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Parallel C Ochil
The future of rehabilitation: recent advances

>> Speaker: I'm going to ask the first speaker Monica to come up and speak about rehabilitation and older -- old people hip fractures.

>> Speaker: Yeah, that's true.

>> We'll allow questions at the end of each session. If you have questions, we'll allow that.

>> Speaker: We will. This study I'll elaborate on today is the study on the performance of post rehabilitation in central region Denmark. The study -- the study includes two teams. This study contributes to the discussion of suitable ways to plan and perform post-discharge rehabilitation after hip fracture. It also highlights problems within the problem and performance of post-discharge rehabilitation which need be addressed. I now have to switch. The theoretical framework is based on the definitions of rehabilitation and also the international classification of functioning disability on health also known as the ICF model. The reason for using this is it refers to ways of working with individuals who experience a traumatic health condition like a hip fracture can be in a Danish hospital and municipal setting and can provide a multi-facetted picture of the adult's functioning which can be use -- functioning which can be used by practitioners. This originated from an interpretive survey I conducted prior to this study.

This review showed approximately 60% of older adults surviving a hip fracture had reduced functional performance and report managing daily activities than older adults without a hip fracture. Additionally, the studies showed pain affected the older physical and mental functions, performance and social participation. More than 10% of the older adults were unable to return to the homes after hip fractures and one in four needed long-term follow-up. These findings made me and the other authors wonder how post discharge rehabilitation of community dwelling of older adults of performed. There was evidence showing that Scandinavian hospital based teams and municipal rehabilitation teams often were involved in post-discharge rehabilitation of the older adults but little was known about the way they perform and planned post-discharge rehabilitation.

We, therefore, wanted to investigate and discuss -- sorry. I'm a bit further on. Excuse me. We, therefore, wanted to investigate and discuss how a multi-disciplinary team and municipal team planned and

performed post discharge rehabilitation older adults after hip fracture and it was done to optimise. We wanted to optimise the present rehabilitation services and programs and hereby enable them to perform with the best possible functioning in their life. To investigate the planning and performance of post discharge rehabilitation of these older adults two focus group interviews with an outgoing team from a large university hospital in Denmark including focus group interviews from the same municipality as the hospital-based team were conducted. The hospital-based team filed for the older patients 30 days after the discharge while the team was for the older adults for four to five months or longer. 16 degree questions developed were posed to the teams in order to make them elaborate on the planning and performance of post-discharge rehabilitation. It was used to understand the content of transscribed interviews while analysis was used as analysis method. the findings revealed that the hospital-based team focused on the treatments of the older adults general health but functions and structures. for example, by assessing drug elimination, body temperature and body pressure.

While the team focused on making the older adults able to cope through care, physical exercise, and practical support.

The hospital based team did seem to use a biomedical approach to rehabilitation while the municipal rehabilitation team seemed to use a predominantly approach. None of the teams stressed how relatives actually contributed to the planning and performance of post-discharge rehabilitation. studies showed that the work of the team were based on a cooperative process. Goals were generally set by individual teams in cooperation with the community dwelling older adults and by focusing on goals in the rehabilitation process, the teams were able to uncover the rehabilitation needs and decide outcomes from rehabilitation. They were able to find out the context of the adults lives, personal values, strengths, activity administrations and living environments. the teams were able to promote clinical team work and enhance the working relationships with the older adults and team members and improve the level of the motivation, training effects. However, the teams failed to share this information with each other and they failed to share how goals were planned and achieved. Information on the teams were shared between the teams which resulted in misunderstanding and fragmented and overlapping elements of treatment and rehabilitation.

From our perspective the core services only covered fragments of the older adults rehabilitation needs and this was due to the fact that the core services and approaches of rehabilitation were not integrated. the missing focus and the older adults mental functions contributed to this fragmented view of the older adults. Since -- we know that studies within the fracture rehabilitation show that low mood depression and even anxiety can seriously hamper the rehabilitation process. to generate a unified and coherent view of older adult process. Research has also shown that relatives play a significant role in the rehabilitation process and help patients reach a higher level of basic activity and mobility than patients without relatives.

Studies have also shown that family-centered care was focused on the strengths and needs of all family members can increase the patient's physical and mental health. and by failing to involve relatives in the rehabilitation process, the physical, mental and even the social functions of the older adults might be affected and as a consequence the older adults may not regain as many abilities as they could have done. We think it's important for health professionals, therefore, to include the relatives in the planning and performance of post-discharge rehabilitation. the teams also failed to share information on how goals wereachieved and performed. They promote the process between teams and build relationship between teams and prevent gaps and overlaps in treatment and rehabilitation. the cooperative problems between the teams may arrive due to the use of am biggous language which allow for interpretation of functioning and health. It's been proven that if you focus an assessment of older adults health instead of delivery of health care services you can hamper the rehabilitation process. a structure base and the language of ICF and identification of difficult areas which the older adults have, goals, target strategies and rehabilitation outcome evaluation, may actually provide a better rehabilitation for these older adults.

