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Disempowerment of workers in vocational rehabilitation: would self-management help?

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Abstract

This case study is a sub-study to a randomised controlled trial (RCT) of adding self-management training to usual vocational rehabilitation for chronic, compensated musculoskeletal disorders. The purpose of this sub-study was to assess overlap and differences between vocational rehabilitation and self-management as it is currently practised in Australia. Analysis of high-level policy and procedure documents, key informant interviews and an audit of seven case files using an adapted tool for assessing the principles of self-management were conducted. Results showed that payer influence is high in the determination of service delivery models and that vocational rehabilitation as practised in Australia currently does not embrace the principles of self-management.

Keywords: Vocational rehabilitation, occupational rehabilitation, self-management, musculoskeletal disorders, process mapping.

Introduction

The context of this case study of policy and procedures for vocational rehabilitation, along with a small series of case file audits, is as a sub-study to a randomised controlled trial (RCT) of adding self-management training to usual vocational rehabilitation for chronic, compensated musculoskeletal disorders.1

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A narrative review of the state of vocational rehabilitation in Australia concluded that economic rationalism has dominated this field, and that the time had come to put humanity back at the heart of services by taking up the emerging principles of health services reform, specifically self-determination, inclusion, community development, holistic and coordinated service delivery and responsiveness to client goals. There is some evidence that this idea has support. Visitors from the Institute of Work and Health in Toronto revealed that they have started research in this field, including self-management principles in vocational rehabilitation. In industry, the need to engage more with workers in the process of recovery and return to work appears to be gaining some recognition. TNT, for example, has a booklet for injured workers which describes in some detail the workers compensation system and the role of various players an injured worker is likely to encounter. In addition, it has a section for the worker to record progress at review meetings through a number of questions which appear to be based on self-management principles:

- What have I achieved since my last review?
- What am I doing to assist my recovery?
- Goals for next review?

A search on Medline found only three studies which addressed the potential benefits of adding self-management training to vocational rehabilitation services. The first, a randomised controlled trial for the rehabilitation of patients with schizophrenia, developed two cognitive-behavioural group therapies, one which included self-management skills for negative symptoms. The researchers found no additional benefit in terms of return-to-work outcomes from adding the self-management component. A case series of people with disabling musculoskeletal pain for more than 12 months' duration who received cognitive-behavioural therapy, including self-management reconditioning, vocational rehabilitation and psychological pain management, resulted in 75% returning to work. Furthermore, results from a study set in the New Zealand workers' compensation environment suggest that a multidisciplinary program which includes a cognitive-behavioural approach with self-management reconditioning may have a significant impact in getting claimants with disabling musculoskeletal pain, back to work. Another conducted a process evaluation of a pilot program aimed at preventing work disability and maintaining at-work productivity in employed people with inflammatory arthritis (IA). Results from the evaluation showed that the program, which combined self-management group sessions with professional job retention assessments, was feasible and well received by participants. Participants also reported improved self-efficacy in managing problems at work due to their IA, along with improved fatigue and at-work productivity. The purpose of this sub-study was to assess overlap and differences between vocational rehabilitation and self-management as it is currently practised.

**Methods**

A case study was conducted in a leading large national provider of occupational health services, including vocational rehabilitation. Information about high-level policy and the service delivery model was obtained from analysis of documented policy and
procedures, guided by key informant interviews. Information about consultations was obtained by analysis of case files. Three business lines (work streams) in the vocational rehabilitation arm of the company had been identified for participation in the RCT described above. In one there was a single payer, a workers’ compensation scheme. In another, also a single payer, vocational rehabilitation services were provided to a government department which delivered disability services. The third business line was a group of life insurance companies with income protection products which offered vocational rehabilitation services on a voluntary basis to claimants.

1. Mapping of policy and procedures

Initially, interviews were undertaken with the managers of the three business lines which had been included in the RCT to obtain an overview of policy and protocols relevant to the model of care for vocational rehabilitation used in this organisation. The foci of the interviews were:

- determination of the extent to which, and how, the practice of vocational rehabilitation had been standardised in this organisation
- identification of key policy and protocol documents which drove the standardisation of vocational rehabilitation care.

Key policy and protocol documents were obtained and analysed by the researchers. The organisation also provided a written description of what they considered typical client pathways for each of the three business lines.

