

Australian Industry Group

Productivity Commission Inquiry into Mental Health

Submission
Response to Draft Report

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Ai
GROUP

PRODUCTIVITY COMMISSION INQUIRY INTO MENTAL HEALTH

SUBMISSION IN RESPONSE TO DRAFT REPORT

INTRODUCTION

The Australian Industry Group (Ai Group) is a peak industry association and has been acting for business for more than 140 years. Along with our affiliates, we represent the interests of businesses employing more than one million staff. Our longstanding involvement with diverse industry sectors including manufacturing, construction, transport, labour hire, mining services, defence, airlines and ICT means we are genuinely representative of Australian industry.

Our vision is for ***thriving industry and a prosperous community***. We offer our membership strong advocacy and an effective voice at all levels of government underpinned by our respected position of policy leadership and non-partisanship.

We also interact with and provide regulators and scheme managers across all Australian jurisdictions with employer views and experience on WHS/OHS and workers' compensation.

We have ongoing contact and engagement with employers across Australia on the broad range of issues related to the operation of their businesses, informing them of regulatory changes, discussing proposed regulatory change, discussing industry experiences and practices and providing advice, consulting and training services.

The mental health of the workforce and the community from which that workforce is sourced is an important factor that can contribute to thriving industry and a prosperous community.

Ai Group is one of two organisations representing employers as a member of Safe Work Australia, a federal statutory body established in 2008 to develop and co-ordinate national policy relating to Work Health and Safety and workers' compensation.

Through this body we have been actively involved in supporting the development of two important documents:

Work-related psychological health and safety: A systematic approach to meeting your duties; and

Taking Action: A best practice framework for the management of psychological claims in the Australian workers compensation sector.

Mental health issues are increasingly becoming a topic of discussion amongst our members, large and small. Some employers have introduced comprehensive approaches to minimising work-related harm and promoting mental health and wellbeing; others have considered the importance of the issue only when an employee has required support for a non-work-related issue. In all cases, employers are learning as they go along.

In 2019 Ai Group commissioned Griffith University to conduct research into the mental health initiatives of Australian workplaces, and in particular to understand the triggers for such initiatives by companies, the nature of the initiatives and barriers encountered by the companies that hampered their efforts (the Griffith Report).

It should be noted that this research was undertaken to fill a specific information gap, not to address the full range of issues associated with reducing psychological harm from work.

The research, annexed, to this submission consisted of a review of existing research on these issues and interviews with ten managers from six companies from a range of sectors and sizes all of whom had undertaken some form of proactive action on the mental health of their workforce.

Some of the outcomes of the research are discussed in the relevant parts of this submission, however in summary the findings included:

- The prevalence of stigma as a barrier to effective support by employers on mental health.

- There is a surprisingly wide range of initiatives being undertaken (up to 30 identified) most common being providing EAP support, RUOK-type days, team or group discussions on mental health and mental health first aid training. However, each workplace feels their response has been formed individually to suit their culture and demographics.
- Companies are approaching workforce mental health holistically, not just as a work-related issue. The case studies confirmed an employer perception that many of the issues can be grounded in individual or community conditions that are not related specifically to that particular workplace.
- Key drivers of initiatives are having a business case for taking action and having senior management support. A key trigger appears to be one or more leaders having a personal commitment to mental health as a workplace issue, perhaps driven by direct or indirect lived experience. Conversely, lack of management commitment, or reluctance, is a key barrier to doing more.
- The more companies do in mental health, the more they uncover that needs doing.
- Mental health emerges as an issue behind many other HR activities the companies undertake including disciplinary action, performance management, absenteeism, flexible work requests and even poor employee driving records.
- Employees may accept support and accommodations afforded by the workplace in response to a mental health challenge, but do not always seek external medical advice or support.
- There are differences in how mental health is perceived based on differences in gender and ethnic background.
- Some employees do not see their mental health as the employer's concern.
- Some mental health support resources are not well suited to blue collar workplaces.
- Companies feel they have more work to do in forming their discrete initiatives into a cohesive mental health or wellbeing strategy and in measuring outcomes of initiatives.

GENERAL RESPONSE TO THE DRAFT REPORT

We note the introductory comments on Page 4 of the *Overview and Recommendations* document:

“... this inquiry examines how people with or at risk of mental ill-health can be enabled to reach their full potential in life, have purpose and meaning, and contribute to the lives of others. This benefits individual. But is also enhances the wellbeing of the wider community through more rewarding relationships with family and friends; provides more opportunities for carers; scope for a greater contribution through volunteering and community groups; a more productive workforce; and an associated expansion in national income and living standards.”

At in excess of 1,000 pages, the report encompasses all aspects of the mental health picture across Australia. As an organisation representing employers, we will focus our comments on those issues that are specifically related to employers and workplaces: how the psychological harm caused by work can be reduced and mitigated; and how employers can support those with non-work-related mental ill-health, and their carers.

