value).

There was a statistical³⁴ reduction in the level to which 2016 Coordinators (Mean=2.6) believed there was a process barrier to RTW due to workers being encouraged to RTW before they were physically able when compared to 2010 Coordinators (Mean=2.9, see Figure 57). This is most evident in a reduction in perception that this was ‘very’ or ‘quite’ significant (see Figure 58).

Figure 58: RTW process barriers: Encouraged to RTW before physically able, 2010 & 2016



Note, in 2010 the response option referred to “‘Pressured to RTW...”

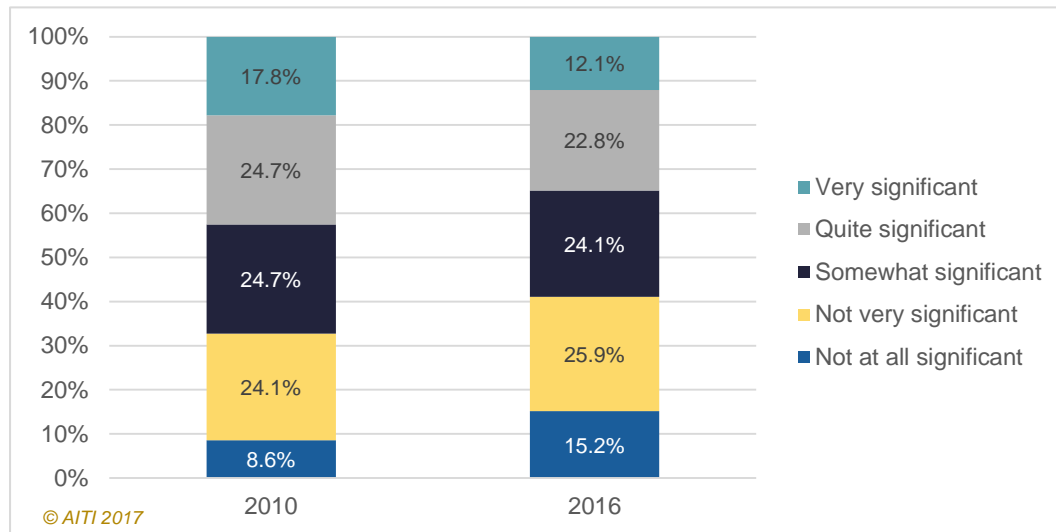
Perceptions about barriers caused through conflict or inadequate communication with others engaged in the RTW process was statistically³⁵ reduced from 2010 (Mean=3.2) to 2016 (Mean 2.9, see Figure 57). In this case there was a 6.6 percentage point increase in Coordinators who

³⁴ t (698) = 2.0, p<.05.

³⁵ t (699) = 2.8, p<.01.

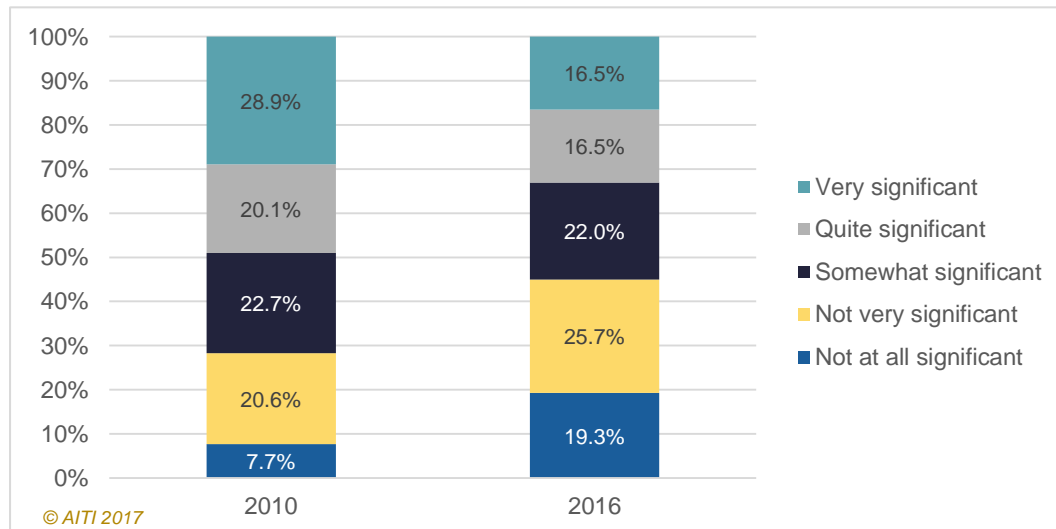
reported this was 'not at all' significant and a 5.7 percentage point reduction in the number of Coordinators who felt it was 'very' significant (see Figure 59).

Figure 59: RTW process barriers: Conflict or inadequate communication with others in RTW process, 2010 & 2016



The statistical difference³⁶ was greatest between 2010 (Mean=3.4) and 2016 (Mean=2.9) for Coordinators who felt insufficient management from claims managers (CMs), mobile case managers (MCMs) or RTWSA (see Figure 57) was a barrier. For these ratings, there was a 11.6 percentage point increase in the number of Coordinators who thought this was 'not at all' significant, with an addition of 5.1% of Coordinators reporting this as 'not very' significant, in effect reducing those who felt it was quite or very significant from one half in 2010 to one-third in 2016 (see Figure 60).

Figure 60: RTW process barriers: Insufficient action from CM, MCM or RTWSA, 2010 & 2016

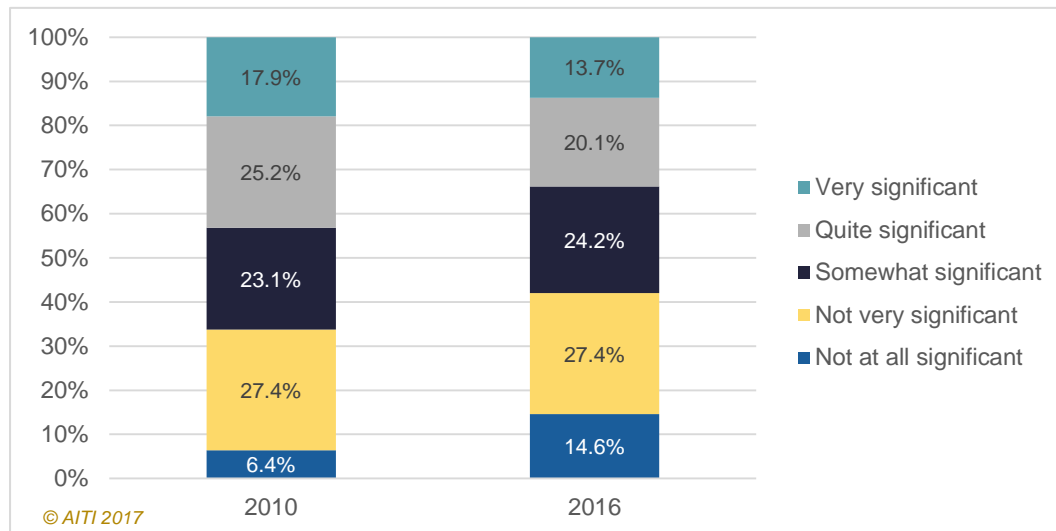


³⁶ t (683) = 5.2, p<.001.



Perceptions about the role that red tape and paper work associated with a formal claim play as a barrier to RTW have statistically reduced over time from a mean of 3.2 in 2010 to 2.9 in 2016 (see Figure 57). Specifically, there was an increase in the proportion of Coordinators who felt red tape was not a significant barrier at all (see Figure 61).

Figure 61: RTW process barriers: Red tape associated with formal claim, 2010 & 2016



Finally in 2016, Coordinators were asked to indicate if insufficient action from RTW service providers (see Figure 62) or if passive treatment by medical/ health care professionals (see Figure 63) were barriers to RTW. Responses with regard to insufficient action from service providers (Mean=2.9) aligned fairly consistently with other RTW process factors. However, passive treatment by health professionals (Mean=3.5) was an outlier in this category – more than half (54.0%) reported this was a ‘quite’ or ‘very’ significant barrier, reflecting the comments pointing to doctors when asked to identify other significant personal or workforce barriers, and reiterated with regard to other RTW process barriers.

Figure 62: RTW process barriers: Insufficient action from RTW service providers, 2016

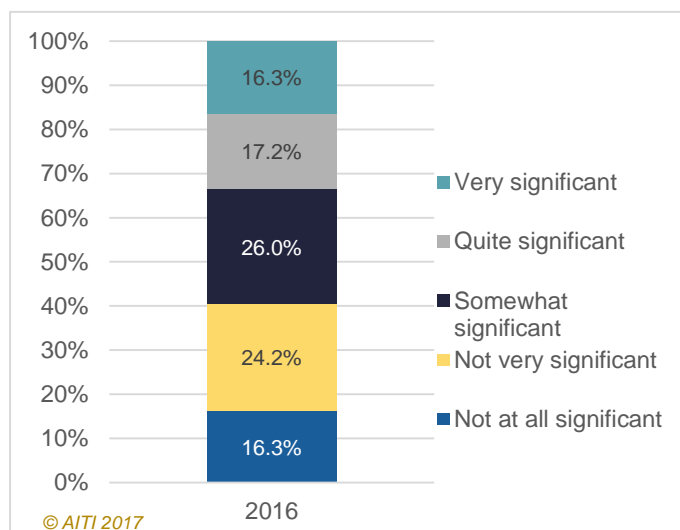
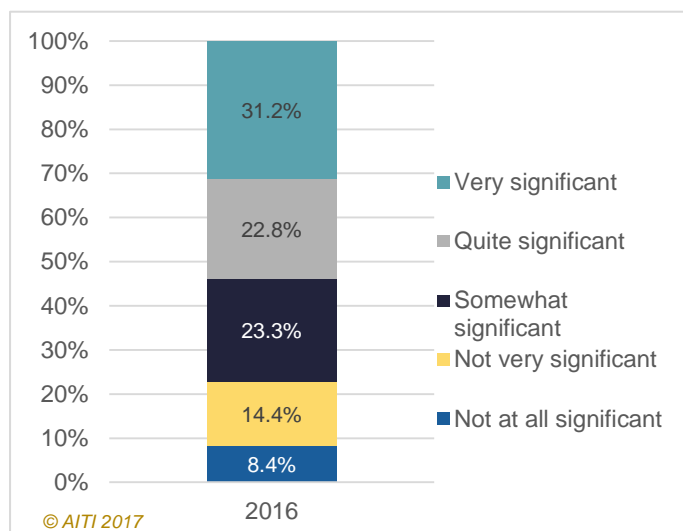


Figure 63: RTW process barriers: Passive treatment by medical/ health care providers, 2016



3.6.4 Comments

Fifty-nine Coordinators in 2016 took the opportunity to provide additional insight into the barriers they experienced and how they were able to manage them. All verbatim responses are provided in Appendix A:, with a summary of key comments below.

Doctors and other health professionals continue to be identified as significant barriers to RTW. They are seen by some as being on the side of the worker and somewhat obstructive in this role - and lacking in a real understanding of the workers compensation system or the value of RTW for the injured worker, for example:

A number of doctors in my experience just 'mail it in' and do not in any way assist the workplace to understand and accommodate the employee's needs. They are often unresponsive to phone calls and emails, and when you do manage to get them, they are uninterested and dismissive.

There were mixed responses with regard to the role played by the agents and claims managers. However, mobile case managers were seen to be an improvement both in liaising with the workplace and with others involved with the injured worker:

The vast majority of my experience with RTW service providers in last 2 years (mainly at my previous workplace) has been extremely positive. The change in legislation and structure of service provision has been fantastic. Mobile case managers make a huge difference to the worker and also to me as a RTW coordinator in reducing my workload and need to attend as many GP visits. At times there may be barriers with GPs or health providers in getting clarity on treatment plans or support with moving the worker forward in their return to work but this is very rare.

One Coordinator summed up the comments and perspectives of many recognising there are many significant factors at play which delay RTW outcomes. However acknowledging it is important that all those involved in a claim work together professionally to achieve the desired outcome:

All of the above prove to be significant factors and barriers whilst trying to facilitate a RTW. The most significant would be time frames from the medicos and/or treating allied health and at times from the claims agent as they seem to hinder progress which can impact on recovery outcomes. But all of the above play some part in coordinating the rehabilitation and RTW. In my experience if the injured worker is also managed in a reasonable manner and with a professional approach the outcome is not only achieved quickly but without too many of the

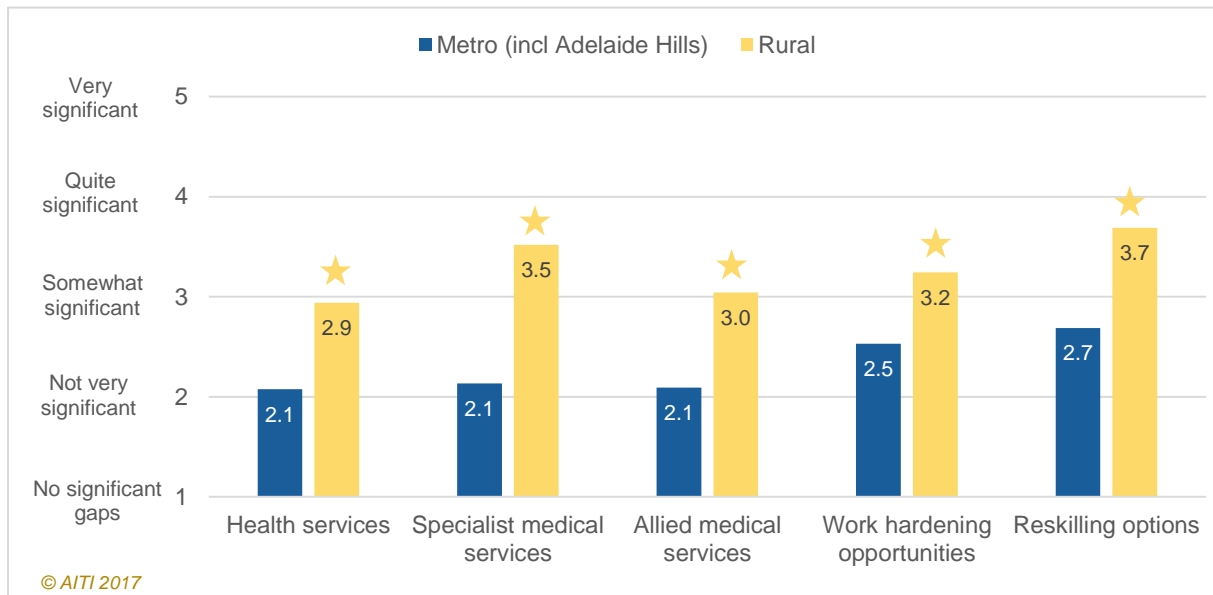


abovementioned barriers causing impact and undue delay. Attitude of the workplace, claims agent and the RTW coordinator to be non-judgemental also assists the injury party to achieve a positive recovery. The model for RTW is multi-faceted and if failure occurs in any area it can create angst and subject all parties to ongoing issues that impede progress. All in all everyone has to be working professionally and in harmony towards the same goal

3.7 Regional service and support gaps

Coordinators in rural regions were statistically more likely to experience service gaps for injured workers thereby limiting their ability to function in the role when compared with Coordinators in metropolitan regions (see Figure 64). Metropolitan areas tended to report limited impact from health, specialist and allied services, rating them as not very significant issues (Mean=2.1). In comparison, rural areas rated health (Mean=2.9) and allied medical services (Mean=3.0)³⁷ as 'somewhat' significant, and gaps in accessing specialist medical services as more problematic (Mean=3.5).³⁸ Opportunities for work hardening in metropolitan areas was rated 2.5, statistically lower than rural areas (Mean=3.2)³⁹ as were reskilling options (Mean=2.7 & 3.7, respectively).⁴⁰

Figure 64: Injured worker service gaps in region impacting Coordinator function, metropolitan & rural, 2016



Note, question was not asked in 2010.

