



Productivity Commission Inquiry into Mental Health

Submission by the Australian Council of Trade Unions

18 April 2019

D No. 16/2019

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Introduction

The ACTU welcomes the opportunity to make a submission to this Inquiry.

The work environment has a significant impact on the mental and physical health of the Australian population. Job and financial security are crucial for positive mental health outcomes, and conversely poor quality, insecure work promotes poor mental health.¹ Therefore, workplace laws that promote safe, fair and secure working conditions are likely to protect and enhance the mental health of Australian workers and their families. The ACTU encourages the Productivity Commission to carefully examine the impact of changing work arrangements and ineffective, inadequate workplace regulation on workers' mental health.

This submission comments on the mental health system more broadly, and then focusses in on mental health at work, including the mental health workforce, the workplace health and safety and workers' compensation frameworks, workplace rights for parents and carers, and the VET and apprenticeship system.

We would be happy to provide further information on request.

Terms of Reference

The Commission should consider the role of mental health in supporting economic participation, enhancing productivity and economic growth. It should make recommendations, as necessary, to improve population mental health, so as to realise economic and social participation and productivity benefits over the long term.

Without limiting related matters on which the Commission may report, the Commission should:

- a. *examine the effect of supporting mental health on economic and social participation, productivity and the Australian economy;*
- b. *examine how sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity;*

¹ See for example: Australian Psychological Society (2000). The psychology of work and unemployment in Australia today: an Australian Psychological Society Discussion Paper. Melbourne, Australia: APS.
http://www.psychology.org.au/Assets/Files/work_position_paper.pdf

- c. examine the effectiveness of current programs and Initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups;
- d. assess whether the current investment in mental health is delivering value for money and the best outcomes for individuals, their families, society and the economy;
- e. draw on domestic and international policies and experience, where appropriate; and
- f. develop a framework to measure and report the outcomes of mental health policies and investment on participation, productivity and economic growth over the long term.

The Commission should have regard to recent and current reviews, including the 2014 Review of National Mental Health Programmes and Services undertaken by the National Mental Health Commission and the Commission's reviews into disability services and the National Disability Insurance Scheme.

List of Recommendations

Australia's current regulatory framework fails to adequately or effectively prevent or respond to mental health issues at work in a number of ways.

The ACTU considers that the following reforms should be priorities for any government seriously committed to promoting good mental health at work:

Improvements to the mental health system

- Increased funding for mental health services to allow the system to move beyond a reactive, crisis-based approach.
- The creation of a National Partnership for mental health funding to better harmonise funding, end cost-shifting and to provide secure, long-term funding for the workforce at all levels.

Stronger WHS laws

- A new WHS Regulation should be developed in consultation with social partners and experts requiring duty-holders to identify and eliminate or minimise psychosocial risks to health and safety at work, requiring at a minimum:
 - Genuine consultation and engagement of workers and their representatives in the identification, assessment and control of psychosocial hazards;
 - Training to equip HSRs, workers and supervisors to effectively prevent and address psychosocial hazards
 - Workplace policies and procedures that ensure confidentiality for individuals.

- Existing guidance material and laws should be reviewed and amended to address the current problematic definition of ‘bullying’ in workplace law and WHS law, and the confused messages about the relationship between harassment, violence, discrimination and bullying at work.
- The definitions of ‘notifiable incident’, ‘serious injury or illness’ and ‘dangerous incident’ in WHS laws should be reconsidered and redrafted to require effective reporting in relation to psychosocial hazards.
- The requirements for managing risks to health and safety that are set out in Part 3.1 of the WHS Regulations should apply to all risks and hazards, not just the risks set out in the Regulation.
- WHS regulators in all jurisdictions should be required and supported to develop the appropriate expertise and capacity to effectively address psychosocial hazards at work.
- Unions should have the right to prosecute for breaches of WHS laws.
- Safe Work Australia should conduct research into the influence of systems of work on psychosocial risks and mental health issues associated with workers compensation processes.
- Establishment of a ‘Workplace Mental Health Hub’ to build capacity in unions and delegates to develop best practice in identifying and eliminating psychosocial hazards from the workplace.