This disclosed structure has been found effective in adults with brain tumors in the Netherlands and it is our belief that such a structure may improve the process since it could promote communication, and cooperation between the teams. The present study is limited due to the teams and further studies and the topic could confirm or challenge the findings. Future research could also focus on how hip fracture affects the older adults and relatives mental functions after discharge including the investigation of the roles that relatives have the rehabilitation process. Research is also needed to investigate whether a giant structure, which I mentioned before, which is an assessment of the presentation of the older adults based on the municipal team and hospital based team, the ICF, graduated areas, goals, plans for goal achievement. This takes into account the services provided from those rehabilitation providers. Additionally a comparison between the conventional planning and performance of post discharge should be investigated. Further research should investigate whether or not communication and cooperation between the teams actually did be eliminated due to the structure. and then lastly, I would like to say thank you for your attention and warm thanks to the health professionals who participated in the study and for the funding provided for the study. Thank you.

[*Applause*]

>> Thank you, Monica. I think that highlights how important communication is not only to each other as professionals but with the cares and families who help support individuals within their own homes. Any questions for our speaker before we go on to the next person. If you can introduce yourself and speak on to the mic we can get to the screen. Thank you.

>> I wanted to know which age group did you include?

>> Older adults on the 65 years and older.

>> Okay.

>> We can move on to the next speaker. If we move on to Maren. She's going to talk about German recommendations for post-discharge neuro-rehab.

>> Speaker: Thank you very much. Good afternoon, thanks a lot for giving me the opportunity to talk to you today about this topic, the post-discharge neuro-rehabilitation in this case. I think our presentations, Monica's and mine are really good in addition to each other. It's an association of funding bodies in Germany so asked what perspective we take for presentations when submitting the abstract I checked funder perspective, but I think it's really essential to also include the views of the person's affected, in this case, the persons with neurological disorders and also the professional perspective and scientific perspective. And I hope this becomes a bit clearer in my presentation. This one? Yes. So before I came to work with BAR, I was actually involved in a project on rehabilitation goal setting. I'm a fizzo therapist myself and health scientist. We were working out a manual for health professionals on how to facilitate rehabilitation goal settings. the questions that any person with a chronic condition after a major injury has to ask themselves in this process is to -- first of all, what do I want to research after discharge from patient, medical rehabilitation and second, is it a realistic goal? How can I get there? Now in a metaphorical sense, one could say, well, my goal is to climb the Eiffel tower. This is what I always wanted to do or this is what I did once a year so far so I want to do it again.

This picture is showing Paris, a scene with full visual fields. Mind you in any person, any middle aged adult person, it's in the a common question to ask and people have difficulties to come up with a concrete answer in this. So they might need some assistance with that and then also they might need help to assess whether it's a realistic goal and also to implement the plan how to get -- how to reach the goal. So there's some professional advice and guidance necessary in many terms. Then coming to rehabilitation goals for brain injured person, the questions are basically the same. However, they are facing the additional challenge that the central organ for information process, for perception, for planning motivation and so far has been affected in many cases. This is actually effecting rehabilitation goals, setting as such, identifying the gels and pursuing them. -- the goals and pursuing them. So people with a quiet brain your, whether it be from tumor, trauma, from stroke or even from degenerative neurological conditions, yeah, they have this additional -- this additional task to master. Of course, on the professional side this also means specific competencies and very much sensitivity on how to work out these goals together in a participative manner. What does that have to do with what I was talking about? to give you background the neurological rehabilitation model has been worked out 20 years ago, sorry, in Germany. It defines the phases A to F in rehabilitation starting from acute emergency care to phase F which is the long-term care, actually residential care in most cases. It doesn't mean that you have to go through from A to F. There might be other ways to go through the phases. But what it does, it is defining some entry and exit criteria