However, we wish to highlight that the ability of employers to provide the necessary protection and support within workplaces is greatly influenced by broader mental health issues. Every action, or inaction, within the broader community (incorporating all the factors considered in this report) has an impact on the capacity to effectively engage in these areas.

An inherent difficulty with mental health issues is associated with assigning causation. In practice it is often not possible to neatly categorise them into work related or non-work related; and there can be elements of both in any given case. Additionally, there are incentives for wrong categorisation in both directions - some individuals may be discouraged by stigma from making a workers' compensation claim for conditions that could be largely work related, whilst others may see benefit (including stigma avoidance) in lodging a claim in situations where, objectively, work was not the key cause of the condition.

In many cases it may be a challenge for the medical profession to make the distinction on causation.

Nevertheless, Ai Group welcomes the effective implementation of recommendations that increase the mental health of all persons and supports effective and efficient responses when mental ill-health occurs. Healthy children and adolescents become productive workers; healthy workers contribute to the success of businesses; healthy older people support their working family members and reduce the need for workers to become carers.

It is interesting to note that Figure 1 (page 5 of the *Overview and Recommendations* document) includes a diagram that illustrates a significantly higher level of high and very high psychological distress amongst those that are unemployed (approximately 70%), compared to those that are employed (approximately 10%). The question arises as to whether the high level of distress has resulted from unemployment, or whether unemployment has resulted from high levels of distress and lack of support and/or coping mechanisms.

An ongoing challenge when dealing with mental health issues in the workplace.

There is a strong movement seeking legislative change to drive improved mental health within Australian workplaces; this is reflected in some of the recommendations of the draft report. However, there is already a legislative obligation to provide workplaces that minimise the risk of psychological harm; these obligations are supported by guidance material to assist employers to achieve this outcome.

It is Ai Group's view that we will not achieve major breakthroughs in mental health outcomes through legislative change which is too prescriptive.

In many cases, improving mental health is about creating a caring culture where individual concerns and differences are considered and supported. This requires developing an increasing understanding of mental health issues by enlisting the support of employers, rather than merely creating a compliance culture.

We note that the Griffith Report did not find any of the employers interviewed saying that they were addressing mental health issues due to legislative obligations. It was generally due to having a business case and having senior management support.

RESPONSE TO DRAFT RECOMMENDATIONS, FINDINGS AND INFORMATION REQUESTS THAT ARE SPECIALLY DIRECTED AT EMPLOYERS AND WORKPLACES

Chapter 19 (page 737) of the Draft Report highlights:

4.1.

Successful intervention requires ...

As a priority:

- Making psychological health and safety as important as physical health and safety in Workplace Health and Safety (WHS) arrangements.
- Providing clinical treatment for mental health related workers compensation claims, irrespective of liability, for a period of up to 6 months.

Additional actions required include:

- Developing codes of practices to assist employers, particularly small employers, better manage psychological risks in the workplace
- Having WHS agencies and employers work together to collect and disseminate information on the effectiveness of workplace programs and interventions.

Ai Group acknowledges that psychological health and safety is as important as physical health and safety in WHS arrangements. However, with the broad range of issues that can create psychological risk in the workplace, it is our view that it is difficult to achieve this with a “one size fits all” approach. Ai Group continues to work with Safe Work Australia, regulators and employers to identify how this can best be achieved in a practical and effective manner.

The provision of appropriate clinical treatment for work related psychological injury is an important initiative, as it is for all work-related injury and illness. However, determining a policy position and its practical implementation that addresses all issues associated with costs, equity and fairness will be difficult.

Draft Recommendation 19.1: Psychological Health and Safety in Workplace Health and Safety Laws.

Psychological health and safety should be given the same important as physical health and safety in workplace health and safety (WHS) laws.

In the short term (in the next 2 years)

The model WHS laws (and the WHS laws in those jurisdictions not currently using the model laws) should be amended to ensure psychological health and safety in the workplace is given similar consideration to physical health and safety.

- ***All WHS legislation should clearly specify the protection of psychological health and safety as a key objective.***
- ***Necessary amendments should be made to ensure that the relevant legislation and regulation addresses psychological health and safety similarly to physical health and safety.***

The recommendation does not provide specific detail about what changes are proposed. However, some insight is provided in the commentary.

Include psychological health and safety in the objectives of the Act

At page 744 it is suggested that “including psychological health alongside physical health upfront in the objectives of the model WHS legislation would send a clear signal as to the importance of a (sic) psychological health and safety in the workplace.”

Ai Group does not object to such an amendment being made.

Notification of serious psychological injuries

It is stated that “serious psychological injures should be notifiable [to the WHS regulator]”, with reference to the 2018 Review of the Model WHS Laws (p. 744).

It is Ai Group’s view that the current structure of the incident notification provisions (s.38 of the Model WHS Act) that require immediate notification, and the related obligation to preserve an incident site (s.39) do not lend themselves easily to the notification of psychological injuries.

