



Assoc Prof Antonio Di Dio (00:00:01):

Everyone and good evening and welcome to the Return to Work Bridging the Communication Gap Conversation here presented by the Mental Health Professionals Network. My name's Antonio Dio and I'll be the moderator this evening. I'm an agency head in the Commonwealth. I look after a wonderful group called the Professional Services Review. I've also been a GP for just over a hundred years, I think, and have helped many hundreds of people get back to work, and this is an area of great passion. Our panel tonight are just wonderful. Sarah Hellwege, Lisa Natale and Liarna Natoli, psychologists, occupational therapists, and return to work support experts who have wonderful insights to share, and will also be taking your questions. The webinar's aim is to equip healthcare professionals with practical strategies and useful tips to improve the communication that exists between clinicians, service users, supporters, and also to understand the coordination of that care and how that feeds into the recovery of our patients and our clients.

(00:01:20):

By the end of the webinar, we hope that all participants will be better equipped to identify common communication breakdowns between clinicians, employers, service providers, and a multitude of other stakeholders, how these contribute to delayed recovery, confusion, and barriers to return to work. Secondly, outline practical communication strategies that improve the clarity and the timeliness of that communication, and thirdly, to integrate those communication approaches into clinical practises, but I'm sure that there'll be plenty more along the way.

(00:01:59):

So could we move on to the next slide, please? But also, at this time, on behalf of the Mental Health Practitioners Network, acknowledge the traditional custodians of the lands, season waterways across Australia, upon which our webinar presenters and participants are located and to pay our respects to their elders, past, present, and acknowledge the memories, traditions, culture, and hopes of Aboriginal and Torres Strait Islander people. Their work and their efforts and their love have got us 60,000 years here, and I hope very much that we walk together for 60,000 more. My gratitude is immense, and particular to the Ngunnawal and Ngambri peoples of Canberra upon and from whose lands I speak to you tonight. Next slide, please. So as I said, our panel are Sarah Hellwege, who's the director and principal psychologist at Psych Group, Lisa Natale, who's an occupational therapist with years of experience in this field, and Liarna Natoli, assistant director and return to work supporter at Comcare.

(00:03:18):

So Lisa, Sarah, can you tell us without us embarrassing you in putting you on the spot, what is it that drives you to speak about communication and return to work?

Sarah Hellwege (00:03:31):

Yeah, thank you, Antonio. Yeah, thank you everyone for joining, and I'm really pleased to be here. I think what drives me to participate in sessions such as this is that when people have sustained either a



physical or psychological injury during the course of their work, it's a life altering event where individuals can feel scared, vulnerable, unsure, lacking confidence, security, et cetera. And so they need to be heard, they need to be understood and they need to be supported. So that's part of some of the information that I'll be sharing today and yeah, looking forward to it.

Assoc Prof Antonio Di Dio (00:04:12):

Sarah, thank you. Next is Lisa, can you tell us what drives you to speak about communication and return to work?

Lisa Natale (00:04:35):

Good evening, everybody. And thanks, Antonio. I think from my end, I've been an OT for over 28 years and not quite Antonio's a hundred years, but I just am very passionate about safety and communication, and that's across not just in the return to work sector. I'm a national supervisor for a company with OTs in various sectors. So yeah, safety and communication is my big passion. So I'm very excited to get to share that with people tonight.

Assoc Prof Antonio Di Dio (00:05:11):

Lisa, thank you, and we're looking forward to that. And finally, Liana, can you tell us what drives you to speak about communication and return to work?

Liarna Natoli (00:05:20):

Thanks, Antonio. Hello, everybody. Good evening. I've worked in the return to work space in a range of sectors. So I've seen how communication, I guess, could either support and really propel someone's recovery, but also how communication can unintentionally become a barrier to somebody getting better and recovering at work. And across the sectors, the pattern is the same. So when an injured worker feels heard and supported, the outcomes improve. So I guess I'm motivated by the opportunity to help organisations shift from that process-driven approach to being genuinely supportive and curious when it comes to helping somebody to get better and get back to their job.

Assoc Prof Antonio Di Dio (00:06:04):

Fantastic. Thank you. So we'll now move on to the individual presentations. We'll have a presentation from each of our excellent panel members, followed by the next section, which is going to be a Q&A from everybody on the screen. That Q&A will start with some questions that we've already got from people who've already communicated with us. And then there'll be some from tonight, which will be moderated by my catastrophic old man use of technology, which I'm sure will be entertaining for us all. So Leanna, can you take us through what you'd like to show us? And the floor is yours.



Liarna Natoli (00:06:50):

Thanks, Antonio, so much. I've put coffee on there because it is a late webinar, so appreciating we're well into the evening. But what I'd like everyone to do is just take a moment to think about how you like your coffee or beverage of choice, strong or weak, milk, arm and milk, soy, hot, iced, sugar. Now imagine that you ask somebody else to get your coffee, but you didn't explain it clearly what might go wrong and communication can be like ordering a coffee. So if we're not clear, others fill the gaps based on their preferences and not necessarily ours. So effective communication is a core psychological factor which directly shapes and influences recovery trajectories and the worker's ability to recover at work. Thank you. Next slide.

(00:07:46):

So the biopsychosocial model identifies communication as a mechanism that can influence beliefs, expectations, and behaviours in recovery, and the research is well documented. It shows that early, consistent, and validating communication supports earlier return to work, whereas conflicting or ambiguous messaging predicts poorer outcomes. So stronger communication with an unwell worker from health professionals, employers, rehab providers, and insurers can help to influence expectations about recovery, recovery timeframes, and importantly, instil a high sense of control for workers. On the other hand, silence or poor communication often reflects in feelings of uncertainty, distrust, abandonment for the injured worker. And I guess if communication didn't matter, we wouldn't see the outcomes change so dramatically when it breaks down. Next slide, please.

(00:08:46):

So workers often report not feeling listened to, passed between parties or reduced to a number, and breakdown frequency can increase with the more stakeholders which are involved, high administrative burdens or time pressures on health professionals. So on your screen are just some very general patterns that we often see. Another frequent issue can be inconsistent messaging between all parties, so between the healthcare providers, insurers, and employers. So an example might be where a GP certifies a worker as unfit for work based on how they've presented and their symptoms. Their psychologist might be emphasising the need for graded exposure and functional conditioning or improvement, and an employer sitting back waiting for an insurer approval before offering any suitable duties. So these parallel conversations can often occur without direct collaboration, and it can result in a really contradictory message for the worker. Delays in the flow of information, so slow report turnarounds or indirect communication through administrative channels can further compound the problem.