for patients. In medical terms and also the treatment, requirements and treatment goals for the different phases this was a model worked out and issued at the funding bodies that is for people -- these are mainly facility services or day clinics. What is special about phase E. In phase D which is the phase before there's an increasing focus on vocational rehabilitation in recent years. It can also be provided in an out-patient setting, phase D rehabilitation. In phase E this focus used to be much more dominant aside -- maintaining the results and the achievements of medical rehabilitation, of course, and to further facilitate the reconciliation or the healing process actually. What is new is it's been negotiated from 2011 to 2013 on the platform of BAR, our organization is that there is also the social sphere of living in the community if possible which has been put more -- has been taken up. It's representing actually a shift from a rather medical model to a more social model in a way. and it means that various services from various sectors are potentially relevant when it comes to living in the community when it comes to long-term arrangements. This could be vocational rehabilitation services of different kinds. Could be medication and other forms of therapy, independent living care arrangement and so forth. Phase E recommendations, it's actually -- this is my one copy. Distinguished three groups of persons. Person with mild impairment, medium impairment and considerable impairment. Since we're in a system of social insurance, it's somehow obvious that getting back to work, returning to work to paid employment is also a central goal on behalf of the funders and this is reflected in these categories. the first cat under youy, the first group -- category, the first group is the one with good chance to return to work or school with specific support and a good chance to work in the primary job market. the second group needs major efforts in rehabilitation or schooling and maybe they will not be able to work on the primary job market but secondary job market and sheltered employment. And the third group with considerable high level of care required on a long-term basis and maybe they'll find some daily time structure in day care centers in an occupational sense. Mind you, again, that the impairments we're talking about here are not always visual impairments like gross motor skills or fine motor skills affected but very often non-visible impairments and deviation of functions such as difficulty with speech, seeing or hearing and reduce psycho, physical or cognitive personality. This is only visible when people leave the setting or return to work, maybe, or live in the previous environment again surrounded by their family or by their friends and colleagues.

So it takes a lot of assistance in this transition to reach stable arrangements for these people on a long or medium term basis. German rehabilitation system is specific in the sense that there are many different funding bodies, social insurance bodies, that are actually involved in rehabilitation. And BAR is like providing the platform for the coordination. And there are different types of assistance outlined in social code book 9. First of all it's the medical rehabilitation services or talking about services securing the results of medical rehabilitation. Then it's the services for participation and social sphere. And the services for participation in the occupational sphere and the educational sphere. Now, this is actually already drawing

on something we'll have new the legislation but it's especially for younger patients or younger clients we have here. Very important to look at this as well. In addition, we have income support and supplementary assistance. And all this, of course, need it's be held together by strong coordination mechanisms. by good information, sound information, counseling, planning, the initiation of service and coordination of the ongoing services. And this, of course, needs to be very individual with any client or patient that we face. And again the coordination part is central. This say task that the funders themselves are obliged to do even in the individual case to coordinate the different types of assistance if a client is actually benefiting from different funds. But it's, of course, also a task of the service providers very much closer to the people on a day to day basis to give advice and initiate things and last but not least, of course, the peer support and counseling is also a very important thing to involve at this stage of planning. So people who have made their own experiences with this system can actually be a very good support.
So the phase E recommendations are meant to frame individualised transition. What remains to be done at the individual case level to implement actually these recommendations? Both funders and providers need to develop their staff. That's really essential in terms of neuro-competency and in terms of participatory goal setting. Neuro-competency meaning they need the specific information, what kind of services are available to do the counseling and coordination of case management. And also the therapists or people providing services need to know what is specific about neurological conditions. Goal setting means to empower the client. Oops sorry and to involve relatives and others as well. Not an easy task.
>> a couple minutes.
>> Yes, thank you. What remains to be done at the intraorganizational level? the providers need to come forward with concepts and cooperations for rehabilitation services in the community but also in residential care. And funders need to further clarify which kind and scope of services are required and will be he refunded on which legal basis. It's still a rather broad framework and it requires a lot of work on the local level and individual case level. Coming back to the initial picture or metaphor, it takes 1665 steps to get up the Eiffel Tower -- unless you take one of lifts. It makes it a bit easier. to get up there involve people at the levels. In order to adapt available is structures and not create parallel structures to what is there in the community to.
Develop local and regional solutions in a federal system like Germany, it will not be possible to have a one-size fits all. and then to get better services from and within various sectors as I said earlier to get greater coverage and flexible delivery for individual participation and inconclusion. by this would
I -- inclusion. by this, I would like to conclude and thank you very much for your attention.
>> Thank you, Maren. If we just see if there's any questions that anybody has following that presentation? We've got time for one or two. No. Hopefully we'll have some time at the end as well once all the speakers have concluded. Next we have Ann from Norway. While waiting, everybody take a deep breath.

Raise your hands and get moving. Get started.