Better Workers Compensation

- Workers compensation regimes in all jurisdictions should be comprehensively reviewed to ensure that they respond effectively and fairly to workers who suffer psychological injuries, including the removal of all ‘reasonable management action’ type exemptions from workers’ compensation provisions in all jurisdictions.

Support for Parents and Carers

- The Fair Work Act should be amended to provide for a guaranteed, enforceable right to flexible working arrangements for parents and carers, with a right to revert to former hours once caring responsibilities have ceased.
- Paid parental leave should be increased to a minimum of 26 weeks at full-pay (accessible to either carer in any amount) in the National Employment Standards, with superannuation paid on paid and unpaid periods of parental leave.

Part 1 – The Mental Health System

The Australian mental health system is reactive. It is not equipped to provide effective prevention, early-intervention, community-based or multi-disciplinary services. The system is operating in ‘crisis mode’.

The causes of the system’s inability to move beyond ‘crisis mode’ and to provide effective services can be loosely grouped into the following areas:

- barriers to efficient funding and person-centred community care
- the lack of national strategy, policy continuity and harmonisation.

Barriers to efficient funding and person-centered community care

Inadequate funding

Effective preventative and holistic treatment of a person’s mental ill-health, illness or disorder requires sufficient and stable funding for services that accommodate individual needs. Funding provisions for mental health in Australia are not commensurate with the prevalence of illnesses and disorders in society. The Australian Institute for Health and Welfare has estimated that mental health issues represent 12.1% of the total burden of disease in Australia. Despite this, only 7.4% of government health expenditure is spent on mental health-related services.² The economic cost to Australia of mental health is high and rising; an estimated \$70 billion per annum, or 4% of gross domestic product, was attributed to lost productivity and job turnover, as well as increased costs to government through the welfare, housing and justice systems.³ Funding for mental health services is patently insufficient and inadequate when considered against the magnitude of Australia’s mental health issues. This lack of funding has meant that services have clustered in certain areas of the mental health spectrum – namely at the relatively minor end and at the crisis point.

Lack of holistic, community-based services

Gaps in funding are most significant in community mental health services, which are critical to psychosocial support and recovery. The absence of community-based treatment increases the likelihood that people suffering mental health issues will be required to seek assistance only when the condition is so serious that it can be dealt with by acute care, placing unsustainable pressure on hospital emergency departments and in turn diverting funds to acute, reactive treatment. This creates

² Australian Institute of Health and Welfare, *Mental health services: In brief 2018*, September 2018, p. 3.

³ National Mental Health Commission, *Monitoring mental health and suicide prevention reform*, national report, 2018, p. 34.

a logic whereby funding is diverted to the parts of the system where it is least effective and least efficiently utilised. Therapeutic environments that provide whole-of-person care centred in community and catering to individual needs that help keep relationships intact, maintain safe housing, manage physical health and comorbidities, retain meaningful employment, and assist patients to remain connected to the community are much more effective and efficient expenditures of limited funding but are largely missing from our mental health system.

Ensuring accessibility to a full-suite of local services is particularly important for high-risk populations⁴, including people living in remote and regional Australia, Aboriginal and Torres Strait Islander peoples, older Australians, culturally and linguistically diverse groups, and the LGBTQI community. At present, there is a correlation between accessibility and geography; service shortages are more common in rural and remote areas, particularly for specialist care such as youth mental health or substance abuse treatment.⁵

The lack of national strategy, policy continuity and harmonisation

The 1992 National Mental Health Strategy and its plans and policies were a monumental demonstration of collaboration between each state, territory and federal government - however, the implementation of the Strategy has not always occurred with the same cohesion. While shared responsibility arrangements between Commonwealth and the states can be effective, they also 'create scope for duplication and waste to occur, and regularly feature disputes over funding levels and cost-shifting between different levels of government'.⁶ The result, nearly 30 years on, is a disjointed mental health system marked by an absence of targeted and responsive policy, national harmonisation and oversight.