Ai Group will participate in any review undertaken by Safe Work Australia, and any jurisdictional regulators, in relation to this recommendation of the 2018 Review of the Model WHS Laws.

Draft Recommendation 19.2: Codes of Practice on Employer Duty of Care

In the short term (in the next 2 years)

Codes of practice should be developed by Workplace Health and Safety authorities in conjunction with Safe Work Australia to assist employers meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace. Codes of practices (sic) should be developed to reflect the different psychological profiles of different industries and occupations.

The commentary in this section of the Draft Report indicates a clear understanding that Regulations are not appropriate to deal with the broad range of psychological risks that may be relevant to various work situations.

However, it does not recognise the major work required to develop and implement Codes of Practice which require the development of Regulatory Impact Statements (RIS) and ministerial approvals. In relation to Codes developed by Safe Work Australia, it also requires the agreement of at least two thirds of the jurisdictions in order to progress to a formal process, considering the following criteria¹

A document is assessed as being suitable as a code of practice if the majority of the following criteria are met:

1. Guidance is a necessary part of enabling compliance with the duties contained in the Work Health and Safety Act and/or Regulations, particularly to support legislative provisions that are outcome focused or do not provide much detail.
2. There is clear evidence of a significant risk or widespread WHS problem where the evidentiary status of a code will elevate the importance of the issue.
3. There are certain preferred or recommended methods to be used (or standards to be met) to achieve compliance.
4. The information on the hazard, risks and control measures is well-established, reflects the state of knowledge and therefore will not require frequent updating.
5. Whether there is a clearly identified need supported by evidence for nationally consistent material.
6. Whether there is an identified information 'gap', where supporting material is required to assist duty holders to meet their obligations under the Model WHS laws.

¹ The first four criteria are outlined in a [2012 Safe Work Australia Fact Sheet](#) on Codes of Practice and Guidance Material. The final criteria were agreed by Safe Work Australia Members in 2015.

Ai Group does not believe that criteria (3) or (4) would be met in this situation.

Further, it is our view that guidance can:

- provide more succinct assistance on discreet issues than a code of practice;
- in relation to determining what is reasonably practicable, contribute to the necessary “state of knowledge” for specific industries and situation; and
- be more quickly updated as knowledge and practice develops.

Draft Finding 19.1 – Return to work is more difficult in smaller businesses

Return to work for those with a psychological injury or mental illness is difficult if the injury or illness was related to personal conflict or wider cultural issues in that workplace that have not been addressed prior to return to work. These difficulties are more acute for smaller businesses operating from a single location, as unlike larger organisations that have multiple sites, the business is unable to provide return to work at a different location.

Ai Group agrees that smaller businesses can face more difficulty in providing return to work opportunities for workers with a psychological injury. However, even in large businesses this can be a difficulty. Larger organisations may have multiple small sites, but it may not be feasible for a worker to travel to other sites.

When a workers’ compensation claim arises from mental ill-health it is not unusual for a certificate of capacity to state that a worker is fit for duties, but not with the current employer. Where the worker is unwilling, or unable, to cooperate with the employer to identify and resolve issues it will be difficult for the employer to address the actual and/or personal conflict or wider cultural issues at the workplace.

Further work is required to identify effective intervention strategies, supported by the medical profession, to facilitate resolution of these issues in a timely manner.

Most workers’ compensation schemes establish a period of time in which an employer is required to provide duties to a worker with an accepted workers’ compensation claim. In some cases, scheme managers will not consider the provision of support services to a worker to find employment with a new employer until this period has expired. The rationale for this is to ensure that the employer does not avoid their obligations. However, in some situations such delays may exacerbate the worker’s condition and options with a new employer should be considered. This is relevant to both small employers and larger organisations.

Draft Finding 19.2 – The role of workers compensation in addressing mental health

Workers compensation arrangements can most effectively deal with mental health claims and improve outcomes by providing for:

- **early intervention**
- **early treatment**
- **successful return to work.**

This finding is presented directly after the section of the report entitled “Claims for psychological injuries and mental illness are treated differently”. In this section it is highlighted that workers compensation legislation “provides a defence or an exception for psychological injuries resulting from reasonable management action carried out in a reasonable manner or reasonable way.” (p.755).

Hence our response to this recommendation relates to situations where the application of this exclusion is being applied.

There is a very difficult intersection between necessity of employers to be able to efficiently manage an organisation for commercial success (including for the welfare of the workforce as a whole) and the right of individual employees to receive workers’ compensation for injury or illness that arises out of or in the course of employment.

It is essential that an employer is able to reasonably manage performance, investigate complaints of bullying or harassment, initiate disciplinary action, and make decisions about required manning levels. The exclusion applies to allow these things to occur whilst minimising the risk of a workers’ compensation claim being accepted, as long as the action was reasonable and carried out in a reasonable manner.