(00:09:59):

And I guess as health professionals identifying these breakdowns is essential. They represent a modifiable system factor that can directly influence somebody's return to work journey. Next slide. Thank you. So the evidence highlights that psychological distress is actually a stronger predictor of delayed return to work as opposed to the severity of the injury and perceived injustice or invalidation is



associated with poorer functional outcomes, increased conflict in the return to work process, and lower sustainability when we look at somebody actually reentering the workplace. So effective communication or supportive communication can actually be a regulator of nervous system safety, and medical or rehab professionals can intervene by clarifying expectations, normalising recovery and return to work, and interrupting the cycle and rhetoric of the worker to move towards more functional and meaningful goals. And that'll be explained by my wonderful panellists this evening. Next slide, please. So this very simple diagram that I want to leave you with, it's very basic visual, but it reinforces that the worker is at the absolute centre and core, but the outcomes really do depend on the strength and alignment of the whole web.

(00:11:25):

Thank you, Antonio. And thank you. Next slide.

Assoc Prof Antonio Di Dio (00:11:34):

Fantastic. Liarna, thank you so much. Liarna, you mentioned that good communication leads to a high sense of control, and that really rang very true for me. Some of the worst outcomes I've seen in patients over the years have been when they've just literally been sitting by the phone or the computer, waiting for a call or an email for months, sometimes from a provider, not knowing where they stand. We've reviewed those common communication breakdowns through your excellent presentation. What can we put in place to make our communication more effective, in your opinion?

Liarna Natoli (00:12:13):

In my opinion, it would be the early and collaborative approach. So at the moment, the last six years, I've sat on the insurer side of things, and the insurer is very much included in this. I think early and clear communication with all stakeholders and inviting a sense of curiosity when it comes to returning to work. So there is the old do not assume, and I think that rings true in this sense. Be curious, be open, and early communication can really set things up for success or turn things around when they haven't been travelling as well as we would hope.

Assoc Prof Antonio Di Dio (00:12:49):

Thank you. And now to some more expertise on that communication and making our communication more effective. I'll hand over to our next panel member, Lisa. Hi, Lisa.

Lisa Natale (00:13:01):

Hello. Thanks, Antonio, and thank you, Liarna. I'm going to dive straight into my passion, safety and communication, beginning with worker safety. And I guess my first question to all the health professionals in the room is, are you even the right person? That, I guess, comes back to referral allocation at a case management level in the insurance world, as well as a management level in our



practises, but are you the right person to deal with a psychosocial referral in the first place? If you're not the right person, the worker's not going to feel safe and the return to work process will be somewhat stunted. My second point, and this is my extreme passion area, is the careful handling of private and confidential information. I think generally the workers don't trust us because, oh, you're just here on behalf of the insurer. You're just here to help my employer.

(00:14:02):

Whereas being very upfront about the consent and what information we will and won't pass on, right at the start of our engagement with somebody can just build that level of trust and start building that rapport so that the worker feels safe with you, and then you can help facilitate their return to work. And along those lines, I have a rule for myself in that I always copy my injured workers into all email communication. There's a saying in the disability sector, nothing about us without us. And I take that into my return to work practise as well. Next slide. Thank you.

(00:14:47):

The next part of making sure that we facilitating safe communication is to consider our environment. So with my OT rehab consultant hat on, obviously the workplace is one of my big places that I like to go to, but you could be a mental health nurse or a psychologist and your clinic is your primary first appointment place. But sometimes after an initial phone discussion with a worker, we may need to reconsider what's going to be the best for them. So often I will go and visit people in a local cafe or even in their house, but obviously we need to consider the privacy arrangements within that, consider the travel costs within that process, and then consider our risk assessments. I'm sure I'm not the first OT or rehab consultant who's had someone say, "Yes, I do have a snake, but it is well contained." Obviously, we want to be practising safety for ourselves as well as the workers that we're dealing with, but location, location, location for safety.

(00:15:53):

Next slide, please.

(00:15:56):

And when we are engaging in that, I guess, first appointment with someone, that first communication, I think that's the make or break process for good collaboration moving forward. And it comes back to all our uni work that we did on Maslow's hierarchy. I always, always ask my injured workers, excuse me, are your basic needs covered? Are you being fed? Are you drinking? Do you have transportation? Do I need to arrange an ADL assessment to make sure that those basic support needs are covered? Because the more that they feel safe, the more we can progress and the more that we're building rapport. Do I need to facilitate some other referrals to make that process happen? And also at that first appointment, I'm talking with them about appointing a safe contact at person at work. So often they will assume that they need to deal with the return to work manager, the appointed return to work manager at their place of employment, but I reassure them that that's not always the case.

(00:17:05):



Years and years ago, I dealt with a young man who was an IT specialist at a high school and he was on leave for a psychosocial injury, and his appointed return to work person at work was the vice principal. That made him feel scared just by virtue of being the vice principal. So we appointed his line manager as his contact person and the principal or the vice principal was the person in the background that he never actually saw until he was fully engaged in the process. So making someone feel safe, your holistic actions, communicate your intentions to keep the communication safe at all times for someone. Next one, please.

(00:17:46):

Obviously being an OT, I can't talk about safety without talking about communicating the graduated return to work process safely. And Sarah will be going into this in more detail as well, but we need to be looking at the cognitive effort of the tasks when we're talking with our injured workers and sometimes, well, not sometimes all the time, perception. Their perception is the most important thing. What they find the easiest task might not be what you would think or what the employer thinks, but if it's their favourite thing to do, it's going to produce dopamine, maybe we start there. And having their input and their perception of what's the best thing to go back to is just, I guess, my favourite thing to do with people because sometimes they really surprise you what they believe is the best thing for them to get back to work with.

(00:18:36):

And when we're doing physical return to works, the biomechanics are the prime thing that as an OT or a physio, we might be considering, but that favourite task concept goes a long way to achieving an early return to work. I've written in my notes here, the comfort circle example, talking to people about what feels comfortable right now, what feels like you might be able to get too soon, and what at the moment feels so far off the page that you can't even consider going there. And so having that discussion upfront really makes the worker feel like they're being supported through the process. It can be simple as discussing preferred shift times. So my IT gentleman, he could not face the concept of rocking up to work at eight o'clock in the morning because every single high schooler was like, "Mr. X, help me with my laptop.

(00:19:29):

Mr. X, I can't get this email to open." And so for him, that was just too stressful. So we negotiated his preferred starting time of 9:00 AM for his initial step through the door. And that worked really well for him, but that was his idea. It wasn't my idea, but just him feeling safe to be able to bring that up was what got him back to work in the first place. Obviously, we need to discuss other barriers that come up for this particular gentleman. He also brought up a very strange barrier, but he said to me, he's like, "I've got dreadlocks, I've got tattoos, and I'm worried that I'm not accepted at work." And so he was already feeling down upon himself when I spoke to the vice principal about it and he's like, "No, he's the best staff member we've got. It's not an issue.

