

EARLY INTERVENTION REPORT

A Comcare Research Team
Publication

October 2014



Australian Government

Comcare

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EXECUTIVE SUMMARY

BACKGROUND

The use of early intervention strategies following workplace injuries and illnesses have long been espoused to be important in ensuring a fast recovery and shortening the length of time away from work. Little, however, is known about the effectiveness, use or perceived cost benefit of early intervention within the Comcare scheme.

METHODOLOGY

In order to best capture information from employers about the effectiveness, use and perceived cost-benefit within the Comcare scheme, a three phased mixed methodology was used. Phase One involved the exploration of premium payer claims data, Phase Two involved semi-structured one-on-one interviews and small group discussions with 12 premium paying and licensee organisations, and Phase Three consisted of an online survey to which 110 early intervention professionals from premium paying agencies and licensee organisations within the Comcare scheme responded.

KEY INSIGHTS

The key insights derived through the Project included, but are not limited to:

- > Organisations appear to be realising, or at least starting to realise, the benefits of early intervention.
- > Many organisations, particularly premium paying agencies, have yet to really become involved with early intervention.
- > An agreed definition—‘early intervention is any activity that responds to an identified issue at the earliest opportunity’.
- > Early intervention programs were viewed as benefiting both the organisation and the employee.
- > The main reasons cited for using early intervention were ‘concern for workers’ and ‘minimising the likelihood of a workers’ compensation claim’.
- > Most early intervention programs consisted of a combination of both proactive and reactive elements, as well as formal and informal components.
- > Most considered early intervention to overlap slightly with prevention and to go through to the early stages of a workers’ compensation claim.
- > Organisations who participated in the project were at different stages in relation to the maturity of their early intervention programs, although most had dedicated resources and funding for their programs.
- > Organisations placed constraints such as timeframes, cost and number of sessions on their programs to manage costs and ensure their sustainability.
- > Most organisations provided early intervention support for non-work related injuries/illnesses, especially if the workplace could aggravate the condition, or it impacted work performance.
- > The three key components identified as contributing to the success of early intervention were: organisational commitment (especially from the top down); appropriate support for those who deliver/oversee/monitor early intervention programs and/or components; and, a positive organisational culture.
- > The benefits realised by premium paying and licensee organisations were slightly different, with most licensees reporting a lower number of incidents becoming claims, and most premium payers reporting an improved capability of managers/team leaders.
- > Many participants believed that early intervention was not being used to its full extent within their organisation, or that it was as successful as it could be.

Work Health and Wellbeing

The key insights pertaining to the health benefits of work included:

- > Premium paying agencies identified mental health as their biggest health challenge both now and over the next two to three years.
- > Licensee organisations identified musculoskeletal injuries as their biggest health challenge now, and an aging workforce over the next two to three years.
- > There was a perception that senior managers, middle managers and team leaders lacked confidence in supporting staff with a mental health issue.
- > The link between work and health well recognised.

WHAT IS IN THE REPORT

This report draws together the information collected through the qualitative and quantitative phases of the project. To ensure that readers have a full understanding of the project the report has been divided into five sections:

1. Background
2. Literature Review
3. Methodology
4. Key Results
5. Key Insights

BACKGROUND

The use of early intervention strategies following workplace injuries and illnesses has long been espoused by medical specialists, rehabilitation providers, regulators and others to be important in speeding up recovery and shortening the length of time away from work. Logically, this seems to make sense, but, little is known about the effectiveness, use or perceived cost benefit of early intervention within the Comcare scheme.

Further, while early intervention by employers is encouraged, there is a lack of understanding about the influence this may be having on claims that are entering the scheme, the recovery of those who do not submit a claim, or the financial benefits or costs to employers who invest in early intervention. In recent years, the average cost and duration of claims within the Comcare scheme has been increasing. The influence that early intervention is having in relation to the increased cost and duration of claims, or even the potential role that it could play in helping to reverse this trend, however, is not known.

The aim of this Early Intervention Project was to determine:

- > who within the Comcare scheme uses early intervention, why they use it and what role it plays
- > what effective early intervention looks like from the employer's perspective
- > why employers do or do not invest in Early Intervention.

The information contained in this report amalgamates the findings from an exploratory examination of data contained within the Commission Data Warehouse, qualitative research undertaken by Sweeney Research on behalf of Comcare, and an online survey conducted by the Comcare Research Team with employer representatives within the Comcare jurisdiction.

LITERATURE REVIEW

HISTORY OF EARLY INTERVENTION

While the notion of intervening early has been evident for centuries, the term 'early intervention' appears to have been forged within the context of childhood development, when, in 1986, the American Congress established a program of early intervention for infants and toddlers with disabilities.

The idea, use and sophistication of early intervention has come a long way since 1986, and has also been adopted into many different sectors, including workplaces, workers' compensation and rehabilitation. Within this context, early intervention has been embraced as a positive way to engage with employees following a workplace injury or illness, to help speed up recovery and/or shorten the period of time they are away from work.

While there is a high level of agreement about the potential contribution of early intervention to the effective management of workplace injury and illness, there is considerably less agreement as to what it looks like, how to best apply it within workplaces, or even what works (or does not work) in what circumstances.

DEFINING EARLY INTERVENTION

Despite the lack of agreement about the specifics of early intervention, a broad definition which places emphasis on an early and effective response, be it medical, emotional or vocational treatment and/or rehabilitation, is generally accepted across all sectors, including work health and safety.

It is also generally accepted that the overarching objective of early intervention is to incur an expenditure in relation to an intervention today that, not only improves the individual outcomes beyond that which would occur in the absence of the intervention, but also lowers the potential costs and impacts associated with the 'disability' for the individual and the wider community over the longer term (Productivity Commission, 2011).

More fundamentally, early intervention seeks to reduce the impact of 'disability' for individuals and the wider community by mitigating or alleviating the impact of a newly acquired, newly diagnosed or existing 'disability', and/or preventing the deterioration of an existing 'disability' (Productivity Commission, 2011). Importantly for workplaces, early intervention may also be seen as including strategies to reduce the risk of a new or secondary condition.

Good early intervention programs are generally characterised in the literature (for example: Injury Treatment, 2014; Hoefsmits, Houkes, and Nijhuis, 2012; Raising Children Network, 2009; NSW Department of Community Services, 2005) as being:

- > initiated as quickly as possible
- > multidisciplinary and holistic
- > flexible, yet targeted to the specific needs of the individual
- > multifaceted, that is, consisting of suitable interventions that focus on different domains (where required)
- > structured and well organised
- > run by trained and competent staff
- > focused on what can be achieved, not what can't
- > structured to contain strategies that monitor the progress of the individual
- > evaluated to determine the success of the program.

Importantly, the appropriateness of a service has been found to be dependent upon both the individual and service providers involved, as well as the context in which the program is being delivered. The precise timing and duration of early intervention is also dependent upon a range of factors, including the type of “disability” the type of intervention and the individual’s particular circumstances. For example, the Victorian Coalition of Acquired Brain Injury Service Providers, and the Victorian Brain Injury Recovery Association, made the following statement in their 2011 submission to the Productivity Commission inquiry into Disability Care and Support:

There are several aspects to the timing and nature of rehabilitation and disability support. It is also clear that every individual’s recovery process is unique and is built upon a whole range of pre-injury skills, connections, family supports (or lack of them), and is highly aligned to the age when the injury was received.

In their submission to the productivity commission, CASA (the Counselling Association of South Australia) also stated that early intervention should be provided as soon as possible in order to secure the best outcomes for the individual. These insights, and that of others, highlight how difficult it is to be prescriptive about the timing or the duration of early intervention, as well as how important the individual at the centre of the intervention is.

Within the context of workplace injuries, early intervention is generally regarded as something that is undertaken in the period immediately following an injury/illness. There is acknowledgement in the literature, however, that early intervention has a role to play in the initial phase post diagnosis, for example, once a workers’ compensation claim has been accepted. The length of time an intervention is considered to be early, though, is limited, and definitely does not enter into what is referred to as the tertiary intervention phase, or the period of ongoing treatment. The one exception to this was the discrete changes in a person’s condition, such as a sudden deterioration or change in mobility. In these cases, early intervention was considered to be appropriate as there had been a specific change to the individual’s condition (Productivity Commission, 2011).

EARLY INTERVENTION OR PREVENTION?

A question which is often raised within the context of work health and safety/workers’ compensation, is: “where does prevention end and early intervention begin?” While there are a plethora of responses that have been provided to this question, agreement has perhaps only been reached in relation to the idea that there is no clear delineation between the two concepts, but rather, that they overlap. For example, Fabius, Thayer and Konicki et al (2012), found that workplaces with a focus on the health and safety of their staff, and who actively engaged and promoted better wellness among their staff, reduced the risk of workplace injury/illness, mitigated complications associated with chronic illness, and had better outcomes in terms of costs associated with healthcare, productivity and performance.

These findings suggest that if an employer really wants to reduce the costs of workplace injury/illness, unplanned absence and workers’ compensation that there would be value in implementing both prevention and early intervention strategies.

BENEFITS AND COSTS OF EARLY INTERVENTION

Early intervention programs essentially seek to reduce the impact of ‘disability’ for individuals and the community (Productivity Commission, 2011). Decades of research in Australia and internationally have demonstrated the benefits of early intervention for children, families and communities. Early intervention has also been shown to achieve, at a relatively modest cost, changes to prevent harms that are potentially expensive to remediate (Valentine and Katz, 2007).

Some of the benefits associated with early intervention include, but are not limited to:

- > reduced public expenditure
- > greater independence
- > improved quality of life
- > improved health outcomes
- > reduced impairment
- > reduction in secondary conditions and risk of injury
- > improved rehabilitation outcomes
- > improved employment outcomes
- > greater community participation
- > reduced exclusion.

These types of benefits have been realised in a number of different sectors. For example, Walsh et al. (2007) undertook actuarial modelling of changes to the handling of whiplash claims under the New South Wales CTP Scheme and showed that there were both long-term benefits to the individuals harmed, as well as significant cost savings as a result of early intervention, including:

- > a 40% reductions in the average cost of claims
- > a 27% increase in the proportion of small claims finalised 12 months post injury
- > a change in the pattern of costs to reflect earlier assessments and interventions.

A Victorian study also monitored the average number of days compensation and claims cost in 16 companies. Where proactive management strategies for supporting injured/unwell workers to return to work were initiated, the average number of days compensation decreased from 33.5 to 14.1 days, while the average cost of claims reduced from \$6019 to \$3910 (Iles, Wyatt & Pransky, 2012).

Within the context of workers' compensation, it is widely accepted that early intervention programs can assist both the employee and the workplace, as well as reduce the economic and human costs associated with work related injury/illness (WorkCover Queensland, 2010). For example, return to work plans, medical treatment, or even modifications to a workplace have traditionally not been instigated until a medical condition has been diagnosed and/or the claim has been accepted. Early intervention programs, however, aim to circumvent this delay by implementing strategies to support the worker as quickly as possible.

From an individual's perspective, early intervention programs have been found to have a positive effect not only in terms of improving their outcomes (recovery), but also in terms of their capacity to remain at work, reducing the length of time they are away from the work, reducing the likelihood of further sickness absences, and ultimately, improving their longer term perceptions of the workplace (Hoefsmit, Houkes & Nijhuis, 2012). Similarly, workplaces using early intervention programs have found that they reduced the number of days employees are absent from work, their costs, and the amount of lost productivity. Importantly, workplace based early intervention programs have also been shown to have a more positive outcome for individuals with mental health issues than workers' compensation.

Despite the success and potential of early intervention programs, though, there is a cost to the employer associated with their inception and implementation. These costs include, but are not limited to, the recruitment and training of staff, the development of systems and processes and the establishment of program components. Employers can also bear early intervention costs associated with the purchase of new equipment, re-training and even additional wages.

While the cost of early intervention to an employer can be high, there is also a potential cost to the employee associated with early intervention. These costs tend to be more intangible than financial and include things such as time commitments, emotional energy, social isolation, reduced confidence, family interruptions, a sense of not making a significant contribution to work, and even a sense of not being valued.

RETURN ON INVESTMENT

An internet-based search of websites such as PubMed, BioMedCentral, and Social Care Online, revealed a large number of efficacy/effectiveness studies on a wide range of interventions to reduce the impact and risk for many different types of disabilities. For example, a 2010 cost-benefit analysis of the Western Australian Brightwater Care Group's Oat Street program for people over the age of 16 with an acquired brain injury, found that the estimated cost-benefit ratio for the program was around 1:4, or an estimated net benefit value of \$25.7m (ACIL Tasman, 2010). Much fewer economic analyses of early intervention, particularly in Australia and pertaining to the management of workplace injuries and illnesses, however, were identified.

Within the Australian context, Australian National Accounts estimated that in 1992–93, a total of \$4.83 billion worth of payments were made to households by workers' compensation schemes. In 1995, an Industry Commission study estimated that only 25% of the total cost of work-related injury/illness was due to the direct costs of a workplace incident. The remaining 75% was accounted for by lost productivity, loss of income, and lost quality of life.

The 1992–93 estimate of workers' compensation payments to households has been updated twice, first in 2004 by the National Occupational Health and Safety Commission, and second in 2008, by the Australian Safety and Compensation Council (ASCC). The total estimated cost of workplace injuries/illnesses to the Australian economy for 2000–01 was \$34.3 billion, the equivalent of 5% of the Australian Gross Domestic Product (GDP) for that year, while the estimate for the 2005–06 financial year was \$57.5 billion, or 5.9% of the GDP for that year.

The results of these various studies therefore strongly suggest that there is potential to substantially reduce the social, health and economic burden of workplace injury and illness through the implementation of early intervention programs. Given the potential for early intervention to yield beneficial outcomes not just for an individual or an employer, but also the broader community, it is perhaps appropriate for an employer to view costs associated with early intervention as an investment in their workers, rather than an expense. With an estimated 40 million working days, and £13 billion, being lost each year in Britain due to workplace injury and ill health, a trend which is similar in other industrialised countries, taking this approach may not only be beneficial to employers and employees, but also the broader community, with back pain, musculoskeletal injuries, acute medical conditions, mental ill health and stress being among the most common causes of long-term absences.

READING THIS REPORT

The current report explores the use, effectiveness, and perceived cost benefit of early intervention within the context of the Comcare scheme. The next section of the report, Methodology, outlines how the current project was undertaken, while the Key Results section draws together the central findings of both the qualitative and quantitative research components. Given Comcare's prioritisation and efforts in relation to the health benefits of work, as well as its links to early intervention, a brief exploration of the attitudes and perceptions of organisations was undertaken.

The final section, Key Insights, outlines what project participants, Sweeney Research and the Comcare Research Team believe to be the most important findings for early intervention within the Comcare scheme.

METHODOLOGY

The Early Intervention Project was undertaken in three separate, yet interrelated, phases. Each phase was intended to provide a platform on which to build the next phase of the project. Each of these phases are outlined below.

PHASE 1: PREMIUM PAYER DATA EXAMINATION

Purpose

The first phase of the Project was intended to provide insight into whether or not early intervention activities had an impact on the incapacity duration of serious claims (claims with one week or more incapacity).

Data Source

The Comcare Performance and Analysis Team utilised workers' compensation claims data captured on the claim form by Comcare in its role as regulator of the Commonwealth workers' compensation scheme. Early intervention was considered to have taken place if an employer indicated on the form that action(s) aimed at returning an employee to work and preventing further injury had taken place.

Sample

The analysis considered serious claims that had been accepted, and were initially determined in the period 2007–08 to 2012–13.

Procedure

Two different methods of analysis were used to identify the presence of early intervention. The first used information on the workers' compensation claim form, specifically, the actions identified by the employer as having been taken prior to the claim being lodged. This method was referred to as the benchmark.

The second method looked at rehabilitation costs incurred before the claim compliance date, that is, the date on which a completed claim form, including medical evidence had been received. Rehabilitation costs were defined as costs incurred by the employer when arranging either an assessment of an employee's capability to undertake a rehabilitation program, or the provision of the rehabilitation program itself under section 36 or 37 of the SRC Act.

Analysis

Significant differences between claims with and without early intervention were explored across each 'nature of injury' group. Results, however, were mixed and contradictory due to spurious data collected through the claim form from employers. As such, no key insights have been extracted.

Limitations

A key limitation of the first analysis method used was that there was no means available to verify the accuracy of the information provided by the employer. The Performance and Analysis Team therefore predominantly focused on the second method. The second method, however, also provided confounding results, for example, a reduction in the average incapacity of serious psychological claims appeared to be associated with the use of early intervention, while the reverse appeared to be the case for serious disease and injury claims. These mixed results, coupled with an absence of information on non-claim related incidence of workplace injury or illness, confirmed the need to undertake jurisdictional based research to better understand the impact of early intervention.

PHASE 2: QUALITATIVE RESEARCH (SEMI-STRUCTURED INTERVIEWS/FOCUS GROUPS)

Purpose

The second phase of the Project was designed to provide an insight into the language, role, application and definition of early intervention amongst premium paying agencies and licensee organisations.

Participants

A total of twelve premium paying agencies and licensee organisations within the Comcare scheme participated in the qualitative research component. Employer representatives were in senior management positions, located within either the Australian Capital Territory or Victoria, and worked in areas of Occupational Health and/or Workers' Compensation.