Any situation which limits the ability for an employer to undertake such actions may lead to other causes of stress and psychological injury; either directly related to the actions of an individual or through a sense of poor organisational justice.

Even the provision of interim or provisional payments and support to a claimant in this position may lead to other workers feeling that the claimant has gained from their poor performance or bad behaviour.

Draft Recommendation 19.3 – Lower premiums and workplace initiatives

In the medium term (over 2 – 5 years)

Workers compensation schemes should provide lower premiums for employers who implement workplace initiatives and programs that have been considered by the relevant Workplace Health and Safety authority to be highly likely to reduce the risks of workplace related psychological injury and mental illness for that specific workplace.

The Draft Report considers that “there is potential for WHS agencies and workers’ compensation schemes and their insurers to work together to incentivise employers to identify and mitigate risks to psychological health and safety in the workplace” (p.759). This is supported by reference to lower premiums being provided in other insurance markets where policy holders undertake certain actions to reduce the risk of a claim, for example burglar alarms and deadlocks on home contents insurance.

In relation to other insurance classes it could be argued that the presence of “controls” may not actually reduce the risk of the claim. The existence of a deadlock on a house front door does not mean that the householder will use the deadlock, or even that they will lock their doors at all.

In relation to workplaces, the connection between risk controls and claims is even more tenuous, especially in relation to psychological injuries where the connection to work is often difficult to make.

The reaction of employers to this proposal may initially be a positive one. However, there are several key issues that need to be considered in relation to a practical application:

- With premiums calculated ultimately on individual or pooled claims costs, if any employer is granted a premium reduction merely for implementing a specific set of controls (as opposed to having fewer claims), other employers will need to make up the shortfall, irrespective of their claims experience, if the controls do not lead to the expected reduction in claims. This is particularly relevant in the government underwritten schemes but is also relevant to private insurance, where the cost of claims needs to be recovered in some way.
- A similar approach was applied to at least two schemes (SA and NSW) in the early to mid-2000s. Employers were able to receive a reduction in their premium if they successfully completed an external audit of their OHS management systems.

The reductions were predicated on an expectation that overall claims costs would reduce. Both of the schemes were abandoned due to not delivering on the expected outcomes.

- The recommendation includes a reference to the WHS authority making an assessment in relation to “that specific workplace”. This implies that each workplace that sought a reduced premium would need to be individually assessed by the WHS regulator. Regulators currently do not have the resources to undertake such work and are unlikely to want to be part of a process that “verifies or certifies” compliance.

Draft Recommendation 19.4: No liability treatment for mental health related workers compensation claims

In the short term (in the next 2 years)

Workers compensation schemes should be amended to provide clinical treatment for all mental health related workers compensation claims, regardless of liability, until the injured worker returns to work or up to a period of six months following lodgement of the claim. Similar provisions should be required of self-insurers.

Information Request 19.1: How should the clinical treatment for workers compensation claims (irrespective of liability) be funded until return to work or up to a period of six months be funded?

Changing the burden of proof

The Draft Report considers the role of presumptive legislation in relation to psychological injury claims for workers’ compensation. Presumptive legislation applies in some jurisdictions where, for example, if a first responder is diagnosed with post-traumatic stress disorder; the claim is accepted unless it can be proven that the condition was not work related.

Ai Group agrees with the conclusion that “changing the burden of proof to have workers’ compensation schemes accept all claims for mental health would not be feasible given that not all mental health problems are a result of employment.” (p.761).

Provisional liability

The Draft Report outlines some jurisdictions are required to make payments before claims are accepted. This is in the form of: provisional liability for up to 12 weeks in New South Wales; interim payments in South Australia (if the claim cannot be determined within 10 days); and “without prejudice” payments in Tasmania.

It is also highlighted that Victoria is considering a provisional acceptance model for mental health claims and Queensland had recommendations to do something similar. Since that time Queensland has introduced a requirement that the insurer makes reasonable attempts to provide reasonable medical treatment and reasonable medical supplies until a decision is made to accept or reject the claim.

Ai Group recognises the potential value of workers receiving early intervention and early treatment may be part of that support. However, some key factors must be considered:

- Unqualified access to medical treatment for six months would be excessive; any entitlement should be linked to the point at which a decision is made to accept or reject the claim;
- Linking the alternative end date to when the person returned to work may have the unintended consequence of reducing the incentive to return to work;
- Funded treatment must be clinically proven to assist in the resolution of work-related psychological injuries and provided by a person who is recognised as having a specialty in dealing with mental health issues²;
- Any entitlement should be reliant on the worker cooperating with at least the insurer, and preferably also the employer, in attempting to resolve issues within the workplace and establish a process focused on returning to work; and
- Any adoption of such approaches could be open to overuse if the schemes provided opportunities for treatment that were not available on the public health system.

