The RSI & Overuse Injury Association of the ACT, Inc.

ANNUAL REPORT

Financial Year
2015-2016

Room 2.08, Griffin Centre, 20 Genge Street
Canberra City 2601
Mondays and Thursdays 10.30am—2.30pm
(02) 6262 5011 | admin@rsi.org.au

www.rsi.org.au
www.facebook.com/RSIACT

Contents

Aims and Objectives

Aims of the Association:

a) To assist people with RSI to manage their condition

b) To inform and educate individuals and organisations in order to prevent RSI

Objectives of the Association:

a) to empower people with RSI to manage their condition successfully, to recover direction and find meaning in their lives

b) To inform and educate treating and rehabilitation professionals about the condition

c) To provide referrals and advice to assist people with RSI

d) To advocate on behalf of people with RSI in order to advance their interests and reduce the stigma of the condition

e) To inform and educate the community about the prevention of RSI

Committee & Staff

President:	Position vacant
Vice-president:	Christina Winkler
Treasurer:	Irene Turpie
Public Officer:	Ann Thomson
Secretary:	Robert Hawes
Committee members:	Lisa Blanch
	Stefan Wythes

Staff

Director:	Ann Thomson
	BA, Dip Ed., MA, MEd
Office Assistant:	Olivia Duczek
	Joseph Penington
Office Volunteers:	Robert Hawes
	Irene Turpie

Our Key Partnerships

Health Care Consumers ACT

ACT Chronic Conditions Alliance

ACT Council of Social Service Inc (ACTCOSS)

Volunteering ACT

Pain Support ACT

Arthritis ACT

Dutch RSI Association

UK RSI Association

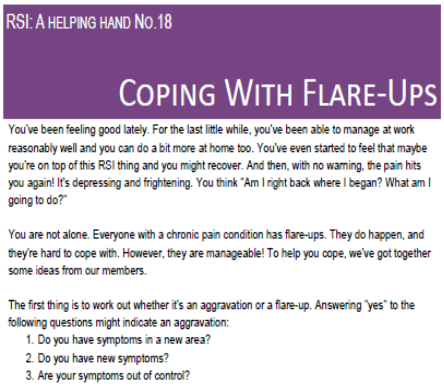
DIRECTOR'S REPORT

2016 was a busy and productive year for the Association. We continued to expand and improve our resources, including our books, website and "helping hand" information sheets. Our work in referral and information continued to keep us busy as we responded to many calls for help from our members, over the phone, by email and in person.

We continued to make improvements to our website and the number of visitors increased markedly over the year. In April 2016, we had over 1300 pageloads compared to 800 for the corresponding month last year. Over 58% of site visitors come from Australia, with a further 20% coming from Great Britain, 5% from the USA and most of the remainder from Europe. We were successful in getting a grant from Google Adwords which seems to have increased the number of visits to our page.

We were also active on **Facebook** and increased the number of "likes" to 156 as of June 2015. This is is high compared to the UK RSI Association and the Dutch RSI Association. We are happy with this figure as we know that many of our members prefer not to use computers. Our posts regularly reach 100-200 people and sometimes as many as several hundred.

This year we decided to expand our work on prevention, developing **safer computing seminars** for community organisations in the non-profit sector. We marketed this through a notice in CDNet and gave four one-hour presentations to two organisations as a result. Evaluations of this seminar revealed a high degree of satisfaction with its content and presentation. Unfortunately, we found that the time taken to deliver these seminars (including travel time) was impacting on our core activities and we decided not to offer them for the rest of the financial year. However, this is something we will reconsider in future.


RSI: A HELPING HAND NO.18

COPING WITH FLARE-UPS

You've been feeling good lately. For the last little while, you've been able to manage at work reasonably well and you can do a bit more at home too. You've even started to feel that maybe you're on top of this RSI thing and you might recover. And then, with no warning, the pain hits you again! It's depressing and frightening. You think "Am I right back where I began? What am I going to do?"

You are not alone. Everyone with a chronic pain condition has flare-ups. They do happen, and they're hard to cope with. However, they are manageable! To help you cope, we've got together some ideas from our members.

