

Productivity Commission Inquiry into Mental Health

Jo Farmer response to Draft Report

23 January 2020

Dear Commissioners,

Thank you for this opportunity to respond to the draft Productivity Commission report into mental health, released in October 2019.

Given the nature of my experience, I intend to focus my response to Chapter 19: Mentally Healthy Workplaces. More broadly, as a mental health consumer, I applaud the Productivity Commission (the Commission) on the draft report. Having heard Commissioner Stephen King speak at the Grace Groom Oration in November 2019 about the Commission's vision for a consumer-centred mental health system, I am extremely excited about the possibility of creating a system that puts our needs first and foremost. For too long, Australia's mental health system has been siloed around the constraints of federalism, service and clinical siloes, which fail to adequately recognise the individual experiences of mental health consumers, their carers and loved ones.

About me

I'm a policymaker and evaluator, focused on improving the health and wellbeing of all Australians, particularly those who experience mental illness and complex disadvantage. I use my skills to design and drive systemic change, supporting the development of a health and social services system that puts people at the centre.

My experience includes strategic planning, evaluation and service design in not for profits, government and service delivery agencies. I am currently an independent consultant and was previously Workplace Mental Health Policy, Strategy and Evaluation Lead at Beyond Blue, during which time I was actively involved with the Mentally Healthy Workplace Alliance. Since launching my own consulting business in November 2019, the focus of my work has been providing evaluation and policy services in the mental health sector, primarily workplace mental health stakeholders.

As well as my professional experience, I have lived experience of complex mental illness as both a consumer and a carer. The community and those with lived experience are at the heart of my work. As someone who combines lived and professional experience in my own work, I recognise the value of genuine engagement and collaborative design that balances evidence with the needs of consumers and those of delivery agents to deliver long-term, meaningful change.

More information about my experience can be found at jofarmer.com.

Comments

Overall, it was heartening to see the Productivity Commission place workplace mental health as a high priority among the key issues for the future of mental health in Australia.

However, the Commission has failed to adequately capture the role of an integrated approach to mental health in supporting workplaces and workers. While I appreciate the unique role of the Commission in speaking to governments about their reform opportunities, the draft report focuses too heavily on the role of regulatory authorities.

As a result, chapter 19 focuses predominantly on solutions to address mental *illness* in the workplace. There is a much greater role for government in supporting mental health and wellbeing in workplaces by emphasising the importance of prevention and health promotion. The Commission has underrepresented the productivity benefit that comes, not just from preventing harm and supporting recovery, but in encouraging workplaces to truly thrive.

This means workplace mental health is not just about implementing effective interventions – and evaluating them well – but about creating healthy, supportive work cultures.ⁱ

An integrated workplace mental health approach encourages workplaces to prevent harm, promote the positive of work, and address mental health problems.ⁱⁱ One of the strengths of this approach is in recognising the positive role that work plays in addressing mental health conditions, through social connection, meaning and financial stability. There should be strong links between a policy response to workplace mental health, and those to income support, housing and social isolation.

The Commonwealth Government recognised the value of an integrated approach to workplace mental health through announcing funding for a National Workplace Mental Health Initiative in the April 2019 budget. This will be led, via the National Mental Health Commission, by the Mentally Healthy Workplace Alliance. I encourage the Commission to explore the opportunities such an Initiative presents to address the challenges workplaces face in implementing an integrated approach – primarily a high level of confusion around what and how to actually implement in their context.

Specific responses to the draft findings and recommendations are below.

Response to draft findings

F19.1 – Return to work is more difficult in smaller businesses

I agree with the Commission's finding that supporting return to work is more challenging in small businesses, primarily due to their structure and resourcing. Small business employers require more focused support, and to be holistically enabled to support the return to work process.

The implications of work absences and the return to work process are often broader in small businesses. Support should recognise that many small business owners and employers lean on a community of support in managing workplace mental health conditions, including family, small business services (e.g. accountants, lawyers) and government agencies (e.g. the Australian Tax Office). I commend the work already happening in the sector to address these gaps, primarily by Everymind through Ahead for Business and the Beyond Blue small business program.

As well as focusing on return to work, it is vital that small business owners are supported, themselves and on behalf of their employees, to stay at work. The default assumption that time away from work is the best solution for all employees in the acute phases of a mental health condition can be damaging. We know that work can be a place of meaning, social connection and recovery. Unfortunately, small businesses often lack the flexibility afforded to larger organisations to support people to stay at work, for example through reduced or alternative duties. Providing clear and practical examples of how they might support staying at work would be highly valued in the small business community.

F19.2 – The role of workers compensation in addressing mental health

I agree with the Commission's finding that workers compensation arrangements can be a critical success factor in – or barrier to – early intervention and treatment, and successful return to work. As it stands, the system tends to hinder effective recovery. Beyond Blue research with police and emergency services found that 61% of employees engaging with the workers compensation process found it had a negative impact on their recovery.ⁱⁱⁱ Clearly, the system needs reform.