A quote from The Griffith Report:

One thing that I am finding is that when we have people with issues, they want allowances and consideration for their issues. But when it comes to seeking help and support ... unfortunately a lot got to a bulk billing clinic for antidepressants and that's the answer, the solution to the problem ... Then when you talk to the people it's really great that they've got support, but: "Have you got a mental health plan?", "What else are you doing to address some of the issues?"

² The Safety, Rehabilitation and Compensation Amendment (Improving the Comcare Scheme) Bill 2015, which did not progress through parliament, intended to introduce a concept of a mental health practitioner for psychological or psychiatric claims, as defined below:

For the purposes of this section, *mental health practitioner* means:

- (a) a legally qualified medical practitioner who is registered under a Health Practitioner Regulation National Law in the speciality of psychiatry (other than as a student); or
- (b) a legally qualified psychologist who is registered under a Health Practitioner Regulation National Law in the speciality of clinical psychology (other than as a student); or
- (c) a legally qualified medical practitioner who has completed mental health training, where the training was covered by an approval under subsection (7).

Funding no liability payments

As indicated in the “request for information” associated with this recommendation, the key question arises as to how such services are funded.

The cost should not fall to individual employers if the claim is rejected.

A fundamental starting point is that individual employers should not pay the cost of a claim that is ultimately rejected in line with legislative provisions.

This is currently achieved in relation to medical expenses in the following way – South Australia and New South Wales do not use medical expenses when calculating the individual premium of an employer; in Queensland the medical costs will only be included in the premium calculation if the claim is accepted; it is our understanding that in the current Victorian trial for first responders the costs are covered by the Department of Finance and Treasury, not the individual department.

However, no such exclusion is applied for provisional payment of weekly compensation in New South Wales, which can continue for up to 12 weeks; employers strongly feel it is a major injustice when their premiums reflect the costs associated with rejected claims.

Workers’ compensation schemes should not bear the cost burden of non-work-related issues.

Even if individual employers do not have the cost of provisional payments allocated to their individual premiums when a claim is rejected, the cost of such payments will need to be funded somewhere. The SA interim payment scheme does allow for costs to be recovered from the worker, but this does not apply in other jurisdictions where such payments are made.

If provisional payments are adopted across schemes:

- Cost should be monitored to identify any trends that indicate an excessive use of the workers’ compensation scheme for claims that are ultimately rejected; and
- consideration should be given to entering into an arrangement with the Federal government to transfer costs back to the Medicare scheme if claims are rejected.

Draft Finding 19.3: Employee Assistance Programs (EAPs)

Employee Assistance Programs (EAPs) are reported to be highly valued by at least some employers and employees. The type and level of EAP services an individual business required to meet its needs and those of its employees is best determined by the business itself.

The services provided by EAPs, as well as concerns around the reliability of the services and the reputation of providers, would be enhanced through further evaluation of their outcomes. To facilitate this, the EAP industry could:

- **develop mechanisms to enable individual businesses and EAP service providers to evaluate outcomes for that business**
- **invest in research to improve external evaluation and benchmarking of best practice in the wider provision of EAP services.**

The Griffith Report also identifies that EAPs were widely used by employers to help workers to address a range of mental health issues. As a key service provision, it is essential that it is providing the right outcomes for both employers and the people that access the service.

Accordingly, Ai Group supports these findings. Further we recommend development of further guidance for employers about how an EAP can fit within their total approach to mental health support in their workplaces, and how GPs can engage with the EAP services.

As outlined in our submission in response to the Terms of Reference and Issues Paper, some concerns about EAPs have been identified that could be assisting by such guidance:

One employer who found that the EAP was not adding value, came to the view that by engaging the EAP and doing little else they had actually outsourced their mental health support to that provider, which may have contributed to, rather than resolved, issues. They subsequently moved to a more holistic approach.

In a recent forum which focused on the role of GPs in supporting workers' compensation recipients to return to work, one GP highlighted that there was often a disconnect between the services provided by an EAP and the medical treatment that is being provided.

When effective, EAP services can be very helpful in a workplace and for individual workers.

A quote from the Griffith Report

“I thought EAP was a waste of time and a load of gobbledegook, but actually I went and it was brilliant.”

Draft Recommendation 19.5: Disseminating information on Workplace interventions

In the medium term (over 2 – 5 years)

WHS Agencies should monitor and collect evidence from employer initiated interventions to create mentally health workplace and improve and protect the mental health of their employees. They should then advise employers of effective interventions that would be appropriate for their workplace.

Ai Group strongly supports the collection and dissemination about successful employer-initiated interventions. However, there are limited opportunities for WHS agencies to undertake this role, for the following reasons:

- individual employers will mostly be unwilling to put their hand up to advise the regulator of the activities they are undertaking in case they are found to fall short of expectations.
- Not all interventions are directly related to WHS legislative compliance; the role of the WHS agencies in this space is questionable, given that they are funded to ensure compliance with regulatory obligations

The Griffith Report provides some insight to employer initiatives by obtaining detailed information from a small number of employers who are trying to make a difference to the mental health of their workers. More initiatives such as these can contribute to further knowledge and information sharing.