* Indicates statistical differences were found (with the colour denoting the group with the higher value).

Even with low responses from rural areas, it is clear the further from Adelaide the more problematic and entrenched are some of these issues. Notably, Kangaroo Island and Barossa Light and Lower North rated their responses more aligned with metropolitan areas than their rural counterparts. Eyre Western, Far North, Limestone Coast, Murray Mallee and Yorke Mid North indicated quite significant gaps for reskilling options for injured workers were a quite significant gap. With the exception of Murray Mallee, these rural regions reported a similarly problematic gap in their access to specialist medical services. Coordinators in the Far North and Limestone Coast were the only regions reporting difficulties with accessing health services, with Far North

³⁷ t (207) = -4.3, p<.001 and t (198) = -4.5, p<.001, respectively.

³⁸ t (205) = -6.6, p<.001.

³⁹ t (118) = -3.1, p<.01.

⁴⁰ t (190) = -4.2, p<.001.

citing similar issues with accessing allied health services - the only region citing large gaps in all three health related services. Eyre Western and Yorke Mid North also cited gaps in being able to access work hardening opportunities.

Table 1: Injured worker service gaps in region impacting on Coordinator function by region, 2016

	N	Health services	Specialist medical services	Allied health services	Work hardening opportunities	Reskilling options
Eastern Adelaide*	108	2.1	2.3	2.1	2.5	2.7
Northern Adelaide	59	1.8	1.9	1.9	2.1	2.1
Southern Adelaide	35	2.4	2.4	2.5	2.8	2.9
Western Adelaide	51	2.0	1.9	2.0	2.8	3.0
Adelaide Hills	10	2.3	2.3	1.8	3.0	3.2
Barossa Light and Lower North	13	1.9	2.4	2.4	2.9	3.2
Fleurieu Kangaroo Island	3	2.0	3.0	2.0	1.0	2.5
Eyre Western	6	2.7	3.7	3.3	3.6	3.8
Far North	5	3.8	4.0	3.7	3.3	3.8
Limestone Coast	19	3.6	3.9	3.4	3.4	3.8
Murray Mallee	10	2.8	3.3	3.0	3.0	3.7
Yorke Mid North	9	3.1	4.0	2.9	3.6	4.2

Note, question was not asked in 2010.

* Eastern Adelaide includes Adelaide and North Adelaide.

Highlighted cells denote where gaps were rated at more than 3.5 indicating a 'somewhat' to 'quite' significant gap or higher.

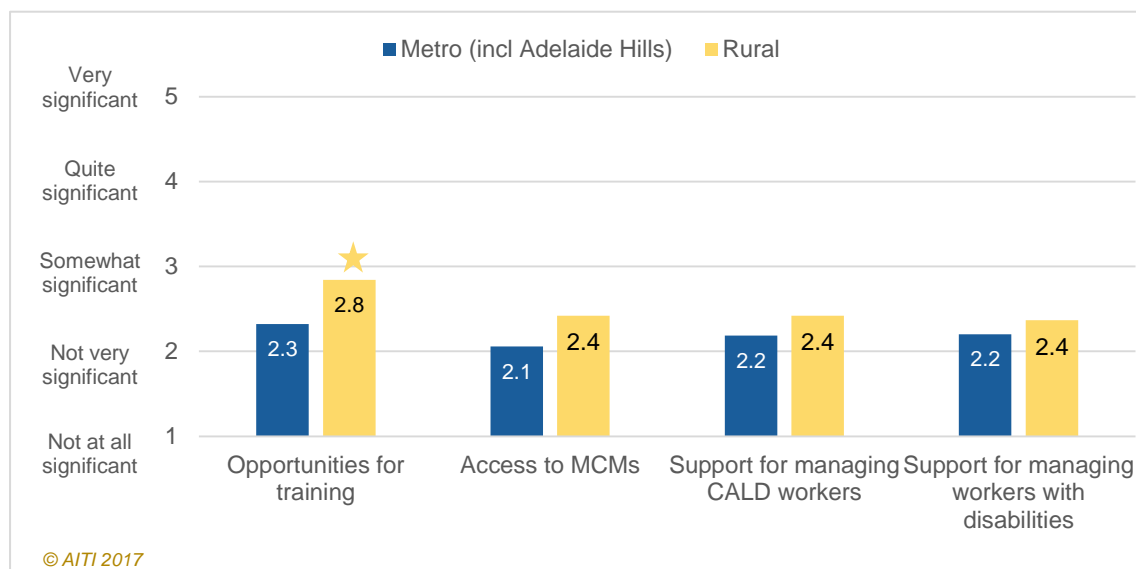
Coordinators were also asked to indicate whether they experienced difficulties accessing the supports they required for themselves to perform their role (see Figure 65). Responses from metropolitan areas reported a similar quantum (i.e. 'not very' significant) as those responses provided for gaps relating to injured workers, above. However, in this case the only statistically higher response related to rural Coordinators reporting more gaps in their access to training opportunities (Mean=2.8) compared with metropolitan Coordinators (Mean=2.3)⁴¹.

Correspondingly, the only local region to rate the gaps in support available to them at over 3.5 was Yorke Mid North who reported they had quite significant issues accessing support for managing culturally and linguistically diverse (CALD) workers.

⁴¹ t (216) = -2.6, p=.01.



Figure 65: Coordinator support gaps in region impacting their function, metropolitan & rural, 2016



Note, question was not asked in 2010.

* Indicates statistical differences were found (with the colour denoting the group with the higher value).

Table 2: Coordinator support gaps in region impacting their function by location, 2016

	N	Opportunities for training	Access to MCMs	Support for managing CALD workers	Support for managing workers with disabilities
Eastern Adelaide*	108	2.3	2.0	2.3	2.3
Northern Adelaide	59	2.2	1.9	1.9	1.9
Southern Adelaide	35	2.6	2.7	2.8	2.8
Western Adelaide	51	2.5	2.0	1.9	2.1
Adelaide Hills	10	1.8	1.6	2.4	2.4
Barossa Light and Lower North	13	2.1	1.8	1.3	1.6
Fleurieu Kangaroo Island	3	1.7	1.3	2.0	2.0
Eyre Western	6	3.3	2.8	2.3	2.3
Far North	5	3.3	2.8	3.3	3.3
Limestone Coast	19	3.1	2.9	2.6	2.8
Murray Mallee	10	2.5	2.0	2.5	2.0
Yorke Mid North	9	3.3	2.7	4.0	2.5

Note, question was not asked in 2010.

* Eastern Adelaide includes Adelaide and North Adelaide.

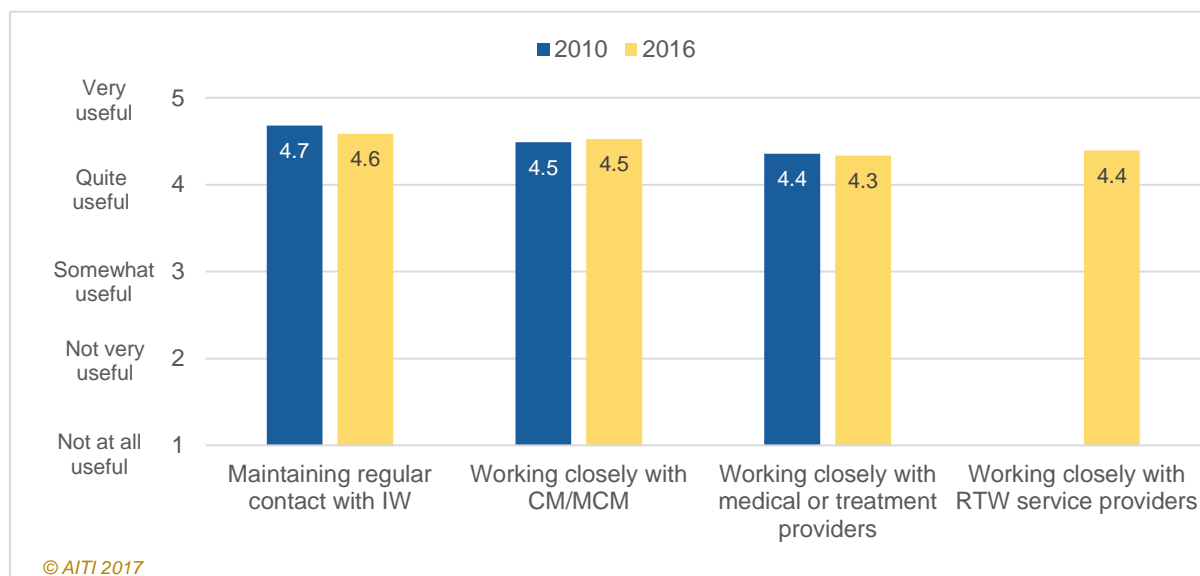
Highlighted cells denote where gaps were rated at more than 3.5.

3.8 Key strategies to assist RTW

3.8.1 Communication and support strategies

Communication and support strategies were considered 'quite' to 'very' useful by most Coordinators (Figure 66 through to Figure 70) – with no statistical differences found between those who responded in 2010 or in 2016. Details of specific responses for each strategy are shown below.

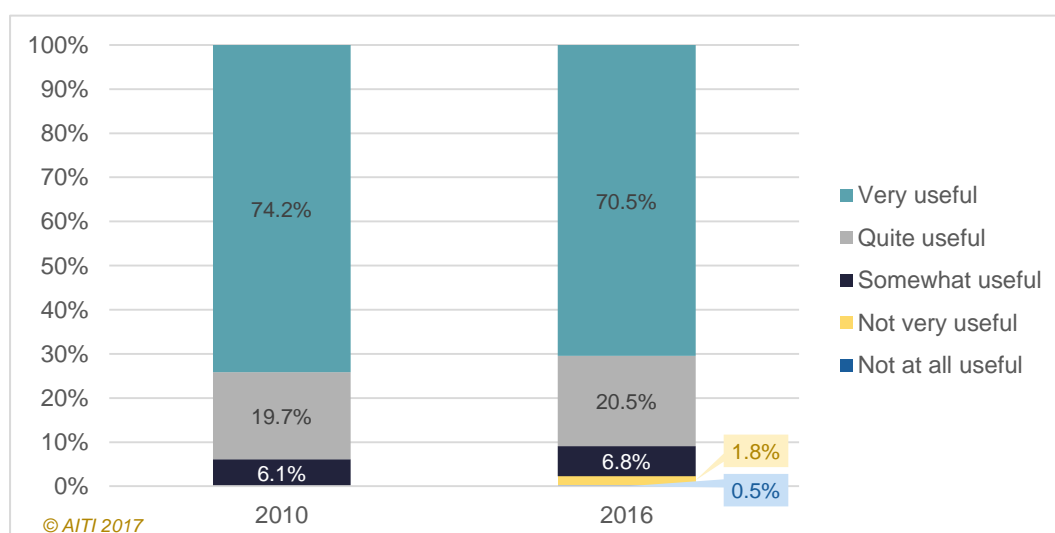
Figure 66: Usefulness of communication and support strategies (Part 1), 2010 & 2016



Note, Usefulness of communication and support strategies (Part 2) is presented in Figure 71.

Responses to perceptions about the usefulness of maintaining regular contact with injured workers (IWs) reveal that more than seven in ten Coordinators found this to be a ‘very useful’ strategy both in 2010 and 2016 (see Figure 67). However, a handful of 2016 Coordinators did not believe this strategy was useful - interestingly all but one of these had been in the Coordinator role for over 6 years. One had no experience of injured workers, while others had managed an average of one to three injured workers per year. With one exception, these workers performed their Coordinator role an average of 2 hours per week as part of full-time positions (i.e. for around 5% of their work week). Moreover, most of these had indicated similar ratings (‘not very useful’ or ‘not at all useful’) for more than half of the other communication and support strategies, they were equally unimpressed by the questions addressing ‘helpful strategies’ (see Section 3.8.3) but saw value in the workplace policy and process strategies (see Section 3.8.2). From this it would seem this cohort placed more value on process factors rather than interaction with the worker.

Figure 67: Useful communication/support strategies: Maintaining regular contact with IW, 2010 & 2016



Although not statistically significant, working closely with case managers (CMs) and mobile case managers (MCMs) was more likely to be considered ‘very’ useful in



2016 compared to 'quite' useful in 2010 (see Figure 68). Slight variations in the same directions were also seen with working closely with medical or treatment providers (see Figure 69). A similar question about working closely with service providers was only introduced for the 2016 survey (see Figure 70).

Figure 68: Useful communication/support strategies: Working closely with CMs & MCMs, 2010 & 2016

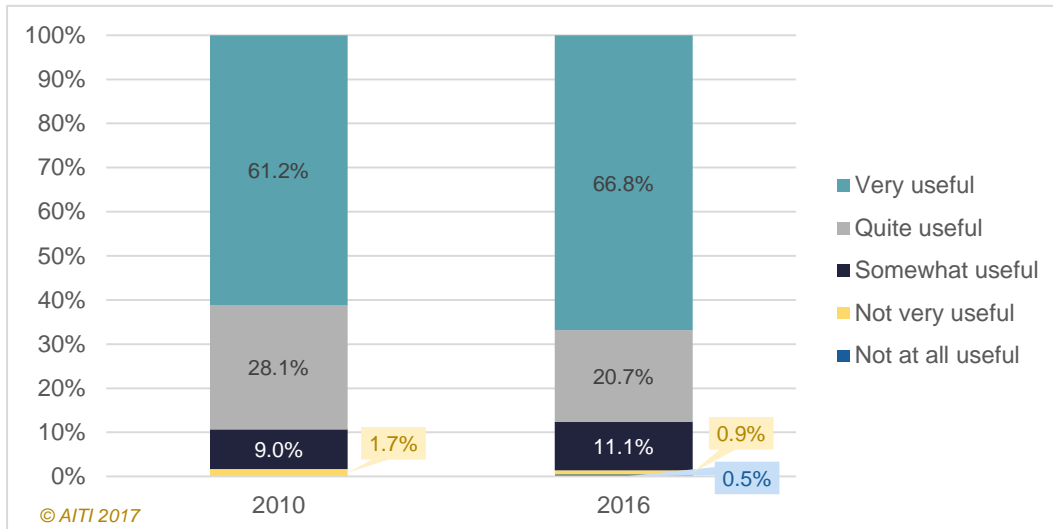


Figure 69: Useful communication/support strategies: Working closely with medical or treatment providers, 2010 & 2016

