RI World Congress
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Parallel A Ochil
New approaches to rehabilitation

>> So we'll just allow a couple of more minutes and then we'll start prompt if that's okay. So this is new approaches to rehabilitation. So if you're not interested in that, you are in the wrong room. Maybe we'll just start and take a couple of extra minutes if that would be okay. So Hi. I'm Allison row, an advisor at the Department of Health in London, and I'm going to be chairing, moderating this session. We are going to run it a little bit like a tight ship just so that we can finish on time, giving people ten minutes to go downstairs two floors for their VIP session. I'm also going to be taking notes here. We're want to go get feedback and find out what people are thinking about and discussing. We might have Q&A times. If do you have a yes, speak to the microphone. We need that for typing purposes. Without me blathering on any further, I want to introduce the first speaker. Oliver.

>> Thank you. My name is Oliver Freugen. I work in the [Indiscernible] umbrella organization of all accident, insurances in Germany. I'm the head of the department of disability management. In my presentation today, I would like to tell you how the return to work process after accidents or illness is regulated in Germany. I have structured the presentation in three parts. First, revolution for the residual reintegration in Germany. Second, the training programme to disability manager to prepare companies for this task. And third, the obligation for constant further education of the disability manager.

To item one. Germany has a statutory regulation which has worked, but unique in other countries. This regulation applies to all operations and institution employing people, regardless of their size. The employer is obligated to take care of his employees if they are unable to work for more than six weeks. [Indiscernible] has to be conducted each month to check which persons fulfill these requirements in the last 12 calendar months. The employees then remember receive a letter which proposes a personal meeting. For the content of this meeting, it could include.

What can the employer do to support the employee with respect to health issues? How can the employer help in object taping the correct report for Social Services providers such as health insurance, pension fund, or Workers' Compensation board? Can working hours and tasks be adapted to the health

situation? Our technical aides required to make working and original workplace possible and could it be necessary to arrange an internal move to a different workplace?

This is more a selection of options, which the employer can offer the employee. However, in most cases, it is not the employer himself would deal with individual cases. Instead, certain persons of selected with operation then that can carry out this task. These persons are usually from the Human Resources, the workers council, occupational [Indiscernible]. It is particularly important to contact the employee very early in the case to be able to implement essential measures.

In Germany, the six week limit was chosen, because employers' obligation to obey wages after this period is usually followed by compensation in the form of short-term benefits for health insurance. In the meantime, many countries have recognized that long-term sick people require more than mere financial aid in the form of nonrecurring financial assistance or pension payments. The early beginning of the return to work process was objective of bringing performance impaired people back to the old workplace. It's not only important for self-esteem, but can also lead to reduction of social benefits. Since social target could be useful for all parties in the context of win/win situations.

I believe that this approach is also possible without statutory relations. In the context of said duty to care, employers should deal with this topic and Social Services providers should support the employer in this matter, not least all in their own interest.

To item two. As I have described in the first part, this task places huge demands on employers and the respective persons acting for the company. Detailed knowledge is required to monitor employees in this process. The requirements include a certain understanding, for example, of medical context and [Indiscernible] fundamentals, behavior, and ability to communicate very successfully. The training to disability manager is to learn such abilities and effectively deal with the performance impaired people. The foundation of the education is a programme for training and further implication for manager in Canada and by the German insurance as license for the German speaking countries. This programme cakes into account global movement to preserve the workplace for people with medical limitations and keeps them in the workforce. Today, Germany has more than 1,500 certified disability managers who are either taking care of colleagues as employees of a company or active for companies as members of service providers organizations. The objective to the programme is to impart competencies to return employees back to the old workplace following illness or accidents.

At this time, I would like to introduce a Fu Hong Society important competencies imparted by the training programme. Knowing the system of the country and the social benefits, learning the technique of communication, analyzing and securing performance at the workplace, knowing the context of health, disability, and prevention and exhibiting social behavior. The main points of the training are presentations, educational dialogues, case studies with teamwork, homework, and [Indiscernible] the training is

concluded with a test containing a total 300 multiple choice questions. The respective answered is issued upon successful conclusion of the test. Germany is very successful in this process. Many countries, particularly from the Asian area, have sought contact with us to learn from our experiences with objectives to intensify the return to work concept and avoid ineffective benefits. Next to many countries, we are in constant contact with China, Indonesia, or Malaysia.

