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The Australian Society of Rehabilitation Counsellors Ltd. (ASORC)

Submission

to
State Insurance Regulatory Authority (SIRA), NSW

Inquiry on the revised workers compensation guidelines for allied health treatment and hearing service provision

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Emailed to:
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Introduction

The Australian Society of Rehabilitation Counsellors Ltd (ASORC) welcomes and thanks the State Insurance Regulatory Authority, NSW (SIRA) for the opportunity to provide a submission on the *Workers compensation guidelines for allied health treatment and hearing service provision draft for consultation (*available at the link here). We are pleased to provide our submission and have chosen to provide responses to the draft guidelines under consideration for both allied health providers and hearing service providers.

ASORC is concerned that the existing draft guidelines do not provide sufficient recognition of the breadth and depth of expertise that exists within its membership with regarding the provision of psychosocial counselling services. Such services provided by our members include adjustment to disability counselling (particularly with regard to acquired hearing loss) and the care and management of clients with post-traumatic stress disorder.

This submission provides evidence regarding the necessity to:

1) recognise ASORC members as being appropriately qualified counsellors under the allied health guidelines, and
2) recognise ASORC members as being appropriately qualified to provide necessary treatment services to people with congenital and acquired hearing loss.

For those unfamiliar with ASORC and the profession of Rehabilitation Counselling we take this opportunity to bring the following information to your attention.

ASORC is the peak professional body representing Rehabilitation Counsellors throughout Australia and has been doing so since it was established in 1976. ASORC is a non-party political, non-sectarian and not for profit organisation. Its mission is to promote the profession of Rehabilitation Counselling and to foster the professional capability of its members.

ASORC provides:

- a long standing and respected voice for the profession (over 40 years since inception)
- Resources, education, mentoring and supervision necessary for members to achieve career advancement and enhanced credibility in the profession and in the community
- a robust set of Core competencies and Code of Ethics
- access to the latest research and academic commentary through the ASORC Journal, the *Australian Journal of Rehabilitation Counselling*
- access to a network of similarly skilled and like-minded professionals across Australia.

As there exists some confusion in the community on this topic, it is important to note that Rehabilitation Counsellors should not be confused with Rehabilitation Consultants. The former is a distinct and respected Allied Health profession whilst the latter is a generic title often used by WorkCover authorities to describe anyone who delivers return to work and associated services. This confusion in nomenclature can often undermine the superior skills held by Rehabilitation Counsellors' which are not necessarily present in a Rehabilitation Consultant.

Draft Guideline 1: Approval requirements for allied health providers

ASORC understands that Section 1.1 of the Draft Guidelines outlines the professional membership or certification required to be appropriately qualified for the purpose of providing allied health treatment or services to injured workers under Section 60 of the Workers Compensation Act 1987. Our members are allied health professionals with a unique skillset for counselling treatment provision in the workers' compensation context, yet they have been omitted from these Guidelines. Equally the Guidelines do not recognise ASORC as the relevant peak body which qualifies Rehabilitation Counsellors (RCs) to give or provide a treatment or service to a worker in NSW for the purposes of the Act.

This is perplexing, given the long-established and unique professional skills, knowledge and experience of Rehabilitation Counsellors, and their ideal placement to provide counselling services within a workers' compensation context. Given the range and relevance of the skills which Rehabilitation Counsellors possess, they should be recognised as an appropriately qualified provider of counselling treatment for the purposes of the Act and in conjunction with this, Full ASORC membership should be recognised as an appropriate qualification to provide these services under the Act.

Rehabilitation Counsellors are Allied Health Professionals who work within a counselling and case management framework, across the biological, psychological and social domains, to assist people with disability, health conditions and disadvantage participate in employment or education, or live independently and access services in the community to achieve their personal, educational and vocational goals.

Rehabilitation Counsellors possess advanced skills in personal counselling, vocational assessment, vocational training, job placement, case management, injury prevention and management, service coordination and independent living planning. All levels of ASORC membership require tertiary qualifications. Typically, these are obtained in Rehabilitation Counselling at a post graduate level following an undergraduate degree in psychology or behavioural science. This provides Rehabilitation Counsellors with a deep understanding of the impact of disability, health conditions and disadvantage on a person's life, and especially the importance of work and education in attaining inclusion and fostering independence and self-esteem. Consequently, Rehabilitation Counsellors are highly qualified to provide services that are often not in the repertoire of other allied health professions.