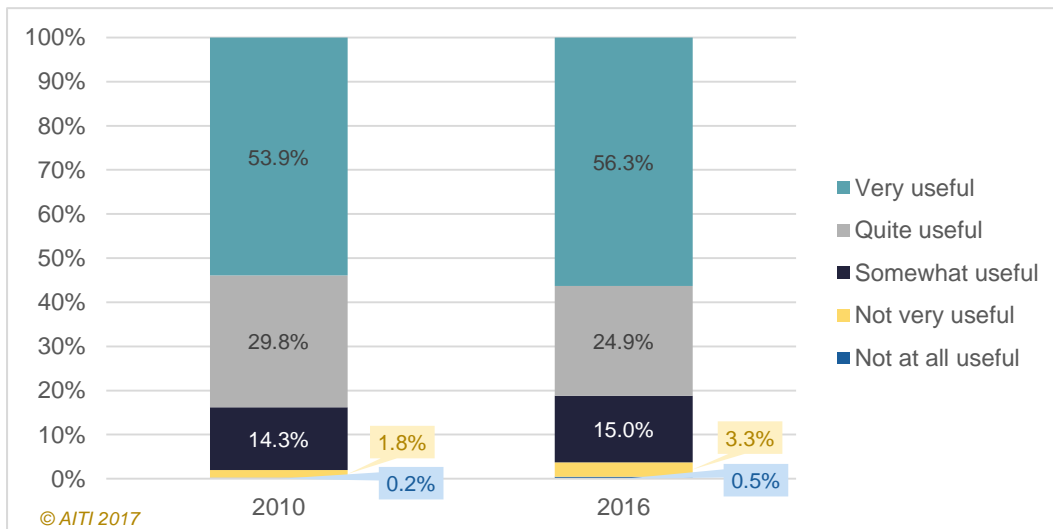
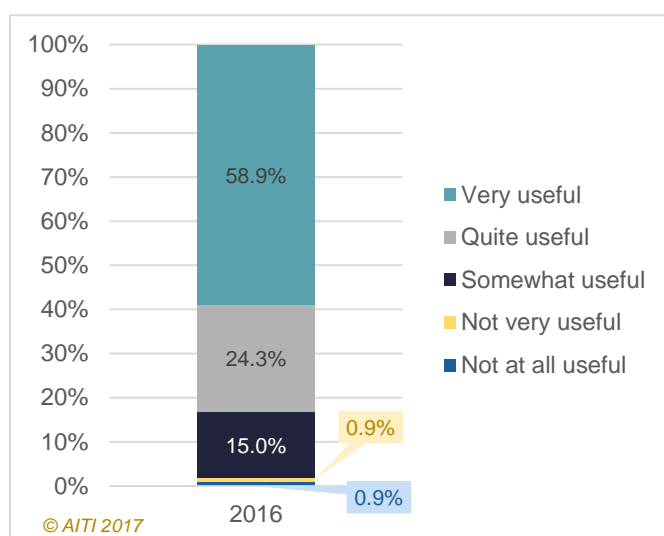


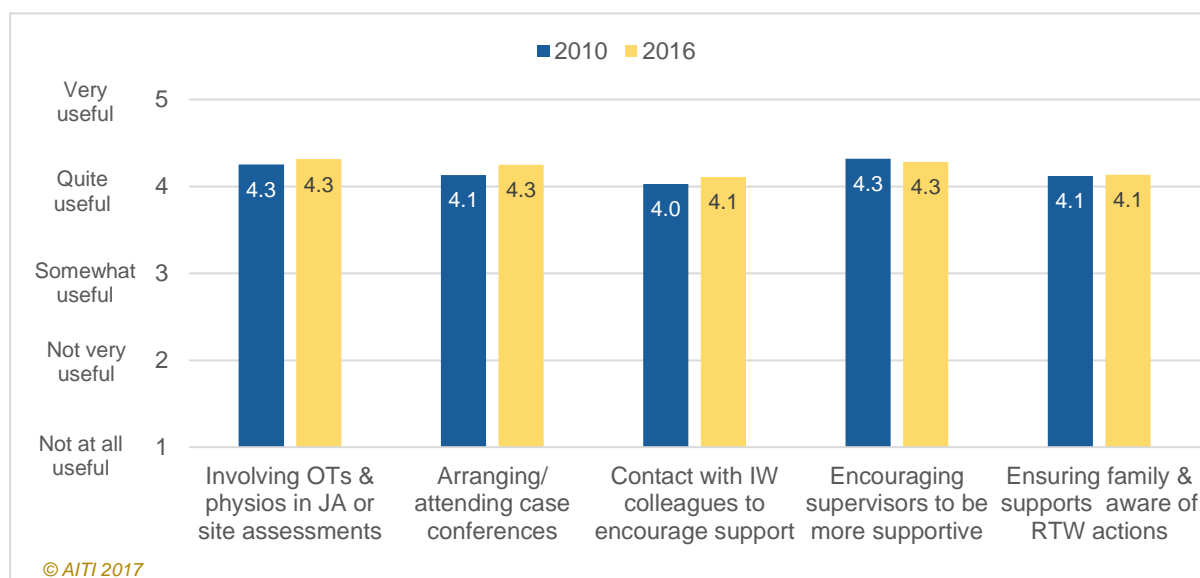
Figure 70: Useful communication/support strategies: Working closely with RTW service providers, 2010 & 2016



Trends for an increase in the proportion of Coordinators in 2016 reporting ‘very’ useful were also seen with regard to involving occupational therapists (OTs) and physiotherapists in jobs analysis (JA) or work site assessments (see Figure 71); arranging or attending case conferences (see Figure 73); having more contact with the employee’s colleagues to encourage support (see Figure 74); and ensuring, through the worker, that the family or other external supports are aware of required actions to return the injured worker to work (see Figure 76). Encouraging supervisors to be more supportive and accommodating (see Figure 75) was seen to be a ‘very’ useful strategy by more than half the Coordinators across both time periods.

Only two Coordinators provided additional comments about other useful support strategies with one indicating the appointment of an independent rehabilitation provider was very useful. The other stressed the importance of the worker knowing there is support available at all times.

Figure 71: Usefulness of communication and support strategies (Part 2), 2010 & 2016



Note, Usefulness of communication and support strategies (Part 1) is presented in Figure 66.



Figure 72: Useful communication/support strategies: Involving OTs and physios in jobs analysis or work site assessments, 2010 & 2016

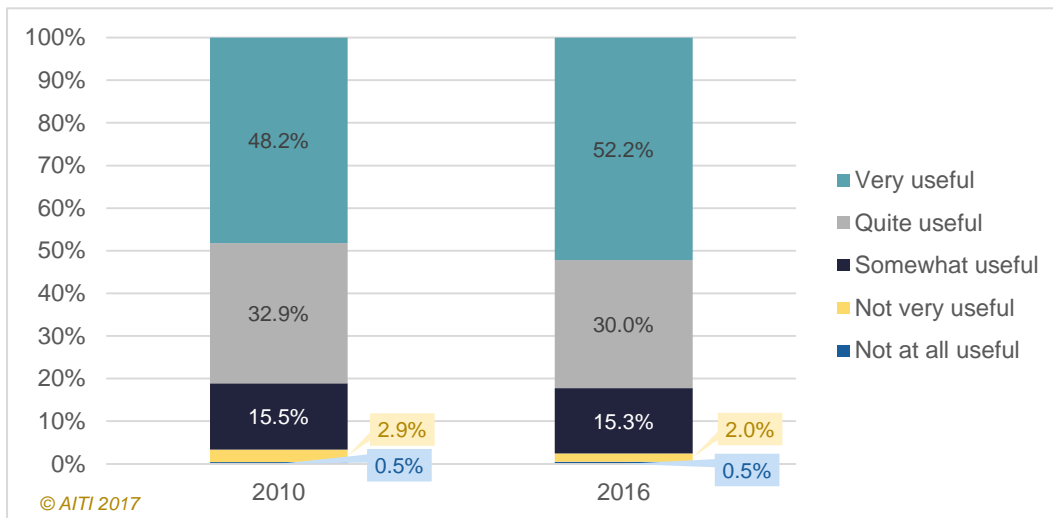


Figure 73: Useful communication/support strategies: Arranging/attending case conferences, 2010 & 2016

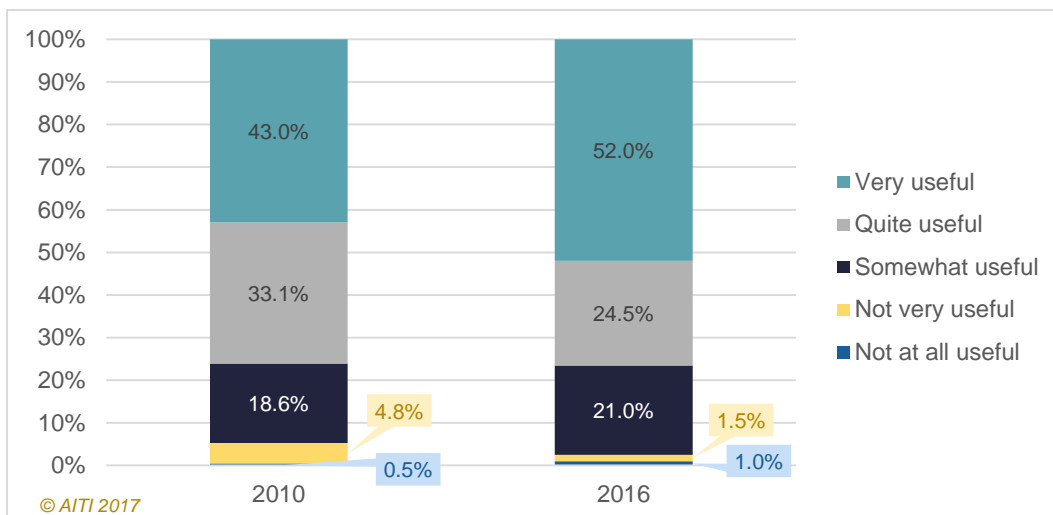


Figure 74: Useful communication/support strategies: Contact with IW colleagues to encourage support, 2010 & 2016

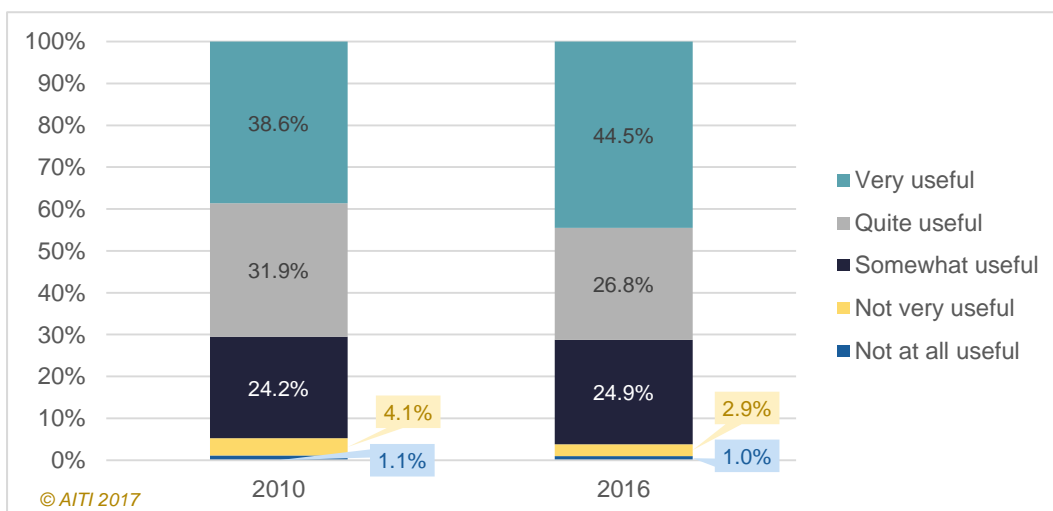


Figure 75: Useful communication/support strategies: Encouraging supervisors to be more supportive/accommodating, 2010 & 2016

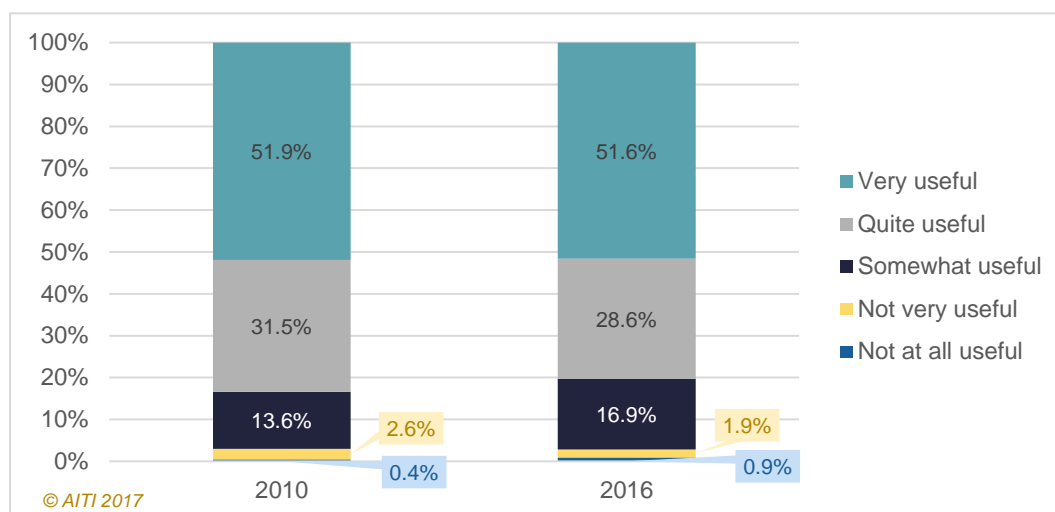
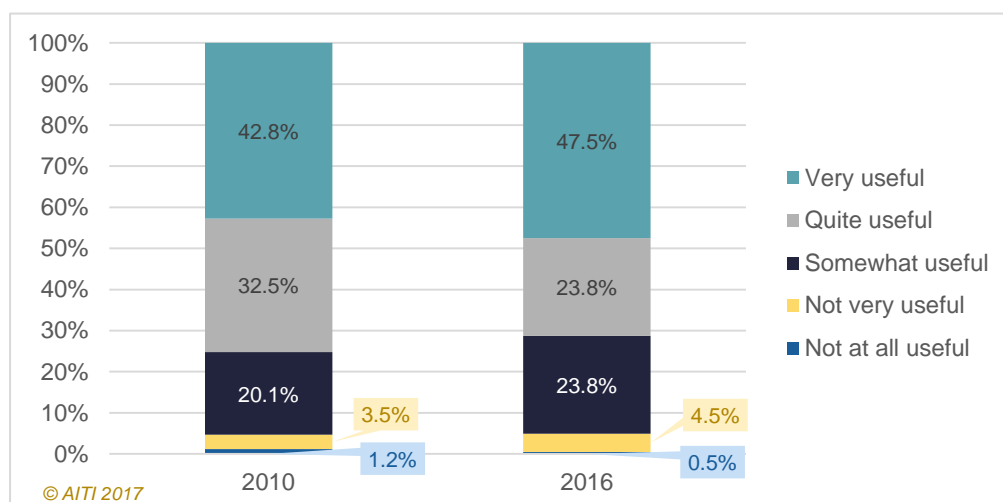


Figure 76: Useful communication/support strategies: Ensuring family and supports are aware of RTW actions, 2010 & 2016

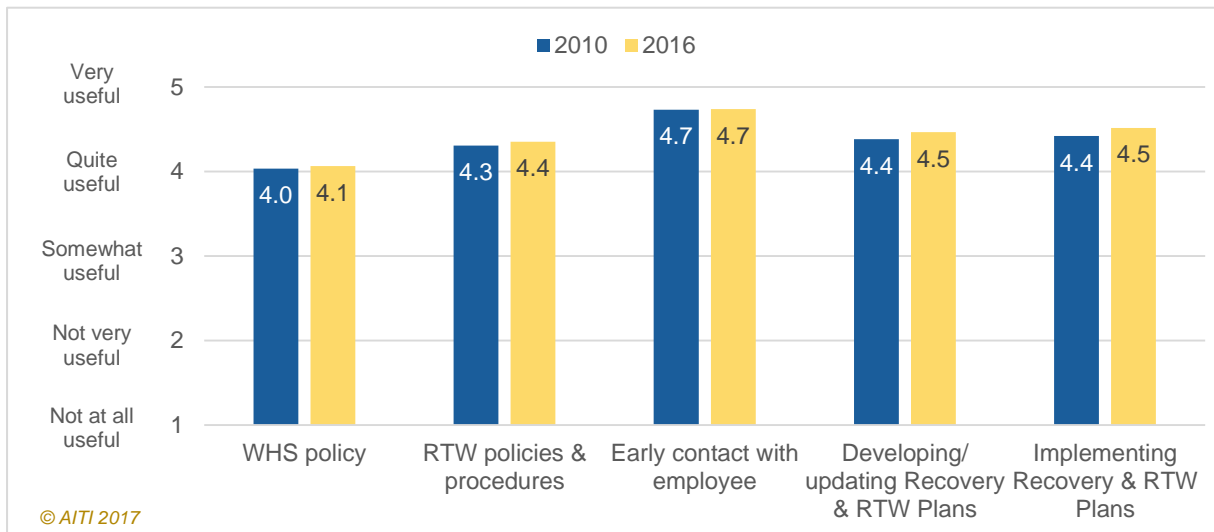


3.8.2 Workplace policy and process strategies

Policy and process strategies were reported to be ‘quite’ to ‘very’ useful by Coordinators in both 2010 and 2016 (see Figure 77 and Figure 83). Around half the Coordinators indicated Work Health Safety (WHS) policy (see Figure 78), RTW policies and procedures (see Figure 79), developing and updating Recovery and RTW Plans (see Figure 81), and helping to implement the Recovery and RTW Plans (Figure 82) were very helpful. However, more than three-quarters of Coordinators acknowledged the importance of ensuring early contact with the employee (as soon as possible after the injury, see Figure 80), while only one in twenty indicated this was ‘somewhat’ significant (or less). No statistical differences were found between the years in terms of the usefulness of policy and process strategies. However, with most mean scores above 4.3 these responses were likely to be impacted by ceiling effects.