Using all three sources: key informant interviews, analysis of policy and protocol documents obtained and written descriptions of client pathways for vocational rehabilitation, a matrix was prepared which logged corporate policy and work performed in each of the three business lines as follows:

- a description of the work undertaken
- type of clients
- description of client journeys
- types of policy and protocol documents which exist
- content of above.

This was analysed by researchers.

2. Analysis of case files

2.1 Selection of case files

The research team member based at the national rehabilitation provider selected seven case files for the audit from those locations participating (ie Adelaide and Brisbane) in such a manner to ensure a mix of business lines, return-to-work plans and return-to-work outcomes.

2.2 Adaptation of tool

The Flinders Human Behaviour and Health Research Unit provided a tool they had developed and used for assessing the competency of students in undertaking clinical
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consultations for self-management. The tool was based on the questions in the four Flinders tools ie Partners in Health scale, Cue and Response interview, Problems and Goals assessment and the Care Plan. All tools are based on assessment of the six principles of self-management used to determine the client’s knowledge, behaviour, skills, strengths and barriers to self-management.

A team of three researchers, two from the University of Queensland and one from the national provider organisation, adapted the assessment tool to vocational rehabilitation as follows:

- reference to discussion of results from specific screening tools not used in vocational rehabilitation deleted
- criteria related to notes being written in the client’s own words and using first person, softened to the inclusion of client views about their problem and its management being included, and at least some notes being written from a client perspective, and in their own words and in the first person
- references to goal statement and care plan changed to return-to-work (RTW) plan
- criteria assessing that all issues raised in the cue and response interview had been transferred to the plan and that the plan contained aims about what the client wanted to achieve, changed to assessing the extent to which the RTW plan addressed the client’s perceived problems.

The tool was tested on three case files. The national provider organisation provided three de-identified case files of vocational rehabilitation consultations. The three researchers each reviewed one case file using the tool. The results of the three assessments were compared and further minor modifications were made, mainly to clarify how to rate the use of the client’s own words.

The final tool comprised 15 questions covering:

- inclusion of client views about their management, with notes written from their perspective
- record of discussion about goals and recommendations, and evidence that the client agreed to the goals
- RTW plan written in the first person, and client’s name appearing in the who’s responsible section
- information on their problems, the consequences and how the client feels
- internal integrity of RTW (goals linked to problem, RTW plan allows goals to be achieved, manageable interventions, review date for interventions)
- RTW plan is specific, measurable, action-based, realistic and time-framed
- RTW plan is written in client-friendly language.

As well researchers were asked to make a concluding comment on the extent to which principles of self-management were employed in the development of the plan.

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2.3 Assessment of extent to which vocational rehabilitation practice incorporates self-management using the tool

The researchers used the tool to assess seven de-identified case files, including the three used to test the tool initially. The cases were divided among the three researchers for an initial assessment, then reviewed collectively.

The findings from the review of the seven cases were logged on a spreadsheet and analysed.

Results

1. Mapping of policy and protocols

1.1 Corporate policy

At a corporate level, the national provider had a high-level statement of best practice work instructions for return to work and the initial needs assessment which included:

- definition of injury management, rehabilitation and return to work
- responsibilities of managers, team leaders, case managers and administrators
- flowchart of the process from request of service to finalisation
- mechanisms for quality control and improvement.

In relation to self-management it was noted that:

- case managers are required to develop and manage RTW plans
- case managers are required to maintain quality files, which is reported as meaning that the consultant is required to ensure all case notes, reports, correspondence, etc is within the file and up to date
- client feedback, from both the worker and the payer, is the basis for one of the organisation’s performance indicators.

1.2 Service delivery model

Through interviews it was ascertained that usually the service delivery model, ie when and what services are provided, is determined by large payers and specified in their contracts. This was confirmed to be the case for the two large government clients — the workers compensation scheme and the disability services department. The flowchart included in the contract for one of these government agencies clearly shows that the injured worker is expected be involved during all stages of communications with relevant parties. For one of the business lines, where the clients were life insurers with an income protection component, the national provider had developed the service delivery model based on best practice and the demographics of the client group.

2. Analysis of case files

Table 1 shows the assessment of the extent to which vocational rehabilitation practice included self-management based on an audit of seven case files using the tool adapted from that used to assess student competency at Flinders University.
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Discussion

Relationship between vocational rehabilitation and self-management

The following definition of self-management was adopted for the purposes of this study: Self-management is defined as the learning and practising of the skills necessary to conduct an active and emotionally satisfying life while living with a chronic condition.9

Essentially, two types of approaches to self-management have been developed:

- one which targets people with chronic diseases and their carers directly, and
- one which targets the health care professionals providing chronic disease prevention and management.

