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Addressing Psychological Injury and Its Consequences in the Workplace: The Intensive Case Management Trial

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This study documents the findings of a qualitative investigation of the structure, process, and outcomes of an Intensive Case Management (ICM) program that was implemented in several government departments to improve the management of psychological injury and to reduce costs. The study demonstrated that the ICM model was effective in meeting its intended outcomes. Specifically, the model facilitated the delivery of timely and coordinated services to the workplace, and consequently, reduced the incidence of claim lodgment, assisted with accommodated return to work and minimised time away from work. Issues for future consideration included how the model could be integrated more firmly into the organisational culture and how to incorporate systematic follow-up and the capacity to address longer-term issues for injured workers.

Work-related psychological injury has become an issue of great concern over the last decade, both internationally and nationally. The escalating costs associated with stress have been noted in most western countries. The cost to organisations created by stress lies anywhere between 200 and 300 billion dollars per year as a result of high staff turnover, increased health and workers compensation claims and decreased productivity (Wojcik, 1999). One of the most visible costs of work-related stress is that associated with workers compensation claims (Toohey, 1993). This cost is mostly associated with the delay of lodgement and/or acceptance of

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claims, compounded by the potential chronicity of the condition (Kenny, 1998). Other factors that can increase the cost of stress claims include the high likelihood of misdiagnosis, the negative perception of key stakeholders such as employers, co-workers, and rehabilitation providers that hinder appropriate treatment and the conflict that often surrounds these situations.

Case management offers a method for minimising some of these issues by playing a key role in the effort to integrate services into a seamless continuum of care across time and setting to bring about better outcomes (National Chronic Care Consortium, 1997; Scharlach, Giunta, & Mills-Dick, 2001). While there is a range of different case management models (Austin, 1993; Hammer, 2001; Hyde, 2004; Murphy et al., 2003; Scharlach et al., 2001), the current study focuses on one — the Intensive Case Management (ICM) model.

The Intensive Case Management Program

Several Queensland State Government departments recently adopted an ICM model to assist them in managing workers who have sustained work-related psychological injury. The aim of the model was to effectively manage psychological injury at work, and simultaneously to reduce the cost and incidence of workers compensation claims. The ICM was implemented as a whole-of-government stress management initiative and was based on an initial assessment of the situation, the development of an agreed return-to-work plan, and necessary intervention (i.e., services, counselling, negotiation, mediation). The program sought to facilitate the delivery of timely intervention by using external providers to coordinate an early and sustainable return to work.

The ICM model was based on three important structural features, namely a funding pool for each injured worker, the use of external providers, and the integration of ICM with existing organisational systems and cultures. Six external service providers (case managers) were appointed who could supply up to 15 hours of intervention for each injured worker, to a maximum cost of \$2000 per worker. Although cost containment remained an essential purpose of the model, there was scope to negotiate additional service delivery if warranted. Within the ICM model, employers were also able to consider additional funding for more complex cases, as required. The current article presents the findings of qualitative data collected from focus groups involving employers and external case managers who participated in this intervention.

Method

Qualitative data were gathered from the primary providers of the ICM intervention and from representatives of the agencies involved in the program. Given that the intervention was administered by different organisations in different ways, it was not possible to conduct a randomised controlled trial. Further, there is considerable existing evidence that case management is a useful tool, but less evidence about whether or not a case management model could be applied in state government departments. The purpose of this study is to examine the utility and acceptability of the ICM model within the government departments, the

barriers and challenges to implementing such a process in this context and the factors that contribute to its success according to key stakeholders.

Employers

Each participant in the focus groups represented one of the state government departments that were involved in the project, namely:

- Department of Industrial Relations (two representatives)
- Department of Primary Industry and Fisheries
- Corrective Services
- Disability Services Queensland (two representatives)
- Department of Main Roads
- Environmental Protection Agency
- Queensland Police Service (two representatives)
- Department of Employment and Training
- Queensland Transport (two representatives)
- Education Queensland
- Department of Natural Resources and Mining.

Participants were nominated to attend the focus groups if they were primarily responsible for the implementation of the ICM in their respective departments. Departments were permitted to send more than one representative as appropriate. Two focus groups were conducted, one consisting of 11 participants which was conducted in the offices of Department of Industrial Relations. The second focus group was conducted by telephone link to enable four participants who could not physically attend the focus group to contribute to the data collection process. Focus groups were conducted with two facilitators.

Providers

The six official service providers were contacted to participate in personal interviews. However, only three providers were able to be interviewed. One rural provider could not be located due to a name and telephone change and another small urban provider was away at the time of the study. The nominated contact person for one of the large providers had left the organisation and an alternative contact person could not be identified until after the study period. Two providers were interviewed by telephone and another two providers (representing one company) were interviewed in person. The four providers who were interviewed included two men and two women, all with backgrounds in psychology.