That said, as discussed above, a key concern with the Commission's response to workplace mental health is the heavy focus on workers compensation and regulation. An effective workplace mental health approach is integrated, incorporating health promotion and prevention, not just response to emerging problems.

F19.3 – Employer Assistance Programs

The Commission incorrectly refers to Employer Assistance Programs, which should be referred to as *Employee* Assistance Programs. However, this error betrays several of the problems that the Commission has correctly identified in relation to EAPs. They are often a superficial exercise without employees' needs at the centre, primarily because employers lack the relevant information to make informed decisions.

EAPs are largely designed as a response to mental health conditions and allow employers to shift the burden of creating a mentally healthy workplace to a health provider, rather than/or in addition to addressing the internal issues contributing to poor workplace mental health in the first place. Most EAPs do not focus on providing preventative mental health support in workplaces, or support to employers to develop a healthy organisational culture.

However, even for those with the best intentions and where psychological support is needed by employees, EAPs are poorly evaluated.^{iv} Many employers do not know what they are purchasing and, once implemented, do not know the outcomes that are being achieved for their employees. Often the only metric supplied to employers is utilisation rate, which tells little about the effectiveness of the EAP and is often a broader indicator of EAP awareness and the organisation's culture regarding mental health.^v Further, there is no 'ideal' utilisation rate so it is a largely meaningless benchmark.

To improve EAPs, employers must better use their power as buyers to encourage EAP providers to:

- develop holistic, integrated and preventative offerings
- emphasise the employee experience of the EAP process
- evaluate the outcomes and value for money of EAPs.

INFORMATION REQUEST 19.2 – Personal care days for mental health

I believe that there is no difference in taking time off work for mental health or physical health needs. The stigma issue identified in this section is broader than the label that is applied to the days we take off work. Personal leave is personal leave, entitled in employment law, and it should not matter whether it is to look after your mind or body.

The requirement that these days could be taken without medical evidence speaks to a more fundamental issue around how we justify time off work. When an employer asks for a medical certificate after only 1-2 days of leave, particularly for someone without a history of absences, this indicates a lack of trust in their workforce. Indeed, there are significant public policy reasons why a leave certificate is not justified for that period of time, e.g. taking infectious colds and viruses to GP waiting rooms and using GP time on paperwork rather than effective treatment of patients in greater need.

Ensuring that there are adequate leave entitlements for carers is perhaps a more pertinent leave issue. Caring for those with mental health conditions is often sporadic and unpredictable. Further, leave policies often restrict carer entitlements to immediate family and cohabiting relationships. This does not adequately capture the nature of caring relationships for mental health conditions, where often a consumer may be well and living independently before a rapid period of decline and greater care needs.

INFORMATION REQUEST 19.2 – Barriers to purchasing income protection insurance

As identified by the Commission, stigma in insurance provision remains a significant issue for mental health. Workplaces are only likely to purchase group insurance for their employees if there is a) negligible financial impact to them and b) a benefit. As a result, I suspect this option would be pursued by large organisations able to offer the insurance as a job 'perk'. For example, a large airline may purchase bulk income protection for pilots but a small, regional airline may not. This is likely to lead to a two-tier system where employees in smaller employers are left more exposed.

Response to draft recommendations

R19.1 - Psychological health and safety in workplace health and safety laws

R19.2 – Codes of Practice on employer duty of care

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

These recommendations have three elements which apply to each of the components of the tripartite model regulatory framework:

- 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.
- developing codes of practice to assist employers to meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace, reflecting the different risk profiles of different industries and occupations.

I commend the Commission on their response to the place of psychological injury in WHS legislation. This view aligns with Recommendation 2 of the Boland Review of Model WHS Laws in 2018, which identified the need for greater clarity in Regulation and Codes of Practice for identifying, eliminating and mitigating psychological risks. This recommendation is currently being considered further by Safe Work Australia following a consultation RIS process in 2019.

Currently, psychological health reads as an afterthought in the Model Laws – while the Act states that health includes psychological health, physical health remains the primary and dominant focus of the regulatory framework. This shapes how employers respond to risk.

As well as strengthening the ability of regulators to respond to psychological injury, the key benefit of amending these components of the Model Laws are in the guidance they provide to workplaces. My engagement with workplaces to date backs up the Commission's findings that employers find the current situation confusing. A significant focus of amendments to the Model Laws should be in providing greater clarity to workplaces on their psychological risk identification and mitigation obligations.

As it stands, workplaces are (mostly) effective at implementing a hierarchy of controls model in relation to physical health and safety, but lack the understanding of how such a model could be applied in relation to psychological health. The national guidance on psychological health and safety in the workplace released by Safe Work Australia in 2018 (following the Boland Review) goes some way to addressing these gaps identified by both the Boland Review and the Commission, however lacks the authority of being codified through the Model Laws.

In addition to the guidance material developed by regulators, there is a broader role for the workplace mental health sector in providing navigation support to employers to ensure they are able to access clear guidance to address the risks most applicable to their context. The National Workplace Mental Health Initiative was funded by the Commonwealth government last year to address this gap. It was disappointing that the Productivity Commission did not focus on the opportunities this may present to address the challenges it identified, particularly as its success will be influenced by government and regulatory buy-in across the states and territories.