In our RCT, existing vocational practice (usual care) is being compared to usual care plus self-management training for the clients. A self-management training program for people with chronic diseases from Stanford University 10 is being used with permission, and is being delivered by a leader, a trained health professional from the provider group and a lay leader from Arthritis Queensland. Two additional modules have been developed covering self-management training for navigating compensation systems and managing return to work.1 In the file audits, we were ascertaining whether vocational rehabilitation already included the provision of self-management. That is, we were determining whether vocational rehabilitation consultants were already using the principles of self-management in their practice to empower their clients to take control of the management of their conditions as much as possible. The tools for two Australian interventions for self-management aimed at health professionals were reviewed. The resources developed by the Flinders Human Behaviour and Health Research Unit 8 and those developed by the Royal Australian College of General Practitioners.11 The former was selected as the model for this aspect of the study.

The Flinders Model states that a client who is a good self-manager would:

- have knowledge of his/her condition
- follow a treatment plan
- actively share in decision-making with health professionals
- monitor and manage signs and symptoms of their conditions
- manage the impact of their condition on their physical, emotional and social life
- adopt lifestyles that promote health.

According to the Flinders Model, a major instrument in self-management is the care plan which should include: issues (problems), agreed goals, agreed interventions, signature of the client and review dates.

The definition of vocational rehabilitation adopted in this study is from the International Labour Organisation which defines vocational rehabilitation as those activities which "enable a disabled person to secure and retain suitable
employment.\textsuperscript{12} These include the "medical, psychological, social and occupational activities aiming to re-establish among sick or injured people with previous work history their working capacity and prerequisites for returning to the labour market ie to a job or availability for a job".\textsuperscript{13} Thus vocational rehabilitation incorporates work retraining, education and counselling, work guidance and ergonomic modifications and psychosocial interventions.

The role of a vocational rehabilitation provider is to navigate a pathway for a successful return to work of a person who has been off-work with an illness or injury. This involves negotiation between the employer, medical and health practitioners and the worker, for an agreed return-to-work plan which includes goals (timelines for RTW, type of work, duration of work), interventions required, eg treatment or medical review, employer/worker monitoring agreement, and RTW program review.\textsuperscript{14}

Accordingly, it was hypothesised that vocational rehabilitation would function consistent with the principles from the Flinders model for self-management. Therefore, the RTW plan would have similar characteristics to a care plan and the vocational rehabilitation consultations on the RTW plan would include efforts to enhance worker knowledge, attitude and behaviour with the aim of empowering them to play a significant role in the recovery from their health problem and return to work.

In this case study, the national provider had defined injury management, rehabilitation and return to work in their corporate policy.

1. Injury Management: Overall approach to minimising the re-occurrence of injury through preventative strategies and efficient rehabilitation. Involving an integrated approach that recognises the importance of combining OHS.

2. (a) Rehabilitation: Occupational Rehabilitation is a managed, coordinated and tailored programme that aims to:

   i. Assist an injured worker to achieve the best practicable level of recovery following a work injury or illness in line with the return-to-work hierarchy.

   ii. Return an injured worker to safe, suitable employment as quickly as possible within medical restrictions.

   iii. Reduce the impact that work injury or illness can have on an employee and employer.

2. (b) Rehabilitation and Return-to-Work Management, Pre-Injury Employment:

   i. Implement strategies to minimise the risk of re-injury and aggravation.

   ii. Identify potential barriers to return to work and implement strategies accordingly.

   iii. Assist the workers' return to full productive pre-injury duties.

   iv. Ensure effective communication with all relevant parties.
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2. (c) Rehabilitation and Return-to-Work Management, Employment Transition:
   i. To secure alternative employment (comparable to pre-injury hours and remuneration) within the worker’s capacity via an individual/integrated job transition program.

What is clear from the rehabilitation and RTW standard is that every time communications and liaison is mentioned, it is intended that it will be with all parties who are stated as being the injured worker, employer, insurer, treating practice practitioner and the union (if involved).

Thus, high-level policy in this leading organisation indicate it expected its professional staff to make efforts to empower clients to self manage their recovery and return to work.

Who is the client?