Item three. The system of this educational scheme has a special feature. What use is comprehensive training and the passing of a test further theoretical signal not replenished and one only learns from the experience, gather it in the duty of a disability manager. So the principle of recertification was introduced. This means that all disability managers or certified disability managers have to participate in murder training measures on an annual basis. We are in constant contact with all disability managers and check whether this obligation is met. If respective further education measures are not executed, the certificate is withdrawn.

In German, an association of certified disability managers have been established, which is [Indiscernible] to the disability managers in many issues. One important task of this association is an organization and proposal of the further education events for the recertification. Possible activities to require certification are 20 hours of further education per year or disability manager educates [Indiscernible] or publications to the return to work issue.

Summary. When dealing with sick or injured people, one should contemplate how the preservation of the workplace is possible at an early stage. Employers have to assume responsibility and Social Services providers should support them. Compared with so-called benefits, return to work concept should be preferred. The disability management developed in Canada is a suitable tool to achieve this objective. We would be pleased to offer our support to this topic and look forward to meet you after this convention.

And now it is time after the presentations for questions and discussions, but I have some problems with my hearing and in combination with speaking English, my English is not so good, a little bit broken, so I suppose for my part to answer questions after the presentation in a break form of conversation in face to face. Okay? I thank you for your attention.

>> Thank you.

[Applause]

>> Great. Thank you. That was really interesting. What we'll do then is we move on to our next speaker, who is coming to it talk, and then as Oliver said, he will take questions in a more one-to-one basis if you want to meet up with him over the next couple of days. Thank you.

>> How do I do it?

>> So there's clicker if you want it. You do it from there. Okay? Thank you. I am [Indiscernible] and I come from Finland. I have been a referrer -- researcher over 30 years, researcher of rehabilitation, and I

drop rehabilitation foundation, and nowadays I have also a job as a researcher in this Finish association for mental health.

I come to present to you results of our research project which concerns 11 organizations that are working for persons with substance abuse or mental health problems. This project is finished by the Finish [Indiscernible] association and it lasts something like four years.

There are three different research projects in this whole project. One of them concerns the knowledge about the organizations, their situation, and the he could second is the need of those citizens that these organizations reach. And of course, how these organizations meet these needs. And then the third one is volunteer work, peer work in organizations, and me and my colleague are doing this research.

The name of the third sub-research, firstly, the exam, critical concepts of voluntary work and PR work or expert of experience. For this part, we have written an article. It's in Finish for this concept. Then there's second one examined by questioners, for example. How important voluntary work is for these organizations. What stands as voluntary work. Why is voluntary work done? How should it be developed, for example?

We use this so-called snowball sampling in our research, because we don't know the correct amount of the voluntary workers and we don't know how many -- how big a part of the person is dealing with the voluntary workers. So these four questions, the key persons of the organizations spread their links to the questionnaires. So the data was collected by this way.

this analyze -- for the analysis that I'm printing now, the results, preliminary results, for them I have combined these questionnaires. To the person, though, 85% of the respondents were women. We know usually in these organizations, the mostly women are working in these organizations. 60% of the residents were employees. 44% say that they have a written plan how to use [Indiscernible] so it's organized in these organizations. 62% say they give professional guidance to their volunteers, and this is very important for the support to these volunteers. And 72% say that they have processed to secure that they don't get [Indiscernible] this work over load. the s not very important. It's also very important. So the voluntary work is elementary for these organizations. And the voluntaries, they are also six 3% were women. They are rather old. The mean was 53 years. And 53% of them are [Indiscernible] but there are also those who work and after work try to do this voluntary work. After paid work do this voluntary work and the others are students or unemployed. And 66% and the mental health organizations. And most of them, these voluntary workers were members of the organizations that they did this voluntary work. A fifth of them had ten years or more done this work. And 11% did voluntary work 20 hours or more in a week, and there were a couple of persons who did 40 hours a week, this vowel you believe tarry work. But the mean was seven hours a week.

Most of the volunteers had got some sort of professional guidance, and 57% said that they got enough. 28% had got it, but not enough. 26%. And then we asked, have they exhausted sometimes when doing voluntary work? And 36% said yes. And if we look at the connection of this, here you can see that those who have not got professional guidance, 62% had felt exhausted sometimes when doing voluntary work, but they got guidance and enough, only 21% get exhausted. So it's very important for the voluntary workers to get this professional guidance.