(00:20:15):



Please reassure him." So always the worker perception is the most important thing that we need to get right at the start. Next slide, please.

(00:20:29):

And just very quickly, I too and froze with myself whether to put the dollar signs in, but I think when we're talking about safety and communication from an employer, there's no doubt about it that they may be feeling quite scared that their business is vulnerable, their insurance claim might be going up, their premiums going up. So all of that stuff, they shouldn't feel guilty about bringing it up, but they generally do. So when we're talking safe communication with them, obviously we need to be clear about what our role is and our purpose. No blame. Leave that to the appropriate authorities to investigate. We don't want to bring that into our processes, talk about the money with them. But in the context of facilitating an early return to work, even if that worker is essentially super numery and not rostered on, but just get them at work to maintain a routine, sense of purpose, foster connection, all that lovely stuff that we all know, but the employer just needs to have that explained to them that it is actually also a cost-effective process.

(00:21:33):

Obviously, clear communication on the duties, the times, expected progression and timeframes. And I guess the most important thing across the board, whether it's talking to a doctor, an employer, a worker, an insurance company is do what you say you're going to do. And that's me. Thank you. Next slide.

Assoc Prof Antonio Di Dio (00:21:55):

Lisa, thank you so much. There was just so much gold in that and I loved so much your comment about copying patients, comments about patients with patients, nothing about us, without us. I thought that was inspiring and something it took me many years to learn. I also noticed what you were saying about that first appointment is crucial and looking at what Maslow would've asked because it rings so many bells. I once saw a young doctor who rang me for their mental wellbeing, and we spoke for a long time about their competence and a long time about their anxiety. And it took about 40 minutes or so for me to figure out that they were actually living in their car, and that probably should have been something that came up first. So that's a really excellent point you make there, Lisa, along a list of excellent points, which we'll explore in the Q&A further.

(00:22:52):

Now, that's a beautiful dovetail into, well, how do we plan our return to work and what expertise and skills can we use? So Sarah, welcome again. And tell us what you'd like to talk to about return to work planning and communication.

Sarah Hellwege (00:23:10):



Thank you, Antonio. And thank you, Lisa and Leanna. I'm really just going to be building on amazing points that have already been made to Lisa's point in terms of the actual worker's input and advocating for the worker and very much cementing Leanna's points around early and clear communication. But I'd like to start just by, I guess, psychosocial hazards and talking about the importance of addressing psychosocial hazards, particularly when someone sustains a psychological injury during the course of their work. So my work primarily at the moment focuses now on prevention. So we know the regulations have changed across the nation in this space in terms of identifying, assessing, controlling psychosocial hazards in our work settings. However, we know that mental injuries are still on the rise. So importantly, when we are thinking and planning for return to work, we need to talk about the psychosocial hazards that may have been evident and that led to the injury.

(00:24:22):

So my experience in my early career as a psychologist, I worked in the rehabilitation space and I worked with injured workers who had sustained psychological injuries. Now, by way of example, I worked with the emergency services sector, and that often share a very rich and detailed story of exposure to trauma, high job demands, and often poor support. So what I've found through talking to a number of different workers was that there was a consistent theme of, I guess, things going wrong at work. And so what that then led me to is an understanding that we actually need better clarity in terms of what went wrong and what do we need to plan for when we're getting this person back to work. But back then, some 15 or so years ago, we were really just talking about recovery and intervention in terms of psychological intervention, maybe OT intervention, but we weren't so much talking about what went wrong in the workplace.

(00:25:28):

So this is where I'm quite passionate about, is really bringing our mind and our conversation back to, let me understand about work and what went wrong at work. And if we are and when we are ready and we are recovered and we are talking about returning to work, what are some of the things that we'd need to manage when we're planning and returning to work? Because often they're the things that really help to facilitate the return to work process in a safe and supportive way. So just some conversation points there. And these are really based off of some of the conversations that I had with injured workers. No one's talking about what happened at work, however they want me to come back to work. I didn't feel safe when I was at work about telling anyone about what was going on, but now you want me to go back to the workplace and I still don't feel safe to talk.

(00:26:20):

So these are some of the barriers that we need to overcome and how we actually need to lean into the psychosocial hazards. Next slides, please.

(00:26:31):

And again, just building on the communication to reduce return to work barriers. So as I mentioned at the start of the session, when we go through a significant life-changing event and we are out of our



work, we're out of our routine, we're out of our structure, we're away from our social networks, we can feel really overwhelmed and we can feel really unsafe, vulnerable, and unsure. So if we think about back to ourselves during the COVID period, we relied heavily on information and communication and what was happening next. The same applies for people when they're off of work and preparing for recovery and return to work. So when we're communicating with people, we need to make sure that we are very clear. We need to be clear in terms of what information we're using for what purpose and when. We need to provide timely updates, potentially even before the person needs to ask.

(00:27:28):

We need to be consistent in our messages and that that information is shared across all parties. And if we remember back to Leanna's slide, the target with the person in the middle and all the stakeholders, the GP, the insurer, the rehabilitation provider, the employer representative, all of those people, where possible, consistent messaging is absolutely key. Person-centered. So I'm very, very passionate and I think all of our themes and sentiments have talked about person-centered communication. So this is really focusing on the experience and the input and the advocacy of the worker, putting them at the forefront of the decisions that are made. And we really want to target their needs, their drivers, their motivation, and most importantly, their agency, because they can empower their recovery and really be at the centre of the return to work planning. Next slide, please.

(00:28:28):

And again, building on this, so safety, privacy, and trust, and Lisa already spoke about this. So the worker doesn't necessarily want personal information that's pertinent to, in particular, their mental health challenges shared with everyone. However, some information is important, right? So it's really important to share with the worker what information will be shared and what won't be shared. So be very, very clear on the information that's being shared, the purpose of which it's being shared, who it will be shared with and when. So they can then expect and know that if someone's received information, they can then infer that they might have better source of information and communication to support them in their recovery. So again, it's around transparency, building trust and influencing clarity and influence so that person can walk that journey with you. Next slide, please.