Figure 77: Usefulness of policy & process strategies (Part 1), 2010 & 2016



Note, Usefulness of policy and process strategies (Part 2) is presented in Figure 83.

Figure 78: Useful policy/process strategies: WHS policy, 2010 & 2016

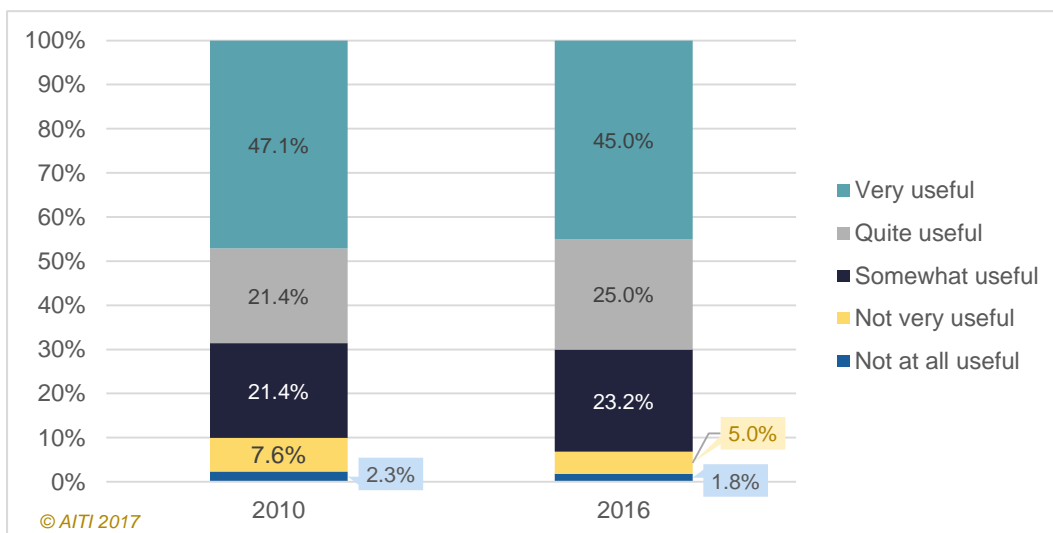


Figure 79: Useful policy/process strategies: RTW policies & procedures, 2010 & 2016

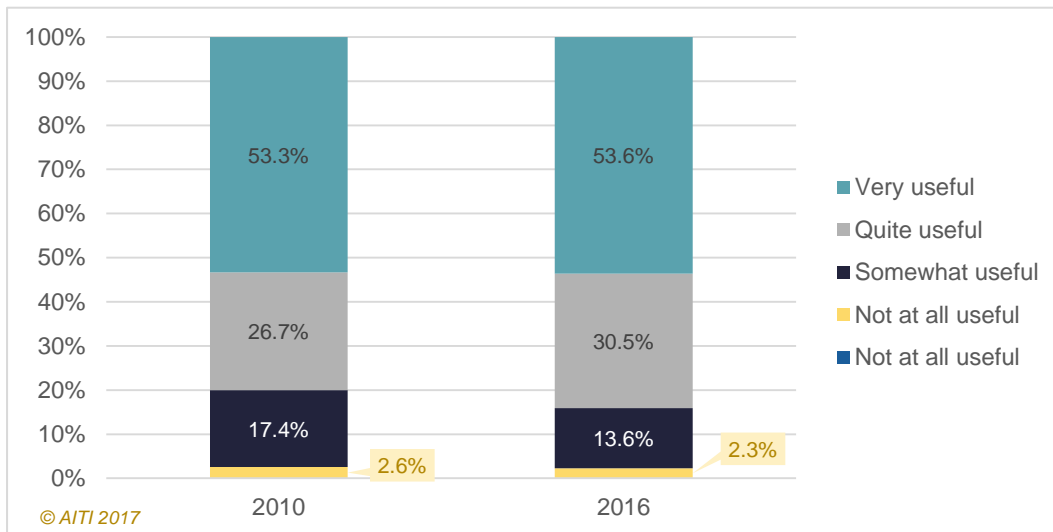


Figure 80: Useful policy/process strategies: Early contact with employee, 2010 & 2016

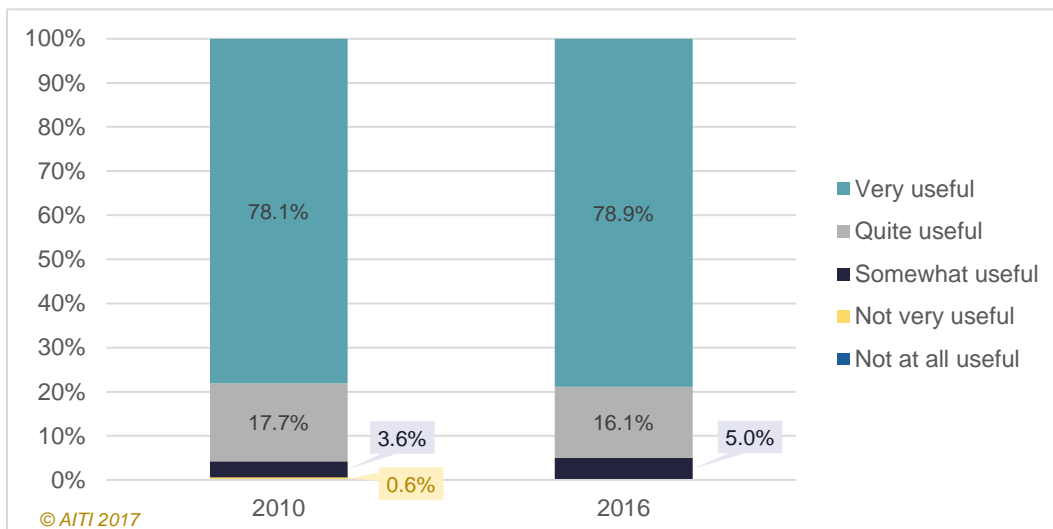


Figure 81: Useful policy/process strategies: Developing & updating Recovery & RTW Plans, 2010 & 2016

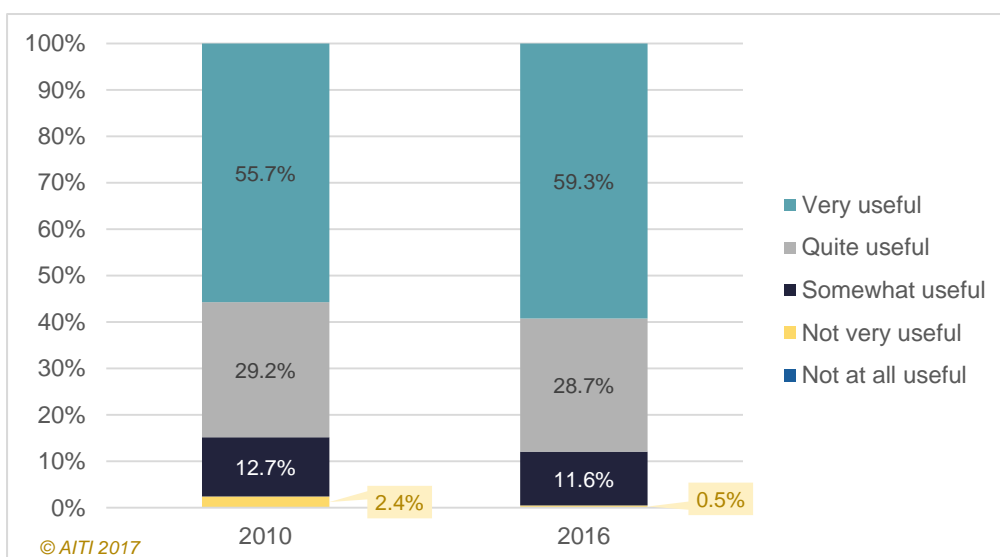
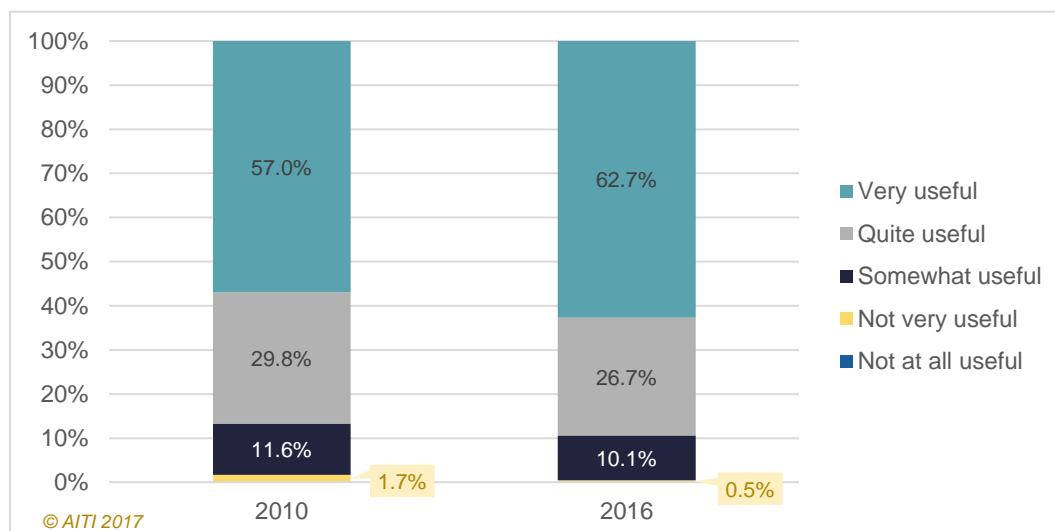
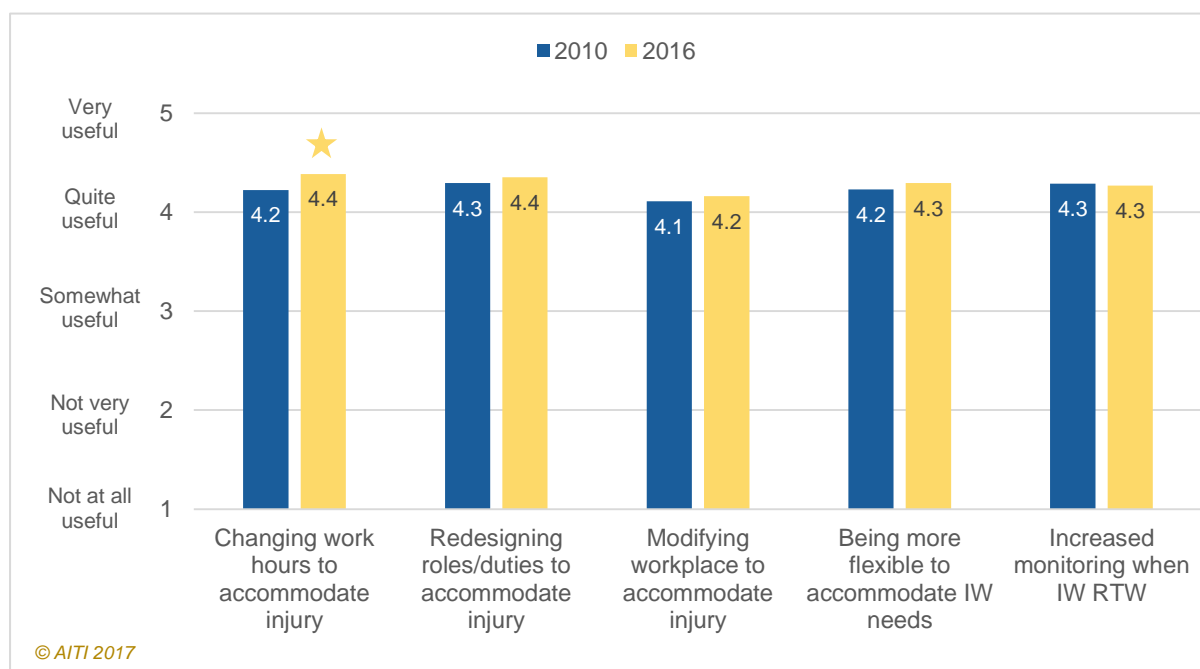


Figure 82: Useful policy/process strategies: Implementing Recovery and RTW Plans, 2010 & 2016



The only policy and process strategy that was statistically different across the two surveys concerned changing work hours to accommodate the injury⁴², which was deemed more useful in 2016 (Mean=4.4) than in 2010 (Mean=4.2, see Figure 83). Differential responses can be seen in Figure 84, where almost two in five (58.1%) Coordinators in 2016 reported changing work hours was very useful, compared with fewer than half (48.3%) in 2010.

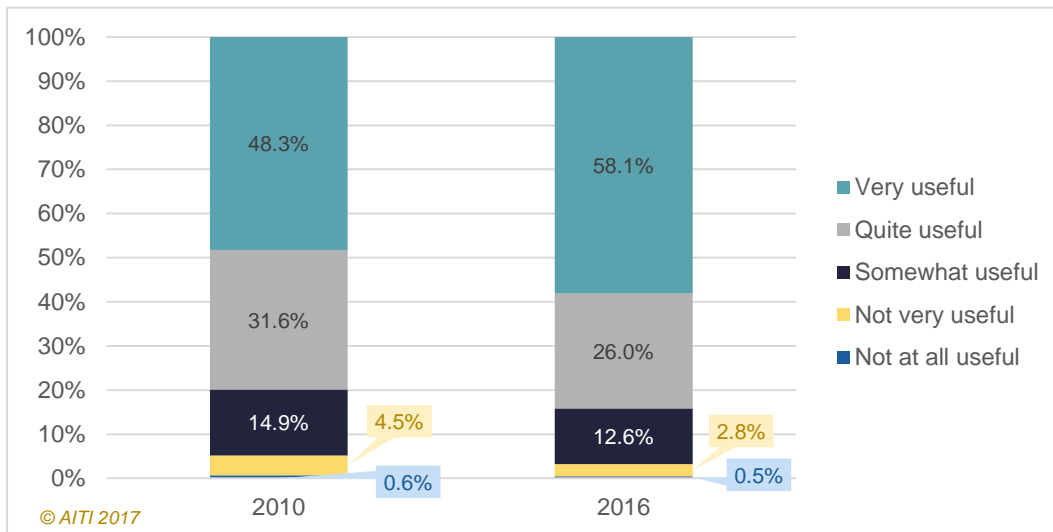
Figure 83: Usefulness of policy & process strategies (Part 2), 2010 & 2016



★ Indicates statistical differences were found (with the colour denoting the group with the higher value).
 Note, Usefulness of communication and support strategies (Part 1) is presented in Figure 77.

⁴² $t(675) = -2.2, p < .05$.

Figure 84: Useful policy/process strategies: Changing work hours to accommodate injury, 2010 & 2016



Although no other statistical differences were found, more than half of Coordinators saw the value in redesigning work roles and duties to accommodate the injury, with 56.0% believing this was very useful in 2016 (see Figure 85). Around four out of five Coordinators felt that modifying the workplace (including the provision of equipment) to accommodate the injury was either quite or very useful (see Figure 86), with a similar proportion seeing value in being more flexible to accommodate the worker's needs (see Figure 87) and increased monitoring when the person has returned to work (see Figure 88).