ASORC upholds rigorous criteria for its members. There are three levels of membership, consisting of Affiliate, Associate and Full categories. In terms of qualifications, those who obtain Affiliate membership typically possess a 3-year APAC accredited degree in Psychology, whereas Associate members typically possess a postgraduate degree in Rehabilitation Counselling or a 4-year APAC accredited degree in Psychology. Full membership typically requires the completion of both an undergraduate degree in Psychology and a postgraduate degree in Rehabilitation Counselling.

Associate members can ascend to the level of Full membership by completing a rigorous supervision program. This program requires the demonstration of professional competence in line with the ASORC Core Competencies under the supervision of a Full ASORC member over the course of 6-12 months, depending on the prior experience and qualifications of the member. Areas of professional competence established through this program include counselling interventions, job placement, vocational assessment, injury and disability

management. Affiliate members can also upgrade to the Associate category by demonstrating professional competence commensurate with a year of relevant work experience.

To maintain the professional skills of our established members, ASORC also requires its members to complete 20 hours of CPD as a minimum requirement annually.

We assert that, based on the knowledge, skills and experience of Rehabilitation Counsellors, ASORC Full members should be recognised as an appropriately qualified allied health treatment provider for the provision of counselling services.

Draft Guideline 2: Approval requirements for hearing service providers

With regards to hearing services, Section 2.1 of the Draft Guidelines (pages 7 and 8) currently only identifies two groups of providers as qualified to provide hearing services:

a. ear, nose and throat medical specialists supplying hearing aids, and
b. a sole trader, partnership or company providing hearing services

Within category (b) above, Section 2.1 of the Draft Guidelines specifies that the only qualified allied health providers of hearing services are audiologists and audiometrists.

As such, the Draft Guidelines frame hearing services as simply being for the provision of hearing aids. ASORC contends that these guidelines are too narrowly drawn. The draft guidelines do not:

a. allow for the staffing of hearing services that will result in a systematically more effective and efficient approach to the provision of hearing services
b. recognise the modes of service and requisite skills-sets that are recognised internationally, as reasonable and necessary for the care and management of acquired hearing loss
c. qualify the multi-disciplinary based team that is required for the provision of a reasonable and necessarily holistic approach to hearing services

Our submission details our concerns below.

The guidelines must provide for the staffing of hearing services that will result in the systematic delivery of necessary hearing services in an effective and efficient manner.

Employers and insurers do not wish to be paying tens of thousands of dollars per noise-injured worker for hearing aids which are not used or for services which are ineffective. The current research literature shows (e.g. Hogan et al. 2020) that one third of people receiving hearing aids in Australia rarely, if ever use them. Approximately 45% of hearing aid owners report that the provision of their device has not fully resolved their hearing difficulties while one-in-four report problems in everyday communication, despite having a hearing aid. Taken together, these data demonstrate that the existing device-centred model of hearing service provision does not meet the hearing rehabilitation needs of one-third to almost a half of all people receiving hearing help under the existing device-centric model of service provision. This outcome evidences reduced quality of life for affected workers and a significant waste of industry and public resources. Similar to a worker with a musculoskeletal injury, who may require aids and devices as well as physiotherapy and pain education, a majority of clients with acquired hearing loss require hearing rehabilitation to enable them to address known and well-documented barriers to the effective use of amplification. The existing model of hearing services funded by SIRA does not adequately account for this situation, as does it not fully recognise or utilise the skills and expertise of allied health practitioners, such as Full members of ASORC, in providing hearing rehabilitation services.

ASORC surveyed its membership in 2016 regarding their expertise and capacity to provide hearing rehabilitation services. The study found that the 112 members who responded:

- have ongoing and extensive experience (mental health assessments, adjustment to disability and motivational counselling services; injury prevention services in return to work) in working with hearing impaired people
- indicated that their expertise included addressing the more complex needs of those whose hearing impairment is severe
- used a variety of assessment and counselling strategies in addressing the specific needs of these clients
- indicated that the client support needs varied by severity of hearing impairment – on average people with mild losses require 8 hours of intervention, moderate 13 hours and severe 21 hours
- indicated that the majority of members (88%) were interested in providing services to this client group and 91% were willing to undertake further in-service training in this field.