(00:29:31):

So essentially my key takeaways, building on everything that we've already talked about is first and foremost, psychosocial hazards matter. They matter, particularly where we've sustained psychological injuries during the course of their work. We need to understand from workers, what were their experiences at work, what led to the injury? And if we're considering returning to work, what are those factors that we actually need to build into our return to work plan, and when we are building our graduated return to work plan, it does need to talk about the specificity and the nuances of those psychosocial factors. Second, being heard, build safety and builds trust. So we need to allow space for agency and collaborative discussions, talking together, building plans together, getting the input and the buy-in of the injured worker to support their agency and return to work planning. Again, privacy creates



psychological safety. So when the person knows what information is going to be shared, when, why, and how, and they're part of that decision making, that then builds trust, security, and safety.

(00:30:45):

And lastly, and most importantly, allowing the person to be at the centre of the process. When we empower people, when we give them agency, when we put them at the front and centre of the decision-making, we find that people actually drive better outcomes for themselves because often the people know what is best for them. And when we can motivate and empower them and listen to them, we get more functional and sustainable return to work outcomes. Thank you, Antonio.

Assoc Prof Antonio Di Dio (00:31:16):

Sarah, that was just fantastic. Thank you so much. I got so much out of that. One of the things I'd like you to clarify for me is that if I went back in a time machine 35 years ago, I wish that I'd heard someone like you saying that needs to be person-centric, such as with privacy, safety, and trust and agency. How would you advise a young person starting off in this business to demonstrate your authenticity in respecting that this is a person-centric process rather than somebody just reading a script, for example? How would you demonstrate that to ... And Lisa said it's so important when you first meet someone. When you first meet someone, how would you demonstrate that you really mean it?

Sarah Hellwege (00:32:10):

Yeah, look, I think it's probably all been shared tonight. It's really around listening to the person. So being really curious about the person and being interested in their experience. So as I mentioned earlier, a lot of the injured workers that I worked with, life-changing crises that happened at work. Often they were over a long period of time. Psychological injuries generally occur over a longer period of time. They're more accumulative, so there are development of things that happen across time. So I think being really, really curious about what actually happened, where the person is at now, and how can you actually walk with them. So really leaning into the person's, I guess, story and background, where they're at now in terms of their recovery, and most importantly, what they feel they can achieve right now, and what they feel and what they might be able to work toward in future.

(00:33:15):

So it's leaning into their conversation, it's building trust, it's building collaboration, it's empowering them and giving them agency and making sure that they know that. I think they're probably the most salient features, Antonio.

Assoc Prof Antonio Di Dio (00:33:30):

Excellent. Thank you. And I loved your last point. It's often a good idea that if people do have a skill or an agency or a resource to make sure that they actually know that they've got it, very well said. We've received so many questions live tonight and during registration for this webinar. We're going to do our



best to answer as many of them as we possibly can, but unfortunately probably won't have time to do so because there are such a significant number of them. While we're waiting for some fresh ones to come in and get organised, I'm going to start off with a question to Sarah. Sarah, tell us about ORS and how we can use it for better communication.

Sarah Hellwege (00:34:16):

Yeah. So essentially ORS is a framework that is designed to build, I guess, empowerment across the return to work process and bringing the person on the journey with you. So it's a very simple four-step principle and ORS facilitates that. So essentially the O stands for questions. So that's opening up the questions, inviting the person to talk, asking them to share their story and being really curious about that. The A is for the affirmation. So when the person shared their stories, it's really affirming all of their experiences and validating their experiences. So it's really leaning into and affirming their story. The R is for reflections. So it's the ability to be able to reflect back and paraphrase what you've heard, and that shows and demonstrates really active listening skills. And lastly, summarising. So when you've actually asked some really good questions, you've affirmed your understanding, you've reflected back and paraphrased, you can then wrap up and summarise that in terms of, this is what I've heard, it sounds like this, validating their experience and then being able to repeat that back in a really nice and succinct way.

(00:35:35):

These are just skills that really help to show that you are leaning into effective communication and listening with the worker.

Assoc Prof Antonio Di Dio (00:35:43):

Thank you so much. That's fantastic. Questions come in for Lisa about the balancing of communication versus confidentiality. I get this every day. In my practise, I look after people changing gender. I look after people who are very old and shamelessly divulging their privacy to their carers who might be their children because it's for a greater good. It's based on decades of experience, but it's still scary. Lisa, you presented some really passionate views about this, which I think reflect the outstanding service that you give. Can you tell us a bit about challenges that you might've had between balancing that communication and confidentiality?

Lisa Natale (00:36:33):

Yes. Look, and I guess this is probably not what you want to hear, but to a degree, we can't balance it. I don't know, that's not helpful, but if someone doesn't give you permission to share their information, they don't give you permission to share their information. It's still their private and confidential medical information, and particularly when we are talking from a health professional point of view. But I think as you go through the process, just building that trust, and I think Sarah covered this as well, is being very clear about what information you will share. So I think I like to give people examples of that upfront, and then they can see what I will and won't talk about with their employer, or will or won't talk about with



their insurer. And so sometimes I'll ... Well, a lot of times I'll be working with young women who just happen to share with me that they're pregnant, but is that a critical part of them returning?

(00:37:31):

Is that the employer's business at the moment? No, it's not. But it could be impacting on their stress levels and something that I need to consider. But if they don't want me to tell their employer, I will reassure them that my lips are zipped. And so I think when you're giving examples to your workers about what information you will be sharing, i.e., Duties, capacity, timeframes, that sort of thing, the trust gets there eventually. And you find that the more you don't divulge at the start, the more that they trust you and then they give you permission. And sometimes it's because we need to go that next step and explain why the information's important. It's no point to saying, "I'm going to tell them this, this, and this, " if they don't understand the why behind it.

Assoc Prof Antonio Di Dio (00:38:27):

I think you've actually given a magnificent answer along those two prongs. One is it's not just how long you've been doing it for, but it's how long you've been doing it for with the individual person as you develop trust with that person. And the other one is getting to know the case just so well that you know where you stand. I think that's very, very true. There's a question here from a number of people for Liarna, which is, how do I get compensated for the time that goes into return to work planning? Liarna?

Liarna Natoli (00:39:04):

Okay. Thanks, Antonio. It's a good question and I guess comes up often from the insurer side, and it's important in return to work planning. So for the health professionals, you're investing a lot of time in helping a person, and it can be laborious in terms of the paperwork, the time, the conversation. So there needs to be a balance in how you're remunerated. I think in many cases, compensation for return to work planning is largely guided by state-based workers' comp schedule of fees or service frameworks. So I think in the first instance, it's helpful to familiarise and understand what activities are recognised and what the value is attached to those activities. But what I'd probably prefer to touch on is where the situation is more complex or it goes beyond that of a standard expectation. And what I would say is it's absolutely reasonable to engage with the requester.