And then for the future, how should voluntary work be developed? The best person's opinions, more young people to voluntary work, because they are rather old, these voluntary workers. And more versatile tasks through these voluntary workers, and get these voluntaries to develop organization, doing more for the organizations. I mean, evaluation and research. Then they also think that volunteers need more support. And then this whole voluntary work needs more publicity and more cooperation between organizations concerning this voluntary work. And for the opinions and the voluntary, they want more responsibility and more of this professional guidance, because it's very important for them. More education, and they also need say that this work needs more publicity. And more collective to voluntaries. Using voluntary work should be more natural in public sector work. I mean, developing the work and services, I mean this planning and heal valuation, planning services. It would be more natural in public sector work and more respect to the voluntary work they need. Thank you for your attention.

[Applause]

>> Thank you. So we have some time for questions if anybody has some questions?

>> What kind of guidance do you offer? What guidance?

>> Well, I think it's some sort of what is work guidance? Discussions, whatever. It's not -- a different kind of professional guidance than all the other workers.

>> Anybody got any more questions to ask? Okay. Woman an we'll move on to our next speaker which is talking about occupational therapists.

>> My name is [Indiscernible] I am from Czech Republic, and I am a medical doctor, but also I represent my country international. So I shall speak -- which way you try move it? I shall speak about [Indiscernible] international, but even more about, well, about occupational therapy. This way? This way?

>> I'll get my technical chap to come and help you.

>> Okay. This way. Yes?

>> You don't have to point it in any direction. Just press the arrow.

>> But it's not that. Okay. And I am very glad to present it here in Scotland, because I know that there was occupational therapy, and also we personally collaborated with Ms. [Indiscernible] university and she supported us in international project for development of our OT course in Prague. And I wish to remind my teacher and colleague, Professor Pfeiffer, who in the eighties first started collaboration with

rehabilitation international and the second he also stressed importance and development of occupational therapy in check oh Slovakia at the time. -- check oh Slovakia at the time.

And according to his examples, I started collaboration with RI in 1988 at the Congress in Tokyo. And since 1991, I was RI national secretary until now, and in 80 years, 2000, 2008, I was deputy vice president for Europe and I tried to support participation of former communist countries? And Professor Cuman from Budapest. And there was very best situation in occupational therapy in check oh Slovakia. After 1985, there were changes that started at the time and check OT association was founded. And during this development, we had strong support from western countries. Yes. We met Mrs. [Indiscernible] Brugan who was contact president at the time, and that's she. She invited us to it participate in the project, and during this project, three year project, we also participated in [Indiscernible] founding. Yes? And here is also [Indiscernible] and we also some meeting of persons of 10CEE countries and we -- so I could see the differences between these countries. It is section of physical rehabilitation. That mean where I also represent Czech Republic and this is European network of rehabilitation doctors and they prepare [Indiscernible] just recently so I gave 16 questions and I received answers from 30 countries and there are many differences. For example, number of [Indiscernible] is 58 how is it in Germany and only two in [Indiscernible] so it is quite different situation, but in many countries, OT is accepted like medical profession and that is [Indiscernible] study in 23 countries, for example, and master's study also in eight countries, Columbia check republic, and there is national association in 23 countries. The important question is how medical doctors support occupational therapies, and in 24 countries, it was answered that they supported in some countries. Also, supported of OT, for example. And they did not express any conflicts or different approaches between medical doctors and occupational therapies. And this experience, which shows quite a different situation in developing countries, I combined with experience from the European OT Congress in Galway this year. There were 700 presentations, but only 32 from CEE countries. Yes? And only from ten countries together. Yes? And 12 other countries have no participation there.

And so I should conclude that this part of the presentation, that after 25 years of effort, of west European countries to develop OT in these CEE countries, I should say that it was successful, but only partially because in more than half of countries, there is no OT programme. We should have other Congress in Prague in the year 2020, so I hope that there will be -- will represent OTs from these CEE countries, and there will be information about positive development of OT in these countries. And what the reason for this presentation, I should say that the expression of importance of occupational therapy for persons with disability on-site, but also I wish to compare the situation in three networks. There is network of rehabilitation physician and CEE countries are fully included. Even Russia and [Indiscernible], for example, and all Baltic states. There are OT organizations of Europe and there is more than half of