Reliable research and data

The disconnected ways in which states and mental health entities collect, monitor and share data on service provision and outcomes exacerbates the lack of coordination issue. The 'lack of real outcome data not only impedes effective reporting, policy development and planning'⁷ it also limits the extent in which decision-makers understand 'how people experience and recover from mental illness; what role any interaction with services plays; and the degree to which treatment results in returning to their homes, families, workplaces and the broader community'.⁸

⁴ A Baciu & JM Sharfstein, 'Population Health: From clinic to community', *Journal of American Medical Association*, vol. 24, June 2016, pp. 2663-2664.

⁵ Royal Australian and New Zealand College of Psychiatrists, 'Mental health in rural areas', website, viewed 18 March 2019.

⁶ A Biggs & L Cook, 'Health in Australia: a quick guide', *Parliament of Australia research paper series*, 31 August 2018, p. 3.

⁷ DW Crosbie, 'Mental health policy – stumbling in the dark?', *The Medical Journal of Australia*, vol. 190, February 2009, pp. 43-45.

⁸ Ibid.

The mental health workforce is and needs to be diverse. The mental health workforce is most commonly identified as Australian Health Practitioner Regulation Agency (AHPRA) registered health professionals. In 2016, there were nearly 550,000 people that reported as registered health professionals. However, nearly 250,000 additional people reported as working in health industries. This included those in unregistered occupations including nursing support, personal and community care workers, medical receptionists, medical technicians, ambulance officers and paramedics, kitchen hands and commercial cleaners (hospitals). Most notably in the health professions “lumped together” are social workers, whose work forms an integral part of many mental health care plans.

The exclusion of these critical occupations from formal research and data sets is reflective of an entrenched undervaluing of these roles, and the over-medicalisation of care for people with lived mental health experience. This has an adverse flow-on effect for related areas such as accurate workforce data and planning, work health and safety reporting, funding, and remuneration.

Part 2 - The mental health workforce: Skilled, healthy and valued

The key issues facing the mental health workforce can be summarised as:

- Lack of specialist training and experience.
- Difficulty recruiting and retaining skilled workers, due to factors including low pay and poor working conditions.
- Staffing shortages and lack of skill mixes.
- High worker turnover due to stress.

The work undertaken day-in and day-out by the mental health workforce and those in related fields is emotionally, physically and mentally demanding. A skilled, healthy and valued workforce will improve outcomes for consumers, mental health and other sector workers, and society.

Education & training, skill acquisition and experience

There is a serious lack of mental health training in the national curriculum. Provision of mental health training for direct and related occupations, along with the return of specialist mental health majors in tertiary education, is the critical beginning point for reinvestment in a skilled, resilient, local workforce. The axing of specialist education programs in the 1990s is producing intergenerational gaps in knowledge. As the older workforce enters retirement, young workers with 20+ years less experience and no specialist training are expected to take on senior roles and responsibilities. The international mental health workforce that was imported with the intention to be a supplement is returning home. The result of the substantial, long-term underinvestment in mental health education and training is driving a staffing crisis for the workforce and people needing mental health care.

Graduates from tertiary and vocational institutions must receive comprehensive clinical supervision upon entry into the workforce. Currently, this is not uniformly provided by institutions and varies state-to-state. Additionally, there appears to be little recognition of the value of employees with lived

experience of mental health issues working in the sector and no significant attempts are made to encourage these individuals to work in the sector.

Workforce support structures

The provision of workplace support structures is known to reduce work stress and burnout, foster a culture of safety (consumer and worker) and contribute to knowledge retention.⁹ At present, Australia's mental health system does not provide adequate workplace support tailored to the specific needs of the sector.

Workforce planning

Mental health services are experiencing significant staffing shortages. The reason for staffing supply issues is three-fold. Firstly, the lack of specialist training deters students from choosing a career in mental health. Secondly, cost-cutting measures by employers, often forced on them by inadequate or inconsistent funding, typically look to reduce wage expenditure as a first port of call – reducing staffing levels and making existing positions less attractive to new staff. Thirdly, the sector is subject to high-rates of staff turnover due to stress, burnout and/or trauma, a lack of ongoing workplace support and poor working conditions, including low wages and job insecurity. For additional information on the challenges facing the mental health workforce, we recommend the Commission refer to submission provided by our affiliated unions including the ASU, HSU and NSWNMA.