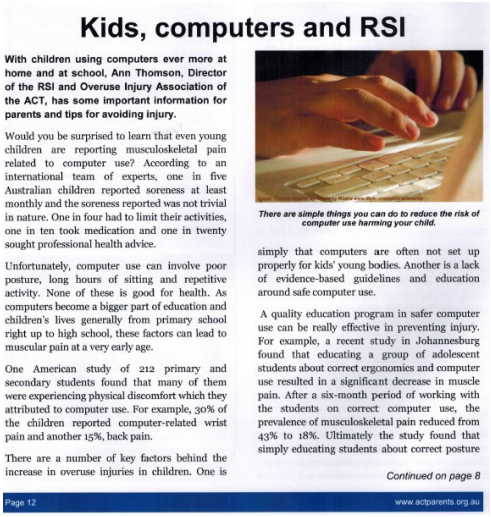
The first thing is to work out whether it's an aggravation or a flare-up. Answering "yes" to the following questions might indicate an aggravation:

1. Do you have symptoms in a new area?
2. Do you have new symptoms?
3. Are your symptoms out of control?

We continued to develop new **helping hand information sheets** for our members and visitors to the website. These included: "10 Steps to Safer Computing", "Coping with Flare-ups" and "Children and RSI ", bringing the total number available on our website to 20.

In response to a request from the ACT Council of P&C associations, We researched and wrote an **article on**

safer computing for children for ParentAction, their regular newsletter for parents. At the same time, we had a number of requests from our members to provide material on this topic so that they could contribute to safer computing policies at their children's schools.



Kids, computers and RSI

With children using computers ever more at home and at school, Ann Thomson, Director of the RSI and Overuse Injury Association of the ACT, has some important information for parents and tips for avoiding injury.

Would you be surprised to learn that even young children are reporting musculoskeletal pain related to computer use? According to an international team of experts, one in five Australian children reported soreness at least monthly and the soreness reported was not trivial in nature. One in four had to limit their activities, one in ten took medication and one in twenty sought professional health advice.

Unfortunately, computer use can involve poor posture, long hours of sitting and repetitive activity. None of these is good for health. As computers become a bigger part of education and children's lives generally from primary school right up to high school, these factors can lead to muscular pain at a very early age.

One American study of 212 primary and secondary students found that many of them were experiencing physical discomfort which they attributed to computer use. For example, 30% of the children reported computer-related wrist pain and another 15%, back pain.

There are a number of key factors behind the increase in overuse injuries in children. One is simply that computers are often not set up properly for kids' young bodies. Another is a lack of evidence-based guidelines and education around safe computer use.

There are simple things you can do to reduce the risk of computer use harming your child.

A quality education program in safer computer use can be really effective in preventing injury. For example, a recent study in Johannesburg found that educating a group of adolescent students about correct ergonomics and computer use resulted in a significant decrease in muscle pain. After a six-month period of working with the students on correct computer use, the prevalence of musculoskeletal pain reduced from 43% to 18%. Ultimately the study found that simply educating students about correct posture

Continued on page 8

We maintained our links with our **international sister organisations**, RSI Action in the UK and the Netherlands RSI Association. We were pleased to see that two articles from our newsletter were translated and published in the newsletter of the Dutch RSI Association.

The association has been a committed and active member of the **Chronic Conditions Seminar Series** and this year was, as usual, responsible for organising an event: "Savings through Medicare" in April.

We also continued to **cooperate with researchers** from time to time. For example, the Association was recently asked to help a researcher at Charles Sturt University with enrolment of subjects in a study on sexual health and repetitive injuries. This was publicised through our website and our regular emails to members.