these countries active. Yes? And there is Europe. Unfortunately, in other Europe, I was yesterday the only one representative of this CE country, so everything east from Vienna and to west from Pacific wasn't represented, which is very sad situation. Though wasn't so bad in the past. Yes? So there was nice conference in Budapest, in Estonia, and we had nice seminar in 2003 in Vienna, but during the last ten years, there was only a decrease of participation from these countries. Yes? So these countries do not participate so leaving the directory of rehabilitation. So one positive point is international. The occupation, leisure time activities, which was held this year in France and out of nine European countries who participated. So it's a positive, but in Europe, there was scheduled conference in worst show. It was practically cancelled. Yes? And so as a conclusion, what should I do to support the ideas of rehabilitation international? Spread the ideas along European rehabilitation physicians. Yes? Where I still participate. Then second to support occupational therapy in my own country in the Czech Republic and in Europe, especially through this Congress. We will be heard in Prague. And also hope in positive development of Europe. Yesterday we election a new executive Committee of rehabilitation professionals, so hope this new executive Committee will support development of membership worse in this part of the world. And so this is Prague [Indiscernible] this is centre of Europe where it will be held the next European OT conference. Thank you for your attention.

[Applause]

>> Thank you. And obviously I have to declare I am an occupational therapist, so I found that really interesting. Do we have any questions at all? Could you speak into the microphone and it will come up on the screen? Thank you.

>> Thank you very much. I'm an OT as well. I'm sure you are aware of the world federation of occupational therapists. As you're asking questions, what should I do? And it's really nice to hear such enthusiasm to, what is the word? To work for more OT in those countries. But I will warmly recommend contacting the WFOT, the world federation. I know they are instantly working with the countries not having an association or not having any university, you know, or bachelor degrees on OT. And it is common way of doing it is by doing some help in establishing both education and the association, and I'm proud to say that the world federation does have a minimum standards on the education of OTs, so there's national standard as to the levels. So there's minimum standards outside KOTEC.

>> [Indiscernible]

>> Yes, it's quite common. Speech therapies is one organization I would say yes.

>> And there's clicker should you wish that.

>> Okay. First of all, Hi, and thank you for being here. It's a long way from Melbourne, Australia, but it's great being here, if today is anything to go by. This is going to be a fantastic two or three days. Quite stimulating. Quite enlightening so far. One of the interests things about hearing things being discussed

through the day. There are a lot in the last plenary that refer to the biopsychosocial model. And so Elwood Mansel, who basically developed that model, Welch academic developed that model and crude steps are when he was looking at reasons for why people report in employment, people with disability on unemployment -- the person, their own sense of self-confidence came in about 89% and the social, that is, the external outside influences of society came in at about 70 plus%. We spend a lot of our focus, and as I'm about to demonstrate in this presentation, we spend a lot of our focus on the individual. Part of what we're looking at in Australia is how we engage employers better or how employers and society engage their own shortcomings, their ignorance, their unconscious buy cast and so on in a more enlightened way. I was pleased with the presentation from park lay's bank, I think it is -- Barkley's bank. It certainly sounded from these fresh ears that that was talking the walk, so that was good.

Anyway in Australia, we've got a Fu Hong Society things going on. One thing that you may have heard of is this huge disability reform called the national disability insurance scheme. I'm only going to touch out with that slightly. And it's significant in relation to disability employment. In Australia, disability employment is a separate programme that sets outside of the NDIA, and one of the things that we are proud of about this disability employment service is that it's the legislative programme and it started in Australia in 1992 roughly with a Fu Hong Society you trial and tests for a couple of years. Roughly 90, 92 it started. And it was based on the advocacy of people with a disability, their parents, their careers, and advocates through the late Seventies and Eighties who basically said we don't want our children to go from school and special school straight into sheltered workshops. We believe they should have the same rights as anybody to go into open employment. References that are used in the nor earn hemisphere to supported employment in Australia, that same concept thereabouts with a Fu Hong Society changes is known as opening employment. So this opening employment programme started in 1992 based on legislation, disability services act, and standards, the disability service standards which set up the framework for how people would engage assisting people with [indiscernible] people. It chugged along. A Fu Hong Society changes, a Fu Hong Society whacks and all that have stuff as you do. It is here today, and last year the then minister basically said, we need to reform the day's programme in line with the principles of the NDIS. The principles of the NDIS, trying to get my 15 minutes.

>> You're all right.

>> No, no. I'll speed.

>> You're okay. . The principles of the NDIS I was referring to are person centre and had individual said.