A Valued workforce

Remuneration and conditions

The average wages across the mental health workforce do not adequately reflect the nature of the work or the importance of these workers to wider social and economic outcomes. When a worker feels undervalued, they are less likely to engage with their work and are more likely to vacate the role or field.¹⁰ Inadequate remuneration together with training, workforce planning, resourcing and support deficiencies, contribute to poor retention rates across the sector. Therefore, the ability to build a stable, quality and local workforce is jeopardised. Additionally, the health care industry is home to one of the highest levels of second jobs in the economy. This means that many people working in the industry have second jobs or that people from other industries are taking second jobs in the mental health space. This speaks to both the insecure and inadequate remuneration of work in the sector and highlights a significant safety risk as fatigue, long hours and financial stress which are key risk factors

⁹ HK Spence Laschinger & MP Leiter, 'The Impacts of Nursing Work Environments on Patient Outcomes and Safety', *Journal of Nursing Administration*, vol. 36, June 2006, p. 259.

¹⁰ J Shen, A Cox, A McBride 2014, 'Factors influencing turnover and retention of hospital consultants', *Health Services Management*, vol. 17, November 2014, p. 257.

for workplace injury. Systemic shifts to the valuing and resourcing of mental health workers is required in order to address this multi-faceted issue.

Mental Health support in Vocational Education and Training

The Commission has expressed an interest in developing an understanding as to the state of support available to those undertaking Vocational Education and Training (VET) courses of study. While the ACTU does not have a specific mental health role in this field, we may be able to provide some information due to our long engagement with, and significant interest in, the VET sector as a whole.

The current state of mental health support in VET

VET is inarguably our most fragmented education delivery system in that it lacks either the centralisation to a small number of large players seen in the university sector or the effective oversight and strong regulation of schools. This fragmentation is then exacerbated in the case of apprentices or other work-based learning programs which split learner's time between two locations. The result of this fragmentation is that very few VET students have access to any sort of formalised mental health support. Some larger institutions may have some support available to students, TAFEs are particularly likely to do so. We have however seen no evidence that even the largest of the non-TAFE providers have anything more than ad-hoc mental health supports available to students. This should be of significant concern as VET students are generally likely to fall into demographics that are at a higher risk of mental health issues; namely low SES backgrounds, CALD and Indigenous people and males aged 18-40. Additionally, as recent media stories have made clear, hazing and bullying of apprentices and trainees are still significant issues in several VET-serviced industries.¹¹ Without adequate support, this can be a deadly combination.

The data problem

One of the issues with advocating for greater mental health support for VET students is that the high risk nature of the student cohort can, in some cases, encourage a sense of complacency about mental health problems. There is a degree to which it can be considered 'normal' for people from these demographics to suffer from poor mental health and so any correlation with VET is dismissed or waved away as a broader societal problem. A lack of authoritative data to indicate whether VET students experience an 'expectedly' higher level of mental health issues than their cohorts in the general population makes this perception difficult to combat.

Part 3 - Workplace Health and Safety Laws

¹¹ <https://www.abc.net.au/news/2019-03-03/stories-of-hazing-rituals-for-apprentices-revealed/10821874>

Australian WHS law¹² requires duty-holders to ensure, so far as is reasonably practicable, that workers and other persons are not exposed to risks to health and safety arising from the work carried out by their business or undertaking.¹³ ‘Health’ is defined to include ‘psychological health’.¹⁴ However, for various reasons, this obligation is not being effectively implemented in practice.