Figure 85: Useful policy/process strategies: Redesigning roles and duties to accommodate injury, 2010 & 2016

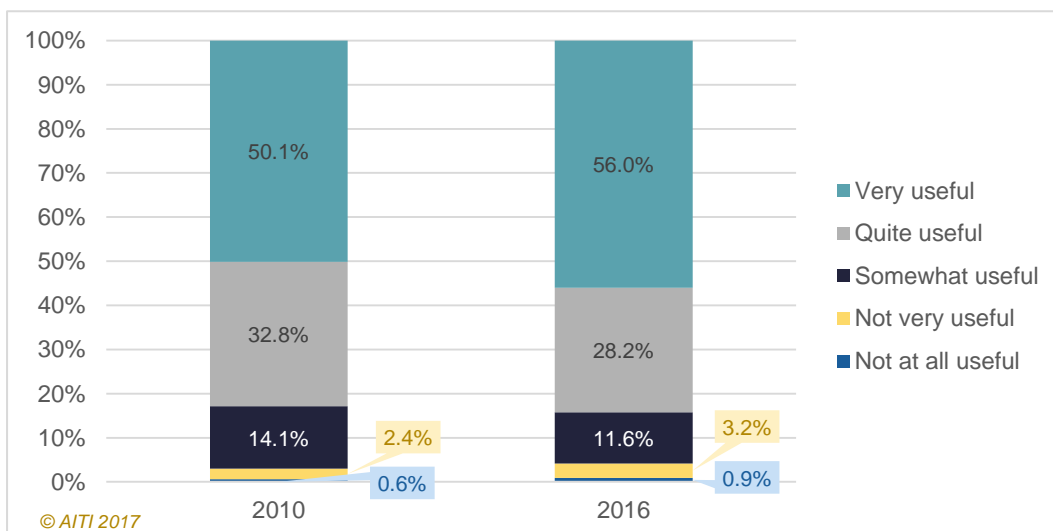


Figure 86: Useful policy/process strategies: Modifying workplace to accommodate injury, 2010 & 2016

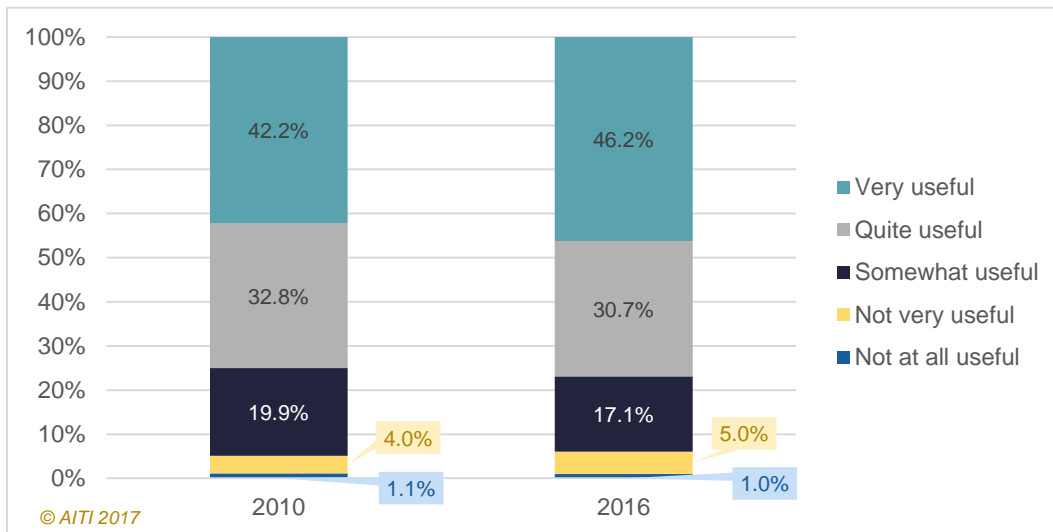


Figure 87: Useful policy/process strategies: Being more flexible to accommodate injured worker needs, 2010 & 2016

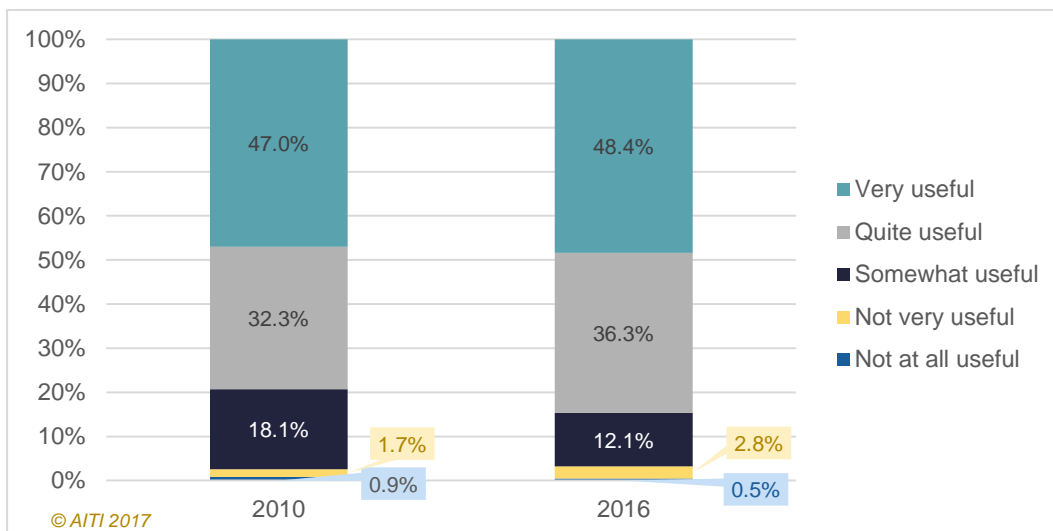
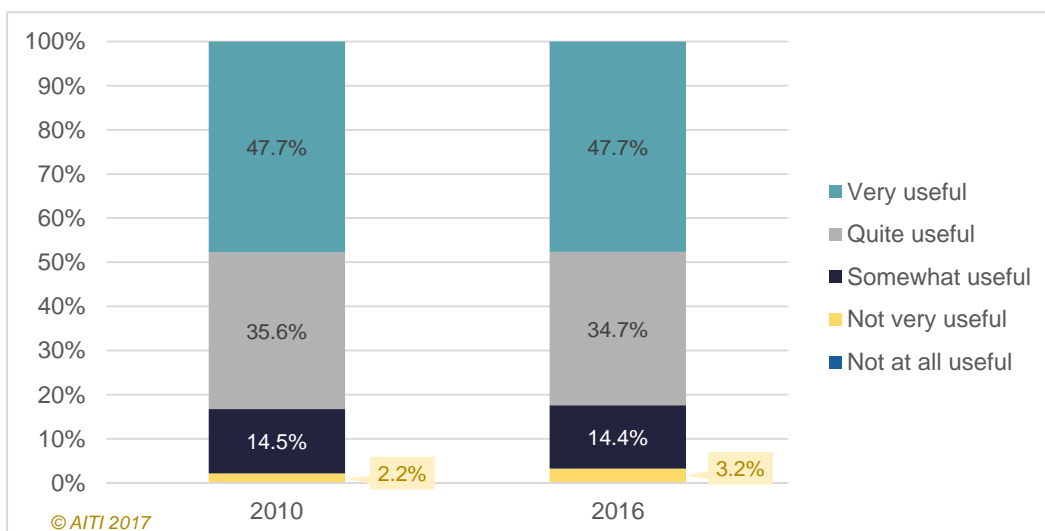


Figure 88: Useful policy/process strategies: Increasing monitoring when injured worker RTW, 2010 & 2016



3.8.3 Strategies to help Coordinators perform role

No statistical differences were found between the surveys with regard to the usefulness of strategies to help Coordinators perform their roles (see Figure 89 and Figure 94). The most useful of these strategies was identified as clarifying who at the worksite was in charge of managing the RTW process - identified by three in five (59.2%) Coordinators as 'very' useful in 2016, and one-quarter (25.7%) as 'quite' useful (see Figure 90).

Figure 89: Usefulness of strategies helping Coordinators to perform role (1), 2010 & 2016

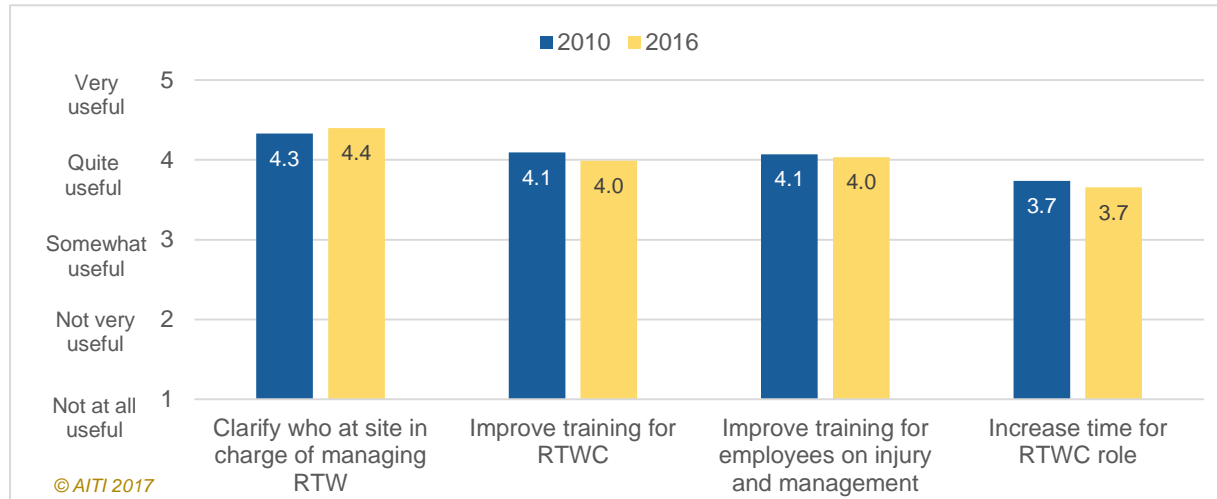
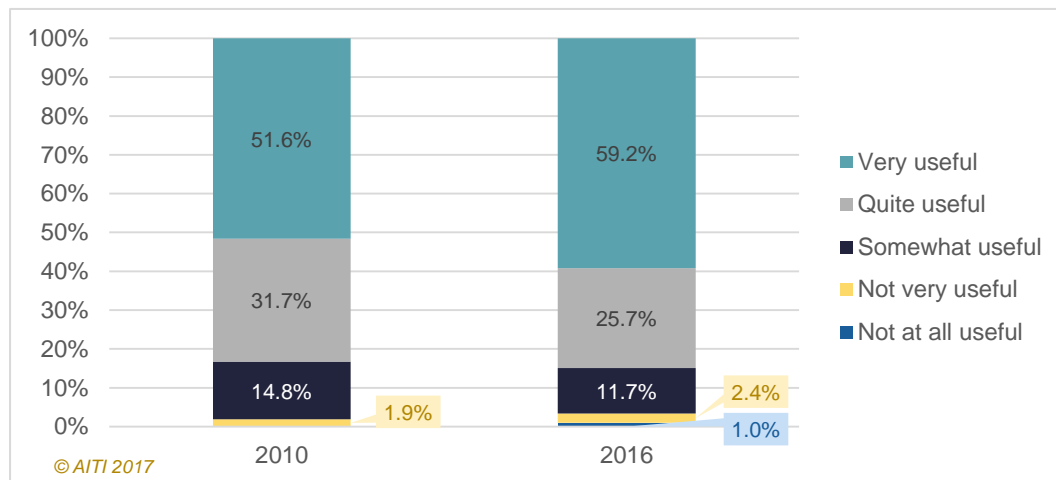


Figure 90: Useful to RTWC: Clarifying who at site is in charge of managing RTW, 2010 & 2016



Around three quarters indicated that improving training for Coordinators would help them perform their role (see Figure 91). While a similar proportion reported that improving training for employees on workplace injury and how to manage it in the workplace would be 'quite' or 'very' useful (see Figure 92). Fewer, less than three in five thought increasing the time available to perform the Coordinator role would be useful (see Figure 93). However, there was a relationship between the number of hours spent in the role and response to whether additional time would be helpful. Coordinators working longer hours in the role in 2016 were statistically more likely to



believe in the usefulness of this strategy,⁴³ with this appearing unrelated to the number of injured workers assisted.

Figure 91: Useful to RTWC: Improve training for Coordinator, 2010 & 2016

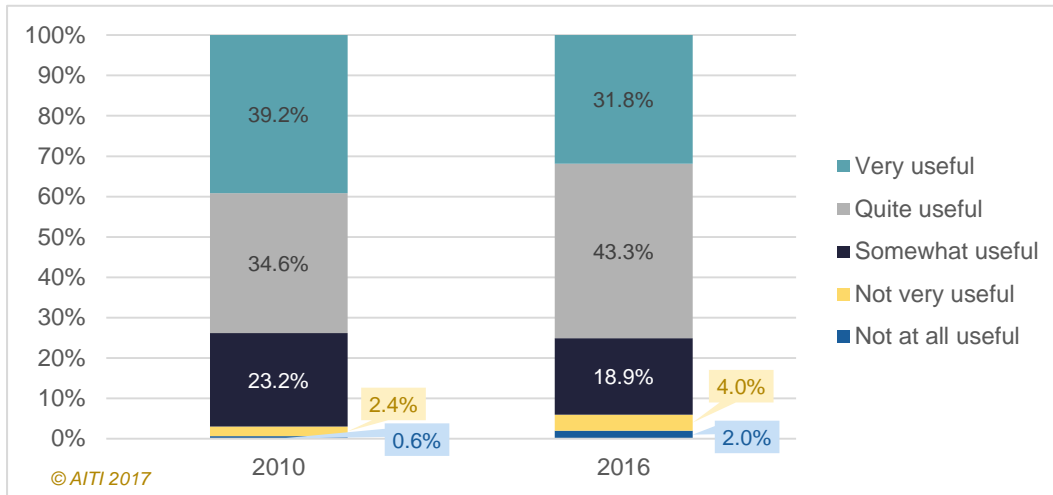
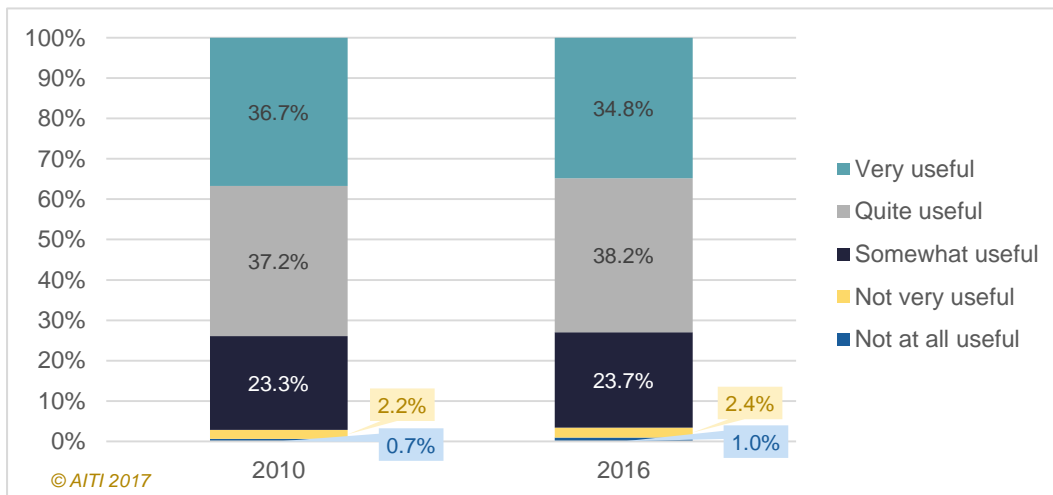
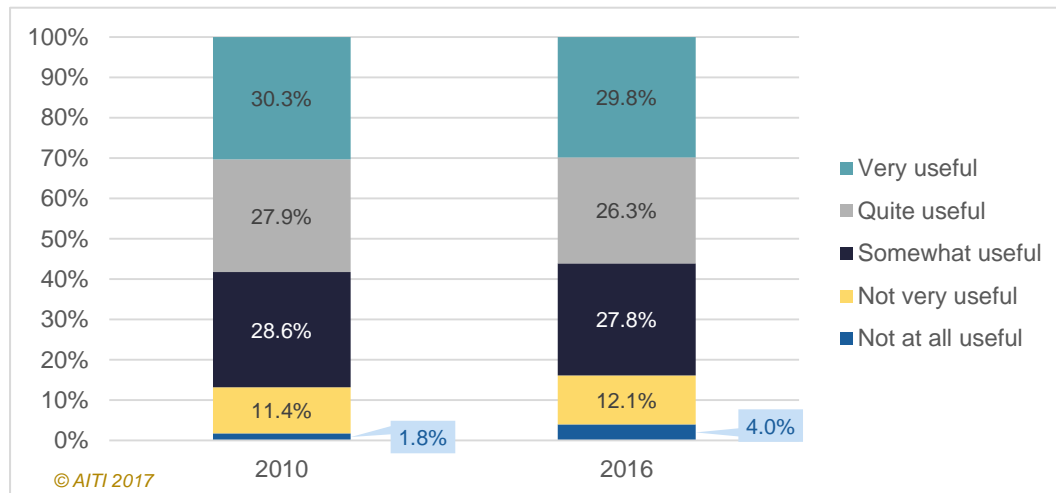


Figure 92: Useful to RTWC: Improve training for employees on injury & management, 2010 & 2016



⁴³ $t(196) = -4.0, p < .001$.