The guidelines must recognise modes of service and requisite skills-sets that are recognised internationally, as reasonable and necessary for the care and management of acquired hearing loss

The World Health Organisation[1] recognises that a wide range of social factors impact on outcomes arising from health services. These determinants of health include intermediate (e.g. psychosocial) as well as structural factors (e.g. socioeconomic status). In examining the literature of psychosocial factors impacting on hearing outcomes, Hogan et al. (2020) noted that a wide range of issues impacted on a client's readiness for hearing services including:

- their potential reluctance to acknowledge (i.e. accept) a hearing loss (Hetu and Getty 1991; Barker et al. 2017)
- a fear of stigma (Hetu and Getty 1991; Barker et al. 2017; Kochkin 2000)
- readiness for using a hearing aid and to manage it socially (Smeeth et al. 2002; Ferguson et al. 2016 & 2017; Hogan and Phillips 2015), and
- self-efficacy skills which are central to the effective management of communication in difficult settings (Heydebrand et al. 2005; Hickson et al. 2014), particularly in settings where devices do not perform well (McCormack and Fortnum 2015).

Hogan et al. (2015) have also demonstrated that higher diastolic blood pressure, anxiety, and reduced self-confidence are associated with a person's decreasing ability to successfully manage their hearing problems. Demographic and socioeconomic factors also impact on hearing outcomes. People who rarely if ever use a provided hearing aid are more likely to be people working in jobs where high noise exposure is an issue, including:

- men
- those on lower incomes
- those from non-English speaking backgrounds

The literature shows that the management of structural and intermediate determinants of health is central to enabling people to benefit from hearing services and participate in community life (NICE 2018). Peoples' who participated in such programs showed greater insight into their hearing difficulties, improved confidence, less family conflict, less stress, and improved problem-solving abilities (Getty and Hetu 1991).

[1] https://www.who.int/social_determinants/en/

The guidelines must qualify the multi-disciplinary based team that is required for the provision of a reasonable and necessarily holistic approach to hearing services

As has been demonstrated above, the existing device-centred model of service provision, advocated by the qualifying guidelines, does not provide for the provision of the services which are demonstrably both reasonable and necessary. In particular, a device-centric model is not sensitive to the social and cultural needs of presenting clients. Moreover, as demonstrated by Hogan and Phillips (2015), historically, university programs training audiologists have not sought to equip graduating audiology students with the necessary psychosocial counselling and interpersonal skills required to readily address clients with these needs. This issue has been highlighted in two recent studies. First, Bennett et al. (2020a) found that two out of three audiologists studied felt that they lacked the skills to provide clients with the necessary emotional support which they required. Second, that audiologists had notable difficulty in identifying hearing impaired clients who were presenting with psychosocial difficulties such as depression (Bennett et al. 2020b). These are significant deficits in the skills base of the workforce which the guidelines propose to singularly qualify for the provision of hearing rehabilitation services. These studies demonstrate the need for the more effective and efficient provision of such services by the professionals who are suitably qualified to provide such services, those being appropriately qualified Full members of the Australian Society of Rehabilitation Counsellors.

To this end ASORC contends that SIRA needs to adopt a revised model of hearing service provision, one which distinguishes between:

- those qualified to conduct audiological assessment and provide hearing devices, and
- those qualified to provide psychosocial and occupational rehabilitation, including return to work services.

With such changes in mind ASORC proposes the guidelines for hearing services qualifies people to provide services within a multidisciplinary framework. Such a framework would ensure that clients would only be fitted with hearing aids when they are psychosocially ready to use them:

1. audiological assessment by accredited hearing service provider
2. hearing Service Provider refers client to a Rehabilitation Counsellor who **concurrently** provides a range of psychosocial Hearing Rehabilitation Services
3. provision of hearing device where psychosocial readiness for using a device is clinically evident.