These are not new ideas, but they coalesced particularly through the U.N. convention and in Australia through the national disability strategy and then through some really hard work and dedicated work by advocates, people with disabilities, careers, families were able to get through this thing called the national

disability insurance scheme, and that is the concept in Australia that is driving the thought, the policy, and the sense of what we do differently, what hopefully we can do bet to assist people with a disability go into independent lives. And when I say assist and support, as I'm saying it, I'm also referring, even though I don't think I'm doing a very good job, of the intermediary people like cast the support moving out of the way so that the person with the disability can make the decision. And that was referred to a Fu Hong Society times today and I'm sure people in this room are very familiar with that.

This is great thinking. It's big thing and it's going to take a long time for it to set until the sort of seek eve of the society. So it's one of the things going on. Another thing, and it may or may not be related, but it actually is the idea that the community the penny might be dropping from the community. It's dropping incredibly slowly, but it might be dropping. The reason why I say that is because a couple years ago we have a productivity commission that looks and things and whether they're valuable, whether they're worthwhile improving, and that's what looked at the national disability insurance game and found that it was worthwhile. So they went ahead.

in Australia, it might have been political expediency behalf of the then prime minister Julia Gillard to make save her position. I'm not as cynical as that. I think she saw its moment and saw its value and pushed ahead, regardless of whatever else would happen. And in the midst of that, with everybody saying, but we can't afford it, they then introduced a levee to go on to what's a medical will he have any Australia of.5%, and nobody blinked. Now, I don't know about the countries that you come from silting in this room, but in Australia, you say the word tax and it compares the bee Jesus out of the community. Politicians use it basically to stop things, to stop an argument, to stop an idea. Just say techs. In the midst of all of this, we introduced a levee and the community didn't blink. And while that might be a superficial way of getting an understanding, we sense that the reason why people didn't link was because people had already accepted the idea that people with disabilities try to get better supports, to be able to become independence without reliance on people like me and so on and so forth. That time had come.

There's been reference to the Paralympics during the day, and I wanted to draw attention to this, because while -- I'm a sports lover, so how Australia does in anything, we go, that's fantastic, and of course Australia finished fifth in the ladder in the Paralympics is brilliant, so we're not arguing that. Right? What we are organizing is this. So we do well on the national and on the international stage. Good on you, Australia. But where it really counts, that is, people getting jobs, getting economic and, therefore, social independence, we're not doing so well. This report it comes from, the Australian Human Relations Commissioner, did a report over the last 12 months, finishing July of this year. The report was looking at discrimination and people with disability in the workplace, and basically, the reason why it was looking at this is because you don't have to do a report to know it, but doing a report gives you a much brighter sense of what is going on. And they found there is discrimination. There's discrimination at the highest levels all

the way down to what is known as unconscious bias. And out of that report, basically, there's a whole set of recommendations, and I won't go into all of them, but one of the things that I did wanting to into was the recommendation in regard to employers, because this is where we also feel that there is room, there are things starting to move. Again, almost glacially, but the movement is there. When I listened to the guy at Barkley's Bank this morning walking, I think, that's great. Now we just have to hear 10,000 more employers talking the same talk, walking the same walk. I saw a presentation from a U.S. employer, Walgreen's, earlier this year, and that was pretty impressive. That wasn't employing 10% of people with disabilities. That was employing people 30 to 50% of their employees at their production warehouses. People with disabilities. That's not employing people with disabilities at entry level. That's employing people at all levels of the company. Gage be that is brilliant. That is great. But we're talking one example out of 10,000, and we have to get to a point where we're talking 10,000.

So the idea there, and you heard some of these examples during the day, so I won't spend too much time on them, but the same principles. The awareness. They dropped the argument of cost and start talking the argument of employing people. One of the arguments, and I'm sure it gets used wherever we're talking around the world, is the argument that you're talking to your customer base. Right? And if your customer base is made up of 50% males, 50% females, 25% people with disabilities, 70% this, 80%, whatever you're talking about, appeal to your customer base, and one of the ways to appeal to your customer base is put people in front of them that kind of look a bit like them. So that's the general arguments. In disability employment serves, we're not talking about giving people a better shot at something. We're talking about giving people a shot at something. And that's the principle. I'm on a reference group with the administrative public service commission and they want to do things better. They called this it project called recruit-ability and the idea was to get people to interview. And people with a disability to interview, and they're really proud, because they got 12 or 15. I couldn't care less what the number S they gotten it or 15 people, and I said, how many of those people got a job? And they said, well, no one. And I said, so why are you so proud of this little project? They said, when we do interviews to get into the job, it's based on merit. And I said, that's great. Can I see the template that you used to determine merit? And they feffed around and said they'd send me something and then called and said there is no template, but they do have this thing called her hit that they use, and apparently they use it consistently, and it must be really good, because not one of 12 people that went for a job was able to get it. So there's still work to be done.