>> Post-lunch sort of --

>> Speaker: Yeah. People are getting a bit filled up. So I'm very grateful. Thank you. to have been given the opportunity to present my work. Any name is Anne-Stine Berquist roberg at the hospital where we office services for patients with severe traumatic injuries or acute illness. And also for uses with chronic disabilities stemming cerebral palsy. And we have a large span over groups. An important question to ask in conferences such as this is actually what is rehabilitation? What is it? We have been talking about so many different things over the last two days spanning over a large map and I think it's important for us to question critically for whom, with what, when and how should we understand rehabilitation? Who are the experts? Who are the ones to decide what it is? And we have already been talking about different mental models to understand rehabilitation and disability today I'll talk about parts of my PhD project and give you a review and a glimpse of findings and some implications of these. I have deconstructed my work into its simplest form for the purposes to fit with the constraints of 15 minutes. I'm trying to make it as well easy and simple as I can.

So today we can conclude that an expanded conceptualization of objects in rehabilitation services has developed to surpass the reductive effect of a medically informed health system to encompass social and holistic perspectives. That's what we've been talking about quality of life, human rights, participation, equal opportunities for people with disabilities. This development, we have -- I have in my study identified as a political turn in policies. They want to expand scopes of health and treatment and care and with a simultaneous increase in service willingness to diagnose, to treat and to follow up. and I think I need to make a point right here that this is the case of Norway. We know we're privileged. Results is rising health expenditures. And recent generations of modern public reforms targets whole of government approaches incorporate holism in health with holism in organization. the objective is to save costs and control and target service provision. Such reform related concepts are promoted by the Norwegian coordination reform reflecting by a both a social and governance TURN IN policy. This places responsibility on professionals to organise, to plan, to implement and report interventions according to available resources and constrained institutional boundaries. However, and this is important, it's still within realm of holistic patient-centered socially invented schemes of care. The Norwegian reform was submitted in January 2012 under the banner right treatment at the right place and the right time. It has the design of an open-ended long-termed reform and it's effects on the conceptualization and practices of rehabilitation is yet uncertain which is the onset by which my PhD project emanates. So it directs a critical gaze on policy developments for disabled and chronic ill using the case of Norway. It undertakes a critical discourse analysis in two influential white papers. the white paper on rehabilitation exclusively submitted ten years earlier named responsibility in coping towards holistic rehabilitation services. You have ten years of difference between

those. the ways medical and social and political conceptual models were embedded in the papers revealed three orders of rehabilitation discourse. I'll come back to those. Also, I have conducted interviews with different rehabilitation professionals in order to generate knowledge from the arena that rehabilitation is practiced applying the same framework as with the documentary analysis. And I talked to professionals in all sectors and all health levels of the rehabilitation system in Norway all the way from the very most specialised services to the home based rehabilitation teams. I asked the professionals what exactly is rehabilitation to you which had a wonderful effect on generating saturated and rich descriptions. People are very concerned with what they are doing. I will present to you the findings in the following. As you obviously understand my work contains lots and lots of words so I simplified them into two conceptual models and anybody in this lecture visually impaired I'll try to describe the illustrations. On the first slide, a blue arrow illustrates time and at the middle a red line is dividing it. This illustrates the point of time that illness or injure occurs with the -- injury injuries with the following need for rehabilitation services. the ways that medical, social and political models are embedded in the white papers reveal the three orders of rehabilitation discourse. First the discourse of reaction as reactive to the needs that have occurred after illness or injury. So you have the reactive rehabilitation concept. It's placed at the right of the blue arrow. the professionals are experts. The discourse is greatly influenced by a medical model discourse and further placed at the middle right above the mid-line dividing the blue. Sorry. I'm sorry. You have the discourse of action having the affect as sort of a moderator of defining who are responsible for what. a discourse of the social contributes to present the individuals as active and in charge. These are words that we use, right? Actively involved, actively participating, responsible. Thursday, individuals are expected to be accountable for their own prosperities in health. This allows for presenting the professionals to focus on working in coordinated and cost-effective matters with less focus on patient preferences. And then the last -- the discourse of proaction placed at the left before illness or injury has occurred contributes to turn the approach to concerned health promotion and illness prevention and an mix of medical and social political discourse allows policies to replace professional rehabilitation services with public recommend decisions on activities to help individuals become active in their spare time, placing health care professionals in services with volunteers and non-profit organizations. As learning and coping centers including peer support, lifetime courses and self-treatment coaching. As such, money can be saved. An important finding is how current techniques of government see the individual as basic entities to which government is applied. Policies of self-conduct are legitimatised by limiting the population, coordination strategies and welfare state sustainability. I conclude that the population of disable and chronic ill are double struck. Services is changing and increasing. How am I?

>> Five more minutes.