(00:39:58):

Most often that will be either the insurer or the employer to talk about the complexities, really understand what it is they need from you, how it's going to be used, and potentially negotiate being compensated for your time if it goes beyond those reasonable return to work activities. And keep in mind that most insurers and even some larger employers these days have dedicated injury managers or injury management specialists and teams. And these individuals, I think, can be a valuable partner in those conversations when a request that's come through to you is more complex and more time-consuming. So I hope that helps.



Assoc Prof Antonio Di Dio (00:40:39):

Oh, that's excellent. Thank you so much. I've got a question here from Tamara directed at Sarah. Sarah, Tamara asks, "How do I communicate well when the other party is challenging, such as being uncooperative or emotionally charged or distant or any other combination of the above?" Sarah.

Sarah Hellwege (00:41:05):

Thanks, Antonio. Look, it's a great question, and I think this is a very common one, particularly if we think about some of those experiences of feeling vulnerable, feeling insecure, lacking confidence, feeling fearful, often the emotions that can be reflected are feeling frustrated, angry, aggressive, sometimes agitated, and that is sometimes very difficult to deal with. And I think, again, it's leaning into bravely sometimes those questions with openness, with empathy and curiosity. So where possible just trying to not take it personally, trying to understand potentially what is driving the emotion and leaning into some of those skills that I mentioned with the ores. So being really curious about your open-ended questions, talking about what you're noticing in terms of, I'm sensing that you're frustrated today, could we start there? Could I understand a little bit more about that? Really opening that up, tell me a little bit more about that.

(00:42:21):

So often what we find is some of the most effective skills for deescalating difficult emotions and difficult experiences is just being heard. So when a person feels that they're heard and someone's actually really listening, and you can show your listening by actually asking more questions, saying, "Oh, validating. Gosh, that sounds really difficult." So what led to that? Asking questions off the back of someone's experience and what they're sharing and then being able to really lean into the validation, that sounds really tough and having moments where you can pause and just for the person to then reflect. I think it's also when someone's frustrated and angry and difficult and a bit resistant, we can jump into solutions as a way to fix it and put a bandaid on it, but often that's decreasing the agency, right? It's decreasing the empowerment. What we want to be able to do is open up that space for listening and validating, and hopefully by doing that and by really leaning into that, we can decrease that level of distress, and then we can get to the co-planning together.

(00:43:35):

That's the bit where we want to bring the person into the centre of the journey and the decision-making, but we need to be able to lean into some of that difficult stuff first. One other thing I think I'd say is it's important to regulate yourself. So sometimes we might not be in the best place. We might've already come off a call from someone really difficult or we might've been out on a visit with a difficult or resistant or upset individual worker. So we need to be able to do our own self-regulation and put our own, I guess, safety mask on first. And some really key skills here, grounding skills is put our feet on the ground, put our hands on our lap if we're sitting at our desk and at home, or even if you're sitting in a



cafe or in a doctor's office or somewhere with an injured worker, it's just being able to ground yourself, self-talk.

(00:44:31):

So positive self-talk such as, I've got this, this person's very distressed. I can manage this. I've got some skills in my toolkit that I'm going to use in a moment. Being able to breathe all the time. We can breathe three breaths in, hold for three, and slowly breathe out for three. So a good real slow breathing cycle helps us to regulate our parasympathetic nervous system, and that helps us tune into our body. And when we can do that, we can then lean into those communication skills. So hopefully that helps.

Assoc Prof Antonio Di Dio (00:45:07):

It certainly does. It's an outstanding answer. I had half a dozen particularly challenging people over the years, one of whom I saw for about 15 years and then felt an enormous sense of relief when they moved into state. But for the next five years, they kept doing all their consultations with me and because they were interstate, I couldn't charge for it and I begged them to see someone else, but they didn't want to tell their story to anybody else. And I remember coming home when my kids were much younger and they would ask and my wife would ask, "Oh, have you seen one of the dozen difficult ones?" Because I would come home and I'd bring it home and I'd be grumpy and I'd be horrible. So we don't just talk about the psychosocial safety of the workers. We need to really do what Sarah said and put the oxygen mask on ourselves first, otherwise you'll become as dysfunctional as I was during that time.

(00:46:02):

It really is tough. And sometimes if you find yourself having four or five or six hours out of a nine-hour day being in a position of emotional challenge, you've really, really got to look after yourself and use a variety of techniques, including that excellent breathing technique Sarah talked about. That breathing technique is particularly good because it's so time efficient. You can do it in a minute, whereas some other ones take ages. We've got a fantastic question here from Olga, which is, it's, if the injured worker withdraws consent and pulls out of therapy, can the allied health treating professional inform the insurer and the referring doctor of this? Now this has come up in my practise many times over the years, and I'd love to hear from any or all members of the panel about what they feel is the right thing to do.

Liarna Natoli (00:47:02):

I'll go first, Antonio. My two cents worth would be, I guess it depends what's being asked of you as the allied health professional. So I guess if an insurer who had been funding specific treatment has asked specifically what's going on and you now do not have consent to provide that or that person's withdrawn, I think simply saying, "I don't have consent to provide you with that information or they're no longer engaged in treatment with me," full stop would probably be enough. That would be my thought, but happy for Lisa or Sarah to jump in as well.



Lisa Natale (00:47:38):

No, I would've said-

Assoc Prof Antonio Di Dio (00:47:40):

Lisa or Sarah, please jump in.

Lisa Natale (00:47:43):

I would've said exactly the same thing.

Assoc Prof Antonio Di Dio (00:47:47):

Yeah. I think there's a great deal of wisdom in that because from the perspective of the insurer, which I have not been, but the perspective of the employer, which I've been many times in the perspective of the clinician, you really, really do need to know if your patient hasn't seen their psychologist for the past 12 months or their physio or their exercise physiologist. It perverts the course of treatment if you don't know. But at the same time, as Lisa pointed out, there are very few things in this entire equation that are not as important as the privacy of the person that you're seeing. And if you're not sure what to do, you need to seek expert advice. Next question. Excellent question. Again, this one is from Dale. What help is available for injured workers with a disputed claim who are not supported? And God knows there's plenty of them.

(00:48:50):

I'm going to take that one first to Liarna.

Liarna Natoli (00:48:56):

Thanks, Antonio. So I think if a claim has been declined and is going, say, through a dispute or resolution process, there's a couple of things. So I guess making sure that if possible, the worker remains connected with the workplace. So employers do have an obligation to support safe work irrespective of whether someone's condition is compensable or not. So first to look inward at what an employer can do or offer to maybe support some adjustments while the claim dispute process is underway, that person's probably going to be financially impacted. If they cannot work, linking them in with Services Australia, like a Centrelink to find out what their options are, people might also have options within their superannuation that they can draw upon. So directing them to the right people who can guide them with that. And then most importantly, they're treating health practitioner, things like mental health care plans, enhanced primary care plans, if that's still what they're being called at the moment.