five minutes. We're going well. Okay. And sticking with the Australian Human Relations Commissioner report, because I think it's really valuable, it's not like the government or business bodies are going to pick it up and say, what do you know? At least it's there as a record and we can quote it. We

can site it. If we do work with people that are interested, we can actually say here is a simple list. Leadership commitment, nondiscriminatory recruitment, et cetera, et cetera.

Okay. The other thing that's coming down the line in Australia, and it is, again, partly to do with the MDIS, is where the jobs are coming from. And the jobs, and this is from Australia's department that measures the prediction of jobs over a five-year forecast, and the jobs that they're talking about basic, basically carer's aides, sales assistants, personal service workers, and hospitality workers. They are, in terms of the disability employment services, because as services work mainly with entry level people, we don't have a disability employment service for university graduates or that level of education. So there's a whole lot of work coming down the line, and it's coming down the line because of this. This is just one of the states in Victoria. I'm presuming people don't really know a lot about Australia, and the Victoria and New South Wales are the two biggest states in Australia. Australia has a population of about 24 million, and in those two states alone, there's about over ten million people living in those two states, but if you look at the stats there, the workforce required to service the NDIS as it grows to that $5 billion, that's the amount of money that's going in to help people with a disability develop their independence and so on. It's predicted about 20,000 more jobs are going to be needed in the next three or so years. So that's a rise of 100% in a three to four-year basis. That's a lot of work coming down the line. I don't need to show you any of the other states, but that's what's going on in the NDIS.

The NDIS principle is very basic. It's basically if you're assessed as needing supports through the NDIS, you can then develop a plan, and at that plan is based on the primary needs, secondary needs, and what I'll call the tertiary needs, which are economic participation supports which will had he the individual go from where they are into employment.

At the moment, and there's about 460,000 people expected to go into the DNIS when it goes furry live in around 2019-2020. When that occurs, of that 460,000, there's expected a third of those will have -- [Indiscernible] participation supports to help them into employment. Now, there's a lot of things balanced in this. One, that the attitudes are changing. Two, that the work is coming down the line and three, that 89 supports and the scheme will be developed in such a way that those things work for the individual to determine what their skills are, what their capabilities are, what their confidence is, and who will support them to build that confidence and build that capability into a job.

when I say there's a lot hinging on this, I'm not being cavalier about it. The productivity commission report that determined this, which was an actuarial study, so wasn't something like me going, oh, yeah, this is great. It was accountants crunching the numbers and using the principle that if this works, we will see a rise in the number of people with disability employed. Therefore, developing independence. Therefore moving off welfare and all of those sorts of things and that will sustain the financial viability of the scheme itself.

I think I've run out of time.

>> I think you have.

>> Sorry. I didn't get that last minute.

>> Sorry. Is there any quick questions for Rick before we have our last speaker? I mean, we have got a little bit of time, but again, it's just to allow you sufficient time to go down two levels for the VIP presentation. So one last question.

>> Thank you very much. Very interesting indeed. I come from Norway. I think I mentioned it before. I'm the Vice President of RI Norway. In Norway, I've found we have similar challenges work-wise. We're now talking more about the people working on the work line have to communicate more with the health line, because there has been a divide there. So many people being not able to work, for example, no mental health problems, drug abuse problems. There's health problem, too. People are struggling with their every day life, getting out of bed, keeping the hours, eating sufficiently, all the other things you have to do to be employed. Do you look into that? How does that work in your opportunity and does the health line in the Health Department, are they in the same -- are they looking at the same problems as you are on the working line?

>> Okay. I'll answer that in less than a minute. Yes and no. So the NDIS itself is a separate quasi government entity, trying to wave a distance even further. That has a whole assessment process that determines a person's needs to go in. A whole lot of other factors that you've referred to. In Australia, you're meshed somewhere between the Department of Health, so the NDS is part of the Department of Social Services. Department of Health and there's one other department that I've just forgotten, but it is basically where social security runs through. Department of human services. And there's concern at the moment that mental health, for example, doesn't have the same capability to be assessed for need as other disabilities. And that's a work in progress, so there's a factor there. We have silos, I guess with any other company, with departments, and we won't resolve those not the short-term. I'm just conscious of time.