Recruitment

A sample list was provided to Sweeney Research by Comcare. The list included the contact details of individuals who had been invited to participate in the research by Comcare's Relationship Coordination Team, and who had agreed to be a part of the Project. Not everyone who agreed to be a part of this phase of the Project ultimately participated. Those who were not involved were contacted by Sweeney Research, thanked for their interest and advised of the online survey (phase three). Comcare was not advised as to which organisations were included in the final sample.

Interviews were conducted between 12 February and 6 March 2014.

Procedure

A total of 12 in-depth face-to-face semi-structured and/or focus group interviews were conducted by Sweeney Research on behalf of Comcare. The use of an external provider ensured both transparency and anonymity for participating organisations. All interviews were conducted at the organisation's place of business, except one, which was conducted at Comcare's Canberra office. Each session lasted approximately one and a half hours and was recorded with the permission of participants. No incentives were provided to participants.

Analysis

The taped interviews were transcribed and analysed by Sweeney Research. While the Comcare Research Team was involved in the discussion of the information gathered through the interview process, Comcare was not provided with copies of either the interview recordings or transcripts. This ensured that the confidentiality and anonymity of research participants was maintained.

Limitations

While efforts were made to ensure that participants in this phase represented a good cross section of organisations within the Comcare scheme, including those who were known to be experienced in the use of early intervention or relative new users, the small number of participants cannot be considered to be entirely representative of the Comcare scheme. The information from this phase of the Project was therefore used to help develop the final phase of the project, the qualitative research component, which was open to all organisations within the Comcare scheme.

PHASE 3: QUANTITATIVE RESEARCH (ONLINE SURVEY)

Purpose

Building on the second phase, phase three of the Project was designed to establish a scheme wide perspective on the definition, use, role, and parameters of early intervention within the Comcare scheme.

Participants

A total of 110 early intervention professionals from premium paying agencies (48%) and licensee organisations (41%) within the Comcare scheme responded to the online survey. The majority of participants (58%) were female, with a higher proportion of respondents in the premium paying sector (62%) being 45 years of age and over, than in the licensee sector (49%).

The majority of participants indicated that they came from New South Wales / Australian Capital Territory (59%), with all states and territories except Tasmania represented. Most of the premium paying agencies represented, had between 100 and 499 employees (49%), while the majority of licensee organisations represented had over 1,000 employees (75%). The Attorney-General's and Treasury Portfolios had the highest representation from the premium paying sector, while Transport and Information, Media and Telecommunications industries had the highest representation from the licensee sector.

Licensee organisations tended to have had early intervention programs in place for longer than premium paying organisations, while individual respondents from the premium paying sector tended to have been involved with early intervention for longer.

Recruitment

The Comcare Research Team made initial phone contact with return to work coordinators, case managers, work health safety managers and/or human resource managers within both premium paying agencies and licensee organisations. The purpose of the phone call was to advise them of the Project, to let them know that an online survey was going to be distributed and to encourage them to participate in the survey.

The online survey was open between 2 and 18 July 2014.

Procedure

The Comcare Research Team sent out an email invitation to 250 members of the Comcare community with an embedded link to an online survey hosted in Qualtrics. Each email recipient was encouraged to forward the email (and embedded link) to their colleagues who were involved in early intervention within their organisation.

As Qualtrics data storage facilities are off-shore, no open ended questions were included in the survey to ensure that the Attorney General's data storage directions were adhered to. Survey participants, however, were given the opportunity to provide comments at the conclusion of the survey via email. All data was treated in confidence and no individual identifiers were used within the datasets to ensure individual and corporate anonymity.

Analysis

Data was extracted from Qualtrics and imported into SPSS for analysis. Excel was also used for the creation of charts.

Limitations

While efforts were made to ensure that the survey participants represented as many organisations within the Comcare scheme as possible, the final sample was dependant on the willingness of individuals to participate in the research. It is therefore possible that there is an under representation of organisations who do not utilise early intervention strategies.

OUTLINE OF THIS REPORT

The data presented in this report is an amalgamation of the qualitative and quantitative components of the Project and is intended to provide insights into the key research questions posed by this project.

The document aims to capture the key sentiments and understandings around the role, application and definition of early intervention, but does not profess to be the definitive view on what early intervention is or could be in the future.

KEY RESULTS

The findings outlined below represent what the Project team considers to be of significance to both Comcare and the Comcare scheme as a whole. The information amalgamates and summarises the qualitative and quantitative research results in an effort to maximise the value derived from the Early Intervention Project. For more in-depth information on either of the research components, please refer to the documents referenced in the Methodology section.

DEFINITION AND ROLE OF EARLY INTERVENTION

The results of the qualitative research indicated that there was a clear and common understanding that early intervention at its simplest level was ‘any activity that responded to an identified issue at the earliest opportunity’. This definition is not only consistent with the literature, but was also supported by almost all of both licensee (98%) and premium paying (94%) respondents to the online survey, suggesting that for most participating organisations, early intervention was most commonly considered to be ‘pre-claim’, or where there was a very low likelihood of a claim occurring (primary intervention). Some organisations, however, recognised the potential value of early intervention within the claim space (secondary intervention), but only very early on.

“Early intervention is about doing that work in the beginning to prevent and address pain or injury or illness that may be there so that it doesn’t escalate into an ongoing case Early intervention is about assisting staff early on, so that it doesn’t become an ongoing issue or severe/exacerbated injury.” (Premium Payer)

Reactive vs proactive

The survey results also suggested that organisations saw the potential for early intervention to have a broader role, with 60% of all respondents indicating that their organisation’s early intervention program was considered to be both reactive and proactive (see Figure 1).

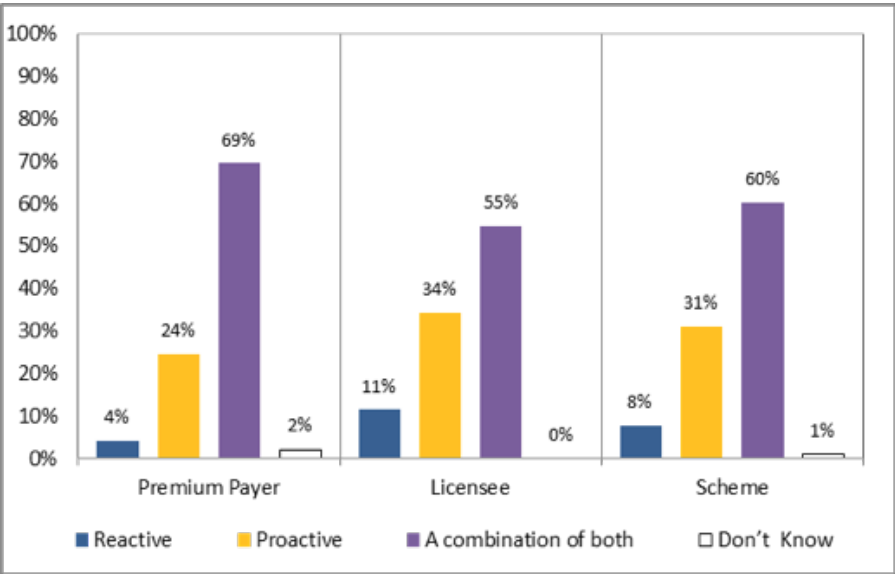


Figure 1: Characteristics of early intervention programs

Despite many participating organisations acknowledging the preventative role of early intervention, they also distinguished between prevention within a work health and safety context, and prevention within an injury management context. Moreover, participants largely understood early intervention to be just one aspect of a broader range of tools being used to manage workplace injury and illness, with all of these initiatives needing to work in conjunction with each other.

“Everything should really be one. To me, our safety guys sit down in half a dozen pods, we should have a room where we’re all in when a claim comes in” (Licensee)

Despite the obvious overlap between early intervention and prevention, most organisations currently differentiate between the two areas, with ‘prevention’ largely being viewed as the domain of work health and safety, while ‘early intervention’ is viewed as a response to a given injury or illness.

Key principles

Based on the experiences of participating organisations, the successful development and implementation of early intervention is driven by eight key principals:

- > A Strategic Perspective: To make sure early intervention activities are considered to be part of a broader strategy to improve the overall management of workplace injuries and illnesses.
- > Appropriate Positioning: To promote early intervention as a program of ‘constructive care’ that helps to ensure the efficient recovery and work health of employees.
- > Feasible and Sustainable Solutions: To ensure that the costs of early intervention are contained and activities sustainable.
- > Flexibility and Expertise: To ensure that the needs of individuals can be addressed by skilled and knowledgeable professionals.
- > Early Identification: To recognise that there are different challenges which required different responses depending on whether the matter is associated with a physical or psychological injury. Early identification was therefore considered critical.
- > Instilling Responsibility: To ensure both managers and employees are prepared to take responsibility for whatever they can.
- > Collaboration: To achieve the full potential of early intervention, all parties must collaborate and set clear expectations.
- > Measuring: To determine the impact and cost benefit of early intervention, it is critical to fully understand the effectiveness of the activities implemented.

USE OF EARLY INTERVENTION

Organisations were found to be at different stages in their investment and implementation of early intervention activities. This generally reflected how long they had employed early intervention type strategies, their unique set of organisational challenges, and the size and complexity of their organisational structure.

Organisational commitment to early intervention

Organisational commitment, especially from the senior executive, was perceived to be one of the most critical factors in the success of early intervention. It was also considered to be one of their biggest challenges. When asked to what extent their senior executive demonstrated a commitment to early intervention, the majority of respondents reported that their senior executive had a great to moderate commitment (see Figure 2).

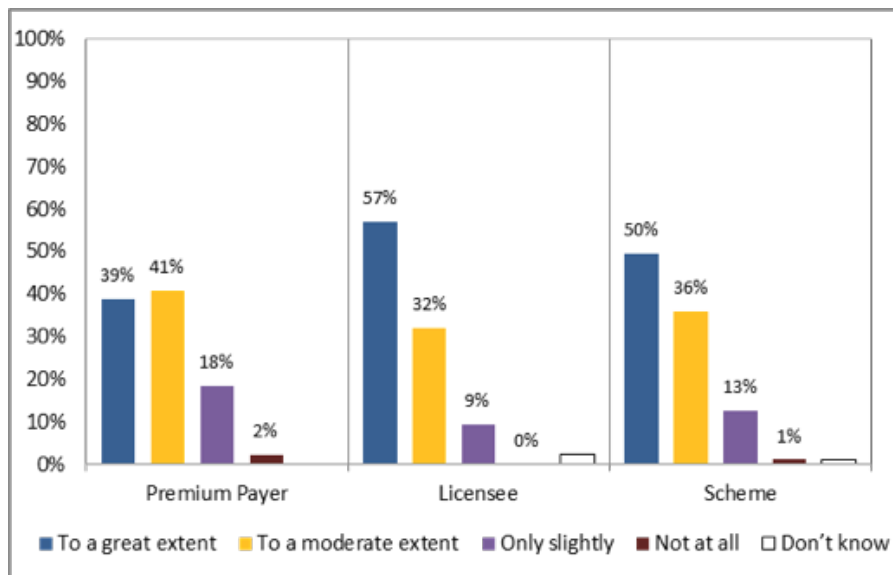


Figure 2: Demonstrated commitment from senior executive

“They (senior management) probably didn’t appreciate why claims were costing so much at the time and didn’t realise that if we get more we can influence them better and still save money anyways.

So there’s been a massive piece of education that we’ve been doing with management here and that’s worked really well.”
(Licensee)

When it came to the commitment of middle management and other staff in the organisation, however, respondents tended to be less positive. Interestingly, respondents from licensee organisations tended to be generally more positive about their organisations commitment to early intervention than respondents from premium paying agencies. This could be reflective of the overall maturity of early intervention in licensee organisations compared to premium paying organisations, the business drivers for cost containment, as well as the extent to which staff across the organisation were expected to be involved.

Despite the positive perceptions of focus group participants in relation to their organisation’s commitment to early intervention, they still indicated that in order to ensure a whole of organisation ‘buy-in’ to early intervention, it was essential for them to gain management support from the top down. This support was also considered to be important in the demonstration of how early intervention aligned with organisational values.

Fundamental to this, was the need to deliver a consistent and unified message across management tiers, between divisions, with all staff, and to the suppliers engaged in the process of managing workplace injury and illness. Participants believed that this consistent message would help to embed the appropriate behaviours and attitudes between all relevant parties.

Governance

What was also considered to be important was the availability of appropriate processes and systems. As can be seen in Figures 3 and 4, well over ninety per cent of respondents from licensee organisations reported having **established early intervention processes** (Figure 3) and **systems** (Figure 4). While over ninety percent of representatives from premium paying agencies also reported having **established process**, while only around two-thirds reported having established **systems**.

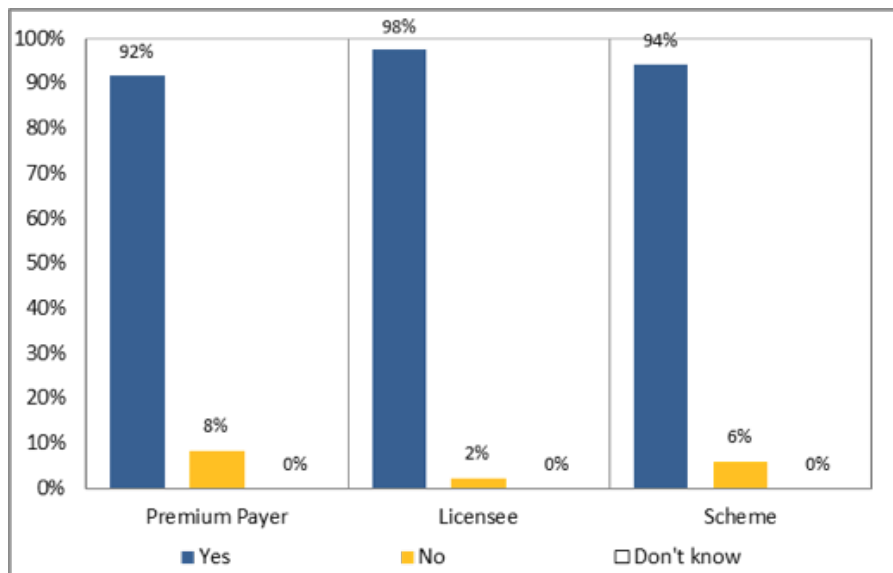


Figure 3: Established early intervention processes

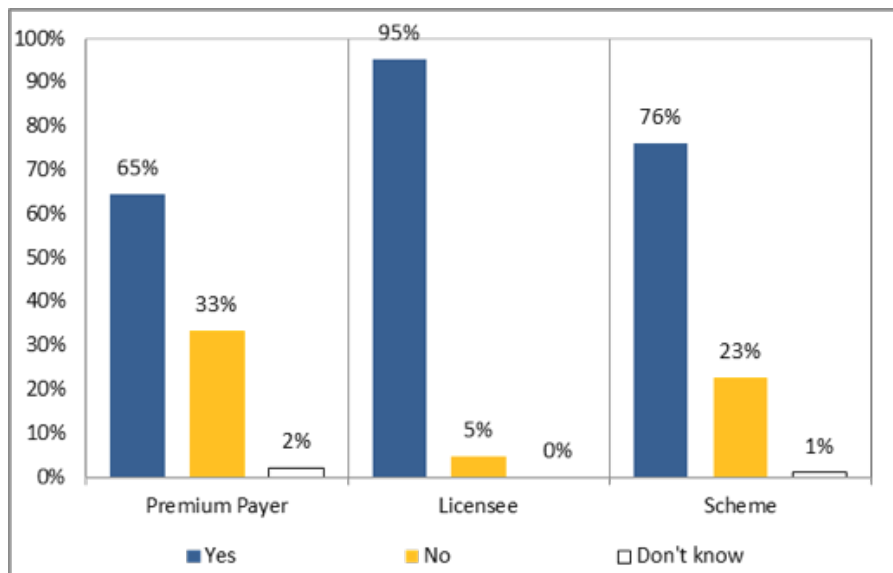


Figure 4: Established early intervention systems

These results again suggest that the licensee sector may have a greater commitment to and maturity around early intervention.

Reasons for use

Early intervention activities were perceived by many participating organisations to provide them with the tools they needed to help regain some control over workplace injuries and illnesses, which in some instances, were reported to have become unwieldy. Respondents who completed the online survey also believed that early intervention played a positive role in the recovery of injured/ill workers, and that it fundamentally benefited both the organisation and the employee.

When asked to identify why their organisation uses early intervention, respondents from both the premium paying and licensee sectors cited **'concern for workers'** and **'to help minimise the likelihood of a claim'** as their primary reasons (see Table 1).

Table 1: Why organisations use early intervention (top five)

	Premium payer	Licensee	Scheme
Concern for workers	88%	75%	79%
To minimise the likelihood of W/C claims	86%	75%	79%
To promote a good organisational culture	73%	70%	69%
To improve the wellbeing of individuals through work	78%	61%	69%
To maximise the productivity of the organisation	71%	64%	66%

Focus group participants also acknowledged the important role work can play in an individual's recovery. As such, they felt it was logical, from both an injury management and cost perspective, that any activities which could feasibly help individuals remain in the workplace would ultimately benefit the employee as much as the organisation. An overarching role of early intervention was therefore considered by many to be assimilating the needs of both the organisation and the individual to provide a constructive and collaborative strategy which facilitated work health management.

Formal vs informal programs

While most of the early intervention programs within the Comcare scheme were identified by organisation representatives as formal, nearly as many were identified as having a combination of both formal and informal components. As can be seen in Figure 5, organisations in the licensee sector were more likely than those in the premium paying sector to have **formal early intervention programs**, while organisations in the premium paying sector were much more likely than those in the licensee sector to have **informal programs**.