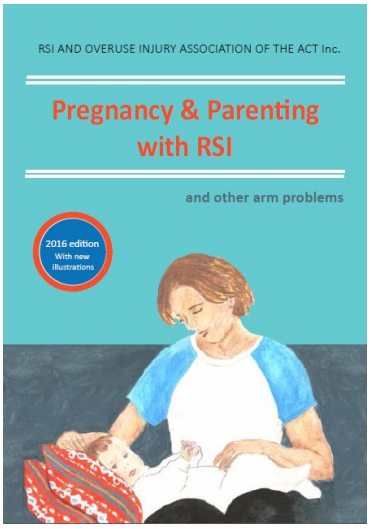
This year, we were very active in the field of **advocacy** with Comcare. This was an extremely valuable opportunity to put the consumer point of view to an organisation that is crucial to the health and well-being of many of our members.
As part of ComCare's "Health Benefits of Work" project, our Director was the consumer representative at a number of meetings of an ACT panel looking at return-to-work case conferences. We put together a survey on the topic for our members and got an excellent response, with many members taking the time to write at length about their experiences and insights. We also carried out a review of the international research into consumer views on return to work case conferences and used both the survey and the research review to put together a report on the topic (See Appendix). This enabled us to make a valuable contribution to a revised Comcare consumer information sheet on return-to-work case conferences.

RSI AND OVERUSE INJURY ASSOCIATION OF THE ACT, INC

FREE SAFER COMPUTING TRAINING AT YOUR WORKPLACE

Does your workforce spend hours at their computers every week? If so, they may be at risk of developing an overuse injury.

In July 2015, our Director gave a short presentation at a hearing of "Willing to Work: National Enquiry into Employment Discrimination against Older Australians and Australians with a Disability" and followed up with a written submission on the difficulties faced by people with a work-related injury in getting employment – or even getting an interview for a job.



Late in 2015, we carried out a major revision and copy-edit of our book, "RSI: a Self-Help Guide", to bring it up-to-date. We worked with a volunteer graphic designer to improve its presentation and lay-out and are very happy with the result.

We also carried out a major revision of our book, "Pregnancy and Parenting with RSI", and updated it with illustrations of new products relevant to people with RSI. A volunteer graphic designer redesigned the layout and cover of the book for us and we made this new version available on our website at no cost. We also provided free copies to Arthritis ACT, the Women's Centre for Health Matters and the QEII Family Centre.

We continued with our **regular newsletters**, which, as always, were very much appreciated by members. Most of our members prefer to receive their newsletters by post and the recent increase in postage costs of 30% has hit us hard. We post out over 100 newsletters each quarter.

This year we were not as active as previously in organising formal opportunities for members to get together, but we did organise a visit to the Tom Roberts exhibition at the National Gallery and a talk by an exercise physiologist.

As always, I am extremely grateful to our committee members and our volunteers for their assistance. Two of our volunteers have been with us for a number of years : Robert Hawes and Irene Turpie. Both have gained a thorough understanding of the Association and have become members of the committee, as has a previous volunteer with a Masters in Public Health, Stefan Wythes. We could not do without the members who so generously volunteer to be part of the committee and I would like to thank them for their hard work and commitment.

Ann Thomson

Volunteers

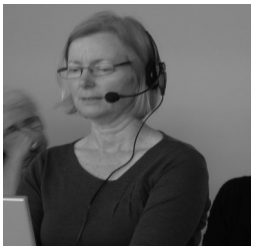
Our thanks to the volunteers who have contributed so much to the Association

Robert Hawes

Thanks again to Robert for his steadfast assistance and good company over the last year. Robert does all kinds of work for us, including research and fixing computer problems. He is extremely knowledgeable when it comes to most common software programs and always a willing helper with whatever needs to be done.

Irene Turpie

Irene contributes to all our publications by bringing her keen proof-reading eye to our writing. She has also done a great job as Treasurer, keeping us on track to deliver a small surplus.



Sue Woodward

Thanks to Sue for her ongoing support of the Association. We frequently turn to her to help us solve our members' difficulties with voice-operated computing and she never fails us!

Computing.

Ellen Poel

Ellen lives in Sydney and very generously translates articles from the Dutch RSI magazine into English. This is a huge help for us and means that we can bring really useful ideas and experiences from our colleagues in the Netherlands to our newsletter readers. Ellen helped us with a translation of the article titled 'Managing Energy Levels with Pain' that featured in the Winter 2015 edition of our newsletter.