R19.3 – Lower premiums for employers who implement workplace initiatives and programs that have been considered by the relevant WHS authority to be highly likely to reduce the risks of workplace-related psychological injury and mental illness for that specific workplace

In theory, this would be an effective recommendation and correct some of the current disincentives (often implemented to address other disincentives in the insurance model, e.g. costs for small businesses) in the workers compensation and insurance schemes which do not see outcomes tied to reduced premiums.

It is imperative that the activities identified as qualifying for reduced premiums are implemented effectively within workplaces. There is a risk that such activities amount to little more than the existing 'lip service' paid by many workplaces to mental health. Currently, as highlighted by the Commission, there is limited evidence on the most effective interventions. While workers compensation authorities do hold significant data on claims activity and could potentially link it to the effectiveness of interventions, the current data is relatively blunt and probably lacks the nuance to effectively evaluate existing interventions in contexts likely to

be impacted by numerous other factors, such as workplace change, stigma and reporting rates.

R19.4 – No-liability treatment for mental health related workers compensation claims

I agree with this recommendation.

As the Commission have identified, it is likely this would lead to increased costs in the short-term as the claims process becomes more accessible to those it currently deters. Over the long-term (and in line with recommendations elsewhere in the report), there may be a decrease in claims as workplaces are clearer on their liability, and subsequent risk management obligations.

Ensuring that there are means to recover costs from those whose claims are not proved would help to address some of the clinical treatment cost concerns identified in **Information Request 19.1**. In the short term, where it is likely that claims will increase, there is a role for government in subsidising those increased costs as it helps to address the existing market failure that sees delayed and inequitable access to treatment.

R19.5 – Disseminating information on workplace interventions

The Commission has correctly identified that there is limited knowledge about what interventions work, for whom and why. While there is increasing knowledge about the broad concepts that underpin an effective workplace mental health approach, e.g. job control and flexibility, there are a limited number of evaluated interventions that work in multiple contexts – the majority of the evidence is based on trialling interventions in office-centred environments. How does a barista work from home? How does a mechanised factory worker implement job control?

As an experienced evaluator in the workplace mental health sector, I know that one of the primary drivers of this lack of evidence is a lack of meaningful data. Currently, most analyses of effectiveness and ROI rely on 'lag' indicators, i.e. evidence that a problem has emerged, such as absenteeism and workers compensation claims. Evidence on productivity is often done through arbitrary calculations of presenteeism. There would be real value in connecting financial datasets (e.g. taxation data, the Business Longitudinal Analysis Data Environment) with validated measures of workplace mental health (e.g. SuperFriend's Indicators of a Thriving Workplace) to assess the impact of workplace mental health activity and culture on productivity outcomes.

Further, return on investment analysis naturally tends to focus on private business outcomes. There is limited evidence on the value of workplace mental health on human services work. Education, health and aged care are growing sectors in Australia, and it would be valuable to assess the extent to which improved employee mental health leads to better care outcomes for clients. Employees in the health care and social assistance industry are responsible for the largest proportion of serious workers compensation claims in Australia (physical and psychological), and the number of claims is increasing rapidly.^{vi} Safety and quality are likely impacted by many of the same factors that lead to poor mental health among health workers, such as long shifts, high patient demands and care coordination demands.

The lack of an agreed national dataset for assessing the extent of an organisation's workplace mental health is an ongoing challenge. One of the key objectives of the recently funded National Workplace Mental Health Initiative should be to develop a national

evaluation approach which provides clear guidance at both a policy level and for employers on how to measure the effectiveness of their interventions. A toolkit that could be used by employers to calculate their own ROI would help to further demonstrate the case that managing for good mental health is simply managing for good business.

References

- ⁱ SuperFriend (2019) *Indicators of a Thriving Workplace*. Accessed from: <https://www.superfriend.com.au/further-resources/2019-indicators-of-a-thriving-workplace-survey/>
- ⁱⁱ La Montagne, et al. (2014) 'Workplace mental health: developing an integrated intervention approach' in *BMC Psychiatry*, 14(131).
- ⁱⁱⁱ Beyond Blue (2018) *Answering the call: National Mental Health and Wellbeing Study of Police and Emergency Services*. Accessed from: <https://www.beyondblue.org.au/about-us/about-our-work/workplace-mental-health/pes-program/national-mental-health-and-wellbeing-study-of-police-and-emergency-services>
- ^{iv} Joseph and Walker (2017) 'Employee assistance programs in Australia: the perspectives of organisational leaders across sectors' in *Asia Pacific Journal of Human Resources*, 55, 177-191
- ^v Azzone, et al. (2009). 'Workplace Stress, Organizational Factors and EAP Utilization' in *Journal of Workplace Behavioural Health*, 24(3), 344-356
- ^{vi} Safe Work Australia (2020) *Australian workers' compensation statistics 2017-18*. Accessed from: <https://www.safeworkaustralia.gov.au/collection/australian-workers-compensation-statistics>