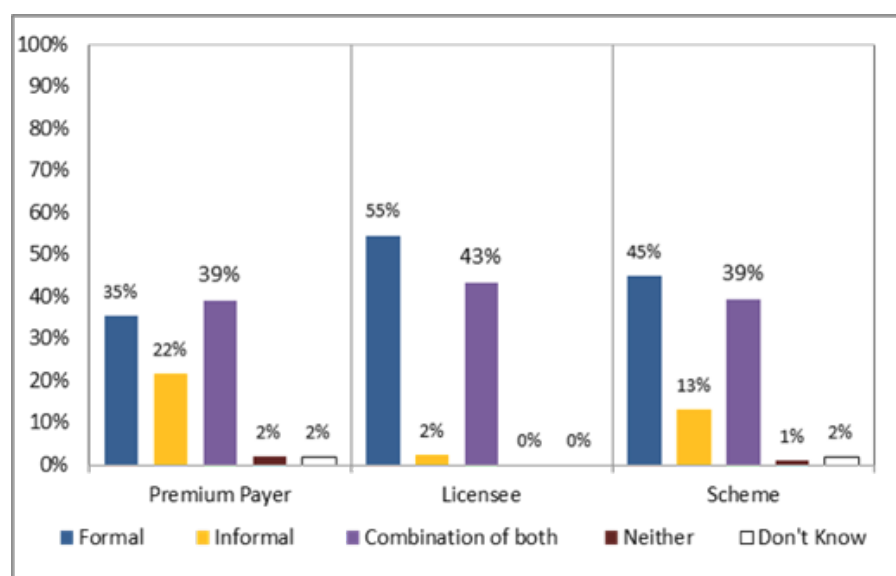


Figure 5: Type of early intervention program

Triggers of early intervention

When asked what triggers the use of early intervention in their organisation, respondents from both the premium paying and licensee sectors identified **formal incident reporting** and **reporting by managers/supervisors** as being the most common triggers (see Table 2). Importantly, while both sectors indicated their reliance on formal reporting, there was a much higher reliance on managers/supervisors in the premium paying sector to raise a concern, than in the licensee sector. Premium paying organisations were also more likely to use prolonged absenteeism to trigger an early intervention program.

Table 2: Triggers of early intervention (top five)

	Premium payer	Licensee	Scheme
The formal reporting of an incident	88%	84%	87%
Managers / Supervisors raising a concern about a team member	94%	59%	76%
Someone raising a concern about their own wellbeing	71%	55%	62%
Prolonged or regular absenteeism	86%	32%	59%
Someone raising a concern about a colleague	57%	34%	45%

Time to respond

The time an organisation took to respond to an issue once they had become aware of it, differed both within and between sectors. Interestingly, nearly seventy per cent of respondents from the licensee sector indicated that injuries/illnesses were responded to the **same day they became aware of them**, while in the premium paying sector less than sixty per cent of respondents identified this timeframe (see Table 3). Disappointingly, though, some licensees indicated a timeframe of **within a month**, while nearly twenty per cent of premium payers were willing to **wait until the injured worker was ready**.

Table 3: Time taken to respond to an issue once raised (% of respondents)

	Premium payer	Licensee	Scheme
As soon as the injured worker is ready	19%	9%	13%
No delay—same day	57%	68%	63%
Next day	9%	7%	7%
Within a couple of days	11%	7%	10%
Within a week	4%	5%	5%
Within a month	0%	2%	1%
Don't know	0%	2%	1%

Resourcing

Early intervention was identified as being more likely to succeed if there were dedicated funding and resources assigned to it. As seen in Figures 6 and 7, the majority of respondents from the licensee sector reported that their organisations had dedicated funding (79%) and dedicated resources (91%) for their early intervention activities, while the same level of commitment was not as evident within the premium paying sector.

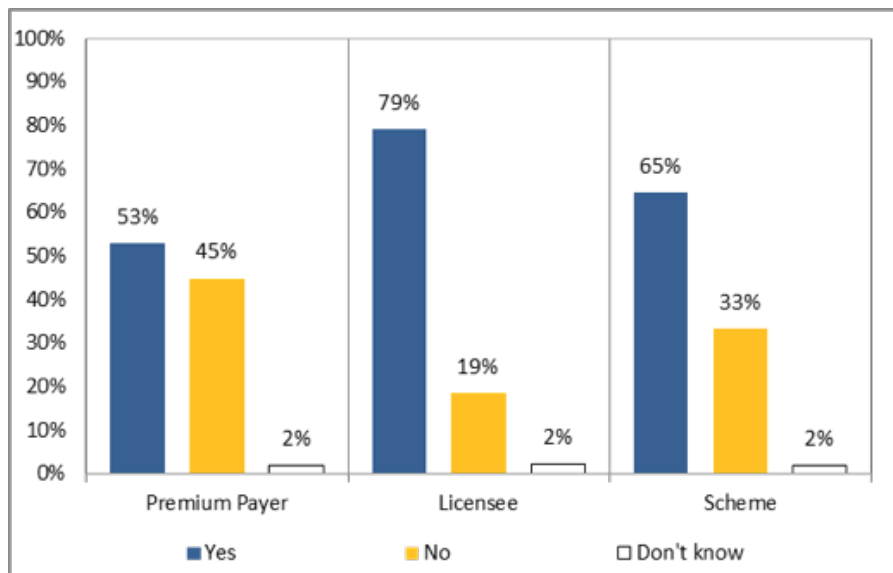


Figure 6: Dedicated funding for early intervention activities

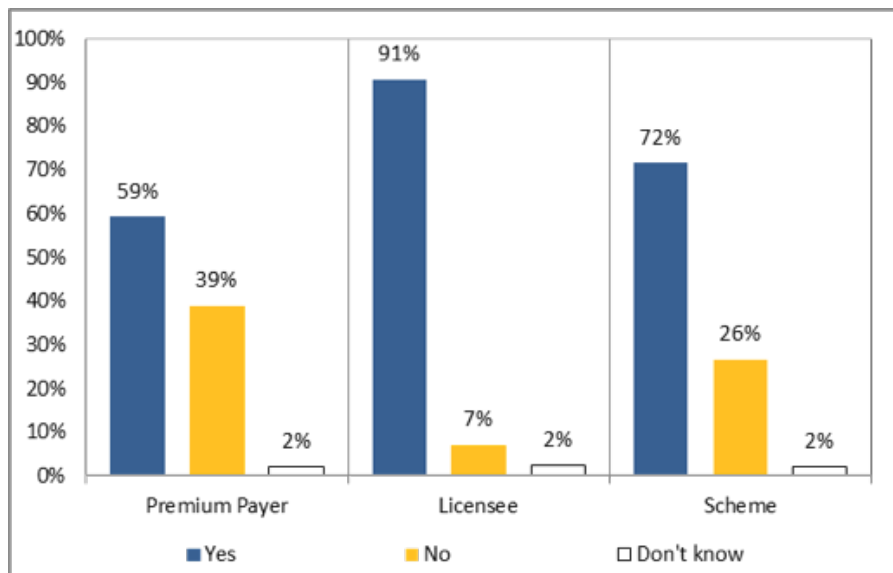


Figure 7: Dedicated resource for early intervention activities

"We invest more resources in implementing early intervention programs and dealing with new compensation claims in the first six months of the claim or absence." (Premium Payer)

PARAMETERS OF EARLY INTERVENTION

Focus group participants were clear that early intervention had to work within specific constraints such as costs, timeframes and number of treatment sessions. The majority of participants also indicated that early intervention was only used when it was unlikely that a claim would come to fruition, even though there was some acknowledgement that it could enter the claim space.

"Within our framework, early intervention is primarily about pre-claim. The minute a claim is lodged, technically it moves out of the early intervention space, but there are still "early interventions" that we do as well within the management of the claim itself, called "strategic intervention." (Premium Payer)

In general, participants considered that it was appropriate to initiate early intervention activities when certain conditions were met. The key conditions identified are discussed below and include:

- > cost constraints
- > service constraints
- > time restrictions
- > work relatedness.

Cost constraints

All focus group participants identified that they had some level of cost restriction on early intervention activities, which were either formally expressed in dollar terms (amounts ranged from \$500 to \$3000), or were informally 'understood' as not to be an exorbitant investment.

Medical related costs

The online survey results showed that nearly all licensee organisations (91%), and just over half of the premium paying agencies (52%) who participated in the survey paid for **medical related treatments** through their early intervention program (see Figure 8). Of these respondents, 15% from the premium paying sector, and 77% from the licensee sector, reported that their organisations **allocated a maximum amount of money per person** for medical related treatments (see Figure 9).

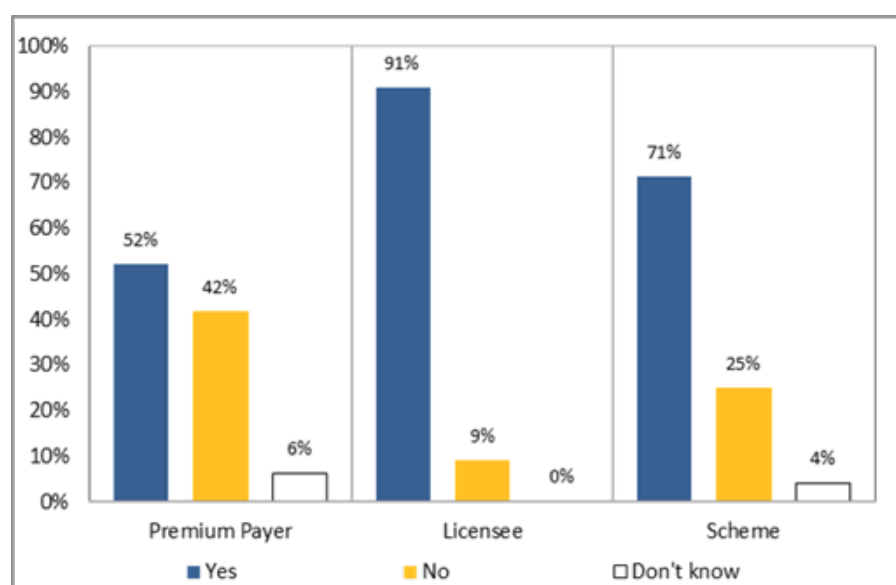


Figure 8: Organisation pays for medical related treatments

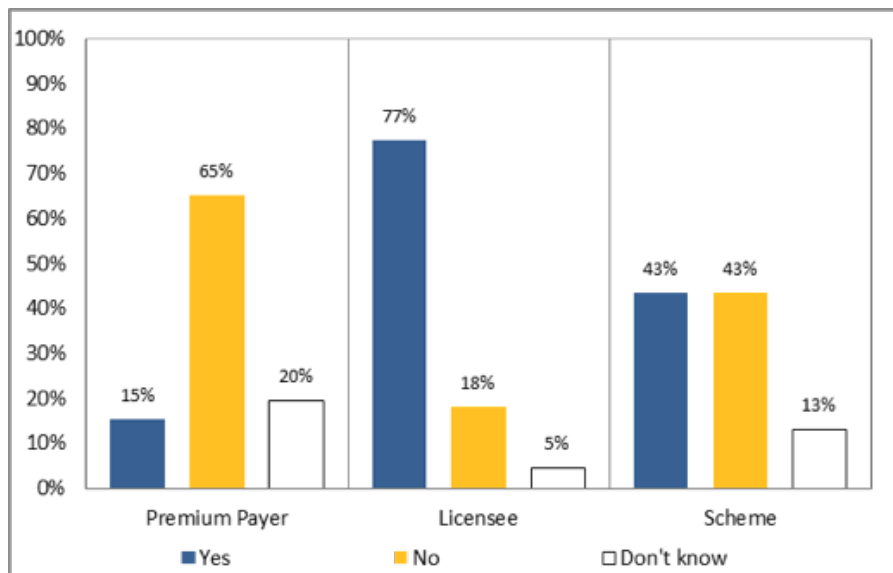


Figure 9: Organisation places a cap on medical related treatment costs

As can be seen in Table 4, around half of all organisations who placed a cap on medical related expenses within their early intervention program, **allocated up to \$1000** for a range of different medical related treatments such as GP visits and physiotherapy.

Table 4: Caps placed on medical related treatments (% of respondents)

	Own GP	Employer's GP	Specialist	Physiotherapist	Psychologist/ Counsellor
Up to \$300 per person	18%	3%	9%	8%	6%
Up to \$500 per person	21%	27%	25%	28%	28%
Up to \$1000 per person	47%	57%	50%	50%	53%
Up to \$1500 per person	3%	3%	3%	3%	3%
Up to \$2000 per person	9%	7%	9%	8%	9%
Unlimited costs as long as they help prevent a workers' compensation claim	3%	3%	3%	3%	0%

Non-medical related costs

The online survey results showed that, almost all premium paying agencies (96%), and just over three-quarters of the licensee organisations (77%), reported that their **organisations paid for non-medical related treatments** through their early intervention program (see Figure 10). Of these respondents, 9% from the premium paying sector, and 50% from the licensee sector, reported that their organisations **allocated a maximum amount of money per person** for non-medical related treatments (see Figure 11).

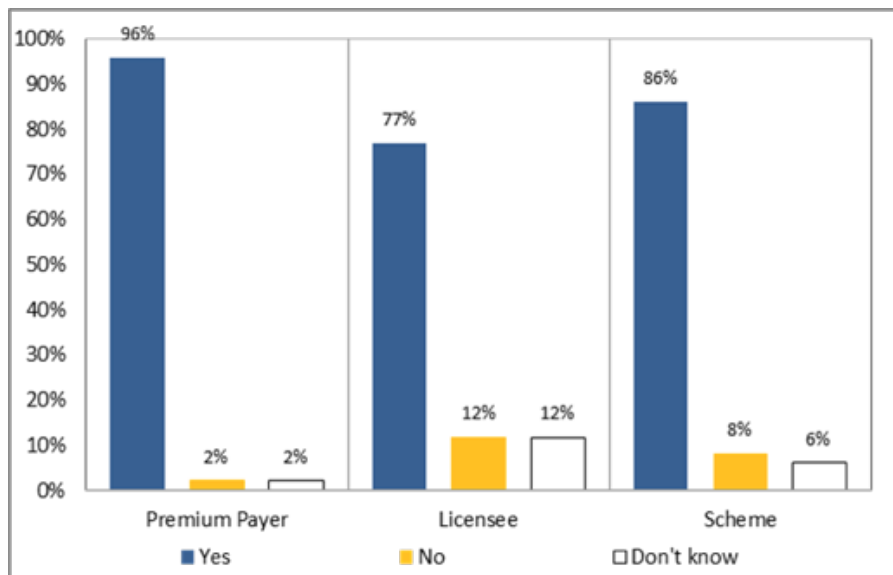


Figure 10: Organisation pays for non-medical related treatments

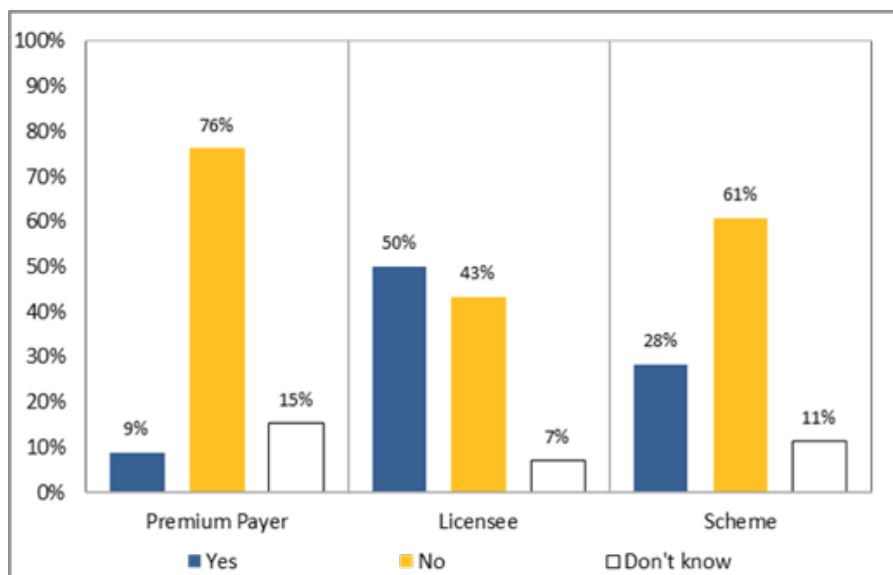


Figure 11: Organisation places a cap on non-medical related treatment costs

As can be seen in Table 5, around half of all respondents who indicated that their organisation placed a cap on non-medical related expenses within their early intervention program, **allocated up to \$1000** for a range of different treatments such as EAP sessions and workstation assessments.

Table 5: Caps placed on non-medical related treatments (% of respondents)

	EAP sessions	Workstation/ ergonomic assessments	Purchasing equipment	Equipment modifications
Up to \$300 per person	5%	5%	5%	10%
Up to \$500 per person	29%	27%	21%	20%
Up to \$1000 per person	43%	45%	47%	45%
Up to \$2000 per person	0%	5%	5%	5%
Up to \$5000 per person	5%	5%	5%	5%
Unlimited non-medical related costs	14%	9%	11%	10%
Unlimited costs as long as they help prevent a workers' compensation claim	5%	5%	5%	5%

Service constraints

When it came to the number of treatment sessions workers could have, most focus group participants indicated that they had very clear guidelines as to what level of treatment was viable. The online survey results confirmed this, with most organisations agreeing that there was a limit to the number of sessions workers could have with medical and allied health providers, as well as with non-medical related service providers.