Information Request 19.2: Would designating a number of days of existing personal leave as “personal care” to enable employees to take time off to attend to their personal care and wellbeing improve workplace mental health and provide information on absenteeism due to mental ill-health? If so, what would be needed to make this provision effective?

It is imperative that the *Fair Work Act’s* provision for personal/carers leave remains equitable and flexible for both employers and employees in forming part of Australia’s minimum standards of employment. Under the FW Act, employees can already take 10 days of personal leave for an injury, to care for a relative or for sickness — be it physical or mental. That is, in many circumstances existing personal/carer’s leave provisions cover periods of absences when employees are unable to attend work because of poor mental health.

Ai Group does not support the specific allocation or designation of existing personal/carers leave for the specific purpose of mental health or wellbeing.

The consequences of implementing such a proposal would disadvantage employees who require their full entitlement of personal/carer’s leave non- mental health reasons. For instance, employees who experience reoccurring migraines, have a long-term illness, or who need to care for a child with reoccurring medical condition.

It would be unfair for statutory minimum employment conditions to single out and favour specific medical or health conditions over others.

There are of course many employers who adopt formal personal leave policies or informal practices that may be more favourable for employees than the minimum safety net in the FW Act. This may include providing for additional personal leave days on a discretionary basis, or for adopting a more flexible approach in respect of not requiring employees to provide the relevant notification and evidence otherwise required by the FW Act. In Ai Group’s experience, employers may provide additional benefits in a wide range of circumstances, including community or family days, mental health or “doona days” but also where an employee is receiving treatment for cancer or looking after a dying relative. It is important that mental health continues to be currently recognised by the FW Act, but it is not the only form of health condition affecting employees and their employers.

It is important that more beneficial arrangements are voluntary for businesses, who due to varying levels of resources and business size may not have the capacity (including available other workers) to cover absences beyond the FW Act’s safety net.

Information Request 19.3: Are there barriers to employers purchasing income protection insurance (including for loss of income relating to mental ill-health) for their employees on a group basis to enable their employees to access this insurance at a lower cost?

Employers who provide income protection insurance for their employees do not generally understand the specific inclusions and exclusions that may apply. Where the insurance is provided through an Enterprise Agreement, employers are often bound to take out insurance with a specific insurer nominate by the union(s) that are a party to the agreement.

Any consideration of additional insurance for high risk workers would need to be done within the context of the broader issue of insurance considered in Chapter 20. There is no point an employer paying for extra coverage if individuals will be ultimately excluded due to a pre-existing mental health issue which may be as simple as seeking help for a resolved episode that occurred many years in the past.

OTHER ISSUES RAISED BY THE COMMENTARY IN CHAPTER 19

Mental Health First Aid Officers

On page 742 of the Draft Report there is commentary about the level of attention paid to WHS psychological health and safety, compared to physical health and safety. As an example of the different focus on psychological injury it is stated that “all workplaces have first aid officers in place, as required under WHS regulations, but the appointment of the equivalent ‘mental health first aid officer’ in the workplace is rare.”

It is Ai Group’s view that a mental health first aid officer is not the equivalent of a first aid officer required by WHS laws.

The Collins Dictionary defines first aid as “simple medical treatment given as soon as possible to a person who is injured or who suddenly becomes ill.”

Once this initial treatment has been provided, there are three possible outcomes: no further treatment required (simple application of a bandaid); recommending further assessment by a doctor, which may include transporting the person for that assessment; or calling for an ambulance. Further involvement of the first aider is unlikely after that initial intervention.

In its simple description, mental health first aid sounds similar, as defined at www.mhfa.com.au: “Mental health first aid is the help provided to a person who is developing a mental health problem, experiencing a worsening of an existing mental health problem or in a mental health crisis. The first aid is given until appropriate professional help is received or the crisis resolves.”

However, the reality of mental ill-health is that the first aid intervention is critically different, as outlined in the table below:

General First Aid	Mental Health First Aid
<p>The injured worker either self-reports and seeks assistance (cuts and burns) or is in a situation where emergency assistance is clearly required and unlikely to be refused (serious bleeding or a heart attack). The first aider is either responding to a request for help or an emergency.</p>	<p>The worker suffering a mental health issue may not seek help or assistance. Even in a crisis situation, assistance may be refused. The mental health first aider is required to make a judgement about the appropriateness of intervening. The mental health first aider is often trying to identify signs of mental ill-health and seeking permission to intervene.</p>
<p>Once initial first aid is provided and recommendations made about further medical treatment, the work of the first aider is complete.</p>	<p>Once a mental health first aider identifies a potential mental ill-health issue there may commence a personal moral obligation to continue to attempt to intervene until the person seeks professional help.</p>
<p>An injured worker is unlikely to return to the first aider for ongoing advice about their injury; and a first aider can relatively easily refuse to provide medical treatment</p>	<p>Once there has been an intervention by a mental health first aider, there is the potential that a worker may continue to seek their support and ongoing assistance. If this occurs whilst the worker is not receiving any professional treatment, it may be difficult to refuse ongoing assistance.</p>