CHRONIC CONDITIONS SEMINAR SERIES PROGRAM 2015–2016

- *Mindfulness*

  Randolph Sparks, clinical psychologist: 16th July, 2015

- *Disability Support Pension and Carer Payment - What You Need to Know*

  Karl Jordt, Centrelink: 20th August, 2015

- *The Importance of Oral Health in the Prevention of Chronic Illness*

  Dr Rob Witherspoon, Oral-Maxillofacial Surgeon : 17th September, 2015

- *Pain, Shame and New Ways Psychologists Can Help*

  Marion Swetenham , Clinical Psychologist : 15th October, 2015

- *Depression*

  Julia Reynolds, Clinical Services Manager National Institute for Mental Health Research, ANU : 20th November, 2015

- *Transport Options and Ride Sharing*

  People with Disabilities ACT: 18th February, 2016

- *Disability Support Pension and Sickness Allowance - What You Need to Know*

  Karl Jordt, Centrelink: 17th March, 2016

- *Communicating With Your Doctor*

  Randolph Sparks, clinical psychologist: 21th April, 2016

- *Managing Depression*

  Karlene Dickens , Clinical Project Officer, National Institute for Mental Health Research, ANU: 21st May, 2016

Community Events & Consultations

- Willing to Work Consultation, Canberra
  6th-7th of July 2015
- Annual Hands Across Canberra Lunch
  Wednesday 2nd of December 2015
- *Community Service Industry Plan Workshop*
  Wednesday 25th of May 2016

Events for members

- *AGM 2015— Exercise Physiology*
  Monday, 30th November 2015, 12pm to 1:30pm.
  As a part of our 2015 AGM members were invited to come along and listen to Daniel O'Sullivan.
- *Free Assisted Tour: Tom Roberts Exhibition*
  Thursday, 25th February 2016, 10.30am to 11.30am.
  Members met to enjoy the National Gallery of Australia's exhibition and each others' company.

OUR THANKS GO TO:

- ACT Health for their continued financial support, which enables us to help so many people with RSI.
- The Southern Cross Club for their generous annual donation, which contributed towards our Information Kit and the provision of VOC training.
- All our volunteers and committee members who helped us so much.
- All those who generously donated to the Association, including
  - Thor's Hammer at Yarralumla, which once again made a generous donation.
  - those many individuals who made donations large and small to help us with our work.

ANNUAL GENERAL MEETING
RSI & Overuse Injury Association of the ACT
Held on 30th November at Dickson Tradies Club

MINUTES

Meeting opened: 1.33pm

Welcome and Apologies

Present: Ann Thomson, Robert Hawes, Christina Winkler, Irene Turpie, Agnes Boskovitz, David Lovegrove, Liane Thomson, Beth Thomson, Olivia Duczek.

Apologies: Stefan Wythes, Lisa Blanch.

Minutes of the 2014 AGM—accepted.

Moved: Robert Hawes

Seconded: Ann Thomson

Director's Report 2014/2015

Treasurer's Report and the audited financial statements for 2014–2015 accepted.

Moved: Christina Winkler

Seconded: Robert Hawes

Appointment of Auditor for 2013/2014—Houston & Hanna

Moved: Christina Winkler

Seconded: Robert Hawes

Election of Office Bearers

President:	**Nominated:** **Seconded:**
Vice-president: Christina Winkler	**Nominated:** Irene Turpie **Seconded:** Lisa Blanch
Secretary: Robert Hawes	**Nominated:** Ann Thomson **Seconded:** Christina Winkler
Treasurer: Irene Turpie	**Nominated:** Liane Thomson **Seconded:** Agnes Boskovitz
Public Officer: Ann Thomson	**Nominated:** Lisa Blanch **Seconded:** Robert Hawes
Committee members:	
Stefan Wythes	**Nominated:** Irene Turpie **Seconded:** Ann Thomson
Lisa Blanch	**Nominated:** Ann Thomson **Seconded:** Christina Winkler