Medical related services

As can be seen in Table 6, survey respondents most commonly stipulated a maximum of 'up to five sessions' per person. Interestingly, between four and five per cent of respondents also reported that their organisation would give access to unlimited medical related sessions, as long as they helped to prevent a workers' compensation claim.

Table 6: Caps placed on medical related treatment sessions (% of respondents)

	Own GP	Employer's GP	Specialist	Physiotherapist	Psychologist/ Counsellor
1 session	5%	9%	36%	0%	0%
Up to 3 sessions	20%	16%	18%	22%	24%
Up to 5 sessions	34%	42%	15%	44%	35%
Up to 10 sessions	10%	5%	0%	11%	12%
Unlimited sessions	27%	28%	26%	20%	25%
Unlimited costs as long as they help prevent a workers' compensation claim	5%	0%	5%	4%	4%

Non-medical related services

As with medical related treatments, most organisations imposed a limit on the number of sessions workers could have in relation to non-medical related treatment. Table 7 outlines the proportion of respondents who indicated that their organisation stipulated a maximum number of sessions with their Employee Assistance Program (EAP) provider, and workstation/ergonomic assessments. As can be seen in Table 7, most respondents stipulated up to a maximum of five **EAP sessions**, and one **workstation assessment** per person.

Table 7: Caps placed on non-medical related treatment sessions (% of respondents)

	EAP sessions	Workstation/ ergonomic assessments
1 session	0%	41%
Up to 3 sessions	22%	18%
Up to 5 sessions	40%	6%
Up to 10 sessions	18%	1%
Unlimited sessions	21%	31%
Unlimited costs as long as they help prevent a workers' compensation claim	0%	3%
Unlimited costs as long as they help prevent a workers' compensation claim	5%	5%

While focus group participants acknowledged the limits that were imposed on workers, they also recognised that non-medical treatment was useful in the prevention of a problem from potentially escalating and creating a scenario when the individual could no longer function at the appropriate level.

Time restrictions

There were two types of time restrictions identified by focus group participants: time off work, and length of time an individual could participate in an early intervention program.

Time off work

In general, early intervention was only considered to be appropriate in circumstances where individuals either had no time off work, or limited time off work. The idea of 'limited' time was variable, with most organisations nominating a timeframe of less than a month, while a few suggested that recovery simply needed to be in the foreseeable future.

Time on early intervention

Interestingly, the majority of online survey respondents indicated that there was **no maximum period of time** that individuals within their organisation could access support through their early intervention program. As can be seen in Figure 12, only 15% of respondents from the premium paying sector, and 20% from the licensee sector, reported that there was a **maximum period of time** individuals within their organisation could access support through their early intervention programs. Of these organisations, the most common time limit placed on accessing early intervention was up to 4 weeks.

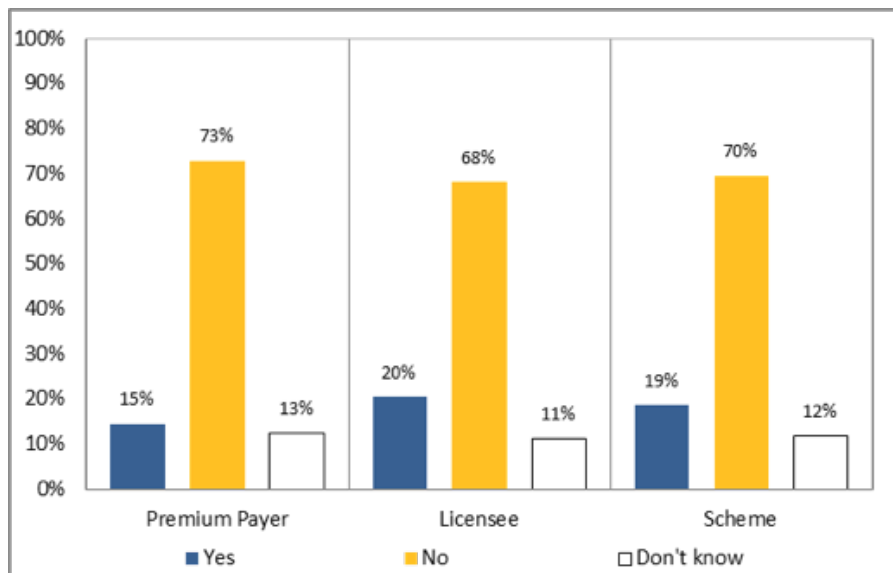


Figure 12: Maximum time early intervention can be accessed

Work relatedness

All respondents who participated in the focus group sessions indicated that their organisation provided early intervention for incidents that were clearly work related, while most also supported non-work related issues, especially if the workplace could further aggravate the condition. Respondents to the online survey supported the focus group discussions to some extent, particularly when it came to a condition impacting work performance.

As can be seen in Figure 13, 29% of participating premium payers, and 34% of participating licensees, indicated that they would provide early intervention support for non-work related injuries/illness when the **condition impacted the individual's work** performance. The licensee sector also appeared to be more conservative about using early intervention to support non-work related injuries than the premium paying sector, with 18% of respondents indicating that early intervention would only be used for non-work related injuries/illnesses in **exceptional circumstances**, and 16% indicating that they would **not use it in any circumstance**. Some respondents from premium paying organisations (4%) also held these views.

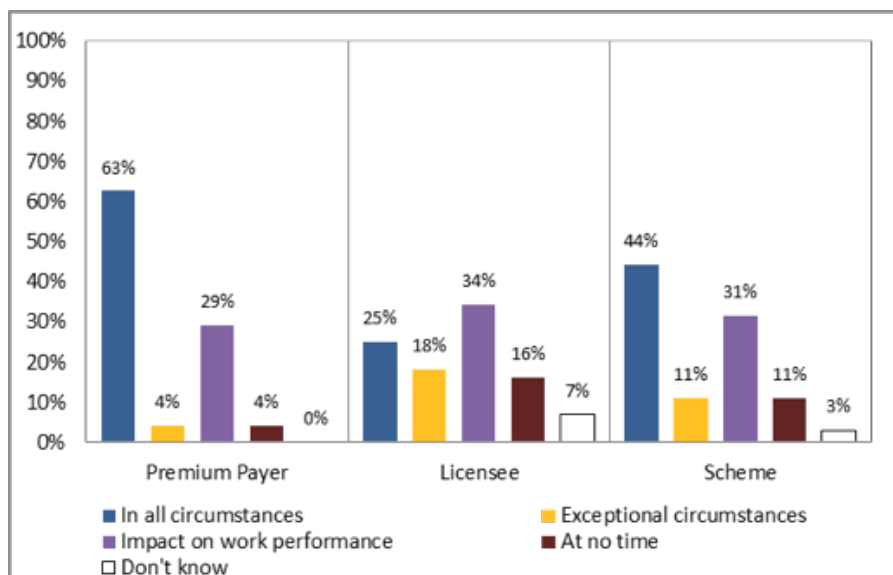


Figure 13: Use of early intervention for non-work related injuries/illness

Interestingly, when asked when their senior management and team leaders thought early intervention was used in their organisation, around three-quarters of all respondents reported that both groups thought it should be used **regardless of a workers' compensation claim**.

Flexibility of parameters

The use of parameters to ensure the viability and sustainability of early intervention programs is logical. Online survey respondents also indicated, though, that while the parameters were in place, there were also **situations in which the parameters could be adjusted**. As can be seen in Figure 14, this was particularly the case for the premium paying sector, with 91% of respondents indicating that the parameter of their programs could be adjusted if required.

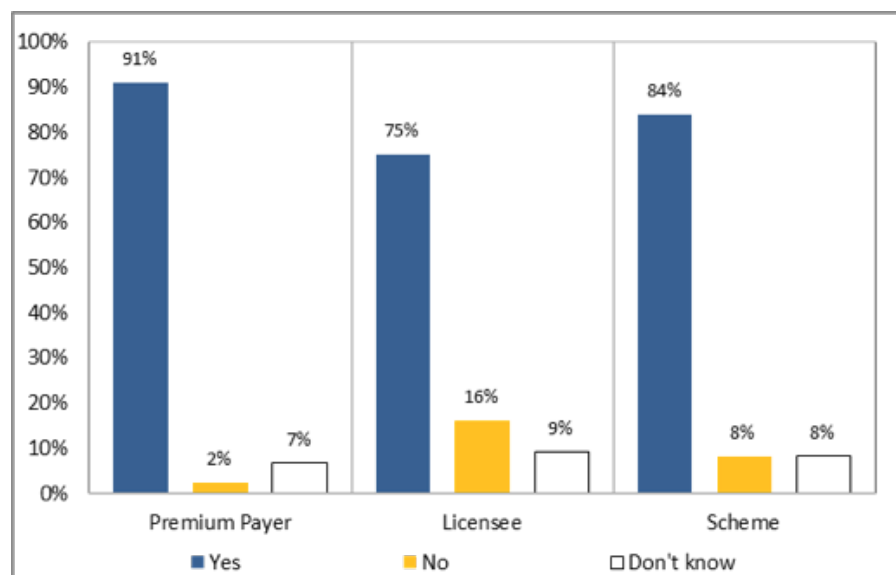


Figure 14: Parameters of early intervention programs can be adjusted

PERCEIVED BENEFITS

Focus group discussions demonstrated that early intervention had been embraced by organisations as a strategic solution to assist in the delivery of a more constructive and immediate response to workplace injuries and illnesses with an aim to better manage employee health and wellbeing.

Benefits being realised

The potential benefits of early intervention to an organisation are well documented in the literature, and were strongly advocated for and supported by focus group participants. The specific benefits focus group participants articulated that they were seeing included:

> Controlling costs

"EI is holding our costs, but we're holding at a higher rate than previously." (Premium Payer)

> Reducing absenteeism

"... it's really about keeping people at work, reducing your absenteeism..." (Licensee)

> Maintaining productivity

"[We] probably have about 40 employees a week who are completely off work and we worked out really quickly here that they need to replace those 40, we need to backfill those roles. They did go through a period where they didn't back ... and it just brought on a cumulative effect within the business." (Licensee)

> Better allocation of resources

"By now having a centralised front of house, it's now freeing my case managers up to concentrate on managing their cases ... focussing on getting employees back to work." (Licensee)

> Minimising the risk of high cost claims

"The real thing about early intervention is that if you take 100 cases that are likely to be work-related and, if I/we apply EI programs to them, it gives the department the chance of preventing one of those that would be the a million dollar case." (Premium Payer)

> Competitive strength and financial stability (licensees in particular)

"We have to apply for tenders and talk about how many people are hurt each year within our projects, we have to talk about how well we manage that return to work and rehab and give references associated with that. That reputation cost associated with the business could mean that next year we don't have projects. So there are a whole lot of reasons within our business as to why you should look after someone and why you should get them back to work." (Licensee)

Online survey respondents also recognised the value of their organisation's early intervention programs by identifying the benefits that they believed their organisation had already realised. Table 8 outlines the five most commonly reported benefits. As can be seen in this table, the benefits realised by premium paying and licensee organisations are slightly different, with the majority of respondents from the licensee sector (82%) reporting a **lower number of incidents becoming claims**, while just over three quarters of respondents from the premium paying sector (77%) reported an **improved capability of managers/team leaders** to support those with poor health.

Table 8: Benefits realised through early intervention programs (top five)

	Premium payer	Licensee	Scheme
Improved capability of managers / team leaders to support those with poor health	77%	66%	72%
A reduction on the number of workers' compensation claims	62%	80%	69%
A lower number of incidents becoming claims	57%	82%	69%
Improved capability of staff recognise and report poor health in the workplace	64%	55%	59%
An improvement in workplace morale	57%	68%	59%

When asked specifically about whether or not introducing early intervention had influenced the number and complexity of workers' compensation claims, respondents to the online survey had mixed views. As can be seen in Figure 15, the majority of representatives from the licensee sector believed that early intervention had decreased the number of workers' compensation claims (73%), while a small proportion thought that early intervention may have increased (5%) or had no affect (11%) on the number of claims. Respondents from the premium paying sector were even more divided with only around third believing that early intervention had decreased (32%) the number of claims, while others thought that the number of claims had stayed about the same (51%) or even increased (4%).

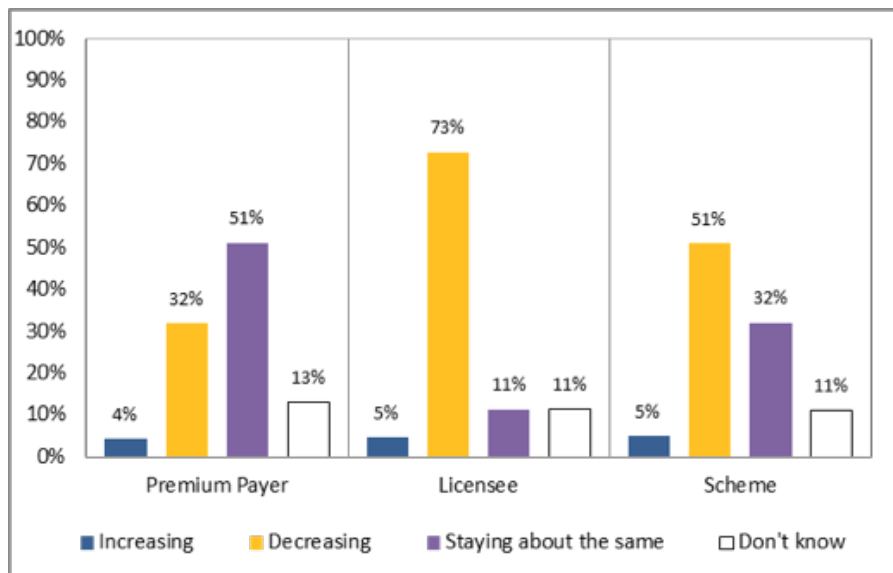


Figure 15: Impact of early intervention on claim numbers

When it came to the complexity of claims, respondents across the scheme were again divided (see Figure 16), with some (11%) indicating that they believed the complexity had increased, twenty-seven per cent believing that claims had becomes less complex and forty-five per cent indicating that early intervention had had no impact on the complexity of workers' compensation claims.

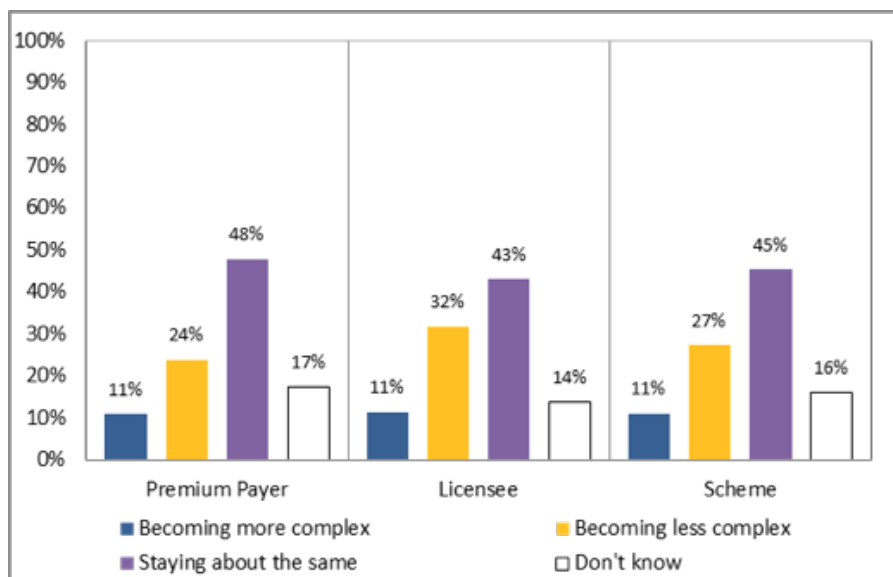


Figure 16: Impact of early intervention on claim complexity

Individual benefits

While early intervention was seen by focus group participants as an organisational solution, early intervention activities were also fundamentally viewed as employee orientated initiatives. This, coupled with their belief in the positive relationship between recovery and returning to work, meant that participants largely felt that early intervention activities which could help an individual remain in the workplace could ultimately benefit both the individual and the organisation.

Respondents to the online survey were asked whether individuals who participated in early intervention activities viewed them as valuable to their recovery, invasive or looking after their best interests. As can be seen in Figure 17, most believed that individuals viewed their participation in early intervention as greatly (49%) or moderately (46%) valuable to their recovery, with only a small proportion (6%) reporting that individuals considered early intervention to be not at all valuable to their recovery.