>> Speaker: I have five minutes. My next slide illustrates two core findings from the interviews. The

rehabilitation professionals repeated in using two metaphors to illustrate how they conceived rehabilitation. The first illustrated as a road to walk has a distant target, gel or finish line -- goal or finish line at the future, a far distance. Along the way are sub goals to achieve. We saw the Eiffel Tower and I think this is what they are talking about when they are talking about long distance goals. A single sentence repeated in virtually every interview was I asked the patient what is important to you? The discourse of meaningfulness relates to service recipients inter-- recipients inner and value focused. It's seen as the approach in rehabilitation. Repeating uses of metaphor as pursuing goal as a laborious journey demonstrates this perspective's patient-centered significance. Fusion of the concepts of pursuing a goal and laborious journey produces a structure in which it's conceptualised as time-consuming, future-focused and shared process. The conceptualization of rehabilitation as a journey warns the active involvement, gradual adjustment and improving compression linked to immeasurable goals. The professional's role is to be supporting and co-walking and not very much intervening. The second illustration is the soccer ball hitting the net of a goal. This discourse was identified by categories such as shared goals, contribution methods, competency and results and was categorised by descriptions of rehabilitation goals set by experts. The object of limiting each professional's disciplinary practice in terms of framing and systematcizing was high lighted. It entails a series of meeting. The act of defining goals with interdisciplinary teams was emphasised. These goals were represented as measures targeted toward functioning and bodily attributes such as gait and hand function. with results imposed measurable changes in the individuals functional ability and rehabilitation professionals might be said to be acting on behalf of the governmental bodies that seek to displace disabled individuals under medical mandate in order to develop independent citizens. The anticipation of measurable goal achievements in rehabilitation was visible but the use of metaphors of soccer and goal scoring to kick in the same direction and play the ball to the individual patient. The fusion of goal setting and scoring goals in soccer conducts goals as concrete, proximal and measurable. This represents the concrete practices and how they make things happen in meetings with service recipients. I have two points left.

>> Go for it.

>> Speaker: Good for it. According professionals hold the power to did he fine goals often by using standardised goal setting tools and anticipating compliance. The other findings imply that specialised services will become less patient centered and problem oriented offered to fewer people. Individuals in need for rehabilitation services after having received necessary medical treatment are deemed to a larger extent mainstream services targeted toward each individual's active accountability. Those with obvious need for support are challenged about a system that exhibit practices in terms of shaping individuals to desired directions obviously difficult taken their conditions into consideration. I think I have top end my presentation here. And I want to just thank you.

>> Thank you. Do we have any question questions for Anne?

[*Applause*]

Do we have any questions at all? I'm sure you can have the conversations after coffee after. I'd like to bring up my next speaker. Who is going to speak? There's another person after you.

>> She's not here. She's tomorrow.

>> Right. Okay. That's a mistake. So you are our last speaker. Okay.

>> You have a handout but I have had a suspicious when my secretary gave me. It looks like pen. Some of pages are not here. I'll be happy to get to you my PowerPoint if you give me your email address. My presentation makes it easier. I'm pleased to see the speakers are doing a good job in the university being a student. You are talking about research and practice and goals in a cycle. That's my point here in my presentation. We're talking about competence needed for return to work, professional outcome for people with disables. Okay. Let's talk about learning outcomes. What are you going to get out of this presentation? This topic is broad. We can spend one whole day and of course 15 minutes I have to cut short on this. Now, I serve as the chair of the employment commission with another from Germany who is my partner. They've been in the employment commission for eight years. He's going to take the chairmanship from next year. We say we're married to the work and employment. So our focus in the work and employment commission is to dealing with, of course, job and employment. There's article 27. The focus of the article 27 is how to comprehend the important role of professional in the lives of people with disabilities and what can role and responsibilities study we can have that tells the competencies of it. What kind of knowledge, skills and structure that can exist in the program? I'm giving ate comparison. I'm not trying to compare with any country or situation. I'm giving food for thought. That in the United States we have studies in rehabilitation focusing only on rehabilitation. There are 100 universities and with 60 at the BS level and associate degree as well. What is happening in Australia, Canada, south Korea and Taiwan, how you this doubling the counseling program that focuses on -- similar, same thing as return to work. But the program in the United States has been in effect since 1954 act of rehabilitation that people with disability has to be served, qualified to serve. We had this role and function study of the specialists already established. Now, so the article 7 the convention for persons with disabilities has major focuses have to be on discrimination, all form of discrimination on work place and also accessibility to work place so the people with disability can function better. In a way to prepare them there's competencies required or technical assistance, guidance, placement services and education preparing for the world of work. There could be some employ, also some self employment. So major focus is return to work. And quality of life. And now even CRPD, the way I see it, there are two major challenges. The first challenge is how we can improve the skills and competency levels of people with disables so that -- disabilities so that they can be gainfully employed. It changes rapidly the information highway, assistive technology, et cetera, et

cetera. Are we keeping up with the pace of the world of work movement and our skill and preparation for people with disabilities?