Australian WHS laws are based on the ‘Robens’ model of regulation, which is characterised by a single statute containing broad, general duties encompassing all health and safety risks at work, supported by detailed regulations mandating risk controls in relation to specific hazards. Regulations are supported by Codes of Practice, which are not legally binding but admissible in court as evidence of reasonably practicable measures in a given circumstance. Non-binding guidance material is also developed by regulators to assist duty-holders. Under the Robens model, regulators are empowered to issue administrative sanctions (such as improvement and prohibition notices) and to prosecute for breaches. Crucially, the Robens model involves a systematic, risk management approach to eliminating or reducing health and safety risks at the workplace-level, which is developed and implemented through cooperation, participation and consultation between workers, management and the regulator (referred to by Robens as ‘self-regulation’).¹⁵

Australian WHS Law no longer relies on the traditional employment relationship as the source of duties of care. Instead of an ‘employer’, a ‘person conducting a business or undertaking’ (PCBU) is the primary duty holder. A broad definition of ‘worker’ has been also adopted, covering volunteers, contractors and others. In recognition of the growth of complex labour market structures such as supply chains and labour hire arrangements, multiple duty holders must meet their duties to the extent of their influence and control; and consult with other duty holders where their obligations overlap. Company officers have a positive duty to proactively ensure that a duty holder is meeting its WHS obligations.

In theory duty-holders are obliged to, in the context of mental health, maintain a ‘work environment without risks to health and safety’ (s 19(3)(a)), maintain ‘safe systems of work’ (s 19(3)(c)), provide access to ‘adequate facilities for the welfare of workers’ (s 19(3)(d), and provide ‘any information, training, instruction or supervision’ necessary to protect workers from risks to their health and safety

¹² In Australia, WHS regulation is the responsibility of the States and Territories. Up until 2011, there was a significant degree of difference between the various regimes. In 2009-10, Model WHS Laws were developed by Safe Work Australia, a tripartite Commonwealth agency, following an extensive independent review process by a National Occupational Health and Safety Panel (National OHS Panel). The Model WHS Laws consist of the Model Work Health and Safety Act 2011, the Model Work Health and Safety Regulations 2011, and a number of Model Codes of Practice. To date, all jurisdictions except for Victoria and Western Australia have now implemented the Model Laws. Each jurisdiction has a regulatory agency responsible for enforcing the laws.

¹³ Section 19 Model WHS Act

¹⁴ Section 4 Model WHS Act

¹⁵ A 1972 UK report resulted in widespread reform of WHS laws: Lord Robens ‘Report of the Committee on Safety and Health at Work’ (1972)

(s 19(3)(f)). Workers and other persons at a workplace must take reasonable care that their behaviour does not adversely affect the health and safety of others (ss 28(b) and 29(b)).

It is clear that the workplace health and safety regime in theory provides a strong suite of regulatory tools with which to eliminate or minimise the risks and hazards that cause poor mental health at work. However, this potential is not being realised in practice.

Psychosocial hazards

A ‘psychosocial hazard’ is a risk to health and safety arising from the psychological and/or social aspects of the work environment, including the design, planning, organisation and/or management of work. Psychosocial hazards include violence and harassment, work overload, fatigue and job insecurity.

Psychosocial risks may cause physical and/or mental harm and are increasingly recognised as a serious challenge to health and safety at work.¹⁶ The prevention of mental health conditions has been identified as one of six national priorities by the *Australian Work Health and Safety Strategy 2012–2022*, due in part to the cost and complexity of psychological injury claims. Most Australian WHS regulators are now at least attempting to develop and improve their capacity to respond to psychosocial risks, primarily through appointing specialist inspectors and developing guidance material.¹⁷ Prosecutions for psychosocial failures are rare, but do occur.¹⁸ However, there is still a very long way to go before the prevention of psychosocial risks is effectively incorporated into WHS regimes, both in Australia and internationally:

- Submissions to the Stop Bullying Inquiry noted evidence suggesting that while WHS law places an onus on employers to protect employees from physical and mental health risks resulting from poor workplace culture, it is ‘extremely rare’ for an employer to be prosecuted in connection with workplace bullying.¹⁹
- A 2011 Australian study found that psychosocial hazards remain a ‘marginal area of inspectorate activity’.²⁰

¹⁶ See for example European Agency for Safety and Health at Work, ‘Expert forecast on emerging psychosocial risks related to occupational safety and health’ (2007)