Procedure

The focus group protocol was designed to address questions about the structural and procedural implementation of the ICM program in each agency. To facilitate this discussion, the ICM program was divided into its sequential components, namely processes associated with prereferral, referral, assessment, intervention,

TABLE 1
Processes Within the ICM Model

Prereferral processes	Identification of injured worker Initial formal contact with injured worker Send of official proforma and information to GP
Referral processes	Notification of WorkCover if relevant Initial referral of worker to provider Introduction of provider to worker Dissemination of information from employer to provider
Assessment	Confirmation of receipt of referral by provider within 24 hours Contact between client and provider within 48 hours Provider assessment of injured worker within 5 days Report on determination of need for intervention
Intervention and reporting processes	Preparation for case conference within 10 days of referral Interim report prepared if case conference is not possible within 25 days Intensive case management delivered within 15-hour timeframe Pre-case conference report provided to employer within 20 days Return-to-work action plan including issues for all parties Agreement on return-to-work plan Injured worker supported to attend case conference Case conference occurs within 25 days (with no surprises) Documentation of case conference outcomes
Closure processes	Closure report within 5 working days of case conference Invoice and payment procedures Implementation of return-to-work plan

reporting and closure periods. Within each process, several prompts were used to ensure discussion of all aspects of the model (see Table 1).

For each process, participants were asked four specific questions as shown in Table 2. In addition, participants were asked some general questions about whether or not the ICM model facilitated positive outcomes, and if so, which outcomes. They were asked how successful the model was in their organisation and how they would change or improve the model for the future.

Service providers were interviewed in person, using a structured series of prompt questions (see Table 3).

Analysis

Focus group discussions and interviews were audio-recorded and transcribed verbatim. Analysis was conducted by three independent researchers using thematic analysis (Lincoln & Guba, 2000). Thematic analysis is based on the

TABLE 2

Prompt Questions for Employers About Processes of the ICM

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- Questions for employers
- Does this process occur? If not, why not? What barriers and challenges have been faced implementing this process of the model and what responses have been made to address those challenges?
 - Does this process occur within the expected timeframe? If not, why not? What barriers and challenges have been faced meeting the timeframes and what response has been made to those challenges?
 - How does this process of the model happen? What roles do each of the following parties play in the process (worker, rehabilitation coordinator, manager, external provider)?
 - How is information communicated between parties at this stage of the model?
-

TABLE 3

Prompt Questions for Provider Interviews

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- Questions for provider interviews
- Could you share your overall impressions of the ICM model.
 - Discuss the ICM in terms of its utility for injured workers, efficacy for return-to-work outcomes, appropriateness for all parties, relevance to other injury types, and ease of implementation.
 - Are the ICM referral processes easy, timely and informative?
 - How would you describe the communication and information transfer between you, the agency and the worker?
 - Are reporting requirements appropriate and timely?
 - How responsive have agencies and injured workers been to the program? Under what circumstances is this good or poor?
 - How sufficient is payment and how easy is administration within the ICM model?
 - Is the time allocated for treatment sufficient?
 - Is the process of developing a return-to-work plan relevant and useful? To whom, why or why not?
 - How acceptable are return-to-work plans to the relevant parties? Were they implemented or not? If not, why not?
 - Is the Case Conference process relevant and useful? To whom, why or why not?
 - If you had to describe the principles that guide your treatment approach when working with ICM clients, what would they be?
 - Under what circumstances is the ICM successful or unsuccessful?
 - What are the success factors that make ICM work and/or the barriers that make it unsuccessful?
 - If you could change anything about the ICM, what would it be?
-

recognition of important concepts in the data rather than considerations such as frequency. Although the application of 'thematic analysis' is open to a wide range of interpretations, this study followed the systematic process outlined by Coffey and Atkinson (1996), namely, initial coding of transcripts, clustering of codes to develop concepts, developing themes and accounting for deviations from the explanations.

Results

The ICM was perceived to result in several beneficial outcomes, namely reduced incidence of claim lodgment, less time absent from work, and successful return to work. Most employers and providers stated with conviction that this model had reduced the impact of psychological injury on both workers and the workplace. Importantly, the model was perceived to be a useful cost containment measure. There was an overwhelming indication from both employers and providers that the model in its current form had achieved its objectives. Commitment to the model as a result of this success was particularly strong among the employers.