We are not. That is the problem. If you see the employment rate of general public, general population, there's a huge gap because we're not preparing for the world of work. The main thing is that how much we invest for people with disabilities that is the focus. So, for example, the parents talk to you from the beginning what do you want to be? Engineer? Doctor? Lawyer? Did your parents tell you you want to be a rehab counselor? Never. We don't talk about rehabilitation until a loved one becomes disable in accident, injury or illness. Then we think about rehabilitation.

This is part of our life. So that's thinking differently. Okay. Now, what is a challenge here? There is one how to enter the skills level of the people with disabilities so they can be competent any of in the open level market. Number two, how to enter the skill set of the professional who serve them. Because if you are qualified you have the skills and all the knowledge and competencies. Then you can provide quality services to persons with disabilities.

We're not talking about the client. We have to think differently. We always talk about client is not motivated. Client doesn't want to go to work? Why he doesn't want to go to work? There's so many things in society. This should be something difficult that affects the skill level. Then they go back to work. Two challenges one for the client and professional. In this presentation we're talking about professional not client. Focus on how to management of social and economic cost of disability and injury. That's what I hear all the time but that's what it is. Okay. So now focus on this moving from emphasizing the role of professional in promoting successful return to work. What can they do for return to work. The term used in Europe and other countries when the United States, of course, we don't use that word but it's all the same. Okay. The key element is the active return to work. They are employed by the insurers, employers and government agency. Return to work is the process of integrating workers with disabilities back into the work force. There's several different kinds of background. They could have a education in human services to home economics, whatever. It could be counselor, PT, OT, physician or psychiatrist. Rehabilitation is multi-facetted services and multi-facetted professional competent sense. That's one. That's the uniqueness of this profession. Okay. What does return to work coordinators do? What are the responsibilities?

They help us plan for return to work and family support and make the decision. So they consult with worker, health practitioner, providers and other community based service coordinators, monitor the progressing for work and then taking steps to how to prevent further injury or aggravation of injury. Act as a point of contact for the employer and dissolves any issues in between in the process.

What kind of competence are we talking about? You can see that skills, behavior, aptitude? These are necessary for return to work workers and could be specific in specific country, specific location and specific

disability. These are the highest rated attributes they should possession. Active listening. They have many things to share. They have to figure out what is most important. Ability to communicate well. Language say barrier often. In terms of personalities. The client and the professional if there's not congruence then their therapy or whatever you are trying to do is not going to progress further. Effective problem solving. In order to be effective you have to have multiple skills. Counselor for return to work is say jack of all trades. No one program will fit. You have to have knowledge of many, many area to help provide the services to persons. And of course confidential and ethical issues. Here are the challenges: I'm given my perspective I'm going comparing with others I'm just giving us food for thought. So developing academic program in college and universities. A certificate, bachelor's masters and state lice sense your, national certification and evidence in infrastructures. I'm pleased to see they are talking before me for structures in this section related to that. Let's talk about the need for free and in-service training program. There's a positive relationship between self efficacy and the quality of job. If you have the skills of competency, degrees, nation federal fiction, all -- certification all of this you feel good about it. You are a professional. You provide good services. Otherwise you are shaky. You are not sure. With the discharging job, it's is knowledge of topics. So, of course education is significant, deciding factor in the competency and Allied health professionals. If you get turning then you are able to provide better services and quality services to your consumers. Now, with the standards, so there's a positive correlation between level of professional preparation of the practitioner and quality of outcome, quality of outcome for the client. Also client satisfaction. So the academic programs and BS often MS, whatever level is needed, think about it. The medical field so many specialization. Lawyer, engineer, many, many specialization. Why rehabilitation doesn't have that yet? We're still evolving? Whatever they do at the center level, then license and they -- there should be accrediting body ensures that the programs and higher education meets acceptable levels of quality. So the agency, a neutral organization away from political, social, governmental, funding agency, a neutral body. This side of the professional standard and monitor them. There should be role and function studies returning to workers, rehabilitation counselor, job placement, whoever it is. It should be he minimum competency to serve your client. That's the thing I'm talking about accreditation. Let's talk about some of the standards of competences. So in the U.S. you have BS programming services. It's BS four year programs. Last two years emphasise on rehabilitation. These are the domain. I don't have time to discuss this in detail. This is lived experience, communication, advocacy, self determination. This is just a measured domain. It's a seven, eight pages long of sub-domains. That is for undergraduate. For graduate program it talks about professional behavior. Human growth and counseling. Research, medical, functional, environmental aspect, case management, employment. That is the focus and clinical experiences. But these standards are always changing every five years. The accrediting body, the role and function studies from the point of view, employer's point of view and the client's point of view, did the