All elected committee members confirmed

Close of meeting: 1:44pm

RSI AND OVERUSE INJURY ASSOCIATION OF THE ACT

STATEMENT OF COMPREHENSIVE INCOME
For the Year Ended 30 June 2016

2015 $		2016 $
	INCOME	
25,961	Community Grants & Sponsorships	26,028
3,077	Membership & Donations	2,780
904	Interest & Other Income	300
29,942		29,108
	EXPENSES	
643	Auditing	660
335	Bookkeeping	335
500	Depreciation expense	297
221	Membership & Subscriptions	186
18,114	Community Care Grant - Admin Support (wages)	17,004
1,292	Insurance	1,126
375	Stationery & Cards	725
636	Newsletters	1,126
630	Office Supplies/Equipment	263
478	Photocopy & Printing	280
811	Telephone & Fax	1,491
416	Postage	338
4,564	Rent,room hire & Electricity	4,341
420	Security	420
326	Miscellaneous	359
29,760	**Total Expenses**	28,950
182	**NET OPERATING SUPLUS/(LOSS)**	**158**

These financial statements should be read in conjunction with the attached notes.

HOUSTON & HANNA
CHARTERED ACCOUNTANT

K D Hanna FCA (Principal)

Telephone: **(02) 6249 8515**
(02) 6248 8175
Facsimile: **(02) 6249 6792**

Suite 15, George Turner Offices
11 McKay Gardens, Turner ACT
GPO Box 810, Canberra ACT 2601

email:kim@khanna.com.au

Our Reference: KDH

INDEPENDENT AUDIT REPORT TO THE MEMBERS OF THE RSI AND OVERUSE INJURY ASSOCIATION OF THE ACT FOR THE YEAR ENDED 30 JUNE 2016

Scope.

I have audited the attached financial statements of the RSI and Overuse Injury Association of the ACT, for the year ended 30 June 2016. Committee is responsible for the preparation and presentation of the financial statements and the information they contain. I have conducted an independent audit of these financial statements in order to express an opinion on them to the members of the Association.

My audit has been conducted in accordance with Australian Auditing Standards to provide reasonable assurance as to whether the financial statements are free of material misstatement. The procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements, and the evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with Australian Accounting Standards and Statutory requirements so as to present a view which is consistent with our understanding of the Association's position and the results of its operations.

The audit opinion in this report has been formed on the above basis.

Audit Opinion.

In my opinion,

(a) the financial statements of the Association are properly drawn up:

- (i) So as to give a true and fair view of matters required by subsection 72(2) of the Associations Incorporation Act 1991 to be dealt with in the financial statements
- (ii) in accordance with the provisions of the Associations Incorporation Act 1991; and
- (iii) in accordance with proper accounting standards, being Applicable Accounting Standards;

(b) I have obtained all the information and explanations required;
(c) Proper accounting records have been kept by the Association as required by the Act; and
(d) The audit was conducted in accordance with the rules of the Association.

.....
Kim Hanna FCA

Date....30/9/16.....

Appendix

Return-to-work Case Conferencing

The RSI and Overuse Injury Association of the ACT surveyed its members to find out about their experiences of return to work case conferences. Seventeen members returned the survey. Below is a summary of their responses.

How well prepared did you feel for the case conference?

A strong finding here is that only three out of seventeen respondents felt well prepared for the case conference. In their comments, respondents noted that they did not properly understand the different roles of the rehab provider and the doctor.

Did you understand the purpose of the case conference?

Only around 40% of respondents understood the purpose of the case conference very well, so clearly it is very important for this to be explained beforehand in some detail.

> *I still believed that rehab were really there to cooperate with my doctor's recommendations. I understood it very quickly that we represented 3 sides to the matter and it helped me later on.*

Do you think your doctor had a good understanding of how your condition affected you at work and at home?

The majority of doctors had a good understanding of how their client's condition affected them both at home and at work, with only a few having little understanding (at work 11%, at home 6%).

> *New Dr and team were fabulous in understanding and assisting me in very difficult circumstances with employer.*
> *I think the doctor couldn't appreciate how disabled I was at that stage, and what kind of tasks could realistically be offered, e.g. 15 minutes of computing per hour – how does a person do this in reality? I wasn't really able to do this much.*

> *My GP (who I had been seeing for 6 years) was at times very concerned about my situation and supportive. There was a disconnect about the overall affect on both home and work and a focus on work. I felt like I was being told I should be trying to get my work hours back to full hours at a point when I couldn't look after myself at home. There was a disconnect between the overall impact it was having on me.*

Did the doctor appear to have sufficient understanding of the workplace conditions and tasks you were returning to?