Interestingly, the ICM also linked with outcomes that were less intentional. Indeed, most employers and providers commented on how the structure and processes of the model provided the impetus for change at several levels within the organisations. Specifically, stakeholders concluded that the model provided a safe environment that enabled the reporting and identification of injury at work. In addition, the model was frequently used as a method of risk assessment and management, screening, education, and training. The ICM model was used to provide a framework for motivating change, enforcing action, encouraging responsibility, and for addressing leadership challenges. Most importantly, the ICM facilitated the introduction of a system of disability management within the organisations.

The data indicated that seven key features appeared to account for the success of the model and were considered to be necessary for the ICM model to function effectively. Specifically, the success of the ICM model was thought to depend on (1) early, timely and concise referral processes, (2) adherence to specified timeframes in relation to reporting, but with the capacity for flexibility, (3) collaboration among a team including the general practitioner (GP), injured worker, employer and external providers, (4) clear ongoing communication processes resulting in a 'no surprise' case conference and mutually agreed strategies, (5) use of external unbiased providers, (6) flexible funding structures that enabled employers to take responsibility for the process, and (7) opportunities to embed the model in broader organisational culture and practice.

The Referral Process

Difficulty was encountered by most employers in regard to obtaining suitable referrals for the ICM program, although this improved over time. Difficulty was most often associated with the reluctance of regional and/or departmental managers to draw attention to workplace problems in their area.

Employers used a range of referral processes, and engaged diverse strategies and staff to identify suitable ICM clients. The method employers used to identify ICM clients depended on factors such as existing rehabilitation frameworks,

geographic location, and resources. Some employers utilised existing occupational health and safety personnel to identify appropriate referrals, whereas other employers trained supervisors and managers to undertake referral processes. However, only one employer established a set of referral criteria to ensure suitability of referrals.

This variation in the referral processes was reflected in inconsistent starting points with regard to injury status, thus jeopardising the early intervention framework of the model. For some agencies the majority of clients who accessed the ICM had reached a point of chronic illness and work disability, which raised some concern regarding timeliness of the referrals.

Timeframes Within the ICM Model

With regard to the overall timeframes of the model, there was general consensus that a model based on clearly specified and tight timeframes was valuable. The ICM model provided all parties with a practical structure and clear expectations for action. The timeframes enabled the worker to feel validated and ensured that responses were forthcoming in a timely manner. The speed with which responses occurred within the model prevented the frustration that usually characterises injury management. Further, the structured model provided clarity about the nature of tasks, procedures and roles that functioned to remove ambiguity. According to employers, shorter timeframes were thought to have significant implications for systemic cost reduction. Even for providers, the timeframes were thought to facilitate good practice through inherent checkpoints and delivery schedules.

The importance of the timeframes in the early stages of the model (i.e., referral, initial assessment and development of a return-to-work plan) were considered to be essential. In contrast, timeframes later in the model were thought to be less important, especially in relation to complex cases and to difficult situations that may require extended intervention and follow-up. In order for the ICM to be effective in these circumstances, flexibility was required from providers, employers and injured workers.

Teamwork

Clearly, the ICM model facilitated receptiveness and responsibility of stakeholders and increased awareness regarding barriers of return to work. More importantly, however, the ICM was thought to foster collaboration between essential players in the management of workplace injury. Indeed, the success of the ICM model appeared to be highly dependent on collaborative relationships among all stakeholders and among the various levels of the organisation. It was important for managers, supervisors, injured workers, and GPs to be aware of the purpose of the ICM and to accept responsibility for the process.

GPs were typically considered to be barriers to the rehabilitation process as they maintained a gatekeeper role. Although this issue remained problematic in some cases, employers noted that the ICM provided the impetus to engage GPs. The collaborative process stipulated within the ICM ensured GPs were kept fully informed of the injured worker's situation. Without this collaborative communication, GPs tended to safeguard their 'patients' rights' by recommending extended

periods away from the workplace. According to employers, many GPs were not aware of what could be done to facilitate successful return to work for injured workers and failed to appreciate how extended absences could impact negatively on the worker. External providers were thought to be the most important vehicle for addressing the relationship with GPs, despite concerns that relationships between employers and GPs were not sustainable because providers were only involved for a short time.

Communication

Communication was considered by all stakeholders to be crucial to the success of the model. Providers recognised that failure to communicate effectively contributed to the development and maintenance of psychological injuries. The ICM provided the impetus to overcome communication difficulties and, therefore, contributed to the effective management of these situations. According to employers, the model triggered strategies to improve communications and networks both within and external to the organisation.

Transparent communication was particularly important to the success of the model. For instance, the ‘no surprises policy’ in the lead-up to case conference was vital, as was the delivery of periodic reports from external providers and the use of recommendations that were openly negotiated with all parties in an ongoing manner prior to documentation.