¹⁷ Rachael Poterra et al, ‘Analytical review of the Australian policy context for work-related psychological health and psychosocial risks’ *Safety Science* 111 (2019) 37–48

¹⁸ In 2017 a company was fined by Work Safe Victoria for failing to provide a safe system of work in relation to (male on male) bullying and harassment by a co-director against a subordinate staff member, including sexual inappropriate comments <<https://www.worksafe.vic.gov.au/prosecution-result-summaries-enforceable-undertakings>>

¹⁹ House of Representatives Standing Committee on Education and Employment, Parliament of Australia, *Workplace Bullying: We just want it to stop* (2012) 189, [6.111]

²⁰ Richard Johnstone et al, ‘OHS inspectors and psychosocial risk factors: Evidence from Australia’, *Safety Science* (2011) Vol 49, 547–557

- In a 2018 interview, a SafeWork NSW spokesperson recently advised that sexual harassment complaints are referred to the NSW Anti-Discrimination Board. Although the spokesperson indicates that a SafeWork NSW inspector ‘might’ attend a workplace to ‘identify any ongoing risks to workers and review the employer’s policies and systems for dealing with workplace harassment and bullying’, it is clear from these comments that SafeWork NSW considers other agencies better placed to handle sexual harassment complaints.²¹
- A 2018 UK parliamentary inquiry found that WHS regulators and employers in the UK have failed to treat harassment as a serious health and safety issue, and that the UK WHS regulator’s ‘analysis of the potential for harm caused by sexual harassment appears to be cursory and ill-informed.’²²
- A 2019 submission to the National Inquiry into Sexual Harassment in Australian Workplaces by WA Work Safe states that ‘as a safety regulator, WorkSafe is not sufficiently resourced and does not have the expertise to adequately address sexual harassment matters’.²³
- A 2019 German study has found employers are failing to include workplace psychosocial factors in risk assessments despite their legislated obligation to do so.²⁴
- A 2019 study evaluating Australian WHS regulatory instruments related to psychosocial risk management concluded that, ‘there is poor inclusion of risk assessment, preventive action and poor coverage of exposure factors and psychological health outcomes’.²⁵

There are a number of reasons for this failure. Traditionally, WHS laws have protected workers from physically and visibly dangerous situations arising from working with machinery and hazardous substances, and regulators have been resourced and skilled accordingly. Currently all WHS or OHS regulations refer to physical hazards only. Studies have noted the challenge this legacy presents to inspectorates responding effectively to psychosocial issues in contemporary workplaces, including ongoing gender imbalance in inspectorates and the technical focus of regulators.²⁶ The ACTU has also raised concerns about the enforcement strategies of WHS regulators generally, arguing that regulators in all jurisdictions are disproportionately focusing on ‘positive motivators’ at the expense of deterring non-compliance through monitoring and enforcement activities. This criticism is particularly acute in relation to psychosocial hazards.²⁷ The problems with regulator capacity are further

²¹ OHS Alert, ‘Harassment must be treated as major OHS issue: inquiry’, 30 July 2018.

²² Women and Equalities Committee, UK House of Commons, Sexual harassment in the workplace, Fifth Report of Session 2017–19 (2018), 20

²³ [Submission 204, Worksafe Western Australia Commissioner, 5 February 2019](#)

²⁴ [Beck et al., Consideration of psychosocial factors in workplace risk assessments: findings from a company survey in Germany, International Archives of Occupational and Environmental Health, February 2019](#)

²⁵ Rachael Poterra et al, ‘Analytical review of the Australian policy context for work-related psychological health and psychosocial risks’ *Safety Science* 111 (2019) 37–48

²⁶ John Graversgaard, ‘Key role of labour inspection: how to inspect psycho-social problems in the workplace?’ in Iavicoli, S. (ed), *Stress at Work in Enlarging Europe*. National Institute for Occupational Safety and Prevention (Rome 2004) 65–76.