(00:50:01):

There is treatment accessible under our Medicare scheme. So ensuring that at least the treating health practitioner knows where this person is at and is probably going to be best placed to provide them with



that hands-on support. But as an employer, consider what you can do as well, what's imminent to you and within your resource kit, EAP, whether you've got a wellbeing budget, et cetera.

Assoc Prof Antonio Di Dio (00:50:25):

Yeah, very good points all around. And could I add to that, that any number of my patients who've had a break or an interruption in their psychological care, the Venn diagram of psychologists that will see work related issues and general issues, the Venn diagram is generally one is included inside the other. And so if a claim is suspended or not approved for a certain period of time, I can't remember the last time I wasn't able to get the patient to continue seeing the same psychologist, but just doing a mental health plan for them and at least getting 10 sessions under that system because obviously the condition has to be genuine, which it is, but there are many other resources that are available. And I think that question from Dale did show the kind of compassionate attitude that we need in people who are working in this space.

(00:51:37):

I've got a hand up there from Sarah. Yeah,

Sarah Hellwege (00:51:40):

Thanks, Antonio. I just wanted to build on that. One thing I will say is that often people will submit claims, but however, they won't have even spoken to their employer about what was going wrong at work. So we'll assume that they would've maybe spoken to their line leader, maybe even put in a hazard or incident report or raised concerns before putting in a claim. But where psychological safety within organisations is low, we find that people don't speak up. So often the claim can be the catalyst for intervention. So again, I'll come back to my first slide that I presented around psychosocial hazards. So if it's the injury management team that's looking after this, can we actually have conversations about, can you help me to understand what was going wrong at work or what's been going on? So even if your claim is not accepted or throughout this process, how can we support you to feel safe whilst being at work?

Assoc Prof Antonio Di Dio (00:52:45):

Excellent. Thank you so much, Sarah. We've got the questions coming thick and fast, which is a wonderful sign. The next one I've got here on this list is ... Oops, my apologies. Yeah. The next one on this list is a question for Leanna and it's from Mark who asks, "How do I communicate or quantify hidden challenges that affect someone's return to work?" Mark, I looked at this one and thought, I'm so glad somebody else has asked it because those hidden return to work challenges so often end up being the major problem that an employer has in returning to work and in many cases explains people who are a little bit more resistant than you would, and you're quite surprised by why they are resistant. Liarna.

Liarna Natoli (00:53:51):



Yeah, thanks, Antonio. I agree with you. I think it's an important, but probably often maybe a nuanced challenge when we say hidden factors, we're not getting into particulars, so I'll speak to it broadly, but they can be difficult and they can significantly impact somebody's return to work journey. I guess a helpful approach off the top of my head would be, if possible, to frame these challenges in terms of the functional impact. So what do they mean for a person's day-to-day? What do they mean for a person's workability rather than purely focusing on the detail itself or the challenge itself? So how is it actually impacting somebody's function, somebody's day-to-day? How do we need to consider it in terms of return to work planning? I think by doing that, it keeps it practical, it keeps it relevant, it keeps it aligned to that goal of supporting sustainable return to work.

(00:54:45):

But I think it's also valuable where those hidden challenges might be perceived as being a little bit more complex or not wanting to put something potentially in writing or where you think that it might, how sharing that information might impact or affect someone's claim if they do have an active claim. I'd say it's appropriate to suggest a conversation, again, reaching out to whichever stakeholder you're wanting to have that conversation with, setting some really clear expectations around confidentiality, around the purpose of your chat, and positioning it as a trusted and respectful conversation. So maybe focusing more on support, less about judgement and creating that psychological safety for everyone, including the worker, rather than it being a formal, here are things that maybe aren't compensable but are impacting. It's like, how's their function tie into the return to work planning and when necessary, let's have maybe a more confidential about these BPS factors and looking at the person as a whole and not just what the condition says on their form necessarily, because we know that return to work goes far beyond that.

(00:55:55):

It needs to look at a whole person.

Assoc Prof Antonio Di Dio (00:55:58):

That is very, very good advice. Thank you, Liarna. About 15 years ago, I had a cluster of this exact thing that people are talking about. I had a patient who just, he was well enough to go back, but he couldn't over and over and over again. Something trivial always came up. And the problem was, after about six months when he'd manufactured some lower back pain, was that he was terrified of having lost his skill and his competence. Another person came up with an ankle strain while having recovered from their shoulder to stretch things out. And what was revealed was that the new supervisor who had arrived was a person with whom she had conflict and felt extremely uncomfortable returning to work in a vulnerable position of X hours per day. And so from that time onwards, I've always made a point of asking about any hidden barriers or challenge that didn't appear exactly for the reason that Mark asked that excellent question to avoid that from happening.

(00:57:23):



We've got a great question here from Joan directed to Sarah, and Joan asks, "Sarah, how do I support return to work when the cause of the injury or the psychosocial hazard has not changed?" Sarah, I'd love to hear your thoughts about that.

Sarah Hellwege (00:57:41):

Yeah, I mean, that's precisely why we need to have these conversations and often they won't have changed. So for example, where there is exposure to trauma and high job demands, we talk about maybe the emergency services sector or healthcare as a very real example here where you've got these settings where you can't manage the exposure to trauma, so you can't change the psychosocial hazard, you can't eliminate it, but what can you change and what can you alter? So some of the psychosocial hazards will always be there and we talk about they're kind of inherent in the roles that we do, but some can be altered and adjusted and we can absolutely always lean into them. So I think it's about getting really curious about, again, what went wrong and what do you need to feel safer to get back to work? So acknowledging that the person is the best person placed to be able to think about what it is that they need.

(00:58:45):

For example, the workload is high, but it was the actual emotional demands of the work that often tipped me over the edge. And often people in call centres talk about this. They'll say it wasn't the volume of calls, it was the aggression and violence and the way that we actually or didn't have systems around managing that that actually really impacted my health and safety or the fact that after a very escalated and aggressive call, I wasn't permitted to take a break and I wasn't allowed to talk about it in the workplace. So I think it's really being curious about those factors with the injured worker. And then when we're going back to the workplace and talking to the worker and talking to the GP if possible, we really need to lean into those conversations and we need to have those conversations with the worker. So it's saying to the worker, "What happened?" And based off of that, what do you need and how do we actually communicate that when we're building our return to work plan?