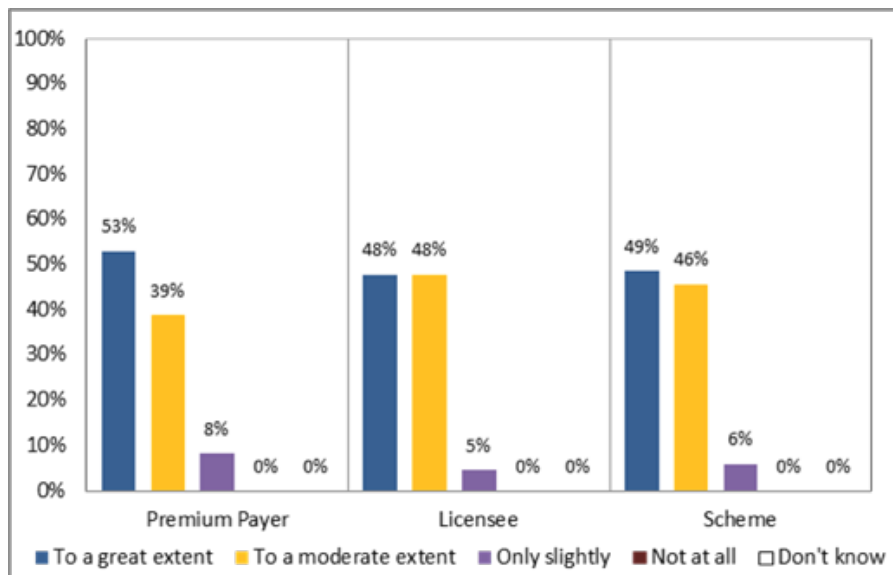


Figure 17: Early intervention seen as valuable to recovery

Similarly, most respondents did not feel that individuals considered early intervention activities to be invasive, but rather that they were designed to look after their best interests. As can be seen in Figure 18, only five per cent of all respondents indicated that they felt individuals participating in early intervention activities viewed them as **invasive to a great extent**, while it can be seen in Figure 19 that most respondents believed that individuals viewed the activities as having been designed to look after their best interests to either a **great extent** (35%) or to a **moderate extent** (52%).

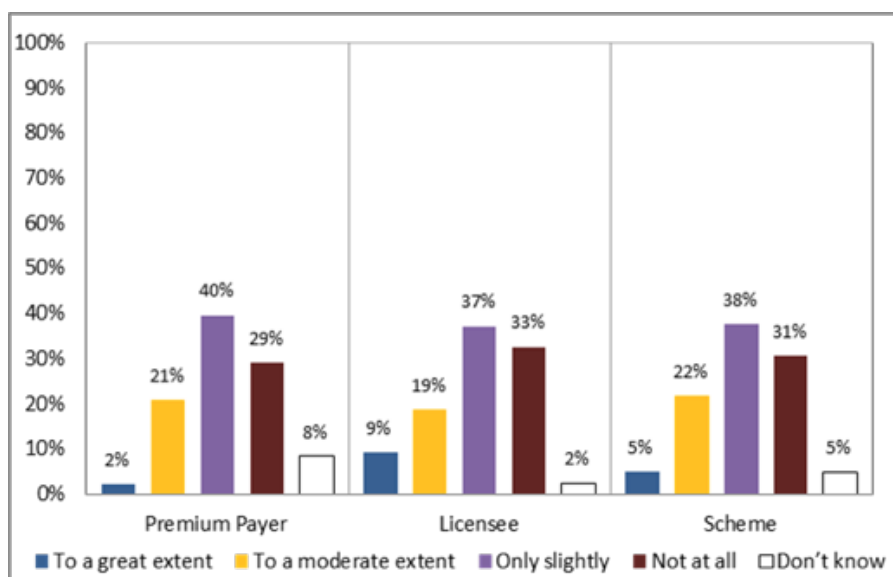


Figure 18: Early intervention seen as invasive

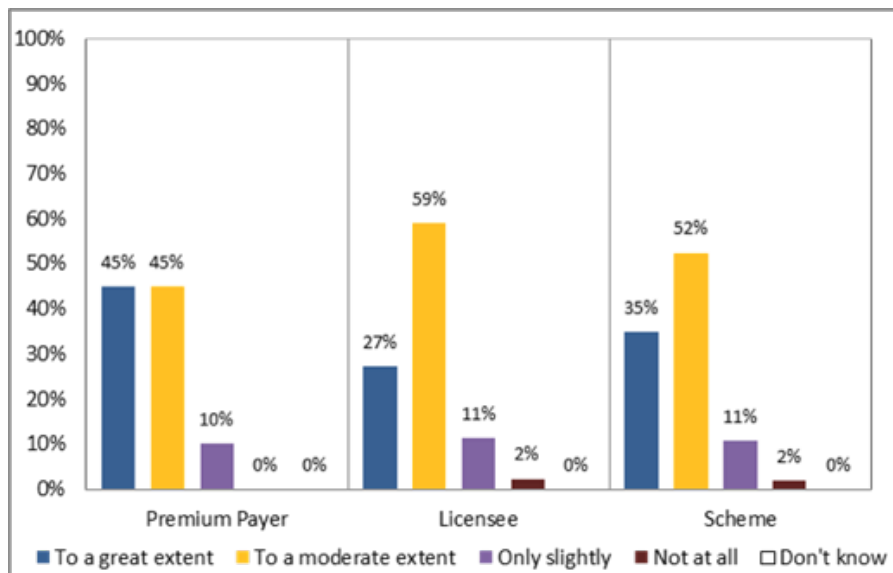


Figure 19: Early intervention looks after best interests

Perceived use and success of early intervention

Despite the potential benefits of early intervention, the perceptions of survey respondents suggested that early intervention was **not being used as much** in their organisation as it could be (see Figure 20), or that it **was as successful** as it could be (see Figure 21). As can be seen in both Figures, representatives from the licensee sector were slightly more positive than those from the premium paying sector, although there appears to be considerable opportunities for the increased use and success of early intervention in both sectors.

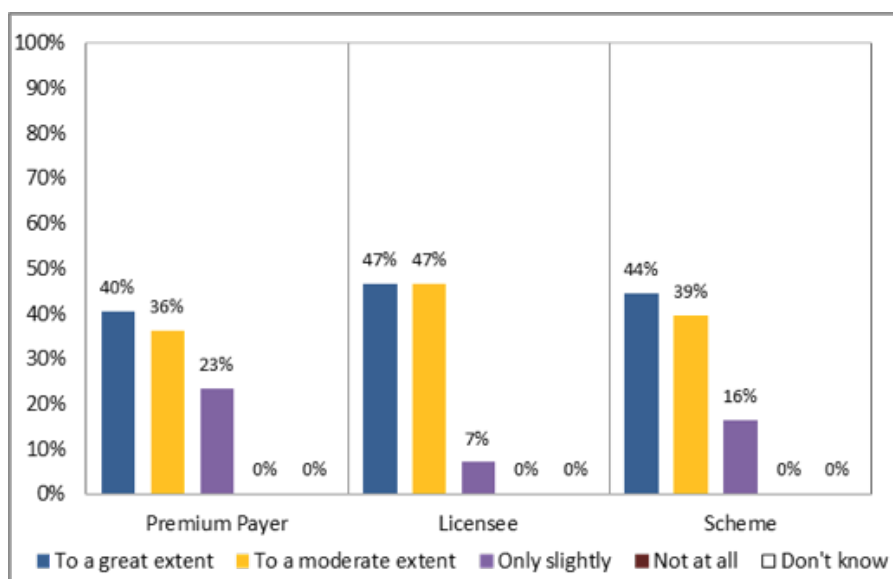


Figure 20: Extent to which early intervention is used within an organisation

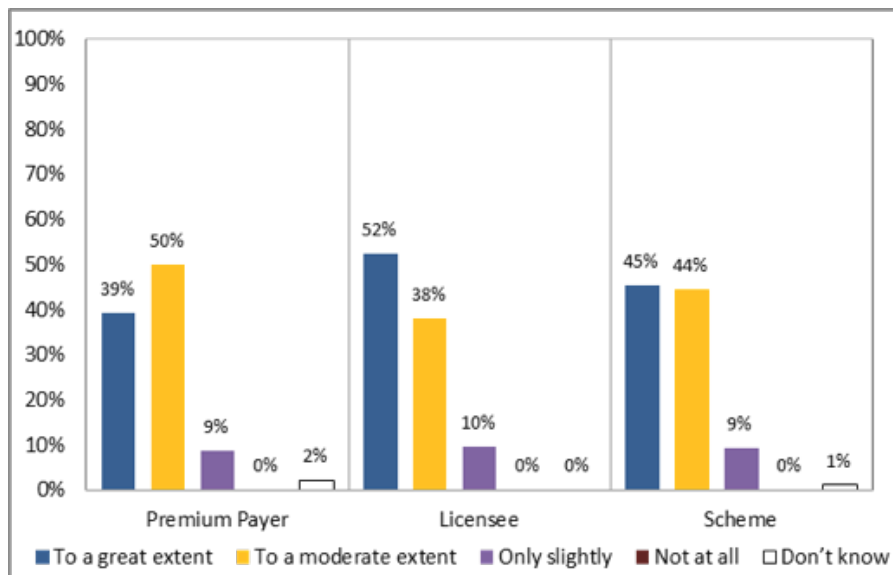


Figure 21: Extent to which early intervention is successful within an organisation

CHALLENGES OF EARLY INTERVENTION

Most focus group participants acknowledged that the implementation of early intervention was not easy. In addition to the cultural context, the attitudes of senior managers, a history of poor management practices and, in some instances, the presence of an 'entitlement' attitude amongst employees, a range of broader sector and social dynamics, such as:

- > rise in psychological claims
- > continued instability in the APS (premium payers only)
- > blurring between performance issues and stress
- > lower resilience in the community in general
- > social health factors, such as an aging workforce and obesity, were also identified as influencing both the implementation and success of early intervention.

According to focus group participants, the introduction of early intervention was simply another step in the process of shifting the mindset around the role and management of workers' compensation, so that it was no longer simply a matter of facilitating a process, but rather was about ensuring proper assessment and solutions.

Four key challenges were identified by focus group participants in the implementation of early intervention as a practice. These included:

- > convincing senior executive
- > educating 'direct line' managers
- > the cultural mindset
- > third party influences.

When survey respondents were asked what they thought the key challenges their organisation faced in relation to early intervention, the two most commonly identified challenges by both the premium paying and licensee sector were:

- > getting staff to inform their supervisor when something is not going so well for them
- > providing line managers with the appropriate skills.

The importance focus group participants placed on providing line managers with the appropriate skills, was reinforced by survey respondents when they were asked how confident they thought their senior management, middle management and team leaders were about providing assistance to staff requiring early intervention support. Respondents from the licensee sector were the most positive, with only seventeen per cent indicating that their **senior managers were not very confident**, and only twenty per cent indicating that their **middle managers were not confident**, compared to twenty-seven per cent and thirty per cent respectively from the premium paying sector. When it came to **team leaders**, around a third of respondents from both sectors indicated that they did not think they were **very confident**.

Respondents from both the premium paying and licensee sectors also acknowledged a range of other challenges (see Table 9). Perhaps the most interesting difference between the perceptions of respondents from the two sectors is in relation to **maintaining a dedicated budget and/or resources**. While only fourteen per cent of respondents from the licensee sector identified this as one of the challenges their organisation faced in relation to early intervention, nearly half (47%) of all premium paying respondents identified this as a key challenge. This again suggests that the licensee sector may have a greater commitment to and maturity around early intervention.

Table 9: Key challenges organisations face (% of respondents)

	Premium payer	Licensee	Scheme
Getting staff to inform their supervisor when something is not going so well for them	74%	62%	65%
Providing line managers with the appropriate skills	55%	52%	54%
Encouraging staff to be aware of when others may be at risk of injury/illness	45%	38%	41%
Maintaining a dedicated budget and/or resources for early intervention	47%	14%	31%
Being aware of when it is appropriate to use and not use early intervention	30%	29%	28%
The cost of early intervention	36%	12%	24%
Continuously demonstrating the impact of early intervention	32%	19%	23%
Continuously refining what activities should be available through early intervention	23%	24%	21%
Accessing medical advice/ understanding medical restrictions	26%	14%	20%
Justifying the continued use of early intervention	19%	7%	13%

When survey respondents were asked about whether they thought there would be any challenges for their organisation in relation to early intervention over the **next two to three years**, sixty-one per cent said yes. Of these, seventy-three per cent from the licensee sector, and forty-eight per cent from the premium paying sector believed that these **challenges would be the same** as those that they are currently facing.

MEASURING THE IMPACT OF EARLY INTERVENTION

Focus group participants acknowledged that the full value of early intervention could not be accurately measured as it is impossible to know, definitely, how many 'issues' may have converted to claims if they had not been resolved or addressed through early intervention activities.

"I'm not certain it's possible to absolutely measure the effectiveness of pre-claim early intervention strategies (in terms of "stopping" a likely claim) – how can you ever know if someone would have ultimately gone through with a claim? You can report broadly, but not specifically relate all early intervention strategies to claim numbers." (Premium Payer)

Despite the perceived limitations associated with measuring the value of early intervention, all focus group participants indicated that they used strategies to measure and track what they believed were the positive impacts of early intervention. Unsurprisingly, the measures identified by the focus groups largely mirrored what they also believed to be the key benefits of early intervention, including:

- > The efficiency and utilisation of early intervention, such as:
 - incident reporting figures
 - the average time taken between an incident and reporting
 - the speed that issues were resolved.
- > The impact of early intervention on organisational costs, such as:
 - a decline in absenteeism figures
 - lower conversions rates from early intervention to a claim
 - a reduced number of claims overall
 - reduced costs of claims
 - increased severity of claims.

These measures essentially allow organisations to demonstrate both the uptake of early intervention initiatives, and the positive impact on human resource figures. They were considered by focus group participants to be the most effective means to garner continued support, momentum and investment for early intervention.

Recording systems

In order to report against the measures outlined above, information has to be collected. When online survey respondents were asked if their organisation had internal systems for recording early intervention and or workers' compensation activities, fifteen per cent of premium payer representatives reported that they had **no recording systems in place** (see Figure 22).

As can also be seen in Figure 22, the vast majority of survey respondents from the licensee sector (95%) reported that their organisation had internal systems for recording both early intervention and workers' compensation activities, while only seventy-four per cent from the premium paying sector indicated that they did.

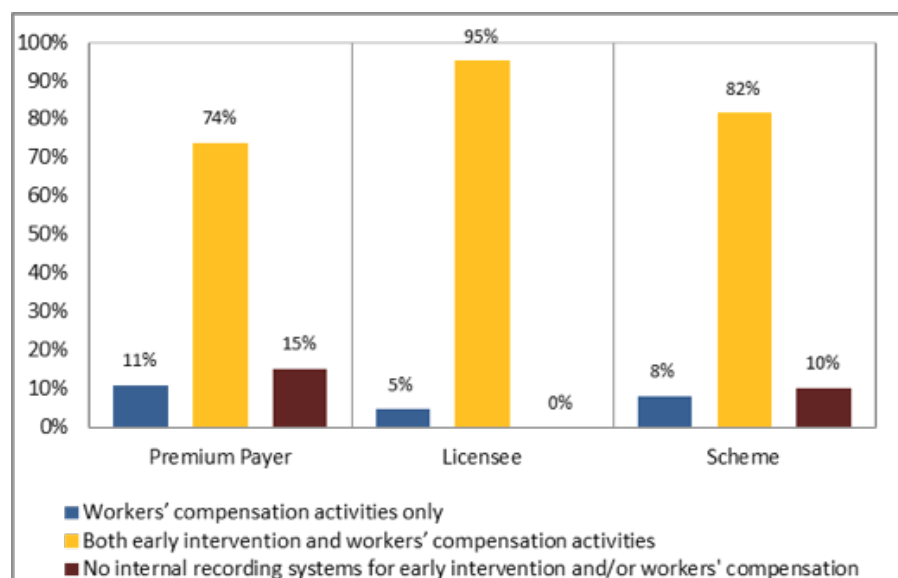


Figure 22: Internal systems to record early intervention and workers' compensation activities

For those respondents without an internal recording system, many expressed a desire to obtain one.

"Until I get a system, I am unable to measure the things I need to measure ... a whole range of things." (Premium Payer)

Reporting systems

Having systems in place to collect information is one thing, having a strategy to formally report the impact of early intervention is another. When online survey respondents were asked whether or not their organisation had a strategy for reporting the impact of their early intervention program, seventy-four per cent of respondents from the licensee sector, but only thirty-two per cent from the premium paying sector, reported that their organisations had a **strategy for formally reporting the impact** of their early intervention program.

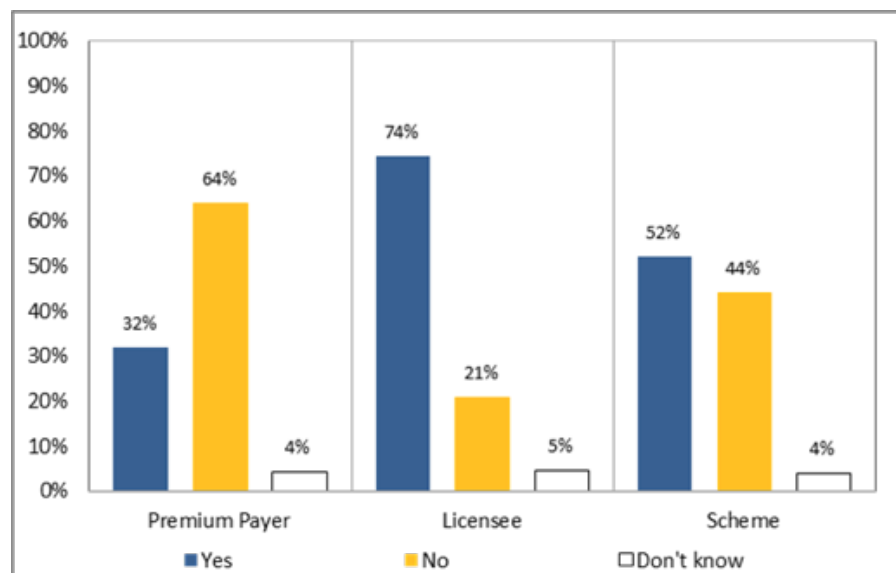


Figure 23: Strategies for formally reporting the impact of early intervention programs

For those organisations with formal reporting strategies, the information they tended to report largely mirrored what research participants had identified as the key benefit of early intervention. As can be seen in Table 10, however, not all organisations with formal reporting systems reported against all benefits. Instead, the most common measures reported by licensees were **reductions in the number and length of workers' compensation claims**, as well as a **reduction in the number of minor injuries and illnesses**, while for premium paying organisations, the most common measures were **declines in absenteeism**, as well as a **reduction in the number and cost of workers' compensation claims**.