client's satisfy the counselors and thereby the standards. Disability management from Canada. They have certification in nine domains which are very similar to the one I showed before. They've been doing this function studies in 1970s. So they have revised every time. I don't see any difference between what it says they need more domain. The question is the education from universities more rigorous. There's nothing wrong with this. I respect it. Don't misunderstand me. We should move forward from medical model and biocycle model. We need to move from there. Position, PT, OT everybody has a role to play in rehabilitation. But same job placement specialty of counseling they have other skills and competencies that they can do better job placement. That's what I'm talking about. Okay. So there are some competencies Australian and German study that found 113 knowledge and skill statements but there's three common domains. Professional counseling is more than one. Work place and disability management and work place intervention and program management. I am out of time so -- okay. That is what it says about defined competence to return to work coordinator in the USA. The mapping program is say statistical approach. I talks about information gathering, et cetera, et cetera. I have developed a system surface to placement. The instruments have two component. One is for the client and one for the professional. I'm going to talk about the professional competency that is measured competency in eight subsystems, patient, family, et cetera. You can see it's high in the 90s. We talk to doctor and his studies were similar in Japan. This shows higher liability. And then we did further study with case counselor et cetera, et cetera. We found by analysis from the eighth domain we can reduce six domain and shows the internal consistency of the experiment. Implication for research and practice that means role and function of professionals employed in public and private sector. We can compare that impact of education and training BS or MS in rehabilitation, disability management from higher education and professionals in the higher quality of service. What is the efficacy of license you're education and continued education mentioning competencies. I'm also talking about transitional knowledge, skill competency and studies to the professionals to different universal minimum standard as standard for professionalization. This is like focus of how we can double up a model that will have international applicability. There could be a field because of location, geographic and type of agency. So majority will have it universal competitions. What is it it require? Continuous theory, research and practice that goes in cycle.

That is how to improve our quality of services and that will give us better outcome and employment. Thank you. Thank you.

[*Applause*]

>> We have some time for questions for the last speaker and previous speakers are still here in case you have further questions for them. Does anybody have any questions to ask? I'm led to believe our last speaker is -- is in a different program.

If you want to say who you are and speak in the mic and then we get on to the system. Our volunteer is

just coming with us now.
>> Thank you. You are allowed three -- are you allowed three questions.
>> Go for it. Why not?
>> To Maren, your presented guidelines from the payer side but what is the next step because we need individual approaches also for what is next step tell rise in this Germany? For example to give pathways for some persons in so that is my question.
>> Okay.
>> the second is very impressive. Give me your answer, what you mean that is the determine rehabilitation is the best. That is my question to you because you asked the audience and I give the question to you back. The third question, madam, is that we know that there are two options. One option is to find a new professional, return to work or whatever. Yeah. And the other options, what I prefer personally is to bring return to all the professions because of the holistic approach.
>> Yes, yes.
>> Because health care services, nurses and further therapists and whatever medical as well as social workers and also, I would say, as I am a lawyer -- as well as lawyers they need to have some skills to have competences in return to work. My approach -- my question is now: What is your argument to have a very specialised new profession again?
>> Thank you. Three questions there. Three different responders. We'll start with yourself because the microphone is over there and then return to the end of that. Okay. Thank you.
>> Thank you very much for that question. I think it touches upon the core of counseling work basically. And this is a -- not a new task but a task is that probably going to be of increasing importance and relevance as we probably get the new legislation in Germany -- legislation in Germany to -- about a professional attitude when I do counseling whether from a funding organization or from a provider organization. To ask about aspirations. I liked approach yesterday in the plenary session to say not to assume too much in the beginning but as we move along you discover what is possible. This is like a really, I think central principal of counseling when it comes to neuro-competency. I think it's important to raise some general awareness about the specifics of this field but not everybody can become an expert in this. For that, I think it's important, at least in larger organizations to have maybe competence hubs on this specific feel -- field that a normal counselor could refer to.
These hubs might engage in public relations to make the subject known a bit more. If we go to what the rehabilitation is.
>> Wouldn't be it wonderful if I could give an answer of that. I can't. I cannot say that I have the best solution of how to define rehabilitation. I think it's important. I think we need to pay attention to the significance of temporary so when we talk about illness orient and heavily. It need it's be specialised. And

when we talk about live if we talk about responsibly perhaps that would be a start in actually being able to define rehabilitation that we divide it into time zones and also that with do not lose the site of rehabilitation being a process. It takes some time. It's not one single intervention. It need it's be something that actually lasts for some time. Did you get the answer.