>> Sorry. Thank you so much. Thank you. I just want to get to the last speaker. Thank you very much for Rick.

[Applause]

>> I'm sure you can continue these conversations over the next couple of days as you bump into people. So I'd like to invite our last speaker to talk around vocational rehabilitation, engagement, and skills.

>> Good Afternoon. I was on the programme Committee and I thought all of this schedule was done nice, but then when it came to the conference, my name is not there. Anyway, what I'm going to talk about is as a vocational rehabilitation engagement of people with disabilities, research, that we develop a

skill. I understand that we have an occupational therapist here? Speech language therapist here? We have a counselor, job placement specialist? No? Social workers? Anyway. This has been interesting to you. I mean, you all work with people with disabilities, so [Indiscernible] that's when we talk about it.

Well, this is a research project funded by the national institute of disability and ability and research. The Grant was given to University of Wisconsin and we are part of the research, also. And actually presenter was Dr. [Indiscernible] but he could not come [Indiscernible] on your behalf. What are you going to discuss about this presentation? Plan engagement human services, PTOT, physician, whoever. So how we engage our client and what has become successful and not successful and why? And then permission of literature on this concept. There's a lot of literature, but I cut it down on the slides, because we have limited time, so I'm going to briefly talk about literature, but not in details. And then why we need an instrument for vocational rehabilitation? There are a lot of engagement skill, but that doesn't pertain to vocational rehabilitation. There's purpose that we started developing the skills. Then we'll talk about developing and editing the real engagement skills that we develop.

Engagement is define as the process to which the client actively engages in their treatment, and also considers the stage of the relationship having positive treatment outcome and my question is as you interact with clients, what kind of difference do you feel right from the beginning? Is this client reengaged? Motivated? Get some outcome? You can sense immediately, no, it is not going the way you think it should.

So here is a question that is very challenging in effective therapy. What clicks the therapy to go along not the nice way or the direction that you want to be? So there's a lot of factors. The engage plans are more likely to bond with a therapist and therapeutic process that is highly developed in engagement right at the beginning and you can feel that. There is that kind of plan to participate very actively and in treatment longer, and the person will report a high level of satisfaction. But on the other hand, a low level of engagement, you will see that probably you feel that, that you are congruent with each other. You have a certain set of ideas, what direction it should go, but you'll find that it is nothing. You are trying to steer the client in your direction than what services provide, that therapy ought to use, but is not going in that direction. So that was ultimately the therapy alternative and the outcome.

Also, the engagement process involves developing agreement on the goals and task to the clap race of the therapist and plan. The process of engagement is universal. It doesn't matter which you are in social work, physiotherapy, occupational therapy, or rehabilitation counseling, but there are questions of voluntary clients and involuntary clients. So if someone volunteered to you, in order to get something from you, it indicates right away that this client is dedicated. He has some motivation. So he will continue to be in the therapy process and he persists that there's reinforcement in this relationship. So the relationship will continue and there will be a good outcome. On the other hand, someone who is a

non-volunteer that brings someone forced to come. F, your therapist says let's go there. we need to do this before we can give you the money. There nobody in outs come as such, because it's not interested. Also, that person, social security and others kind of benefit is largely interested. So I've not talked very much about this -- a lot of literature, because we don't have time, but I'm going to the instrument that we developed.

Now, there are a number of existing methods for measuring the subject of engagement. Self-determination. Help self-advocacy [Indiscernible] therapeutic alliance with a health professional. Openness and participation in treatment and general treatment satisfactions. So there's a lot of research in this area. But also a lot ever instrument has been developed. You can see here a lot of instruments, but the question is this instrument, those skills are very limited to the location of rehabilitation, because they fail to include the critical elements of attendance, participation, and effort in working toward cooperatively establishing goals in accessing peer engagement. So the instrument doesn't pertain to [inaudible] so that's why we wanted to develop a scheme.

This scale is so the items are based on comprehensive review, and this is cognitive, effective, and behavior management. So we developed items reviewed by the 12 experts in the field. And then ultimately we adopt five of them, and then we proceeded with the instrument, line items, five-point liker scale, from strong "disagree to strongly disagree. Scores are calculated by summing the items.