Figure 93: Useful to RTWC: Increase time for Coordinator role, 2010 & 2016



While considered somewhat useful, Coordinators did not generally see a lot of value in allocating more time or getting more assistance to deal with administrative tasks associated with their RTW role, having more effectively diary management skills, or increasing financial resources allocated within the business to support the role of Coordinators (see Figure 94 to Figure 97). Responses for these questions were fairly evenly spread, with one quarter to one third of Coordinators reporting these were 'somewhat', 'quite' or 'very' useful strategies. However, enhancing manager and supervisor understanding of the RTW process and their role was considered 'quite' useful (Mean=4.1) in 2016, the first time it was asked, with all but a few Coordinators believing this was a useful strategy (see Figure 98).

Figure 94: Usefulness of strategies helping Coordinators to perform role (2), 2010 & 2016

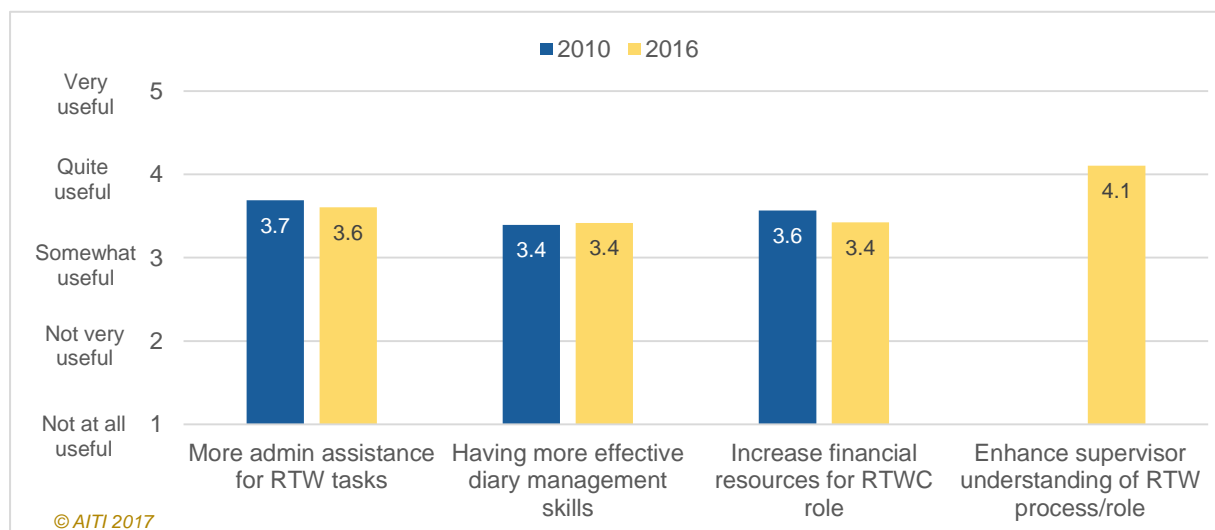


Figure 95: Useful to RTWC: More admin assistance for RTW tasks, 2010 & 2016

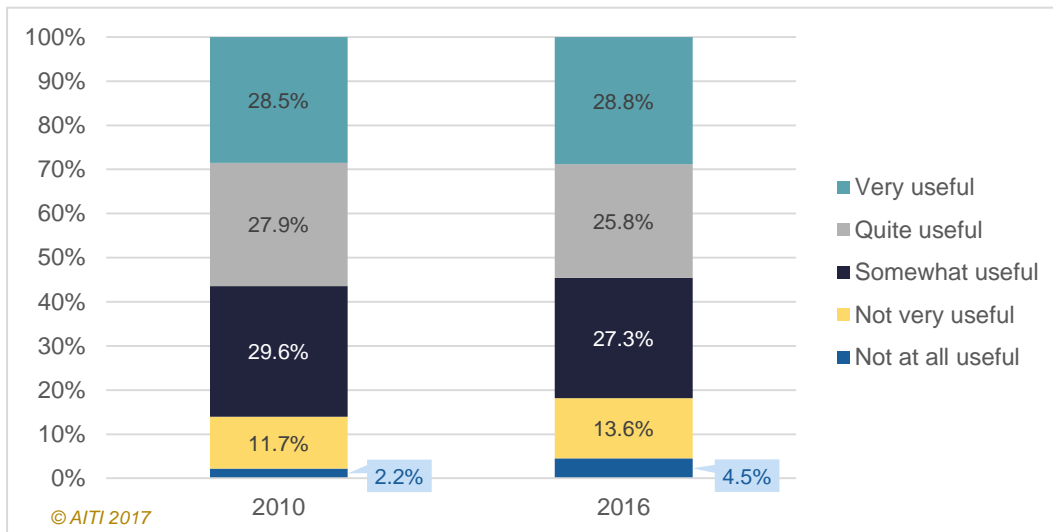


Figure 96: Useful to RTWC: Having more effective diary management skills, 2010 & 2016

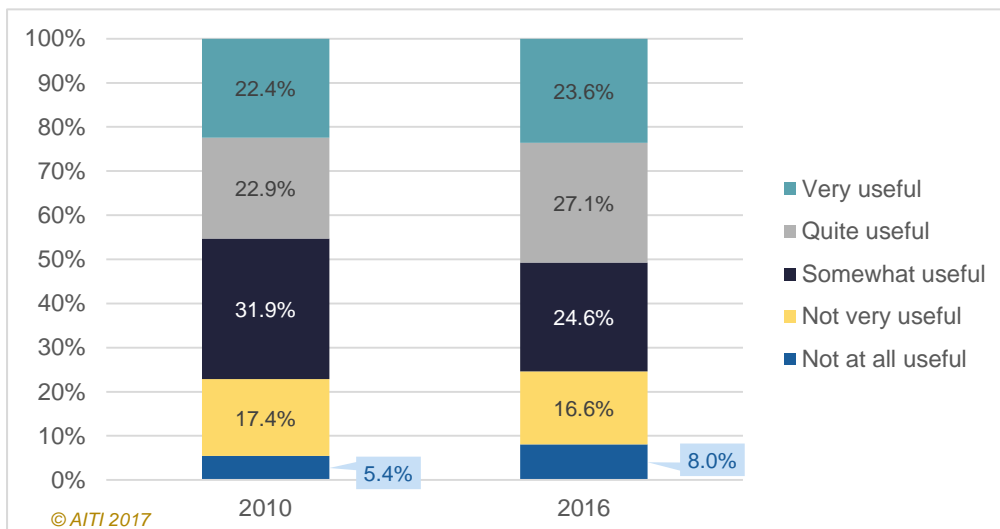


Figure 97: Useful to RTWC: Increase financial resources for Coordinator role, 2010 & 2016

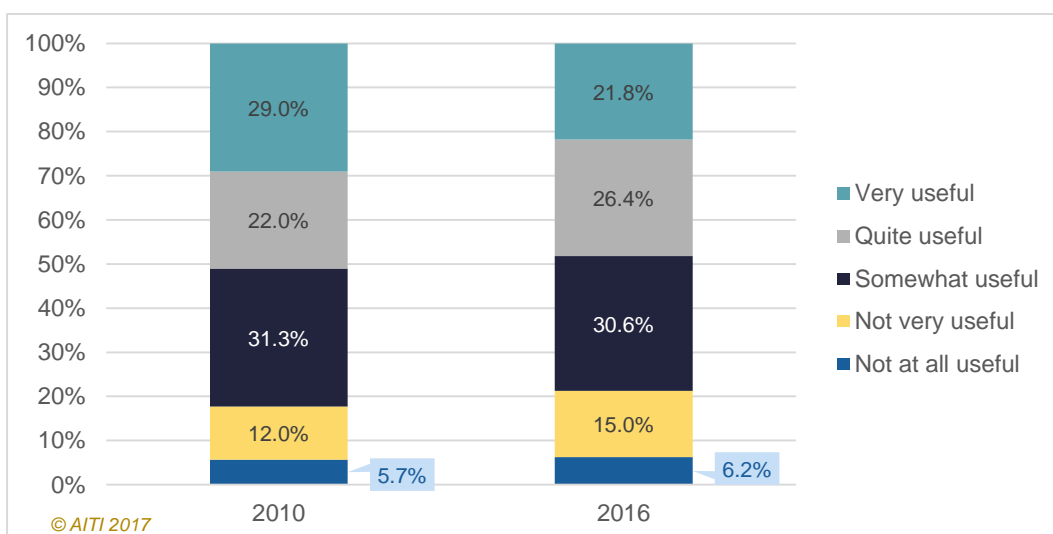
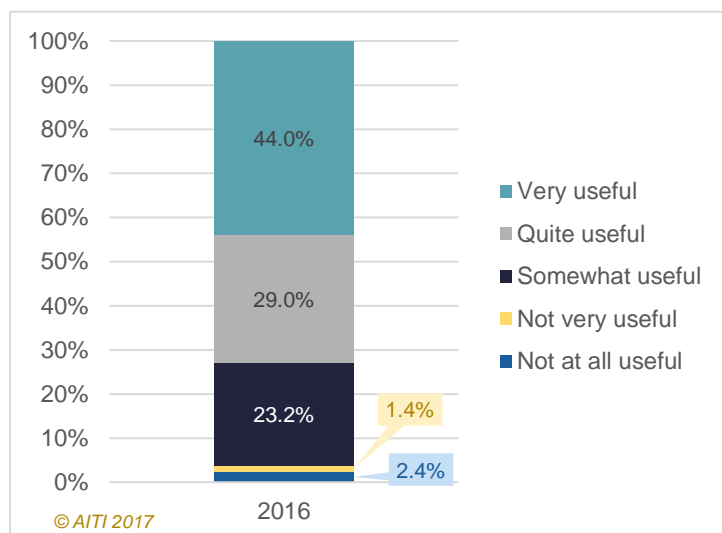


Figure 98: Useful to RTWC: Enhance supervisor understanding of RTW process/role, 2016

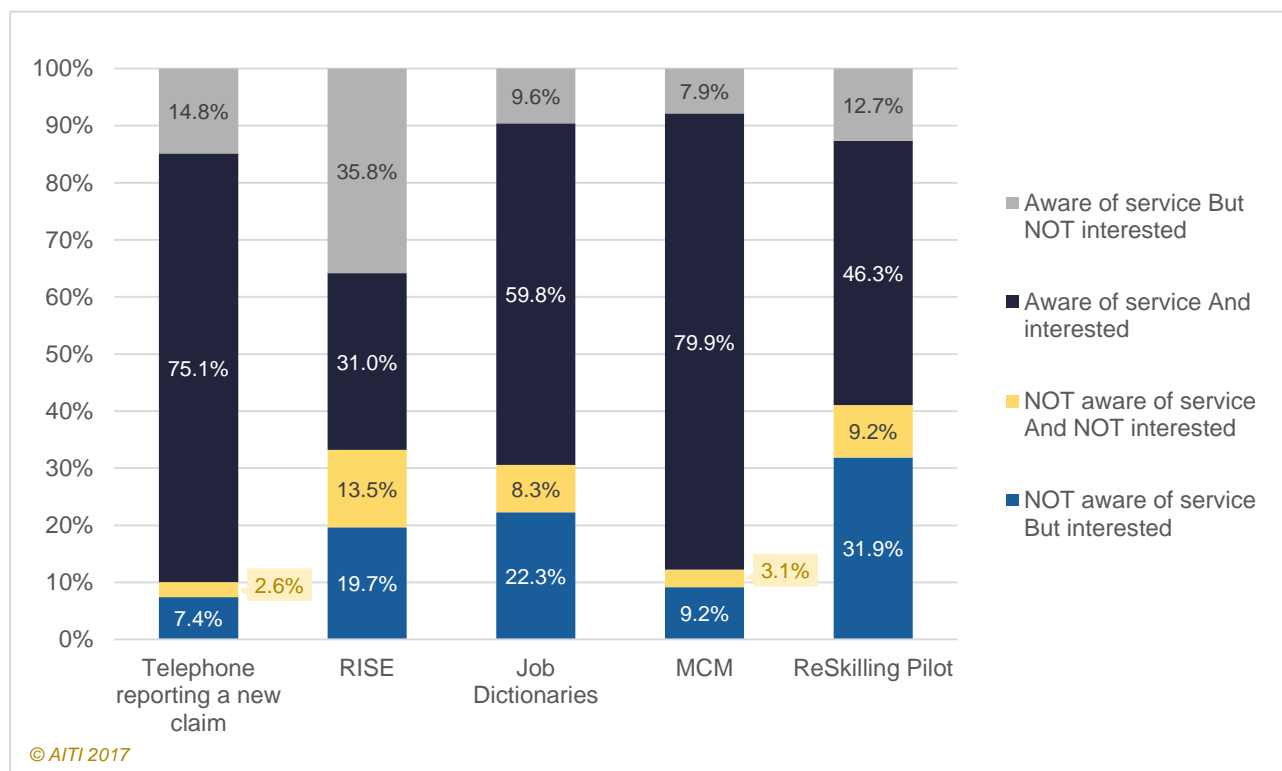


3.9 RTWSA programs and services

RTWSA provides a range of services and programs designed to both support Coordinators and help get injured workers back to work. In 2016, three quarters of Coordinators reported an awareness and interest in telephone reporting for a new claim (75.1%) and in the role of mobile case managers (MCMs; 79.9%). Fewer than one in ten were unaware of the services – but interested in them. Three in five (59.8%) Coordinators were aware and interested in job dictionaries, with almost one quarter (22.3%) not aware of the service - but interested in it. One half (46.3%) were aware of the ReSkilling pilot with a further third (31.9%) currently unaware, but interested. The Reemployment Incentive Scheme for Employers (RISE) was known about by two-thirds (66.8%) of Coordinators with just under half (31.0%) of these interested in the service and 35.8% not interested. Given this program is more relevant to employers than Coordinators it is not surprising that around half the Coordinators had limited interest in it.



Figure 99: Awareness of RTWSA services and programs, 2016



Note, question was not asked in 2010.