There may be several models of psycho-social intervention depending on client need. A Hearing Rehabilitation Counselling model could consist of:

- assessments (Hearing self-efficacy; DASS (mental health) assessment; Montreal Hearing Services Baseline survey (examples of these assessments can be found in the Easier Listening Program)
- provision of an appropriate program of psychosocial hearing rehabilitation and motivational counselling such as the Montreal Program (Hetu and Getty 1991) with specific emphasis on the acceptance of disability, counselling strategies, managing hearing related stressors and engaging family support
- programs centred on:
    a. vocational needs
    b. using assistive listening devices

c. alternate communication strategies

For the approximately 20% of clients[2] that will not receive adequate benefit from a hearing device:

1. assessments (Hearing self-efficacy; DASS (mental health) assessment; Montreal Hearing Services Base-line survey (examples of these assessments can be found in the Montreal Program, noted above)
2. provision of an appropriate program of hearing rehabilitation and motivational counselling such as the Montreal style program with strong emphasis on managing stigma, communication coping strategies and use of Assistive Listening Devices, Lip-reading training and/or AUSLAN as appropriate to need and circumstances
3. evaluation of intervention outcomes
4. report back to Hearing Services Provider

Typically, the program would occur over a six-month period, allowing adequate time for the client to make the necessary psychosocial adjustments to improve readiness for hearing services.

[2] See survey of Disability, Ageing & Carers (ABS release 4430.0): https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features152018

Reference List

Barker AB, Leighton P, Ferguson MA. Coping together with hearing loss: a qualitative meta-synthesis of the psychosocial experiences of people with hearing loss and their communication partners. *Int J Audiol. 2017*;56(5):297-305.

Bennett RJ, Meyer CJ, Ryan B, Barr, C, Laird, E, Eikelboom, RH Knowledge Beliefs, and Practices of Australian Audiologists in Addressing the Mental Health Needs of Adults With Hearing Loss. *American Journal of Audiology*. Vol. 29;129–142 June 2020a

Bennett RJ, Meyer CJ, Ryan B, Eikelboom RH. How do audiologists respond to emotional and psychological concerns raised in the audiology setting? Three case vignettes. *Ear and Hearing*. Accepted – March 2020b.

Getty L, Hétu R. Development of a Rehabilitation Program for People Affected with Occupational Hearing Loss 2. Results from Group Intervention with 48 Workers and Their Spouses. *Audiology*. 1991;30(6):317-29.

Ferguson M, Maidment D, Russell N, et al. Motivational engagement in first-time hearing aid users: A feasibility study. *Int J Audiol*. 2016;55(sup3):S23-S33.

Ferguson MA, Kitterick PT, Chong LY, et al. Hearing aids for mild to moderate hearing loss in adults. *Cochrane Database Syst Rev*. 2017(9):Art. No.: CD012023.

Hétu R, Getty L. Development of a rehabilitation program for people affected with occupational hearing loss 1. A new paradigm. *Audiology*. 1991;30(6):305-16.

Hickson L, Meyer C, Lovelock K, et al. Factors associated with success with hearing aids in older adults. *Int J Audiol*. 2014;53(sup1):S18-S27.

Hogan, A., Donnelly, D., Ferguson, M., Boisvert, I., & Wu, E. (2020). Is the provision of rehabilitation in adult hearing services warranted? A cost benefit analysis. *Disability and Rehabilitation*, 1-6.

Hogan A, Phillips R. *Hearing Impairment and Hearing Disability: Towards a Paradigm Change in Hearing Services*: Ashgate Publishing, Ltd.; 2015.

Hogan, A., Phillips, R. L., Brumby, S. A., Williams, W., & Mercer-Grant, C. (2015). Higher social distress and lower psycho-social wellbeing: Examining the coping capacity and health of people with hearing impairment. *Disability and Rehabilitation*, 37(22), 2070-2075.

Kochkin S. MarkeTrak V:"Why my hearing aids are in the drawer" The consumers' perspective. *Hear J*. 2000;53(2):34-6.

McCormack A, Fortnum H. Why do people fitted with hearing aids not wear them? *Int J Audiol*. 2013;52(5):360-8.

NICE. Hearing loss in adults: assessment and management. *National Institute for Health and Care Excellence, guideline NG98 methods, evidence and recommendations*. 2018.

Smeeth L, Fletcher AE, Ng ES-W, et al. Reduced hearing, ownership, and use of hearing aids in elderly people in the UK–the MRC Trial of the Assessment and Management of Older People in the Community: a cross-sectional survey. *Lancet*. 2002;359(9316):1466-70.