The question of who is a client in occupational health and safety services is a question being raised increasingly in occupational health ethics (p 19). Statements of ethics in occupational medicine usually state that occupational physicians are accountable to both employers and the workers they serve. The Australasian Faculty of Occupational and Environmental Medicine’s statement on ethics and professional conduct from 1998 states,

“In many ways the ethics of occupational medical practice are exactly the same as those for doctors in other forms of practice, but doctors working in occupational health may face some additional ethical issues that are uncommon in other situations. Often these relate to potential conflicts because of the involvement of third parties. At different times occupational physicians have responsibilities to individual patients under their care, workers in a particular workplace, employers, the general public and specific responsibilities under legislation. Responsibilities to these parties may conflict. Problems are most likely to arise if these potential conflicts are not recognised; particularly if one party is not aware that the occupational physician has other responsibilities (p 1). This understanding has been lost with the outsourcing of occupational health services and the reduction of the collective representation of workers in workplaces.

In the Australasian Faculty of Occupational and Environmental Medicine Ferguson-Glass Oration of 2010, Dame Carol Black, an international leader on the future of work and health, particularly return to work, stated that OHS was not fit for the 21st century. Black, referring to the findings of her review of work and health in the UK, found OHS to be isolated, had a poor academic base, a limited remit, uneven provision, lack of good quality data, a poor image and was the servant of the employer.17

A historical review of vocational rehabilitation in Australia was not as brutal, but found that the industry had become too driven by economic consideration, with not enough humanity. Kendall was also questioning the balance of power between the payer and the worker receiving services.2
The analysis of policy in organisations in which this case study was undertaken confirmed the considerable influence payers have in the delivery of vocational rehabilitation services. The case study found that the service delivery model was usually prescribed by large payers in their requests for tenders. It should be noted that neither of the payers who had prescribed the service delivery model in this case study were employers, but in Australia many large employers are self-insured and would purchase these services directly from vocational rehabilitation providers. Recently the issue of the appropriateness of a service delivery model for vocational rehabilitation by Australia Post has been the subject of a Senate Enquiry, with unions claiming that the service delivery model puts too much pressure on workers to return to work earlier than is appropriate, and Australia Post responding that their system is one of best practice, returning workers to work as soon as possible which is the best action for their health. Following reports from their members, unions became concerned that doctors nominated by Australia Post (Facility Nominated Doctors) were returning staff to work earlier than was optimal for their health and well-being. Personal choice of medical practitioner exists in Australia Post’s award-winning rehabilitation program, but it was felt that pressure was being applied to staff by management to attend a Facility Nominated Doctor. During the Senate Enquiry, Australia Post maintained its position that its system was a good one, but acknowledged that there may be individual managers or Facility Nominated Doctors whose behaviour was less than optimal.

In short, the committee found that “the key problem with Australia Post’s treatment of injured and ill workers not being the program itself, but its communications with employees and with unions about the program; the links between EIP [Early Intervention Program] medical assessments and the workers’ compensation scheme; and the lack of involvement and input that employees have in developing their own return-to-work program”. (p 45)

What effect does payer-influence have?

Whether the service delivery models would be different if payer influence was less was possible to consider by comparing the service delivery models of the two payer-determined models with that of the service delivery model for life insurance funds. In this latter business line, payers do not seek to influence service delivery by the vocational rehabilitation provider. The service delivery model has been developed by the head of that business line, a vocational rehabilitation provider. The model was developed using best practice principles and is significantly more flexible in terms of what can be recommended and what will be supported by the insurer.

Does vocational rehabilitation already include self-management?

Table 1 showed that findings of an audit of case files of vocational rehabilitation consultations using criteria developed for consultations for self-management were consistent across all seven case files and all three observers. Results show that RTW plans were developed which were specific, measurable, action-based and realistic in all cases. The plans had internal integrity in that they addressed the client’s problems.
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However, using the Flinders tool the RTW plans did not show that the plans reflected the clients' perspectives about how their problems should be managed, nor that they had agreed to the goals.

In discussion with vocational rehabilitation consultants on this, they stated that their care would include consultation with workers about their views in developing a RTW plan but this would not usually be recorded. However, anecdotal feedback from five consultants who were trained in self-management as a part of the development of the new intervention strongly indicated the course had been a revelation and they intended to change their personal practice as a result. This effect was so marked it is now the subject of a separate study in this program of work.