Table 10: Outcomes of success reported by organisations (% of respondents)

	Premium payer	Licensee	Scheme
Decreases in the proportion of workplace incidents that become workers' compensation claims	60%	60%	60%
Decreases in the number of minor injuries/illnesses becoming a workers' compensation claim	57%	62%	60%
Reductions in the number of workers' compensation claims	60%	64%	59%
Reductions in the length of workers' compensation claims	55%	62%	59%
Declines in absenteeism rates	66%	55%	59%
Declines in the cost of workers' compensation claims	60%	55%	55%
Reductions in the delay between an incident occurring and it being reported	45%	57%	47%
Decrease in premium rates	57%	19%	40%
Increases in the number of early intervention programs provided	28%	36%	29%
Increases in the proportion of workplace incidents for which an early intervention program is developed	23%	24%	21%

Targets

It was identified through the online survey that at least some organisations had set specific targets for a range of measures associated with the success of early intervention. Interestingly, respondents from licensee organisations tended to be much more likely (up to 80% on any measure) to report that their organisation had set targets than those from premium paying agencies (less than a third on any measure).

As can be seen in Table 11, in addition to **reducing workers' compensation claims**, the second most common measure of success for which a target had been set was **improving organisational culture**.

Table 11: Targets set by organisation (% of respondents)

	Premium payer	Licensee	Scheme
Reducing workers' compensation claims	32%	80%	57%
Improving organisational culture	30%	70%	49%
Reducing the number of workplace incidents becoming claims	30%	61%	45%
Increasing staff retention	24%	61%	41%
Increasing productivity	22%	59%	39%
Reducing absenteeism	22%	50%	36%

ROLE OF THE INDIVIDUAL

Focus group participants acknowledged that many of the difficulties experienced in managing workplace injuries and illnesses were associated with the unrealistic expectations of individuals around their rights, as well as the obligations of the organisation. They also acknowledged that in some instances these difficulties were exacerbated by the lack of understanding and confidence amongst direct line managers about how to support individuals involved in early intervention type programs.

Most participating organisations also believed that being 'up front' with individuals early in the process about the options available to them, the procedures involved, and the respective responsibilities of those engaged with early intervention, played a critical role in managing and setting the appropriate expectations. Moreover, the initial interactions with an individual in early intervention were essential to help 'frame' the conversation, including using the appropriate language to set individual responsibilities and focus them on recovery.

"We've had a 31% reduction in claims numbers in the last four years, but it's not because of prevention or early intervention as such, because we're only just getting that in place. It's because of the robustness around holding people accountable at the front end that they know it's not just an easy ride." (Licensee)

Individual characteristics

Based on discussions with focus group participants, the attitude and characteristics of an individual at the beginning of the early intervention process is a strong indicator of potential success. The characteristics that participants believed employees needed in order to have a higher likelihood of success included:

- > embracing ownership of their recovery
- > focusing on resuming work
- > utilising resources available to them
- > taking the initiative to make changes
- > cooperating with others
- > diligently managing issues to prevent escalation.

As can be seen in Figure 24, respondents to the online survey largely concurred with the focus group participants, with around half identifying taking ownership of recovery as the most important individual characteristic for determining the success of early intervention. Interestingly, though, survey respondents did not necessarily agree with their focus group colleagues about the other characteristics they had identified as being important to the success of early intervention.

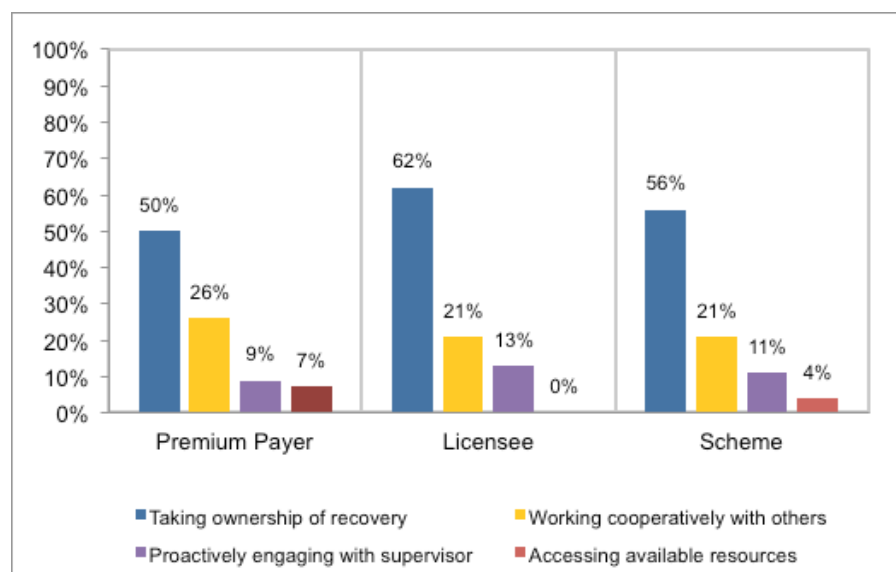


Figure 24: Important individual characteristics

WORK AND HEALTH

One of the key principles of successful early intervention is found on the notion that good work is good for you. Understanding the attitudes and perceptions of organisations about the health benefits of work is therefore important to the contextualisation of early intervention within the Comcare scheme. This section explored these attitudes and perceptions with the intent of improving the uptake of early intervention through the health benefits of work.

Senior management

Discussions with focus group participants highlighted the important role and influence senior management had in relation to the attitudes and perceptions of the organisation towards early intervention, health promotions and ensuring a physically and mentally healthy workplace. When online survey respondents were asked about the attitudes and perceptions of their senior management, more than ninety per cent agreed or strongly agreed that their senior managers believed that **workplace culture** and **workplace relationships** are key determinants of someone's health and wellbeing, and that positive outcomes are more likely when someone **understands the health benefits of work** and is **empowered** to be responsible for their own recovery.

Promoting wellness

Nearly all of the respondents to the online survey (98%) indicated that they believed there was a link between work, and the health and wellbeing of staff (see Figure 25). Similarly, they also reported that their senior managers had a strong belief in work generally being good for a person's health and wellbeing, and, that being away from work has a negative impact on a person's health and wellbeing.

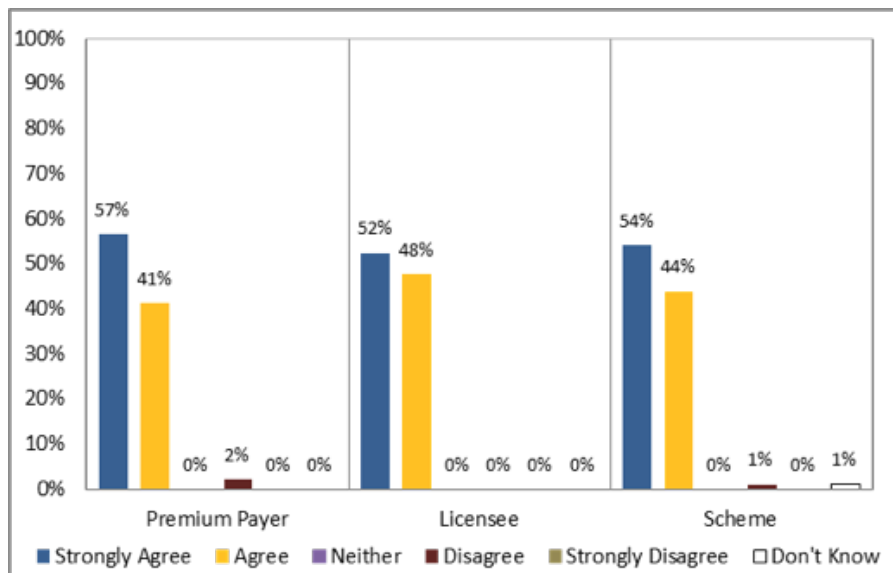


Figure 25: Link between work and health

When asked whether or not they agreed or disagreed that employers have a responsibility to encourage staff to be physically and mentally healthy, respondents from both the premium paying and licensee sectors were positive, with only five per cent disagreeing that the employer had a responsibility in this area (see Figure 26).

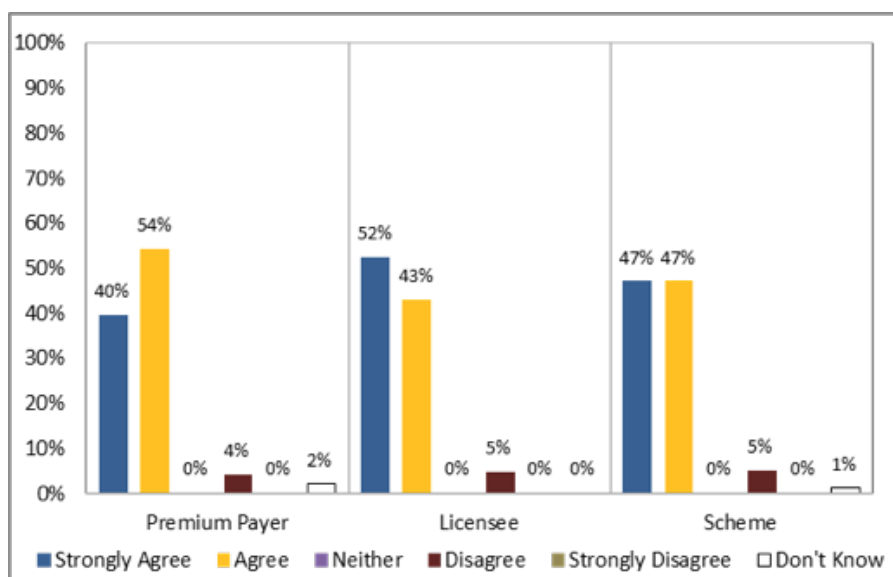


Figure 26: Responsibility of employer to encourage staff to be physically and mentally healthy

When asked whether their organisations promoted the health benefits of work, six per cent of respondents from the premium paying sector and four per cent from the licensee sector disagreed or strongly disagreed that their organisation did this. Respondents whose organisation did promote wellness, identified a range of programs that their organisation routinely used (see Table 12).

Table 12: Programs to promote wellness (top five)

	Premium payer	Licensee	Scheme
Employee assistance program	98%	78%	88%
Flexible work arrangements to support work-life balance	92%	49%	73%
Work area assessments and adjustments	85%	56%	71%
Health promotion programs	65%	73%	66%
Mental Health Programs	58%	29%	45%

Financial benefits

Not surprisingly, nearly all of the licensee respondents to the online survey (96%) and most premium paying respondents (81%) were positive that the financial benefits of spending money on the health and wellbeing of staff outweighed the costs. Similarly, nearly all respondents (98%) reported that their organisation used work as part of someone's recovery, including strategies such as a graduated return to work, workstation modifications, assigning different duties and access to occupational health services.

Health challenges

In addition to the generic challenges that organisations face in relation to early intervention, project participants were also asked about the health challenges that they faced with their workforce. Focus group discussions revealed that many participants believed that there had been a general decline in overall community resilience and that this was reflected in today's workforce being somewhat more predisposed to work health issues, or even leading to a 'victim' or 'entitled' mindset, neither of which were conducive to a successful recovery. Participants also believed that an aging workforce, obesity issues and general poor health and wellbeing practices in the community were key triggers for the prevalence of certain injuries, but that they were also difficult for organisations to effectively influence.

"Obviously you aim for no claims but ... the Australian population is ageing and obese, and with that population in a no fault scheme it's very likely that you're going to have a lot of aggravations or a pre-existing disease and I think I'm seeing that more in our staff." (Premium Payer)

Given that the context and culture of each organisation is unique and presents different challenges, respondents to the online survey were asked about their organisations' biggest health challenges, both today and over the next two to three years. As can be seen in Figures 27 and 28, respondents from the licensee sector identified **musculoskeletal injury** as their biggest health challenge today (52%) and an **aging workforce** as their biggest health challenge over the next two to three years (42%). Respondents from the premium paying sector, however, identified **mental health** as their biggest health challenge both today (65%) and over the next two to three years (71%).

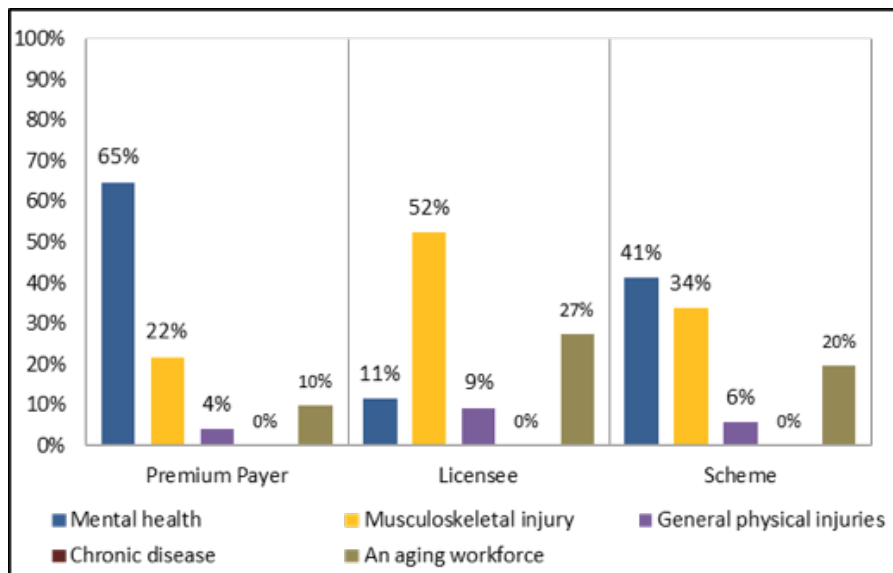


Figure 27: Biggest health challenges today

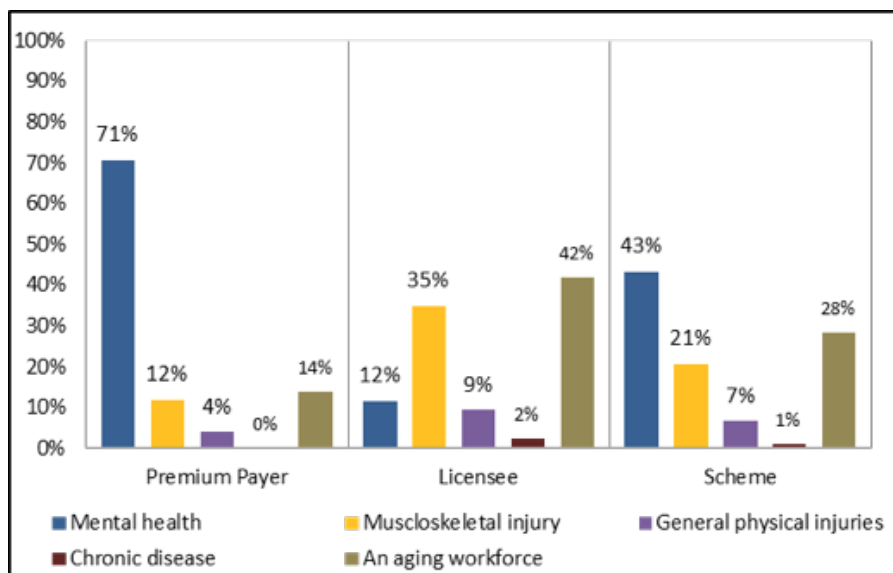


Figure 28: Biggest health challenges over next two to three years

Supporting mental health issues

When asked how confident they thought their senior management, middle management and team leaders were at providing assistance to staff with a mental health issue, online survey respondents had mixed views. As can be seen in Figures 29, 30 and 31, respondents from the premium paying sector were slightly more positive about their managers and team leaders than those from the licensee sector. Even so, between forty and fifty-four per cent of respondents from the premium paying sector indicated that their managers and team leaders were **not very confident or not at all confident** in providing assistance to staff with a mental health issue. This compares to between forty-nine and sixty-eight per cent from the licensee sector, while respondents from both sectors tended to believe that their senior managers would have the most confidence, followed by middle managers and then team leaders.