Most doctors had at least some understanding, and a large percentage had a sufficient understanding, when it came to the workplace conditions and tasks.

We had spoken in depth about it.

RSI is virtually all on the person returning to work to keep on asking and asking and aiming to establish duties that are safe.

Some felt that doctors had little understanding of the intensive and high paced nature of their workplace.

Especially of over working – little understanding of the impact of long term stress at work from high paced/ intensity environments.

Did you feel your doctor was supportive and constructive during the case conference?

Three quarters of respondents said that their doctor was supportive and constructive.

Absolutely, he would not be bullied by the employer, his priority was me and my health.

My GP was very patient-centred and believed patients should be in control of their health and have the knowledge to be so.

However, respondents noted their doctor's impatience with the system:

My doctor got sick of the carry-on with my supervisor and department manager and workplace worker's comp.

The doctor would get a bit angry / frustrated and finally told me after about 2 years that she did not want to help me any more and to see a new doctor, however her written reports were OK.

GP was scathing of conference before meeting and felt it a waste of time.

Some respondents felt that the GP did not know enough about the role of the rehabilitation provider.

GPs are generally health-focused, so it feels like they are on your side. Where they fall short is not knowing about the role or agenda of the rehabilitation provider. It is essential to have appointments just with your GP and without the rehabilitation provider.

If you returned to work with light duties, were you able to stick to the times and duties specified?

Not one respondent was able to stick to the times and duties specified easily.

My initial RTW plan (without any conference) started at 2 hrs of typing per day with no support or let up in volume of work so was thus impossible.

Director had no understanding of my condition, was unhelpful and there was no Dragon, no headsets.

Eighteen per cent said there was nothing meaningful for them to do:

Watching a telex machine does not constitute a good return to work plan.

I was physically present at the office but spent a lot of time not doing anything as there wasn't much at all I could do without touching a computer.

Thirty per cent were unable to physically perform the duties required:

The doctors don't take into account what expectations there are of you in the workplace – people will give you a job that seems easy to them, e.g. sorting paper – but exacerbate the RSI.
Placed into an unsuitable and boring job role. Gradual increase to full time but could not sustain.

How helpful was the rehabilitation provider during the case conference?

Only two respondents rated the rehab provider as being "very helpful" during the case conference. 35% were somewhat helpful and over half (52%) were not at all helpful.

They are caught in the middle, paid by the employer. A lot depends on the rehab company and the case manager.

Rehab providers were just interested in my leg in the door, the rest was and has been on me.

They were just pushing me to do more typing and hassled me, there was no real concern for my health, they did not know what to do about me (the too hard basket).

She was a bully with an agenda that was not helpful or useful to meeting my needs of recovery or meaningful work.

I would summarise the rehab provider as being the most incompetent professional I have come across who has no people skills and manages to contradict herself in every conversation I had with her. Both the case managers from the insurance company and the rehab provider were not good during the case conference. I felt I was being interrogated. The rehab provider had been brought in to oversee and guide my treatment, as no one was playing this role, but she did not do this but created extra paperwork for me (she was never able to create a return to work plan for me to sign that was factually correct, requiring me to ask for changes every month).

How satisfied did you feel after the case conference?

Not one person felt very satisfied after the case conference, with 37% feeling somewhat satisfied and 62% feeling not at all satisfied.

I was upset due to being harassed and there was a lack of honesty about the whole process.

Rehab provider always tried to push the doctor to do what they wanted and was not I nterested in what was sustainable but was pushing on.

Extremely distressed (my manager agreed that there was no process), frustrated that the process was so flawed, that the people that were involved in my care were so incompetent.

How could these case conferences be improved?

Respondents made a number of recommendations.

It is clear that injured workers need to be better prepared for case conferences. The role of different professionals needs to be clearly articulated, including whose role it is to chair the conference. The number of people present should be limited – one case conference was attended by six people.

> *(What is needed is) clear guidelines about the purpose, a set structure, who has what role, what everyone wants to get out of it etc.*

A number of respondents suggested that it would be very helpful to have a friend or advocate present. *It can be a very lonely and isolating process when you suffer a work injury. (*Some had actually done this and felt they had benefited.)