(00:59:45):

And they're the actual features that we build into our reasonable adjustments. So they're no longer our physical reasonable adjustments. These are our psychosocial reasonable adjustments. We need time off to process after emotional ... Demands. We need more clarity when we're dealing with high job demands, for example. So there's lots of different nuances. And again, it comes back to having that conversation with the worker.

Assoc Prof Antonio Di Dio (01:00:12):

Thank you so much, Sarah. To that, I would add, just expand a little bit on what you said about knowing that environment that they're going back to is so important. Years ago, one of my patients said to me, "A couple of my employees, you put them on light duties to do office work only. Can you just come to my



work?" And his work was about three doors down, so I went down and we had lunch together. And he had this tiny little office that did invoices and a typewriter back in those days. And there was nowhere to do paperwork. It was a mechanic shop. And so there was nowhere for people to do paperwork. And if I sent people there to do paperwork, they would sit there for eight hours bored and humiliated and would not get better. Similarly, workplaces are so different from each other.

(01:01:11):

I have a friend in Melbourne who works at two different places and he was very, very emotionally unwell, very fragile. He ended up having a long period of time off work. And eventually when he was ready to go to work, he did four hours on a Monday at the first workplace and four hours at the second. And the first workplace at the end of his four hours on his way out the door through the tea room, they all surprised him and made him a cake and gave him a hug and told them how wonderful it was to be back. And then the next day went to his other workplace where he left at midday because his four hours had finished. And one of the other doctors stuck his head out the door and abused him for leaving early and being useless. And then a couple of people in the waiting room did too.

(01:02:00):

So we don't know the culture of the places that we're sending our precious workers back to. Some of them may be great and some of them may not. And that's why that was such a great question. So thank you there to Joan. There's a question here for Lisa from John. And John says, "Please like this chat if you're comfortable answering, what happens? What happens when the clinical notes are requested by the solicitor? The client's already signed the form for releasing the info. How do we then screen that information?" It's a really good question, particularly if you're new to this game. Lisa, what do you think?

Lisa Natale (01:02:45):

First off, I say brilliant question. From my perspective, the first thing I do is ring my insurer to get my free legal advice that I'm entitled to under most of us as health professionals with our insurance, whether that's held by yourself or by your workplace. Most of the insurance companies will actually have a lawyer on standby for you for up to ... Some of them are one hour, some are two per year to give you advice in these situations. So that would always be my first protocol with any requests for freedom of information or privacy policy stuff. Always speak to your insurer's lawyer. But assuming that you do need to pass the information on, I guess it comes back to knowing when you're writing your case notes, they could be subpoenaed or they could be requested. So screening before you write them. And I know that goes against our instincts sometimes, but I tend to write my case notes while the client's there, while the injured worker's there, so that they know what's recorded, so that if it is subpoenaed, they know what I'm going to say.

(01:04:00):

So if someone has told me I'm pregnant ... Well, not I'm pregnant, that's for sure, that has told me that they are pregnant.



(01:04:09):

Do I record that? Possibly not. If they don't want me to write it down with the knowledge that my notes might get subpoenaed. And I think this becomes really important to keep in the back of our minds as we move into a world of AI. I know there are a lot of health professionals out there using different ... There's eviability, there's Heidi, there's flows. And a lot of these processes and case management record systems have AI functions where you can hit record and the device does your clinical notes for you and you read over them and you save it. Once it's saved, that's that and you can't pull that information back. So if you're subpoenaed or your notes are demanded, just something to keep in the back of your mind. If you are using AI, you're not then screening your case notes. And obviously we need to record as much information as we can.

(01:05:04):

However, I think it's always important to be recording in our case notes what's relevant to the return to work and what's relevant to treating the person with respect to that return to work.

(01:05:22):

So yeah, sometimes I will record the pregnancy. Other times I won't because I'm requested not to by the injured worker. So it's definitely an interesting one, but just something to be really careful of that when you're writing your case notes, always have in the back of your mind that at any time you could be asked to provide them. And I think I learned that the hard way very early on in my career. I was summoned to court to give evidence on behalf of Return to Work South Australia or Work Cover of South Australia as they were back then on behalf of one of the insurers. And the whole reason I had to go to court to give evidence and why my report wasn't believed. So a lot of the time from an OT perspective, our reports are entered as evidence and we're never called to actually give any more information than what's in the report.

(01:06:22):

But the opposition lawyer grilled me because my written hand notes, that's how old I am, written case notes, not electronic back then, had an exclamation mark in them that I hadn't then translated into my report. So from that point on, I'm very, very careful with what goes into my officially documented case notes. So thank you, John, for that very

Assoc Prof Antonio Di Dio (01:06:52):

Good question. Yeah, look, that was a great question and also a great answer. What I do in my day job is I look at a lot of medical records from a lot of different practitioners and I certainly enjoy using the AI scribe in my own clinical practise, but for all of the people on the group who are thinking of using those technologies, they are great, but remember they can hallucinate, they can be inaccurate. And one of the things that I enjoy doing with my patients is when I edit the notes, because you must edit the notes under no circumstances, let the scribe just be accepted by you because they're your record. And if they are full of nonsense or inaccuracies, they are your nonsense and inaccuracies. Don't put your name to



anything you haven't read and edited yourself, but it's a great tool to be able to share that with your client and to look at it together and have a bit of a laugh together and say, "Oh my goodness, gee, doc, you swear a bit.

(01:07:58):

We'll get rid of those bits." And we'll also get rid of where you said that your kid had broken his ankle. It wasn't my kid, it was your kid. So make sure that you edit it together and that way if your notes do get subpoenaed, they are of high quality. And as Lisa said, it's not much fun when you end up in court and you look at your notes and think, "Gosh, are they my notes?" Multiple notes were better than that. So check them every single time. It's really, really important.

(01:08:31):

That's all the questions we've got at the moment. So I'm going to ... Sorry, that's all the questions we've got time for at the moment, should I say. I'm going to start a little wrap up to summarise this fantastic discussion. And I'm sure you'll all agree that Leanna Lisa and Sarah have not only been generous with their time, but outstanding in the quality of their advice in relation to these communication issues. And you can see just how experienced they are from some of the things that they've been able to share with us. Through tonight's discussion, we've seen that a few key points. The first is that communication can break down in a multitude of ways in the return to work journey. It's not just one way. It's don't think to yourself, "Oh, well, if I'm curtious and pleasant and I'm not rude, then my communication with my client's going to be great." Communication can break down with the insurer, with a case management worker, with an allied health practitioner.