>> and to the final response for the third question about the utilization of --

>> Sure. Expanding on rehabilitation, definition of rehabilitation. I said that rehabilitation is a restoration of personals with disabilities originating from medical conditions or accident injuries and they improved functionality and maximum level of capacity to function in society. A lot of definition and explanation. Basically that's it. How we can minimise the barriers for the persons of disability to function in the society. The barriers imposed by the society, it disability itself is not that much a measure barrier but the attitude and the social barrier so imposing that is what people with disabilities can not function. If you can remove barriers they are like anybody else. And disability is part of our life. As long as we leave we have disability. That's why we accept it as part of our life and teach our kids right from the school. And there should be curriculum, high school level, all over the place. Think about it. Seven billion people in the whole world and one billion people disabilities. That means 14% to 14% of the people have a disability. But the definition of disability in different countries particularly different nations it varies. It could be 20-25%. Think about it. People are living longer. As long as you live longer you are going to --

>> What about my question?

>> I'm coming to your question. Repeat your question once again.

>> You know the question.

>> I want to hear better. Let's see.

[Laughter]

>> Really I give you only a small memory of my question. One specific new professional called return to work coordinator or using return to work as a message for several existing professionals from the health care sector to a social workers and whatever to encourage everybody in the holistic rehabilitation world to focus on -- that is my question. Very easy.

>> Sure. The word return to work is generally originated in Europe. But in the United States we do not use this word. We called it rehabilitation as a field. So the rehabilitations in order to serve a quality of services we need multiple professionals from different fields. But I agree with you there's no problem. My question is that everybody has a specific role to my in the rehabilitation process. My focus is about job placement outcome. Everybody will do it when the medical position, occupational therapies, physical therapies do their services at the beginning but the condition is stabilised it should be bio, psycho, social model, moving to medical model, disability model and bio, psycho, social model. The question is how we look at -- remove the barriers in social setting so the person can function better. Any place in the school,

college, universities, work place, so we have a lot of work to do to education the employer you can see professionals. That's fine. We say counselor, job placement, especially. Everybody has a special role to play. The bottom line of article 27 is it will be measured by how many people with disabilities received gainful employment. What is the quality of life? We can make all this lecture, presentation and everything. I'm thinking about the bottom line outcome. How many people in disabilities with in world has been helped? That's the point. It doesn't matter what label you have council or return to work professionals, it doesn't matter it's a holistic approach to different professionals. They need to play their role accordingly. My focus is about talking about ultimately job placement. Or quality of life by physical therapy or occupational therapy.

>> thank you. Thank you.

[*Applause*]

Do we have one more question. Two more? Just a couple minutes and then we have to head off to the next -- I'll be quick because I don't want to get in the way of anybody in a coffee break.

>> Absolutely. Absolutely. I'll start affecting the room to be fair.

>> Madam or anyone else whose brilliant presentation I had the pleasure to here is it not true if we move to the implementation of a bio, psycho, social model of service delivery where rehabilitation that the actual function ever return to work as far as competencies and for people engaged in that kind of work, we have to broaden out the definition of those competencies? Am I correct in thinking this way? Yes. So I'm thinking of the comment about attorneys, lawyers. I think that there are brands of new professional areas that are always evolving and when they evolve they tend to become specialised based on the effectiveness measures of their own interventions. That's what happens both in private sector and in the public sector when you are developing new policies. The example I would leave you with would be having worked in war torn countries, Sierra Leone, there's people who would not define themselves as people with disabilities but if there had been no war and if you looked at their behavior on a normal scale, you might say they are a bit impaired. Leave it that way. So it is really relative to the geography and the setting in which return to work is going to happen. But to broaden out the return to work, we need be ready for anything. Is that right? Thank you. So it really is a work in progress.

>> Thank you.

>> Final question. Someone here at the front. Thank you. Say who you are.

>> Thank you. Just a quick one really. From the U.K., I'm used to terms of medical model and social media. Is the biosocial -- social model is the bio-social model the same?

>> Medical and social model, international classification of function it broadens the scope, bio, psycho, social model. That means you are one end of medical spectrum. The other one is the psycho social model. You have to think about the person's time [off microphone] and enjoy the life. Quality of life.

>> Can I ask we go for another round of applause to the speakers, technical chap and volunteers as well. Thank you very much. I hope you enjoyed it.

[*Applause*]