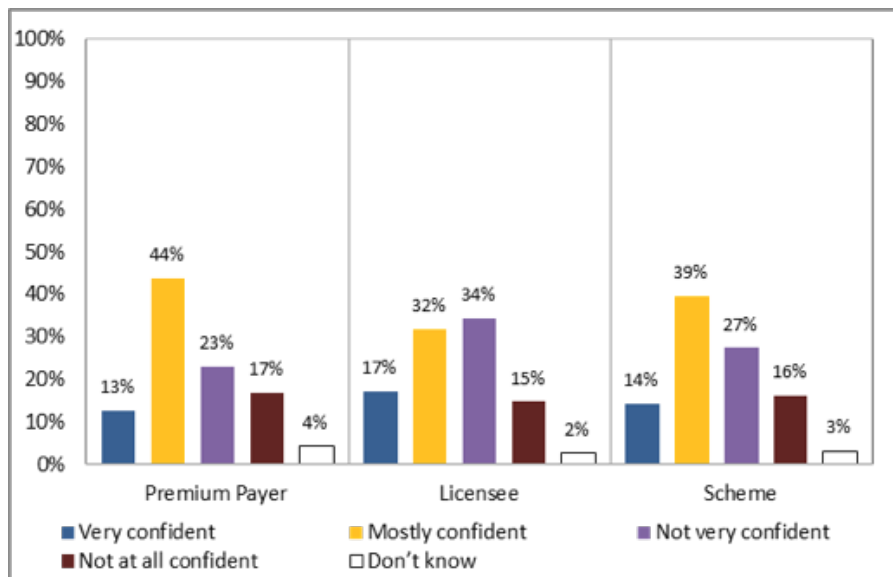


Figure 29: Confidence of senior managers in assisting staff with mental health issues

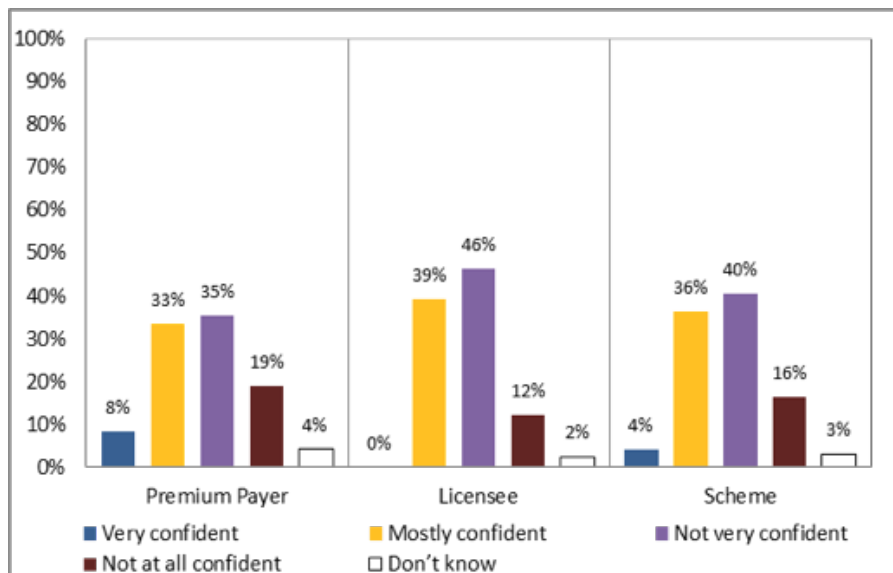


Figure 30: Confidence of middle managers in assisting staff with mental health issues

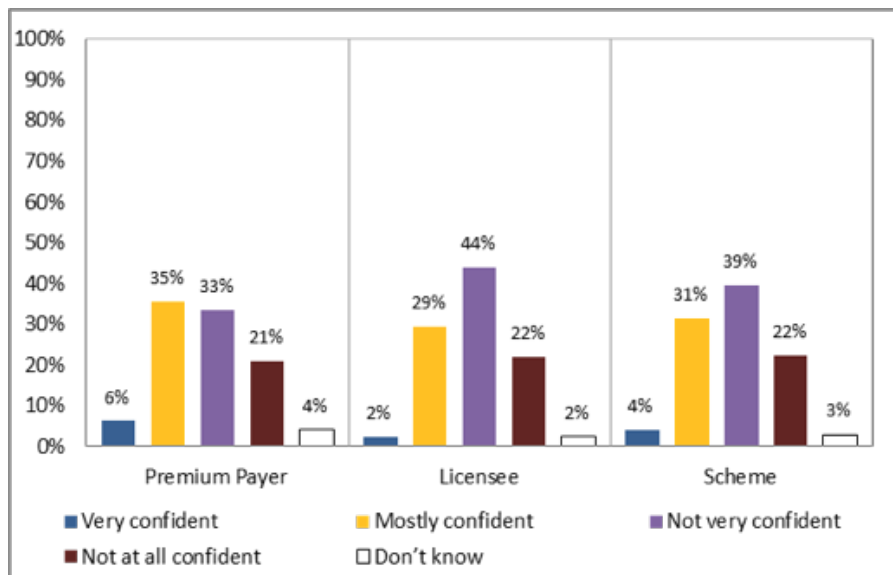


Figure 31: Confidence of team leaders in assisting staff with mental health issues

COMCARE

As the key agency of the Australian Government responsible for implementing federal workplace policies to drive social inclusion and productivity, it is important for Comcare to work closely with and support premium paying agencies and licensee organisations to establish safe and healthy workplaces, to minimise the incidence and cost of workplace injury and disease, as well as support employers to help their workers stay at work or return to work as quickly as possible following a workplace injury or illness.

Comcare does this in a number of ways, including, providing systems, information and advice. Respondents to the online survey were asked to provide feedback in relation to some of these services, as well as to comment on what support they would like from Comcare, as well as the role Comcare could play in relation to early intervention. The following provides an overview of these insights.

Customer Information System

Comcare's Customer Information System (CIS) provides agencies and organisations with access to injury management and claims information that enables them to monitor their performance in relation to the number of claims, the cost of claims, the length of time injured employees have off work, and the estimated lifetime costs of claims. In addition to supporting agencies and organisations to monitor performance, CIS is also intended to assist in the development of effective injury prevention and case management strategies.

Interestingly, eighty-five per cent of respondents from the premium paying sector, and only 9% from the licensee sector, reported that their organisation **used CIS** to help them keep track of workers' compensation claims. When asked how useful CIS was in terms of helping them keep track of workers' compensation claims, nineteen per cent of respondents who used CIS from the premium paying sector, and sixty-seven per cent from the licensee sector, reported that they did not find it very useful.

Based on the discussions with focus group participants and feedback from online survey participants, CIS was perceived to be somewhat impractical and not particularly easy to use. Most licensee organisations also stated that they did not use CIS because they had their own internal systems, and that the data in CIS did not easily fit into these systems.

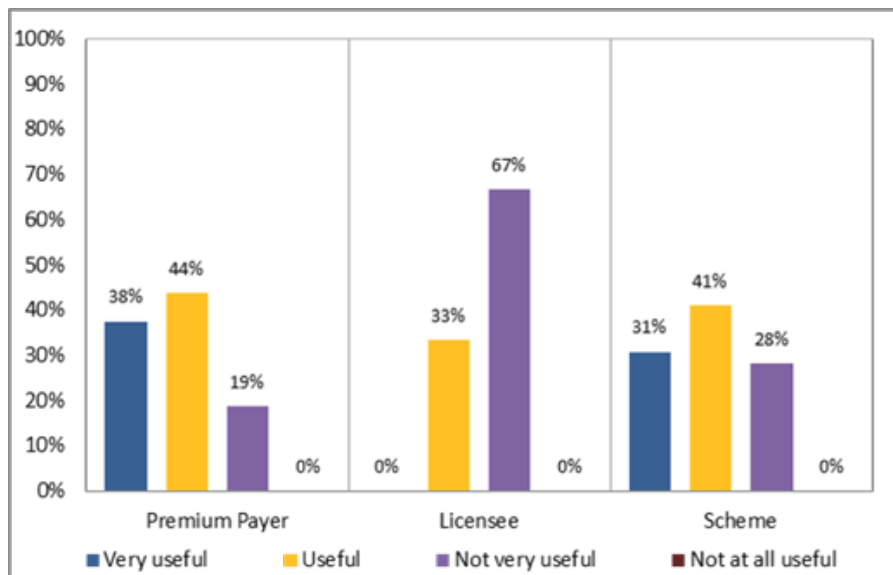


Figure 32: Perceived helpfulness of CIS

Comcare and early intervention

The value Comcare adds to the scheme is determined not so much by what it does, but how effective scheme participants perceive it to be. When asked about the effectiveness of Comcare in relation to promoting, identifying strategies and communicating the benefits of early intervention, respondents to the online survey had mixed thoughts.

As can be seen in Figure 33, both premium paying and licensee respondents tended to be positive about Comcare being **effective in promoting early intervention**.

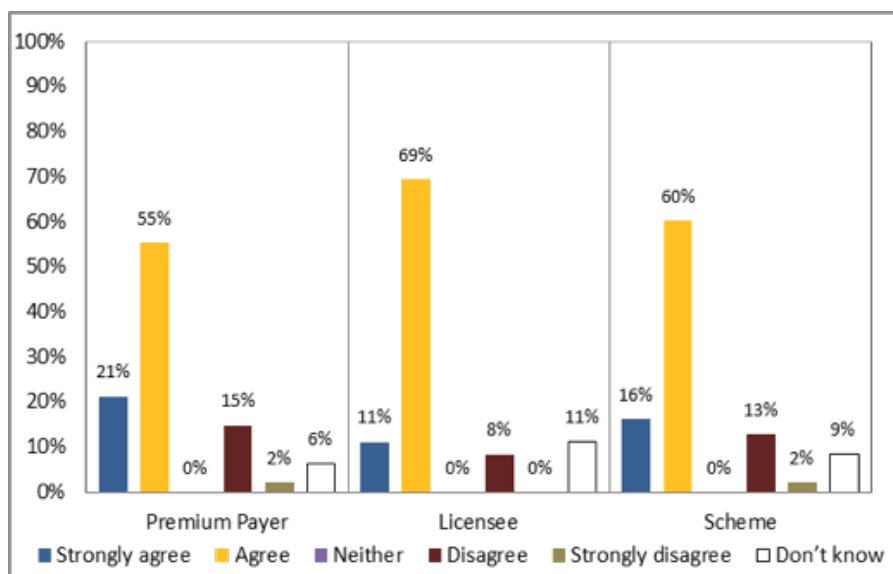


Figure 33: Comcare's effectiveness at promoting early intervention

When it came to **communicating the benefits** of early intervention and **identifying different strategies**, however, respondents were less positive (see Figures 34 and 35) suggesting that there are opportunities to do more in these areas, particularly in relation to identifying different early intervention strategies.

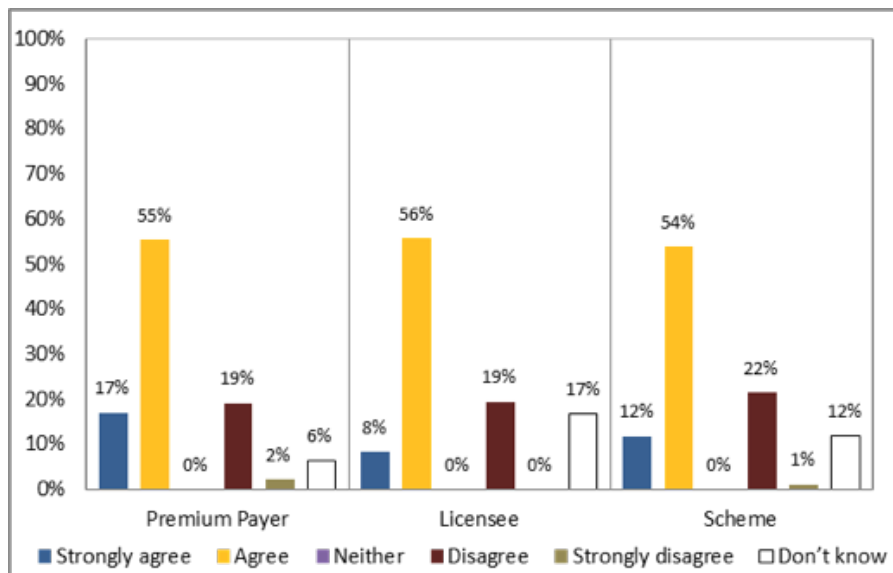


Figure 34: Comcare's effectiveness at communicating the benefits of early intervention

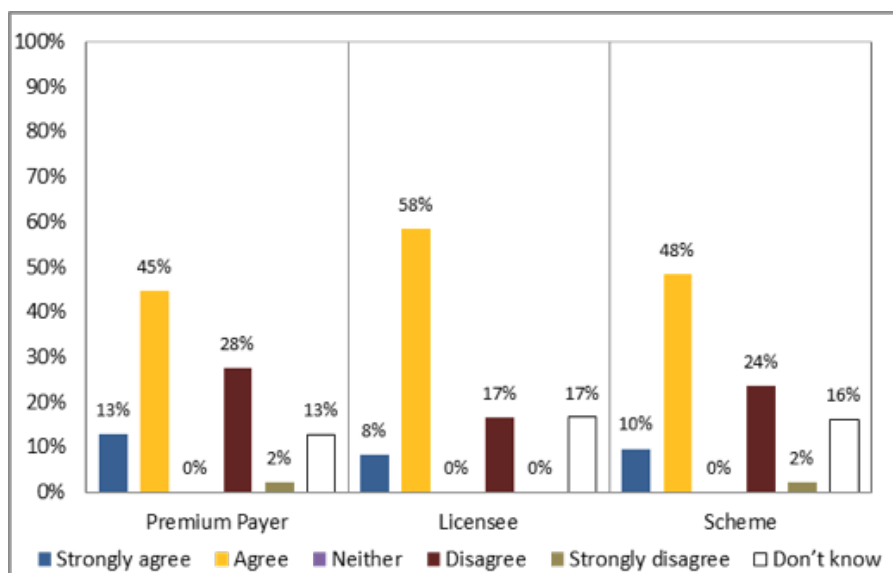


Figure 35: Comcare's effectiveness at identifying different early intervention strategies

When asked whether or not Comcare should have a role in promoting early intervention, identifying strategies or communicating the benefits, the response was overwhelmingly positive with more than ninety per cent of all respondents agreeing or strongly agreeing that Comcare should **promote early intervention, communicate the benefits of early intervention and identify early intervention strategies** (see figures 36, 37 and 38).

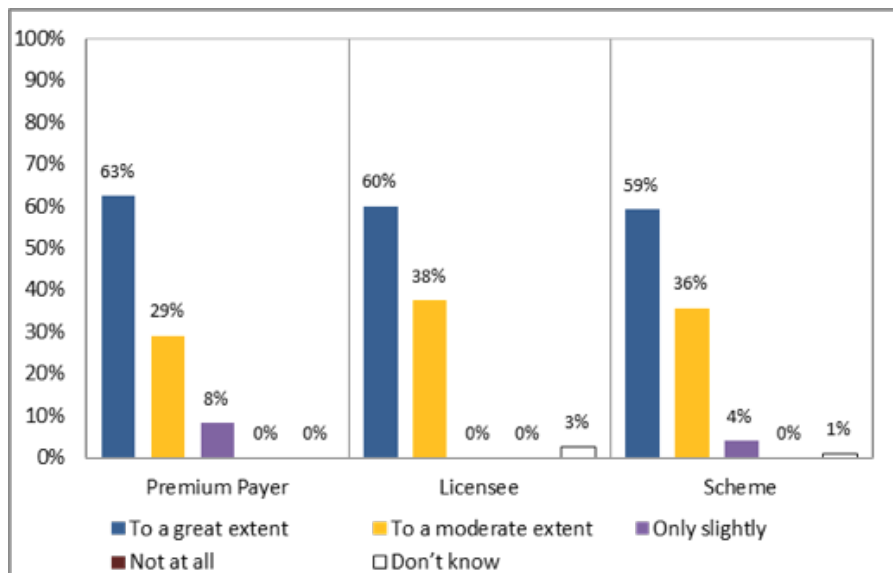


Figure 36: Comcare's role in promoting early intervention

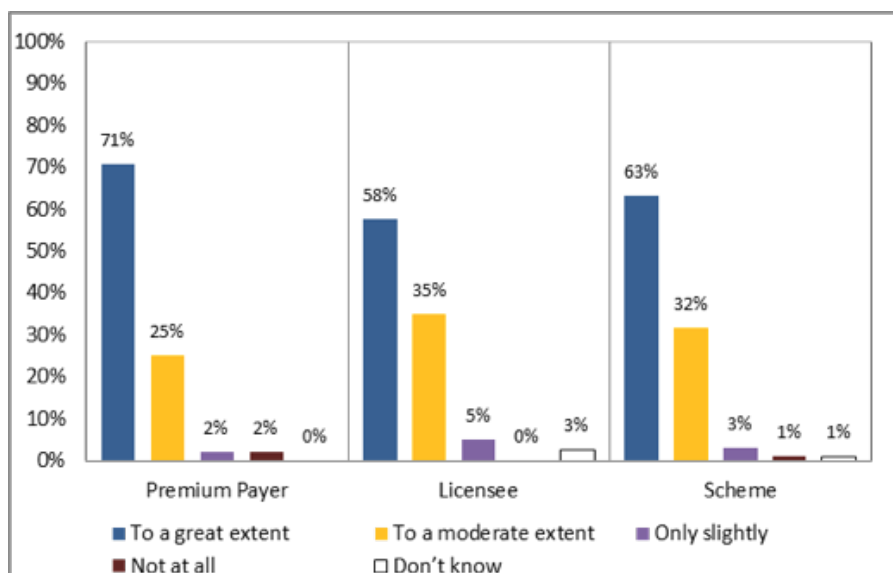


Figure 37: Comcare's role in communicating the benefits of early intervention

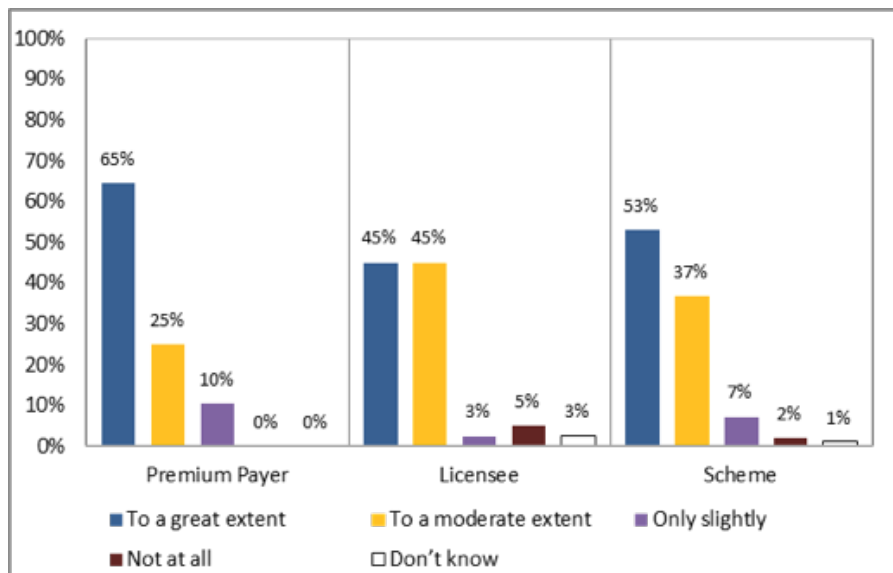


Figure 38: Comcare's role in identifying early intervention strategies

Comcare and the Health Benefits of Work

When it came to the health benefits of work, respondents had similarly mixed views about how effective Comcare was. As can be seen in Figure 39, less than seventy per cent of all respondents **believed** that Comcare was effective in **communicating the health benefits of work**, while it can be seen in Figure 40, that just over three quarters of all respondents **believed** that Comcare was effective in **encouraging employers to support worker's health**.