(01:09:36):

Communication can break down catastrophically with the receptionist staff of one ally provider, and that's it. The whole thing can fall apart. So there's a dozen points at which communication can break down. Secondly, while the challenge we face can feel out of our control, there are so many strategies that we've heard today from our three panellists that we can put into place for safer and more effective work in delivering those services to our clients. And these include meeting stakeholders, where they are at, seeking clarification and being clear in return. And I think Lisa and Sarah made a big point of the third thing, which is do what it is that you say you are going to do. That is the number one building block of trust. If you want somebody to trust you, don't let them down and don't overpromise. In fact, it's safer and it's healthier, particularly when you are junior in the profession and starting out to under promise and over deliver and always communicate well.

(01:10:56):

And finally, I think all of our speakers tonight talked about not just good communication, but good practise puts the worker at the centre. I would add to that, that one of the reasons why psychological injury claims can cost up to four times the average physical injury claim is that not only a worker's not put at the centre, but sometimes they're put at the centre and given extraordinarily difficult decisions to make when they're not really in a position to make those decisions. We need to give them support and



tools and time and space and permission and respect. And we need to respect them when they throw their hands up in the air and say, "I'm a teapot and I just don't want to make a decision right now." And that's not abrogation and it's not patronising and it's not taking over their agency. It's listening to them and their concern and giving them the space to say, "No decision right now."

(01:12:05):

Let's talk about this another time in the near future." I'd like to go to each of our wonderful panel for a 30-second final reflection themselves, starting with you, Liarna.

Liarna Natoli (01:12:21):

Thanks, Antonio. I think for me, one of the things that just popped back into my brain while you were talking is we're all passionate and I think everyone on the line is here to do good when it comes to helping someone to get better, to get back to work, to recover at work. And I think it's okay to be uncomfortable with the tough conversations. I think that tackling tough communication does come with exposure and practise. So again, to someone who's new or if you're working at an employer and you don't have a lot of injuries or claims and then they come about, I think it's totally okay to let somebody know if you don't have all of the answers when you're communicating, if you need to take things away and circle back, or even for yourself, if you need to prepare for that conversation and have a bit of a framework.

(01:13:11):

And Sarah mentioned ors. So do you need to write down a few open-ended questions to help prompt yourself? Because once you get into that meeting or onto the call, sometimes you can be bombarded with information you're not ready to receive. So practising how you can gently and politely accept the information and not have every answer is my takeaway because I think some conversation is better than no conversation at all. And it does take a little bit of courtesy and practise to get it right.

Assoc Prof Antonio Di Dio (01:13:44):

Liana, thank you so much. Lisa, any final comment from you?

Lisa Natale (01:13:48):

I would actually like to build on Liarna's comment if that's okay. I think she totally hit the nail on the head there. I have a saying, and it's a terrible one, but I'm going to tell you all anyway, it's about faking it till you make it. And when I'm training new OTs and new physios in our business, obviously I don't want them faking their profession or faking their knowledge, but it's about just presenting yourself with confidence. And I think what Leanna said about not being okay to not know things, generally as a health professional, if you say to an injured worker or an injured employer, just the employer, "Look, I'm really not sure about that. Let me go and research and I'll get back to you." Provided you get back to them, that's actually never seen as a form of you being unprofessional. In fact, it almost does the opposite.



(01:14:40):

It raises the view that they have a view in their eyes. And so yeah, I'm a big one to always talk about faking it until you make it. And I think the other thing to always talk about when dealing with both workers and employees is just that it is the privilege to be involved in this process with them. It's a privilege to be there and being able to advocate for a worker and hear their story. It's a privilege to be invited into a workplace and see the awesome things as an OT doing rehab consultancy work. I've jumped up in trucks. It's the best fun ever, but that's a privilege. And I think we always need to acknowledge that and acknowledge the privilege when a worker invites us into their home or into their space, their emotional space, and just it's a privilege.

Assoc Prof Antonio Di Dio (01:15:31):

Beautifully said and reflecting a very genuine passion. And finally, Sarah, any final comment from you?

Sarah Hellwege (01:15:38):

Yeah, look, I'm going to build on Liarna and Lisa, the privilege, right? Absolutely. If we can be with the worker and actually sit with the worker and be genuinely curious and genuinely interested in helping them get better and get back to meaningful work, whether it be with a pre-injury employer or a new employer, it's really being committed to that action. And so when we are genuinely leaning into that, the worker knows humans are pretty smart. They know when someone cares and they know when someone's just ticking a box. And I think where we can be more person-centered, and I know we throw around these terms, person-centered, psychological safety, but essentially it's leaning into, with the most amount of empathy as you possibly can, acknowledging that this person's been through some very difficult experiences that might be driving their motivations, their behaviour, and sometimes that might not always come off in the most, I guess, mutually effective way.

(01:16:53):

But I think if we can put ourselves in that position of we are the allied health professional or we are the support person or we have a role to play here and really leaning into those skills of really listening, active listening, empathetic engagement. And I think the only other thing I'd add that I haven't already is with respect to psychosocial hazards, what went wrong at work, but also what actually went right? What were the points, what were the parts about work that actually were working? Because maybe where we can't change some of those other things, maybe we can build on what was working. So maybe that's our kind of motivating factor to get back to work. And similarly, outside of work, where we're actually disengaged from work, we know our identity decreases, our self-confidence decreases, our motivation, and our agency decreases, so how can we build that up?

(01:17:48):

What's actually working now? So even though you might not feel as well as what you could or what you did in the past, what is actually working right now and how can we leverage off of that? That's about all.



Assoc Prof Antonio Di Dio (01:18:01):

That is a wonderful, wonderful way for us to finish up. Please let me thank our wonderful panel, our wonderful panel, Sarah, Lisa, and Liarna. Also, Jamie, the IT wizard and Gaby, our fearless leader, and all of the other wonderful elves that have gone into making this great presentation. But what a great panel. Thank you all so much. I wish I'd met you many years ago, but what a great benefit to hear tonight. And a final reflection to all of the wonderful audience tonight, I was just wondering when you are on your way home from wherever you are, how you might approach communicating with workers, employers, insurers, and other stakeholders after tonight's conversation, a really great thing to think about. I want to thank all of you for listening to us and for the incredible privilege of discussing this. I don't want to thank my third and fourth child, the monsters in the late 20s who've moved back home who've just walked past me and raised their eyebrows brutally asking, "What the hell would dad know about active listening?" But I want to thank Sarah, Lisa, and Leanna for knowing a hell of a lot about active listening and everybody on the audience tonight.

(01:19:21):

Thanks everybody.

Sarah Hellwege (01:19:23):

Thank you all.