In summary, the findings from the audit of case files are:

- the RTW plans met the criteria for good care planning
- the client voice is generally only recorded in the presenting problem, not in the record of planning or management
- there was no evidence of ownership of the goals and plans by clients, although anecdotally consultants advised that there is extensive consultation with clients in consultations. They said that the reason workers views are not recorded is that the documents are for the payers.

Strengths and limitations of this study

This study is an exploratory, very descriptive study conducted as a preliminary component to an RCT. Its strength is the consistency of the findings in the small number of case files audited, ie very similar findings in all seven cases and across three observers. Further confirmation was provided by the anecdotal feedback from five consultants after training in self-management that there was significant potential to change their practice to incorporate principles of self-management.

A major weakness of the study is that only three lines (work streams) of the business were included in the case study. In particular it would be interesting to compare the service delivery model in these business lines to service delivery models used in contracts with large employers, especially self-insurers where there is potentially a greater short-term vested interest. Because this was an exploratory study, purposeful sampling was used to obtain a breadth of information from a small number of case files. This means that we do not have definitive evidence of poor identification of self-management principles; however, our informants in the industry have confirmed the findings from this sample.

Conclusion

Analysis of high-level policy in a national leading provider of vocational rehabilitation services in Australia has confirmed that payer influence is high in the determination of service delivery models for vocational rehabilitation. Comparison of two lines of the business, in which service delivery models were determined by payers with a line of the business where the service delivery model was determined by the vocational rehabilitation provider, indicated that there was little difference however, suggesting
payer influence, at least for the government purchasers, was benign. It is noted, however, that injured workers are concerned about payer influence as was evidenced in the Australia Post Senate Enquiry.

Case file audits of seven consultations showed that RTW plans do meet criteria for good care planning, but that there is little evidence of the worker being actively engaged in the recovery. This was supported by feedback following the training of five consultants in self-management who, after training, recognised the potential to significantly change their practice to incorporate these principles.

It is concluded that vocational rehabilitation as practised in Australia currently does not embrace the principles of self-management.

**Table 1 Results of Analysis**

<table>
<thead>
<tr>
<th>Q1. Are the client's views about their management documented?</th>
<th>Yes</th>
<th>No</th>
<th>Partially</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2. Are there notes written from the client’s perspective in the client’s own words?</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Q3. Do the notes indicate a discussion about the goals/recommendations?</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Q4. Has information on the following been documented?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. The problem (in their own words)</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>i. What happens because of the problem</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>i. How they feel about the problem</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Q6. Is the rehab/return to work plan a concise statement written in the first person? Have pronouns such as “I”, “me” or “my” been used?</td>
<td>Yes</td>
<td>No</td>
<td>Partially</td>
<td>NA</td>
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<tr>
<td>0</td>
<td>7</td>
<td>0</td>
<td>0</td>
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</table>

<table>
<thead>
<tr>
<th>Q7. Is the rehab/return-to-work plan</th>
<th>Specific</th>
<th>Measurable</th>
<th>Action-Based</th>
<th>Realistic</th>
<th>Time Framed</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Specific</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>II. Measurable</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>III. Action-Based</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>I. Realistic</td>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>II. Time Framed</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Q8. Does the documentation show that the client has agreed to the goal?</th>
<th>Yes</th>
<th>No</th>
<th>Partially</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td></td>
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<table>
<thead>
<tr>
<th>Q9. Is the “Goal Statement” a POSITIVE BEHAVIOUR the client can do on a regular basis? (Could you apply the test “can the action be photographed”?)</th>
<th>Yes</th>
<th>No</th>
<th>Partially</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Q10. Does the RTW plan address the client’s perceived problem?</th>
<th>Yes</th>
<th>No</th>
<th>Partially</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Q11. Does the RTW plan allow the goals to be achieved?</th>
<th>Yes</th>
<th>No</th>
<th>Partially</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
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</table>

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Table 1 Results of Analysis

<table>
<thead>
<tr>
<th>Q12. (a) Is the plan written in &quot;client friendly&quot; language and;</th>
<th>Yes</th>
<th>No</th>
<th>Partially</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>12 (b) the client’s own words where possible (avoiding jargon and medical abbreviations)?</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Q13. Does the RTW plan show manageable &quot;Interventions&quot; (something that can actually be done and can demonstrate how it will be achieved)?</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Q14. Does the client’s name appear in the “who’s responsible” section of the RTW plan along with a variety of people who can support the person to achieve their interventions?</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Q15. Is there a review date for each intervention?</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>


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