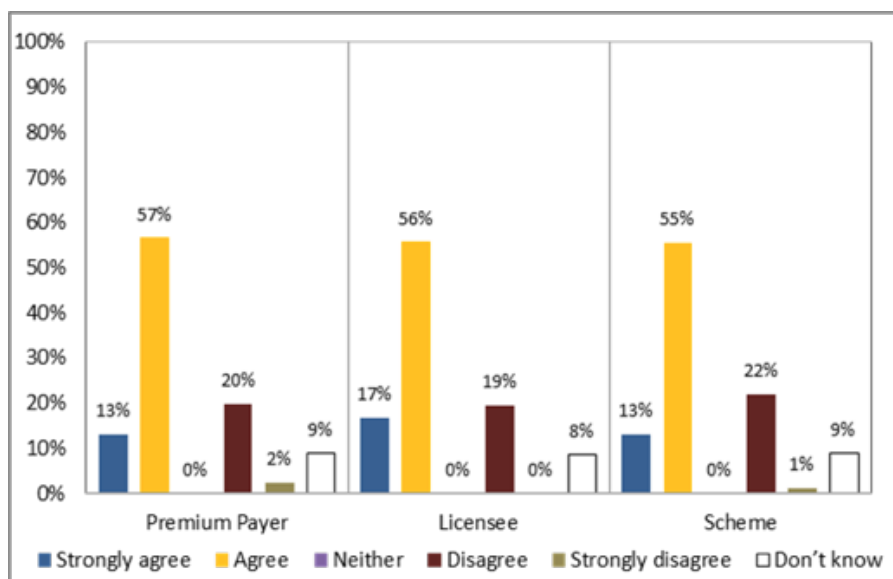


Figure 39: Comcare's effectiveness in communicating the health benefits of work

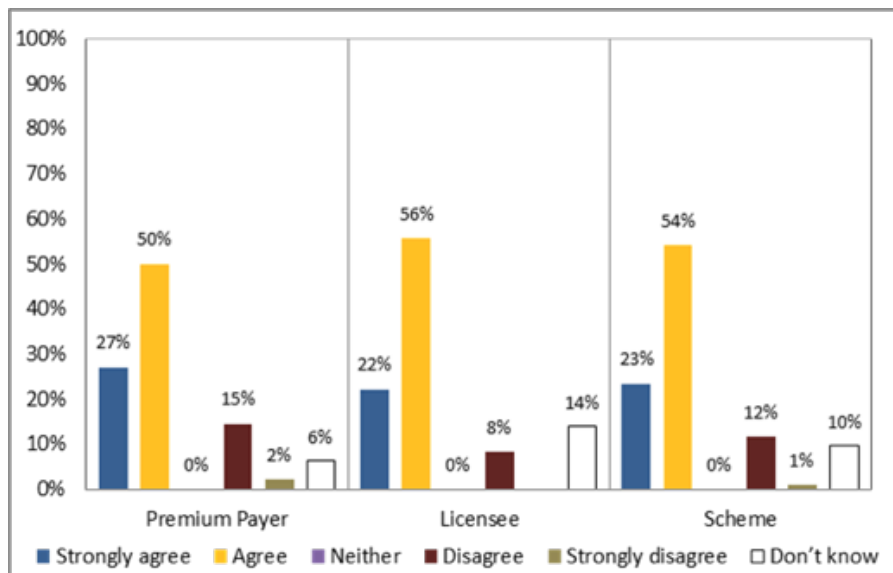


Figure 40:- Comcare's effectiveness in encouraging employers to support worker's health.

When asked whether or not Comcare should have a role in influencing public policy in relation to the health benefits of work the response was overwhelmingly positive with ninety-six per cent of all respondents agreeing or strongly agreeing that Comcare should **influence public policy in relation to the health benefits of work** (see figure 41).

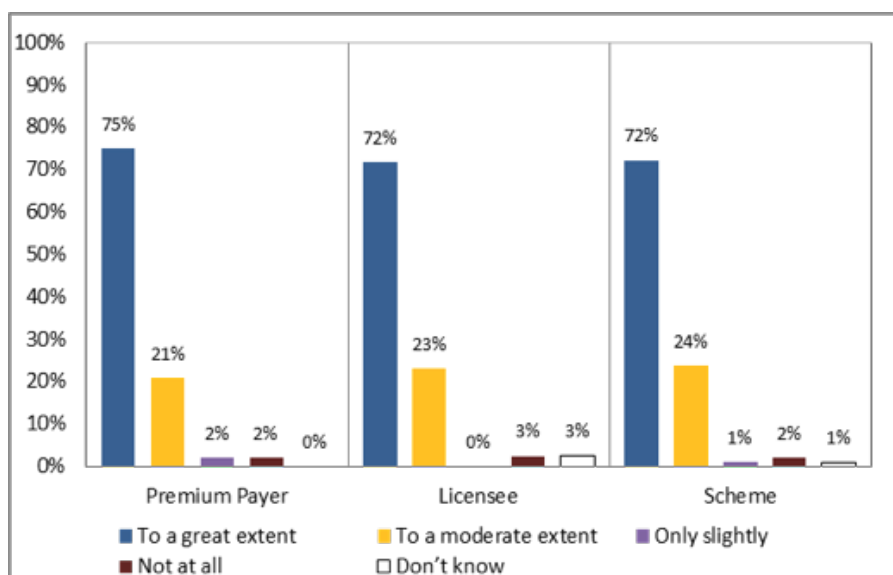


Figure 41: Comcare's role in influencing public policy around the health benefits of work

Other possible roles for Comcare

Focus group participants from both the premium paying and licensee sectors provided suggestions on the possible role that Comcare could play in relation to early intervention. These suggestions included:

- > to be a central source for 'best practise' examples
- > to provide comparative performance data on how rehabilitation suppliers perform
- > to encourage the use of a constructive, positive language, rather than using language that focusses on 'harm'
- > to provide tips on how to have a conversation that will not lead to a claim
- > engage with GPs around the health benefits of work.

Support from Comcare

The results of this project have demonstrated that early intervention has been embraced as a strategic solution to help organisations deliver a more constructive and immediate response to workplace injury and illness. Despite this, focus group participants alluded to requiring more support from Comcare to achieve their aim of better managing employee health and wellbeing, while at the same, mitigating organisational risk. When respondents to the online survey were asked what level of support they might need from Comcare, those from premium paying agencies were much more inclined to indicate that their organisation needed a great deal or at least some support from Comcare (an average of 62%) than those from licensee organisations (an average of 48%). Some, however, indicated that they did not need any support from Comcare (see Figures 42 to 45). This suggests that Comcare will need to work hard to ensure that it is maximising its effectiveness with all employers when it comes to supporting them in relation to early intervention and the health benefits of work.

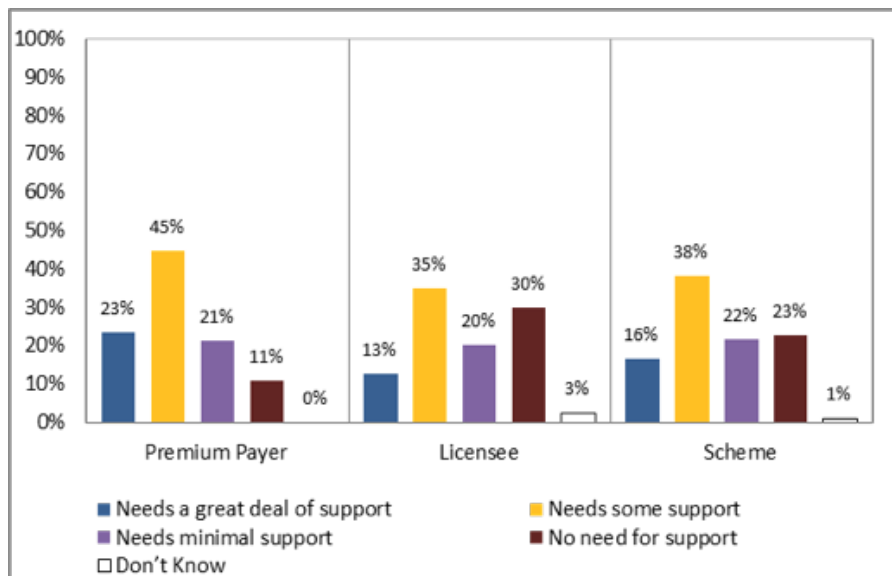


Figure 42: Organisation's need for support from Comcare around understanding the health benefits of work

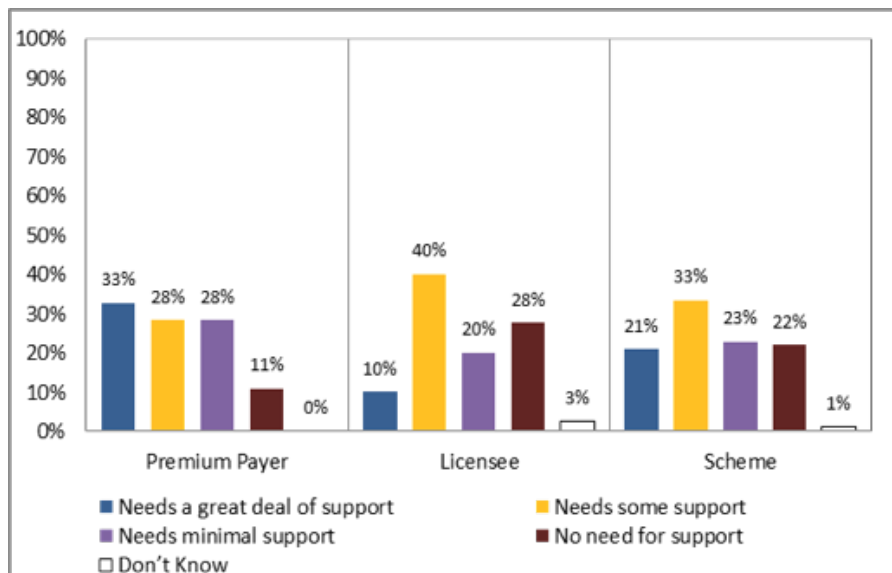


Figure 43: Organisation's need for support from Comcare around identifying early intervention strategies

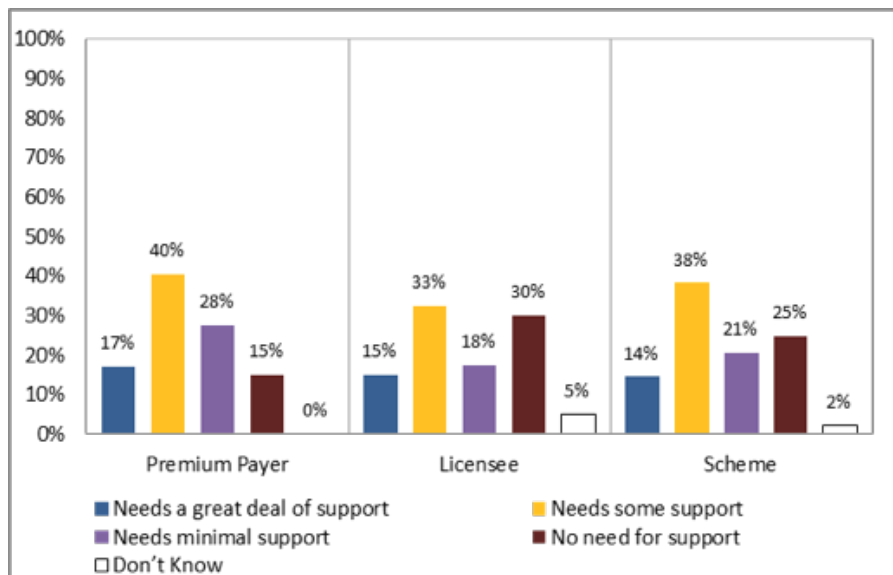


Figure 44: Organisation's need for support from Comcare around promoting early intervention

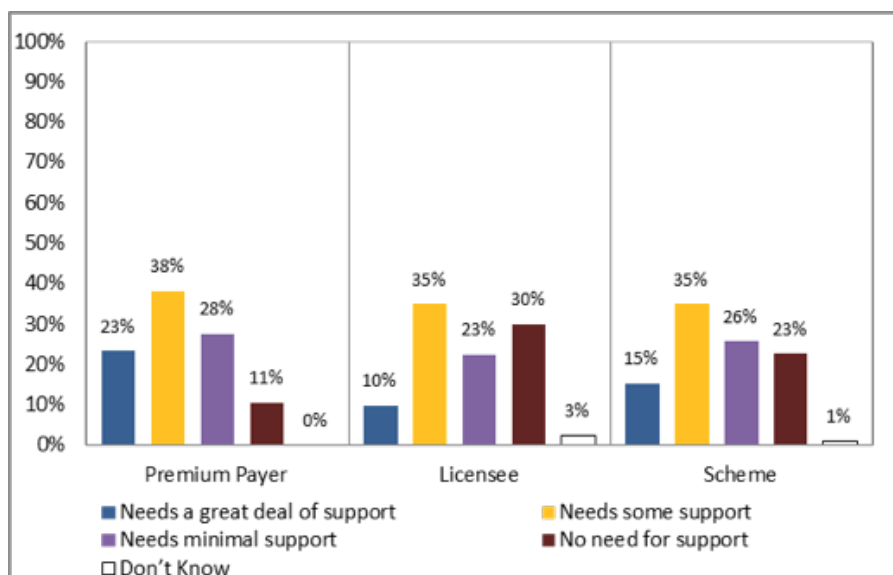


Figure 45: Organisation's need for support from Comcare around communicating the benefits of early intervention

KEY INSIGHTS

The key insights derived through the Early Intervention Project included, but are not limited to:

- > Organisations involved in early intervention appear to be committed to it and to be realising, or at least starting to realise, the benefits of early intervention. The low participation rate in the online survey, however, suggests that there may be many organisations who have yet to really become involved in early intervention, particularly among premium paying organisations.
- > At its simplest level, those participating in the project defined early intervention as 'any activity that responded to an identified issue at the earliest opportunity', where the activity was intended to help the organisations regain control over workplace injuries and illnesses.
- > Early intervention programs were viewed as benefiting both the organisation and the employee. The main reasons cited for using early intervention were 'concern for workers' and 'minimising the likelihood of a workers' compensation claim'.
- > The vast majority of early intervention programs consisted of a combination of both proactive and reactive elements, formal and informal components, and spanned from a small overlap with prevention related activities through to the early stages of a workers' compensation claim.
- > Organisations participating in the project were at different stages in relation to the maturity of their early intervention programs, although the vast majority who participated in the Early Intervention Project had dedicated resources and funding for their programs.
- > Organisations placed constraints such as timeframes, cost and number of treatment sessions on their programs to ensure their sustainability.
- > Most organisations indicated that they would provide early intervention support for non-work related injuries/illnesses, especially if the workplace could aggravate the condition, or it impacted work performance.
- > The three key components identified as contributing to the success of early intervention were: organisational commitment (especially from the top down); appropriate support for those who deliver/oversee/monitor early intervention programs and/or components; and, a positive organisational culture.
- > The benefits realised by premium paying and licensee organisations were slightly different, with most licensees reporting a lower number of incidents becoming claims, and most premium payers reporting an improved capability of managers/team leaders.
- > Many participants believed that early intervention was not being used to its full extent within their organisation, or that it was as successful as it could be.

WORK HEALTH AND WELLBEING

The key insights pertaining to the health benefits of work included:

- > Representatives from premium paying agencies believed that the biggest health challenge their organisations faced both now and over the next two to three years is mental health.
- > Representatives from licensee organisations believed that the biggest health challenge their businesses faced now were musculoskeletal injuries, while over the next two to three years they believed that their biggest challenge would be in relation to an aging workforce.
- > The confidence of senior managers, middle managers and team leaders in relation to dealing with and supporting staff with a mental health issue was reported to be relatively low.
- > There is a generally positive attitude and acknowledgement of the important links between work and health.

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