We note that Coordinators who were aware of telephone reporting for a new claim but not interested in it had been involved with more injured worker claims (18.1) on average than those who were aware of the service and interested in it (7.5 claims), or those who were not aware and not interested (1.8 claims)⁴⁴.

Thirty-one Coordinators provided ideas about how to improve RTW outcomes in the workplace (see Appendix C: for all comments). However, many Coordinators took this as another opportunity to call for improvements in medical engagement with the workplace and better action from doctors to return injured workers to work in a timely and appropriate fashion. There was some frustration about the level of knowledge held by GPs with regard to injured workers, doctors 'siding' with patients, and the implications of medical actions.

While some Coordinators were frustrated about what they considered were recalcitrant employees malingering on claims, others felt an employee focused perspective centred on trust and good communication was a key to good outcomes -

Refocus our energy from 'injury management' to 'employee engagement' which is only possible when there is genuine care of employee's wellbeing. RTWC should focus on building a culture of trust and happiness at workplace which will reduce incidents, injury, unscheduled absenteeism and increase productivity, innovation and quality of service delivery. Help RTWC build soft skills like behaviour management, CBT, mindfulness and make them a coach not just an administrative resource.

I believe that the one case I have dealt with was handled well through being patient and creating a good rapport with the injured worker. Creating trust was so very important and following up and

⁴⁴ F(3,225)=6.6, p<.001.

sharing information with the injured was crucial. Also having the support of RTWSA staff was great.

There were some concerns expressed about the agents and their operations, although it would seem that mobile case managers have generally made a positive impact for Coordinators. Notably, one Coordinator asked for decision flowcharts as a process guide given their workplace has few claims. While it is likely there are decision trees available, this points to the need to ensure this material is front and centre.

As a workplace that has very few injuries I may go a couple of years without a claim. So when I do have a claim it like doing everything for the first time again. Support has always been there when I have needed it and hopefully will continue to be. I would find decision flowcharts helpful too.

Another Coordinator suggested an online system would be a useful first step in the claims process, saving time and streamlining effort for both Coordinator and the Agent -

Have an online reporting system for new claims. The telephone claims process is laboured and time consuming. I feel I could input the data into an online form and submit a lot quicker than it takes for me to call the EML number and verbalise all the information to someone on the phone to then type into a form. I have made these comments known to EML previously.



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Appendix A: Valuing the RTW role, 2016

A particular person who is allocated to help and injured worker so they do not get the run around

Acceptance of my presence as a RTW and approval from Management to attend Mental Health Course

All staff are aware of the importance of the role and how it can help them if they have an injury

Always supports RTW, regularly discuss in safety meetings, RTW Coordinators in all states for the business

An important role in assisting workers to return to work.

As I am new to this business it is hard to say. I want to be more active in the role than has previously been the case and the business is open to that.

As it's a requirement for business, there is already an inherent 'value' to the role.

As we have no lost time of due injuries in the last 2 years

Assist injured workers to remain at or return to work while they recover from a work-related injury and take steps to prevent reoccurrences.

Assistance and guidance in managing injured workers and their claims.

Assists in getting our people back to work quicker.

At the least the employees know they have someone to go too

Be able to talk and discuss issues with the RTW is important to all staff.

Because everything is coordinated and runs smoothly. The workers know who to go to and everything is made clear

Because I get people back to work quickly and safely, reducing operational impact

Bringing claims to an effective close

By being flexible with hours, other duties etc.

By complying with requests for information when required.

By supporting injured employee throughout the process. also informing management.

Certainly it is appreciated by people who need to use it including employees and managers, as it provides a single point of contact where they can get simple advice and assistance, and takes away from the manager needing to perform in this area where they may not use the skills frequently and feel adequately qualified.

Clear guidance on worker recovery & rehabilitation

Communication lines for all parties involved

Confidence that the injured worker will be managed with compassion

Decrease in premiums, supported workers, returning to work in some capacity sooner than before we had a RTW Coordinator



Depends on the individual

Directors and executive managers tend to see the requirement as onerous. However managers and other staff are very positive about the role of the RTWC

Early intervention and assisting injured workers RTW as quickly as possible.

Ensuring all information is made available and workers understand their options.

Ensuring wages are calculated correctly and submitting all paperwork including accounts associated with claims

First point of call for anything RTW related including past claims, current claims & any additional information.

Giving injured workers someone specific to get help from, reducing the lost work hours due to injury.

Have had no injuries in the past 6 years

Having one point of contact for injuries and claims makes it easier

Help manage the process in the event of a workplace injury claim

Helping to understand the process and what they need to do as a worker.

High

Highly as we need the guidance for the injured worker so he/she can get back to normal duties ASAP

Holding the position of GM, involvement of RTW is a directive that must be followed as we value safety

Hopefully valued a lot

[Business] use the services of a rehab provider which has proved beneficial to helping injured workers navigate the process and provide targeted treatment.

I am the link between the workers and the Insurer, an interpreter as such :)

I assist managers following any reported incidents and advise about treatment, modified duties, submitting claims calculating AWE, reimbursements. The managers are often inexperienced in these matters. The employee feels they have a support person and can sometime share things they would not share with others. The doctors and treating specialist can have a better understanding of the workplace

I believe that my workplace places a high value to the role of the RTWC

I don't think there is a lot of awareness around what the role is unless you receive or have to support managing a workplace injury.

I have implemented a number of procedures that has enhanced return to work and the outcomes of injured workers

I have only been with the company for 6months

I help supervisors & coordinators regarding restrictions and keep claim on track

I think that would best be answered by asking individual staff members rather than me commenting. I have made staff and management aware of my role and everyone's rights and responsibilities.

If they do value the role, I am never told. The real satisfaction comes from assisting injured staff in returning to work.

If they haven't been exposed to the RTWC through their own personal experience/injury they generally think it's not important

Important to manage with the goal of returning the worker to pre injury work

Inclusive and seen as an expert, therefore have authority to act in the role

Injured employees appreciate that I am there to assist and help them with their concerns about their jobs, any financial impact that may happen due to an injury.

Input into the RTW process is appreciated and supported.

Is valued when situation arises and coordination of support is required

It allows communication between the workers and management and has someone responsible for helping fix any issue associated with helping injured workers as well as making the work place safer

It frees up managers to concentrate on their business priorities, yet keeps them involved and informed about the injured workers progress and claim management

It gives everyone a point of contact

It is a job that has to be done for the business and the employee

It is a requirement for our workplace safety management plan. It is a priority to look after our people and have a competent person assisting and supporting team members who are recovering from injury or illness.

It is important our [staff] be covered in case they suffer injury while at work.

It is seen as a specialty role, very necessary in containing premium costs

It's important as it deals with the overall WHS of the staff and the office.

Just appointed in order to meet the legislative requirement adds little value to the organisation

Limiting lost time by returning injured workers to the workplace

Line manager is key driver of RTW. RTWC coordinates with Manager and Insurer

Low injury work environment but staff and workers happy they have someone to contact if injured

Luckily we have not had any problems

Management always promote employees to liaise regularly with RTW to ensure a return to work

Management appreciate no LTI's, some time employees aren't always happy to meet their obligations management of Return to work

Managers and injured workers know I am available to assist them.

Managers and workers assist me as much as possible to get the best results for the injured worker.

Many employees don't understand what a RTW Coordinator actually does



More so by the individuals and other teams working with the injured worker, support and communication

Most of the staff are appreciative of how I assist them in returning to work quickly

Most staff know they can rely on me if they injure themselves, they would just not sustain an injury

Much of my role has been educating a very naive workplace as to the role of RTW Coordinator and the benefits of returning injured workers to work.

My employers understands the necessity of having a RTW Coordinator and provides the resources necessary for me to fulfil my duties.

My role has never been promoted to the staff until there was an incident.

No one comes to me, they just do their own thing with the supervisor

Not really understood or valued until it is required.

Not sure they really care unless they get injured.

Offers support to injured workers

Only claim that we have had someone came out from Adelaide, so wonder why we went to all of the expense for training etc.

Open Communication and Support for our Workers/Staff whom require medical treatment to return to their duties.

Open communication between all parties

Our approach to genuinely helping injured workers, rehabilitation and return to work has raised a positive perception of the RTW Coordinator role.

Our workers trust me and I trust them

People feel like the RTW Coordinator doesn't really need to be involved, also find it a bit strange that someone in management is a RTW Coordinator

People rely on me to work with RTW to get them back to pre-injury work

Provide required resources and additional training

Provides support & assistance.

Respects my opinion and comes to me for assistance

Role valued for expertise, someone to answer questions regarding RTW and keeping costs to a minimum

RTW Coordinators are a pivotal inclusion to the safety and wellbeing of all employees throughout the workplace

RTW engagement is measured qualitatively and KPIs set on RTW outcomes - these are reviewed and celebrated in our business

Still to be determined

Strongly valued and appreciated for my work in this role

Support and care

Support given to injured workers; more communication.

Support injured workers and management for the employee be able to return to work (trust)

The company & employees value my many years of exposure in various industries.

The help and support I provide

The position is not seen as relevant until an injury occurs and then the expectation is that the RRTW will manage it

The role is valued as a necessary part of the WHS and general human resource management

The role is valued as I have some expertise in this and injury management as an RN.

The role of RTW Coordinator demonstrates our extended duty of care and gets the worker back to work quicker and easier with the right attitude.

The role only comes into play when someone has an injury

The success/failure of injury prevention etc. can directly affect our Insurance Premium hence Management in particular value it highly in an industry where finances are MINIMAL

The Value of this role has become apparent after the successful RTW outcomes have financially impacted the bottom line

There has only been 1 case since I started this role, the injury occurred prior to my starting, I worked with the person involved and saw it through to the end and was told by senior management that they were very happy with the outcome

They don't care much unless they need the RTW coordinators help with a claim/injury

They know I am the go to person and can get the information needed and deal with GB when claims arise.

They know I will always do whatever is necessary to help with the process.

They know who to contact/talk to in the event of an injury/issues with claims.

They understand the importance of someone co-ordinating the focus of assisting the injured worker

This is my only role, it is promoted to all employees prior to commencing and throughout their employment

This is variable as most do not understand the complexity of injured staff members and the RTW processes until they are associated with a claim...also some still display an attitude in relation to a person putting in a claim so it is always a challenge to get managers and staff to believe there is no stigma attached to claiming for a workplace injury. Constant training and providing information on a regular basis assists to educate everyone but as this is not part of core business it does take a back seat to other business processes even though managers are aware that if a claim is sorted early and well managed it proves to be cost effective.

Those that I liaise with are grateful. Most do not realise what the task is about.

Trusting and guiding role, confidential and sensitive

Valued as they know there is one person to go to.



Very few claims, staff not overly interested.

Vital part of the role because there are so many injuries

We are only a very small business. Owned by my husband and I together, my husband didn't know what he had to do so he asked if I would do it. We have one employee that is not part of our family

We find alternate light duties wherever possible to minimise time off work

We have a very proactive return to work program.

We have minimal claims and few injuries - I think people appreciate I take an interest but not a big deal

We have so little injuries and there is another RTW coordinator on site most people would be unaware of the role

We take on a very supportive role with injured workers and attend all appointments and assist where ever possible

Well supported with education and general support.

Whilst we are yet to have an immediate need for the function, it is reassuring to know it is there if/when required.

With education over past 3 years more valued role

With the case I was involved in senior managers were very interested and continually asked for updates

Worker best outcome, cost saving, reduced premiums.

Workers appreciate a regular, familiar contact person, and the manager's appreciate the RTW Coordinator makes their job easier

Workers compensation and RTW are not valued at all until such time as premiums are renewed

Appendix B: Additional comments – Barriers 2016

A number of doctors in my experience just 'mail it in' and do not in any way assist the workplace to understand and accommodate the employee's needs. They are often unresponsive to phone calls and emails, and when you do manage to get them, they are uninterested and dismissive.

Agreed treatment/Claims Management Plan might resolve this

All of the above prove to be significant factors and barriers whilst trying to facilitate a RTW. The most significant would be time frames from the medicos and/or treating allied health and at times from the claims agent as they seem to hinder progress which can impact on recovery outcomes. But all of the above play some part in coordinating the rehabilitation and RTW. In my experience if the injured worker is also managed in a reasonable manner and with a professional approach the outcome is not only achieved quickly but without too many of the abovementioned barriers causing impact and undue delay. Attitude of the workplace, claims agent and the RTW coordinator to be non-judgemental also assists the injury party to achieve a positive recovery. The model for RTW is multi-faceted and if failure occurs in any area it can create angst and subject all parties to ongoing issues that impede progress. All in all everyone has to be working professionally and in harmony towards the same goal

As we have very few workplace injuries I have found the process very smooth with all involved. I would also like to say that I have experienced workers being physically able to RTW however their mental state upon RTW is a challenge, i.e. working in a different role on light duties (learning new things) feeling they are letting the team down by being absent for their usual station and the feeling of not being believed by other team members. (I assume this is all common in other workplaces as well)

As workers can choose own doctor given our workers are state-wide (we are unable to enforce where to go for medical treatment) it would be beneficial for doctors to be more educated in the return to work system, being made aware of how income support affects employers and that employers are not trying to avoid WorkCover claims, but that they want to manage the worker better at work. Doctors need to identify workers that are using the system to avoid working (not all of course) but my workers only work for 40 weeks per year, while on WorkCover they get paid for 52 weeks, and a lot of workers understand this and of course deter the doctor from clearance at certain times of the year.

At times it can take a while to initiate a RTW program. However, once up and running I find it usually proceeds as planned in the majority of cases.

Certain GPs knowingly support a long-term physical injury when the real issue has become psychological.

Claims agents lack of understanding and the purpose of returning people to work who provide incorrect information to the employer. Information provided has been late and not reflected of agreed decisions i.e.: claims agent not passing on information/communication they have had with worker that relates to the workplace. Slow response to engaging the worker and employer to act immediately so that intervention strategies are in place as soon as possible. Medical/Health care providers working with claims agent and worker not necessarily the employer. Passive advice provided by claims agent that results in unnecessary investigations by RTWSA, and is a waste of everyone's time. Workers playing off the employer and claims agent, by not participating as per their requirements under the Act.

Claims department are very knowledgeable and supportive. In my workplace it is extremely difficult to find other roles as workers are matched with the person they support.

Communication with medical professional at times is very limited and time consuming and does slow the process done from time to time. At times the medical profession seems to favour the employee rather than taking an objective assessment to understand the situation for both parties.



Depending on the type of injury additional support or intervention may be required. On a number of occasions I have enlisted the support of EML to provide a case manager meeting or independent assessment. These types of requests can be slow to receive action.

Doctors are still very hard to deal with. We recently had a GP telling a staff member he would never return to our workplace, but after 5 months they found out the original diagnosis from the GP was incorrect after seeing a specialist, and the worker returned to work. We had already begun the process of looking to fill the position in house, so this put us, the worker and the other employee in a very difficult position.

Doctors play a significant role in influencing the injured worker. Authorise IME to overrule or reconsider GP's opinion. Make case conference a mandate every 4 weeks. There should be one more layer of less serious injury claims which should close within an year and the step down to 80% after 6 months.

Each claim is different and faces its own hurdles. As a labour hire placement it is difficult for us to get Host companies to supply modified duties.

EML have been fantastic with their support and advice. Daniel Whitford is a star as our Mobile Case manager

Experiencing country GP's unsure on how to treat many injuries and continually finding it easy to just write out a unfit for work certificate. What KPI does the likes of Gallagher Bassett or Employers mutual have to return to worker to work against them having time off or not fully buying into the Return to Work process? My experience is that unless I drive it, return to work does not automatically happen from a medical provider

For this and the previous 2 questions all responses are unsure. Why? Because we have had no injuries to date in the workplace. Therefore we/I have no experience.