The use of case conference was considered to be a key driver in fostering effective workplace relationships in a number of ways, namely encouraging open communication, outlining clear expectations, reaching agreement on strategies and responsibilities, and confirming timeframes for action. Stakeholders firmly believed that case conference should present a ‘no surprises’ experience for all parties.

The Use of External Providers

There was consensus that the involvement of impartial and expert providers was crucial. Positive outcomes appeared to depend heavily on the independence, experience, and capability of the providers. Perceived independence, in particular, enhanced their acceptability and credibility to both employers and injured workers. Other essential qualities included the ability to consider a problem from multiple perspectives, the ability to be responsive but firm, to have confidence in the direction of the intervention, and capacity to shift between a range of roles including facilitator, mediator and advocate. Providers also had to be solution focused and future focused.

Considerable time was required to foster the knowledge base and strong working relationships between employers and providers. This time commitment was considered to be essential given the importance of a contextual understanding of the workplace. Employers agreed that investment in the relationship-building process with external providers contributed to successful outcomes for the organisation (in terms of successful return to work, resolution of long-term conflicts and cost effectiveness) as well as for the injured worker.

A frequent difficulty highlighted by employers was the identification of suitably skilled providers in rural and remote areas. Lack of ability to engage appropriate service providers within the more distant areas of Queensland often resulted in long delays. As a result, the likelihood of a successful outcome for injured workers within the established ICM framework was jeopardised.

For providers, a significant difficulty involved maintaining boundaries throughout the ICM process. Although it was appropriate to assume other minor roles within the ICM model, such as management coaching and mentoring, it was important for providers to recognise the limits of their ICM role, particularly in relation to ongoing case management and treatment.

The Funding Structure of the ICM

The defined payment structure was seen as a useful aspect of the ICM (i.e., the upper limit of \$2000 allocated for each referral). The limit gave authority to employers to monitor the quality of the intervention and to assume control over the delivery of services.

A factor that impacted on the cost of the ICM during this trial was the time spent 'clearing up the backlog of cases that had been sitting around for several years but this took lots of time and needed considerable investment'. Not all employers had used the model in this way, instead focusing on early intervention for recently injured workers. Several employers noted that more complex cases usually required the negotiation of more time and funding.

Embedding ICM Within Existing Organisational Frameworks

Employers identified several major conditions that were crucial for the success of the ICM. They noted that the model alone may be necessary, but not sufficient, to bring about successful outcomes. Success of the model appeared to be associated with the ability of the ICM to complement and integrate with existing organisational frameworks and initiatives, the level of organisational acceptance of the ICM, the promotion of the ICM in the workplace, and the organisational culture. Variation was evident in the ways employers integrated the ICM into their injury management framework. The more integrated the program, the more likely it was to be seen as a solution. For instance, some employers viewed ICM as a 'perfect framework to hang everything else on'.

'Employer openness' to the new approach appeared to underpin the effective implementation of the ICM. The importance of organisational promotion for the successful integration of the ICM was obvious, although strategies varied considerably across employers. Organisational culture was also seen as important and it was essential that providers understood and adapted to this culture. Two types of organisational culture were noted as being specifically problematic, namely the 'hierarchical' organisation, where every new initiative had to be sanctioned by differing tiers of management, and the organisation that is underpinned by a culture of 'entitlement'. In the latter, sick leave was considered to be a fundamental right, and programs designed to reduce this phenomenon were often met with resistance.

Discussion

Employers generally believed that the ICM model 'is good and it is working'. There was consensus that, 'if it's not broke, don't fix it'. Employers were generally more concerned with how they would sustain this model in the future when funding was no longer available. They were also concerned with ways they could integrate the model more firmly within their specific culture and how they could ensure that they attended to issues such as early intervention and chronic cases. Clearly, organisational culture plays a critical role in how new initiatives are accepted and implemented. Without consideration of the context in which these initiatives are to be bedded, the success of implementation is likely to be undermined. Although cultures are rarely constant, change takes time. The integration of the ICM into existing organisational frameworks appears to have been a viable strategy for most organisations, as evidenced by the reported changes in the management of workplace injury.

Providers were also generally happy with the ICM model and believed that it was extremely useful. However, they were concerned about the need for strategic modifications to enhance its application across a range of situations, particularly rural and remote areas and complex conditions. They also believed that its future sustainability would depend on the ability to be more flexible in its implementation to allow systematic follow-up and on capacity to address longer-term issues.

The current study has examined the experiences associated with the introduction of an intensive case management model to improve the management of psychological injury in large organisations. The model enabled employers, employees, and providers to engage in the process of reaching consensus about complicated and stressful situations, thus reducing the likelihood of these situations progressing towards claim lodgment and protracted absence from work. Although outcome data and organisational indicators are not yet available, this study has demonstrated considerable support for the model from employers and providers.

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