> *I think it could be useful to have a patient advocate present who is a neutral party (non-injured) from the patient's workplace, and so understands the nature of the work and likely duties available. Ideally this would be someone NOT from the workplace OHS staff or from workplace management. This person would be, in the way that doctors and OHS staff cannot be, a champion of the injured worker and act as an independent point of reference in terms of how realistic the RTW plan is. There is no-one to guide you, reassure you, to 'show you the ropes', tell what all your options are*.

Any decisions reached at the case conference should be available in writing and signed off by the doctor as well as the injured worker.

The role of rehab providers is clearly problematic. Many respondents commented that rehabilitation providers appear to bully both the doctor and the client, that they didn't understand what the client could and couldn't do at work and they felt treated disrespectfully. Possibly some guidelines could be helpful here.

> *I felt like the rehab provider had an agenda, and just pushed my GP into agreeing.*

> *The rehab provider spoke in a pushy, hurried voice and was very forceful. She also used language in a way that was tricky and difficult for my GP to say no.*

I simply couldn't perform normal duties and I was being bullied to do so.

My experience with rehabilitation providers is that what they say is not actually what is happening. They advise that they are there to help you, but they are actually there to make money off the system. Similarly them attending case conferences is them trying to control the purpose, often without value adding.

Issues in their training and the way that they are remunerated are outside the scope of this consultation, but important.

Many respondents felt that rehabilitation providers needed to demonstrate more connection and empathy with the client.

One respondent had experiences of case conferences both at the Pain Management Clinic and at their doctor's and felt that the first was more useful. This is possibly because more medical professionals had an input:

The specialist / physio / psych could put their case and mine and had more influence over the outcome. Also managed more frequently after implementation. Meetings with GPs were really just about the rehab provider ticking the boxes.

Research on Consumer Perceptions of the Return to Work Process

The themes in our members' responses to this survey are supported by a number of research papers that investigate consumer perceptions of the return to work process.

For example, Korzycki et al use the metaphor of a "tug of war" to describe the "barriers consumers encounter in meeting the opposing demands of the return to work and health systems." In their study, consumers view these systems as separate and themselves as having to negotiate between them.

They identify four major barriers:

- lack of reliable and consistent procedures
- lack of system accountability
- lack of system flexibility
- lack of dignity and respect within the system

Facilitators included "knowledgeable and approachable return to work providers who listen to the needs of consumers" and "healthcare professionals who advocated and motivated clients."

Injured workers' lack of knowledge is identified as a barrier by a number of studies (eg Friesen et al, Baril, Roberts-Yates). These studies found that consumers lacked choice within the return to work process and "found it to be disempowering, intimidating and depersonalising" (Korzycki), with consumers not provided with a partnering role. "Much of the information was deemed by consumers to be unclear, misleading or incongruent with the needs of consumers" (Korzycki).
These themes are reinforced by a number of other research papers that explore consumers' perceptions of return to work processes. In particular, the theme of "shame-inducing encounters" with rehabilitation professionals is a strong one (Robert-Yates, Svensson, Korzycki) .
Studies identify trust and credibility as key to successful outcomes(Baril, Korzycki). Klanghed found that "respectful" and "supportive" treatment was described as positive by consumers in their interactions with rehabilitation providers.
Ina discussion paper on "the Role of the Workplace in Return to Work". The Australian Institute for Social Research identified twenty factors critical to achieving positive return to work outcomes. Those relevant to return to work case conferences are:

- employees have a degree of autonomy over how they perform their work, when they take breaks, and structure their time
- injured workers informed about the compensation process and its associated rights and responsibilities
- conditions of goodwill and mutual confidence
- a process that maximises effective communication and informed decisions by all stakeholders
- non-adversarial context for return to work processes

apropriate/timely (rather than premature) return to work.

References

Baril, R., Clarke, J., Friesen, M., Stock, S., & Cole, D. (2003). Management of return-to-work programs for workers with musculoskeletal disorders: a qualitative study in three Canadian provinces. *Social Science & Medicine*, *57*(11), 2101-2114.

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