So the patient, we have 277 consumers from Alaska, Kentucky, Michigan, New Mexico, Texas, Wisconsin. Sampled throughout the country and there's democratic data. I give you the hand out so you can look into it. Then this other 277 people developing two groups, one for an exploratory factor and an assist, and date from the remaining 139th we use for the confirmative factor analysis. So what is the purpose of the explorative factor analysis? Explorative factor analysis uncovered the underlying structure in a database or the latent constructs of relationship among the observed [Indiscernible] whereas the confirmative factor analysis that is established at the firm's structure and test the hypothesis. There's a lot of studies later on, but I'm going to skip all this to the bottom line. So here are some descriptive studies. It shows that gender was not significant and disability type was not significant. But the age was significant. It says as an animal was significant [Indiscernible] is significantly higher engagement scores than transition of youth. 16 to 24. Of course, that young they are not permitted to. They don't know what they want to do. So that's the one good finding. 25 to 50 working age group was significant.

So there's some results here. Because of nine items, nine by nine correlation metrics, we use that principle analysis. I'm going to skip all of this, because there are a lot of statistics and it will take all night to explain.

So ultimately, what he found, one factor measurement model explained 67% of the total values. That's a good finding. Factored from .6 to.85. Okay. Here are the different kinds of questions that

I get, along with [Indiscernible] I understand and accept the need for [Indiscernible] I am hope to it feedback, and I communicate with council regularly. So if you look at each of the discussions you see there is the relationship, how the plan perceives the relationship with the counselor. So you can see the factor on the right-hand side is various.76 to.85. Now, the contributory factor, the instrument using [Indiscernible] so in nonsignificant [Indiscernible] Chi square and all other therapy, details on all of this, if it happened, then the model has a good construct and the model has a good fit.

Okay. I skip all of this. I'm going to show you a diagram here. Here this shows all the variables, engagement and construct, and there are nine factor loading on the right-hand side and the covariants on the left-hand side. So in the process, we change the parameters and see the parameter you want to fit the model. It could be changed and fine the best field. We found one factor in this model. 76% of value counseled by this factor.

So here is some reliability. It shows converged ability. All significant, but die venger end ability is not. That's what you want. So the correlation between the scales in the expected directed, converge he wants and divergent ability of the scale.

So what other limitations? This instrument is a self-report measure. It has a lot of bias involved. And the question is a bias inside to life events happening at that time. There is anchoring effects [Indiscernible] time pressure on [Indiscernible] motivation. So the problem is participants with individual and mental health disabilities like developmental disabilities, so they have some cognitive dysfunction, so that may affect some of the reliability. And also, the data together from [Indiscernible] counselors, so that he may have selected [Indiscernible] to be studies in the expected direction or his direction, so that is the social desirability.

What are the implications? It is a big skill in the cognitive engagement, emotional engagement and behavioral engagements. You need this in order to proceed and have a better outcome. So we did a further study with our expended version of the scale. It is warranted, not to adequately capture the main competence of the engagement, and also, we need to determine the potential scale with specific disability types. Spinal cord injury, epilepsy, and others and cultural and linguistic aspect of it, because if you toss it in another language, it just weakens -- we can't toss it back to get the same results. And working language, some of the clients may not anybody English, so that has an impact.

Thank you. So I'm interested that anyone interested in further study just contact me. I'll be happy to continue to do the research.

>> Thank you. Thank you.

Applause.)

>> So we have time for one or two questions to our last speaker or indeed to any previous speakers who are still here. Does anybody have a question for either our last speaker or our previous ones? If you could speak into the mic and put your hands up? Because we need it to go on to it, the screen.

>> All of you are concerns who are English-speaking? Yes? No?

>> [Indiscernible]

>> I see.

>> [Indiscernible] we toss it back and have done some other instruments, like system to placement. It has been in Arabic, Chinese, Japanese, Russian, and Portuguese, and we've already published those data from Japan and Taiwan.

>> Any further questions for any of our speakers? One question. I'm really interested in what you were saying about the language there and wondered if your scale had been adapted for people with communication disabilities who perhaps their first language might be English, but communication disability, for example, aphasia following a brain injury or if there were communication adoptions to your rating scale.

>> No. That's what I'm going to do. It's a preliminary find and go different types of disability. That is the validity of the instrument.

>> Okay. Well thank you very much for attending. Can we give a last round of applause for all of our speakers? I hope you found an interesting afternoon.

[Applause]

>> And we finished in sufficient time for you to head-on down two floors, I think, to our VIP last session of today. Enjoy the rest of Congress in Edinburgh. Thank you.

[Session Concludes]