²⁷ For example, [ACTU submission to the 2018 Review of the Model WHS Laws](#) (2018), 51, [106]

compounded because workers' and unions' rights to hold duty-holders and regulators to account have been seriously diminished. For example, under the Model WHS Laws, unions cannot bring prosecutions. In the past, this right had operated to shine a light on emerging or neglected areas of WHS where regulators were unwilling or unable to prosecute contraventions.²⁸

Insecure work

The changing nature of work presents significant psychosocial risks, including excessive working hours, job insecurity, lack of autonomy, lack of industrial voice and organisational restructuring, as well as violence and harassment.²⁹ The traditional employment relationship is being undermined and circumvented by business models that include labour hire, sham contracting, franchising, wage theft and the expanding gig economy. Over 40% of the Australian workforce is now employed in some form of precarious or insecure employment; the third highest rate in the OECD.³⁰ Women are particularly at risk, as they are overrepresented among industries and occupations that are award reliant, low paid and casualised.³¹ Insecure employment is itself a health risk, but also limits the ability of workers to address such risks. There are a range of reasons for this, including inadequate training and induction, fear of reprisals for speaking out about safety concerns, lack of access to participation and consultation processes, lack of regulatory oversight, poor supervision, inadequate access to effective safety systems and exposure to frequent restructures and down-sizing.³² There are additional challenges for workers in the gig economy, homecare workers³³ and workers under temporary visa arrangements.³⁴ The 2016 Victorian Inquiry into the Labour Hire Industry and Insecure Work found that workers in labour-hire, franchise, contracting and other precarious forms of employment are routinely denied basic employment rights.³⁵ The Inquiry heard evidence of abuse, violence, sexual harassment, excessive working hours, work in extreme heat with limited drinks breaks, untreated medical conditions, no access to workers compensation and other gross workplace

²⁸ For example, in NSW and New Zealand, trade unions have assisted in bringing cases addressing emerging or neglected areas of concern such as psychological injuries, repetitive strain injuries and the commission of criminal acts in the workplace.

²⁹ See for example Michael Quinlan, 'Organisational restructuring/downsizing, OHS regulation and worker health and wellbeing' (2007) *International Journal of Law and Psychiatry* Vol 30, 385–399

³⁰ ACTU, *Australia's Insecure Work Crisis: Fixing it for the Future, 21 May 2018, 5; Report of the Independent Inquiry into Insecure Work in Australia, Lives on Hold: Unlocking the Potential of the Australian Workforce, 16 May 2012*

³¹ Annual Wage Review 2016-17 [2017] FWCFB 3500 at [55], [78], [99]

³² See for example Richard Johnstone and Michael Quinlan, 'The OHS regulatory challenges posed by agency workers: evidence from Australia' (2006) 28:3 Employee Relations 273;

³³ Michael Quinlan, Phillip Bohle and Olivia Rawlings-Way, 'Health and safety of homecare workers engaged by temporary employment agencies' (2015) 57:1 *Journal of Industrial Relations* 94, 95.

³⁴ The Senate Education and Employment References Committee, *A National Disgrace: The Exploitation of Temporary Work Visa Holders*, March 2016

³⁵ *Victorian Inquiry into the Labour Hire Industry and Insecure Work Final Report, August 2016* at Chapter 4 and pp 124-146; M Quinlan and P Bohle (2008), Under pressure, out of control or home alone? Reviewing research and policy debates on the OHS effects of outsourcing and home-based work, *International Journal of Health Services*, 38*3, 489-525.

health and safety breaches in relation to labour-hire workers in the horticulture, meat and cleaning industries in Victoria.

Our legal framework has not kept up with these developments, leaving many workers without basic statutory protections which are essential to ensuring safe and healthy workplaces.