Found it far too easy for doctor's to provide sick certificates and staff to take advantage of the system. Unfortunately I have not had many legitimate claims and have lost faith in the system. As a RTW coordinator I had one staff member refuse to meet with me to help with the process and RTW SA did nothing to encourage or enforce the meeting. This staff member had no intention of working again, had done a previous similar claim. Not making the effort to meet with the RTW coordinator should not be allowed.

From the One Case I have dealt with I found that the Doctor was Very Much caught up in the workers out of working hours issues (personal issues) and was prepaid to issues days off on that basis not so much the problems faced by worker at work.

Gallagher Bassett were very accommodating and supportive when the system first came into being and we transferred across to them - a GREAT deal has changed in that department since!!!!!!!!!!!!!!!!!!!!!!

GP's signing employee off of work before understanding the workplace and alternative duties we can provide being a larger workplace. Being regional we struggle with access to specialist in a timely fashion.

GP's who have no interest in the workplace, GP's who have no understanding of RTW process, GP's who have no interest in the RTW, Physio's who limit communication, Physio's who have limited experience usually getting RTW cases, Medical services unavailable in regional areas - time off work modifying highly repetitive work tasks. Not putting other workers at risk when carrying injured workers

Haven't really had enough experience with claims as yet since becoming RTW coordinator in August 2016.

Huge problem with GPs because they normally listen to the patient but only the patient, even in circumstances when other doctors give the clearance to return to work the worker's GP don't want to listen other valid opinions. We need more training for GPs.

I find that medical practitioners can be somewhat obstructive, depending on their knowledge of the RTW process. This issue appears to be declining, though obviously, an injured worker's GP is generally going to err on the side of their regular patient, due to business pressures.

I have built up a good relationship with the claims manager and RTWSA, however there are times when injured worker is not following the return to work plan and there does not seem to be enough interaction by the claims agent to make them follow the return to work plan. Unless you go out of your way to make sure you talk to doctors and let them know what work you can offer the injured worker they seem to just want to give the injured worker time off just in case you do not have duties suitable.

I have not had an injured workers , so most questions do not apply to me

I have not yet had an experience with returning an injured employee to the workplace because we have not had any injured workers since I commenced working here in February this year

I have problems with lack of communication from EML constantly. Drs that do not have any RTW goals and pander to the injured worker

I rely heavily on appointing independent rehabilitation providers to get the most successful outcomes for our injured workers. The workers and claims agent always support this initiative if the employer enforces it. RTWSA should always allow employers to choose their preferred independent rehabilitation provider should they choose to appoint one - on a case by case basis.

I was frustrated by an employee that was cleared by a Dr to return to work but was not physically capable, putting his mental health at risk. Very frustrating for employer, case managers and employee.

I've only had 1x hands on claim, it was an existing claim with numerous issues that was handled by a previous untrained co-ordinator

In regards to my answers they are based on some of my general experience so am relating that to what could possibly be the case in SA. Where I have used unsure this is because I have not had to work with anyone from RTWSA as yet.

In some instances there is a lack of knowledge in regard to return to work and the process involved.

In the main, medical provider provide duties that are unrealistic i.e. light duties, seated and no walking for a construction worker.

Inability to make appointments to have medical practitioners in the region see injured employees. Have to chase around all practices or simply head to Accident & Emergency.

Inadequate response from GB with any claim or Injury

Initial claims process is fine, but follow up can be a problem. Frequent changing of claims managers without notification to worker or RTWC. Slows down process of claims as information appears to be lost in the system - not passed on to the appropriate person when someone leaves. All of these barriers could be very significant if they were encountered. A full understanding by all parties concerned is essential. Managers/Supervisors must be made more aware of role of RTWC and their responsibility to the RTWC and injured worker - not just leave it up to the RTWC.

It is very hard at some stages to return the injured work to office / alternative duties, as some GPs would prefer the worker to stay at home with nil capacity to work. Sometimes working is not an option,



but GPs are quick to give time away from work rather than the worker be approved to do modified duties.

Main barriers are worker attitudes and GP's who do not understand that returning to work is better for the worker mentally and physically.

Medicos, GP's in particular seem too eager to keep people off work without exploring the real issues, particularly with psych claims. GPs are also quite inept in making referrals for workers in respect to accessing psychological support. this usually has to be driven by the employer.

Most of our injuries are psychological and these are always difficult and complex to coordinate the RTW

One of my biggest issues is GPs who sign a sick certificate for an injured worker without a clear understanding of the workplace or enquiring whether modified duties are available so the injured worker can return to work.

Please bring back the 13 week drop down in entitlements or something to that effect, 12 months is too long. There needs to be some type of control in the first twelve months, I find it very difficult to bring them back in the first 12 months when they are receiving their AWE for sitting at home. As soon as their pay drops they find miracle cures, it is truly amazing.

Sometimes find that Doctors are too soft on patients when they need to be tougher.

The new system with the Mobile Case Manager is great. Calling in the claim is not as time consuming providing you have all the necessary information at your fingertips. Mobile Case have improved the communication with Medical providers immensely.

The vast majority of my experience with RTW service providers in last 2 years (mainly at my previous workplace) has been extremely positive. The change in legislation and structure of service provision has been fantastic. Mobile case managers make a huge difference to the worker and also to me as a RTW coordinator in reducing my workload and need to attend as many GP visits. At times there may be barriers with GP's or health providers in getting clarity on treatment plans or support with moving the worker forward in their return to work but this is very rare.

There continues to be limited knowledge of the Return to Work Process by GPs who are more inclined to provide unfit certificate even though we contact the GP and send the injured worker with a list of suitable duties available.

There needs to be a big shake up with doctors. We were sending our injured employees to CHG that specialise in WorkCover. Unless it's a minor injury I don't recommend them. From my understanding medical centres that specialise in WorkCover are money hungry.

Treating Medical Officers without an understanding of the workplace or the roles that are available to all injured workers within the organisation are the biggest hurdle to returning a worker to work. They usually deem them as having no capacity, yet we are able to identify alternate duties during this time of limited capacity to accommodate the worker returning to work sooner. It usually results in a case conference to verify to the treating doctor that we have work and we support the worker returning to work with the injury. Most often than not, it is the worker who does not want to return to work with the injury and is happy accepting the time off from the doctor, but they know they have some capacity.

Treatment by medical /health providers needs to reflect RETURN TO WORK philosophy in returning the injured party back to work

We have three different divisions in our horticultural and arboricultural business. Weed division has a lot of manual handling and Parks and Trees division is very labour intensive. We are working in a very competitive industry and timelines must be met. Sometimes the medical/health care providers do not understand what is involved and they can sometimes err on the side of caution, as they do not

understand that other methods can be used to deliver the same outcomes. Depending on the injury we are also in the position where we are unable to provide employment due to the physical work involved. Majority of the time we have been able to accommodate the injured workers and assist them to return to work successfully.

We manage all employees with injuries, including injuries from outside the work place. However, I am continually frustrated with doctors providing sick certificates for medical condition which are fabricated by employees wanting to utilise their sick days as holidays. This is costing industry millions. What is the government doing about this problem? We potentially receive 10 certificates per year x 80 people = 800 days off in a year

We require more action from claim managers and we need answers about a claims, updates. Other barrier is that the RTWSA needs to consider special cases, for example a worker that has a few injuries, because of the age and he is on a return to work plan but he doesn't pick up the phone, he doesn't attend to medical appointments, he tries to delay the process in every way that he can, because he told everyone that he doesn't want to return to work and the company keeps paying his wages and we can't suspend that, this is carried on for 12 months now.

We use the Corporate Health Group Doctors and they are good. But if you go anywhere else a lot of Doctors have no training about the requirements for industrial management of injury and return to work. I recently had a Doctor at a surgery argue that a RTW Coordinator and finding alternate duties a was a whole lot of crap and asked me why I was doing this. I told the Doctor that the science is that helping personnel returning to work helps with recovery. He told me in front of his patient, Gallagher Bassett RTW Officer and Industrial Physio it's all a lot of crap. I would argue that only Doctors with industrial medicine training should only be allowed to handle RTW Claims with this training.

We utilize a healthcare provider who are aware of the type of business we conduct. They have a Job Dictionary for our company which enables them to have a realistic view of what is expected of our workers.



Appendix C: Ideas to improve RTW outcomes in the workplace, 2016

The treating doctors are often ignorant of the workplace, and the employer. They often judge the workplace based on what an injured employee may say. This is not always accurate. There is a lack of communication between medical providers and employers. Doctors are often suspicious of employers involvement and they have negative an attitude towards employers who are often just trying to assist in the RTW. Good communication between all the stakeholders is the key to a good result. Also doctors appear to over prescribe medication. I note most injured employee I have met with who are prescribe Endone for any length of time, end up with a psych claim. I wonder if RTWSA monitor doctors, and their prescriptions? injured workers soon work out which doctors are more likely to prescribe the medications they are after... In my experience the mobile case managers can assist in employer the relationship with the doctor.

The system is flawed, it always has been and I doubt it will change. There are too many that linger on a claim and no matter how many "specialists" you place on them, a Dr will always side with his/her patient. Most Dr's are not welcome to the idea of a RTWC attending appointments. A RTWC is in my opinion a toothless tiger, the stripes are there but the bite is nowhere to be seen. You must review the 12 months of full AWE, reducing this will see an influx of miracle cures at 13 weeks or wherever it is set.

Specialist and doctors should be made to provide their reports in a quicker time frame than they do so treatment can take place earlier. If a worker does not follow the return to work plan as it is written penalties should be put in place to guide them back in line with their requirements. There is known doctors in the system that are very lenient on workers and people wanting to stay on the system certainly go to those doctors. The system should look at what part these doctors play in the cost on the scheme. If a dispute takes place and the case goes to conciliation there is not enough information flow between the insurance providers legal team and their case managers or RTWS to help get to the facts in a dispute.

Refocus our energy from "injury management" to "employee engagement" which is only possible when there is genuine care of employee's wellbeing. RTWC should focus on building a culture of trust and happiness at workplace which will reduce incidents, injury, unscheduled absenteeism and increase productivity, innovation and quality of service delivery. Help RTWC build soft skills like behaviour management, CBT, mindfulness and make them a coach not just an administrative resource.

Recruit staff with the right attitude who what to be at work. In the "not for profit sector" our staff are all motivated by providing a good service to their clients. Make people feel valued and that they really are your companies most valuable asset. Be proactive and try and prevent injuries rather than accept you will have injuries.

More education for non-injured employees.

Maintain pressure on Insurers to maintain their standards more explicitly than simply have them 'butter' you up, get you across to their service and then deliver beyond the first year of service, the things they did in the first year. Phone direct contact to speak with people.

Legislation that better understands casual workers Mobile case managers/coordinators based with medical background

Increased knowledge of managers and supervisors. Training for them by an independent source, not the RTWC. RTWC needs backup support from outside source to encourage more positive involvement from managers/supervisors.

Ideas: Most of the ideas and comments were listed previously (and suggested in the survey), but the most significant issue is ensuring that time is spent with the injured party and any others who happen

to be involved to maintain momentum and contact support - this is instrumental in the outcome. Communication and consultation must be increased and encouraged which leads to the universal problem that not enough people are trained internally or externally to deal with the complex issues managing an injured person back to a responsible meaningful position in the workforce.

I've had my say. Poor claims management makes RTW more difficult. The sooner injury compensation systems get out of the "insurance" mentality, the sooner RTW outcomes will improve.

I have never had to use RTW services other than to report a needle stick injury. So not much help to you. But for the point of the survey it would have been helpful to first ask "" Have you used the RTW services before? "Have you reported an employee to RTW for assistance?" I could have said no and the survey would have been more useful for both of us. All the best with your study/Thesis etc.

I believe that the one case I have dealt with was handle well through being patient and creating a good rapport with the injured worker. Creating trust was so very important and following up and sharing information with the injured was crucial. Also having the support of RTW staff was great.

How about RTWSA, the SAET, and the Insurers understand that the 'No Fault', ethos that pervades the workers compensation system, is not really a 'no fault' system as the employer always pays. This is particularly so when a claim become disputed and the insurers make a 'commercial decision' to use the employers money to pay out on ludicrous and fanciful claims. Also Case Managers being too easily swayed in accepting claims that have no merit. We understand completely about the benefits of proactive and flexible, early return to work strategies. How about getting the Doctor's on board with this idea? How about RTWSA engaging insurers with some interest in looking after the employer's concerns? The mobile Case Managers have been of benefit but they are still hamstrung by 'corporate' greed and ineptitude. Furthermore, too many of the questions in this survey were loaded and demonstrated a lack of understanding of the employers perspective and clearly skewed to elicit certain outcomes. Thanks for wasting my time.

Having all parties work together. We use Rehab plans and detail what the worker will be doing day to day (for the length of each certificate) we find this gives all parties a clear understanding of everyone expectations and requirements. We believe they need to be updated with each new certificate - were as the claims manager believe we only need one.

Have an online reporting system for new claims. The telephone claims process is laboured and time consuming. I feel I could input the data into an online form and submit a lot quicker than it takes for me to call the EML number and verbalise all the information to someone on the phone to then type into a form. I have made these comments known to EML previously.

Get the medical providers to meet their requirements in tell us what and injured employee can do not what he can't do. Be realistic in the duties that they can perform.

Education to all. Discount in premiums for employers who are actively managing their workers

Early intervention; ensure managers know what their role and responsibility is in this process; up to date documentation and processes.

Early intervention is the key, together with a very competent and experienced Case Manager, with strong communication skills and follow up.

Do not delay medical reviews and WSA from allied health. The issue for which I have no solution is when income support ceases, RTW specialists conclude RTWSA role and the worker remains with permanent restrictions for an employer to "fit in" when medical recovery continues indefinitely. While rehab work is provided an ongoing modified role may not be always available in a company of 500 support workers. Many services require fully fit active employees. Where do the not so fit go as the client base becomes more inactive behavioural client ?



Daily interaction with injured workers, use of Injured Workers Log sheets to record activities and times taken during the shift to stretch as per physios etc. Transparency when dealing with injured workers and the changes that may have to be made to accommodate them.

Concerned that there is no longer secondary claims. May affect who employers employ. Mature employees may have the experience but their repetitive actions at work for a specific role may present a common history of injuries in an industry. E.g. tilers may not be employed over the age of 40 due to deterioration of knee joints. Yes discrimination but think this will be a problem across many industries.

Compulsory RRTW regulatory training for GPs & other health care professionals. Clear parameters around RRTW requirements e.g. treatment in own/company time set by RTWSA/regulators.

Case conference with all parties asap when lost time or significant injuries to identify and resolve where possible barriers in RTW and explain claims process to alleviate concerns for all parties.

Be tougher on those who make claims, it is far too easy to be unfit to return to work, even very easy work. It is frustrating for the balance of the staff and management who then need to spend time managing the process of someone getting a free ride.

As a workplace that has very few injuries I may go a couple of years without a claim. So when I do have a claim it like doing everything for the first time again. Support has always been there when I have needed it and hopefully will continue to be. I would find decision flowcharts helpful too.

All employers to source their own Manager of claims. This would improve the current outcomes from both GB & EML

Aligning the medical industry with the RTW. Educating medical practitioners to reinforce the early return to work in a capacity to assist in recovery.

1. Recently, EML has provided an interpreter for meetings with an employee whose first language is not English. This has been extremely helpful. 2. Doctors and Allied Health Professionals also require urgent training in RTW. I am still dealing with their uninformed practices e.g. not using the Work Capacity Certificate until they absolutely have to and even then, still refusing to complete the new document.

Be more flexible and have the opportunity to discuss/take action with difficult cases. - More health partners/GP's to expand their RTWSA knowledge so they can be more objective/fair when assessing an employee.



Australian Industrial Transformation Institute
Flinders Business School
Faculty of Social & Behavioural Sciences
Flinders University
GPO Box 2100
Adelaide SA 5001
P: 08 8201 5083
E: aiti@flinders.edu.au