General First Aid	Mental Health First Aid
The ability to effectively provide first aid is not generally influenced by interpersonal skills and pre-existing relationships.	The ability to effectively provide mental health first aid will most likely be influenced by the relationship between the mental health first aider and the person who may be experiencing mental ill-health.
First aid treatment for a physical injury will generally only involve a short period of time to deliver the treatment and will generally only occur once for each injury.	Mental health first aid intervention can be time consuming and may involve multiple contacts with the worker, either at the initiation of the first aider or the worker.
Whilst first aid treatment can be traumatic in some circumstances, the lack of any ongoing obligation to support the injured worker should reduce any ongoing psychological impact on the first aider. Any specific intervention that requires support can be quite easily identified.	Mental health first aid carries with it a much higher risk of the first aider experiencing their own psychological issues, through vicarious trauma or a feeling of guilt about not being able to get the person to seek help. This type of risk is particularly high if the worker's mental ill-health deteriorates and there is an outcome of self-harm.
It is unlikely that an injured worker receiving first aid treatment will become antagonistic or violent towards the first aid aider.	When mental ill-health issues are being considered, the response of the person being assisted can be highly unpredictable and may result in a long-term breakdown of relationships in the workplace; at worst it could result in a violent response.
Providing first aid treatment is mostly an objective, short term engagement with an injured worker.	Providing mental health first aid can initiate a highly emotional interaction between the first aider and the worker.

This is not to diminish the value of providing mental health first aid training to employees, both for use within the workplace and in general family and community interactions.

A number of Ai Group staff have undertaken Mental Health First Aid training; both to increase the skills within the organisation and to aid our understanding when considering this as a policy issue.

We recognise the value of increasing the mental health literacy of people within the workplace. We support any government action to increase access to mental health first aid training in the community, and applaud employers who are able to find the resources to offer the training to members of their workforce

A quote from the Griffith Report:

“...I have not had one person that has come and said to me 'Geeze, that training was crap'. I actually had so many people say to me – so after the first session – I can give you an example – I had one person actually say 'Oh my God, I think my partner's got bipolar'. He was able to then immediately go and get her help... But if it wasn't for the start of that training, that wouldn't have happened. I had another manager actually ring me and actually had said to me that his daughter – they thought his daughter was an epileptic, and they were giving her epilepsy medication, when in actual fact she actually had anxiety. And, it was through that training that he identified and all of that, that he was able to work through with the issues that he had with his daughter. I had another manager actually ring her father and say 'Hey dad, I'm just ringing to check to see whether you're okay, because I noticed all of these symptoms a little while ago'. And, he turned around and he said to this lady 'You know what? I am fine now, but I wasn't back then'. So, I think to be honest with you, the feedback was 'Oh my God, this training was brilliant'.

However, we would be concerned about any approach that mandated the nomination and appointment of mental health first aiders, in any business size (for the reasons outlined in the table commencing on page 20.

Organisations that do introduce a role of nominated mental health first aiders would need to ensure that they had appropriate systems in place to:

- Clearly articulate the role of the mental health first aider as one that provides initial support and referral options and is not an ongoing counsellor for workers with mental health issues;
- Provide appropriate time for mental health first aiders to undertake their work without creating difficulties for them to meet the requirements of their substantive role;

- Establish and promote sources of support that can be accessed after initial mental health first aid support (e.g. Employee Assistance Programs, community health centres, drug support services).
- Establish systems that facilitate the escalation of issues to others in the organisation (e.g. the HR Manager) if a worker is becoming dependant on their support or not seeking professional help; and
- Support mental health first aiders to ensure that their psychological health is protected.

Where organisations provide mental health first aid training to line managers and supervisors, it is essential that additional systems, training and education are in place to ensure that mental health support is clearly delineated from performance management and/or disciplinary action.

The role of resilience

On page 738 of the Draft Report it is identified that, in addition to taking suitable action to prevent or minimise the potential negative impact of psychological risks, “protective and resilience factors are encouraged and promoted.”

Reference to resilience is often seen as an approach that “blames the worker” and focuses on low level controls, rather than addressing psychological risks in the workplace. However, it needs to be recognised that:

- some roles will have inherent levels of psychological risk associated with them (often arising from interactions with other people, external to or within the organisation); and
- personal factors outside the workplace may make it more difficult for a worker to deal with levels of stress that would normally be within acceptable levels.

It would be unlikely for an individual to not experience some level of psychological stress across their lifetime. If we ignore resilience as a factor that is important to our general mental health, we are ignoring an important consideration for managing all stressors in a person's life.

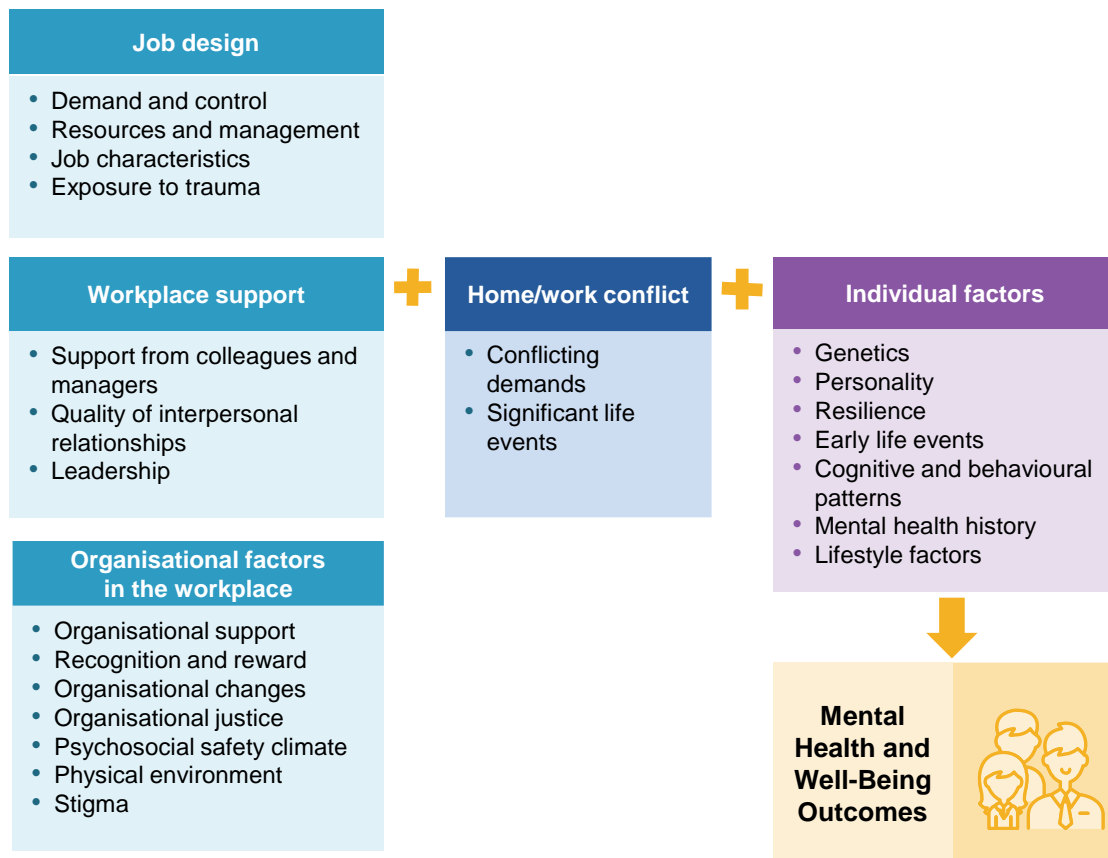
Once an employer has done all that is reasonably practicable to address psychological risks in the workplace, the specific response of individuals can influence the level of potential harm. We must be prepared to have a discussion around the role that individual resilience plays in minimising risk.

If we fail to acknowledge that increasing resilience is part of the equation, we will be doing workers a disservice, especially those that work in industries where some jobs will always have stress involved, such as first responders and emergency workers.

Mentally healthy workplaces as a concept

Ai Group acknowledges the importance of Figure 19.1, included on page 740 of the Draft Report (reproduced below). In all discussions about mentally healthy workplaces it is important to recognise that there is much the employer can control, and much that they cannot. We will only get real improvements in providing mentally healthy workplaces if all policy participants recognise that not every mental health issue that arises within the workplace is due to the workplace.

Figure 19.1 **Factors contributing to a mentally healthy workplace**



Source: Harvey et al (2014).

Some final quotes from The Griffith Report, highlighting some of the difficulties employers face when dealing with mental health issues.

individuals from some ethnic backgrounds “will do their utmost to keep any issues within the family”.

“...you just need a sponsor, you need someone to, at an emotional level, be doing it and really believe in it”.

“pockets of low manager engagement with mental health issue”

“So the challenge is taking it [mental health] through to something that the company wants to help you with and some people don’t see it as the company’s business...:”

“...we coined the phrase ‘be on the bus’...Not everybody wants to be on the bus. Some people, they come here to do their job and leave. They don’t buy into activities”.

“You go to all the training and everything else and even a lot of the workplace training, it’s all about white collar. We’re not white collar. We’ve been through so many [training sessions] - [Operations Manager] and I have gone together to sessions. Everything is really office-based and it’s also very – either office based or very, very work, bullying and harassment, stress type stuff, not really about the issues of ageing, coping with ageing, transitioning through life – all those things that really do impact in your life [in this organisation]”.

Annex provided in separate document
[Click here to view](#)