Regulatory gaps

There are different regulatory approaches to the management of psychosocial risks internationally. Australia and other jurisdictions take the approach of ‘establishing broad duties and obligations in laws that apply to health and safety at work, which embrace psychosocial factors but without explicitly naming them.’³⁶ There is international recognition that a number of countries around the world have struggled to effectively regulate psychosocial risks at work: for example a 2016 meeting of experts convened by the International Labor Organisation identified ‘governance gaps’ at the national, regional and international level in relation to violence and harassment at work.³⁷

As part of Safe Work Australia’s 2018 review of Model Laws, stakeholders were asked to comment on ‘the effectiveness of the model WHS laws in supporting the management of risks to psychological health in the workplace’. It is clear from the submissions to the review that stakeholders hold very strong views about this matter, with most supportive of legislative reform to ensure psychosocial risks are effectively addressed in the workplace. For example, the Mental Health Commission submitted that the Model WHS laws ‘narrow focus on physical hazards and risks creates the impression that physical health is the primary concern of WHS law. Psychological health, while subject to the same duties, feels very much an afterthought’.³⁸

One of the key problems with the current regulatory framework in Australia is that there is no specific Regulation or Code/s of Practice specifically dealing with the management of psychosocial hazards.³⁹ Although psychosocial hazards are referenced in a general way in a model Code of Practice, the issues are not dealt with comprehensively and the specific and unique ways in which they manifest in different industries and occupations are not addressed.⁴⁰ Different regulators have developed various

³⁶ Elizabeth Bluff ‘The Regulation and Governance of Psychosocial Risks at Work: A Comparative Analysis Across Countries’ (Part 3. Society, safety & health, Global Collaborative Research, 2016) 113-168, 117

³⁷ International Labor Organisation, Meeting of Experts, Final Report, p 42

³⁸ [Submission to the Safe Work Australia Review of Model Work Health and Safety Laws, National Mental Health Commission, April 2018](#), at p 3

³⁹ The Model WHS Act confers regulation-making powers in relation to a number of matters, including exposure to psychological hazards: Model WHS Act, Section 276 and Schedule 3.

⁴⁰ There is a Code of Practice for the management of risks generally, which lists ‘psychosocial hazards’ as an example of a common type of hazard that needs to be identified. ‘Excessive time pressure, bullying, violence and work-related fatigue’ are listed as examples of psychosocial hazards which may cause psychological or physical injury or illness.

The Code states (p 10) that the risk management process outlined in the Code should be applied to both physical and psychological risks. For further guidance specific to psychological risks, the Code links to two separate non-binding national guidelines: Work-related psychological health and safety: A systematic approach to meeting your duties

(non-binding) guidance material,⁴¹ but there is no clear, comprehensive national approach. The lack of clear and detailed requirements is compounded because as it currently stands, the detailed requirements for managing risks to health and safety that are set out in Part 3.1 of the Regulations, including the duty to implement risk control measures (s 36 of the Regulations), technically apply only to the risks explicitly set out in the Regulations, not all workplace risks.

Experts have noted that organisations face ‘significant practical challenges’ in implementing effective responses to psychosocial risks.⁴² The continuing high prevalence of sexual harassment presents a clear example of this failure.⁴³ In the absence of specific regulation, duty-holders are likely to continue to fail to effectively manage them. Problems have also been identified with the incident notification provisions in the WHS.⁴⁴ During the harmonization process, a number of triggers designed to identify psychosocial risks were stripped from the Model Laws, including absences from work of more than 7 days. Occupational violence incidents are not notifiable if they result in psychological harm only. Unless psychosocial hazards are required to be reported, employers and WHS regulators are unlikely to take action to address them.

Due to these gaps in the regulatory framework, as well as inadequate regulator responses, psychosocial risks are often ignored or channelled into individual complaints processes, rather than preventative and systematic risk management processes, which has limited the development of effective organisational responses.⁴⁵

Detailed WHS obligations in relation to psychosocial hazards are crucial in order to require PCBUs to take positive, proactive preventative measures. The reactive, complaints-based response to psychosocial issues has proven to be ineffective in making workplaces safer. It is imperative that these issues are seen as, and treated as, serious WHS issues. WHS laws in countries such as Sweden, Denmark, Japan, Korea and some jurisdictions in the USA (e.g. New York State) and Canada (e.g. Ontario) contain detailed mandatory legal obligations in relation to psychosocial hazards. The

(published 14 June 2018) and Guide for preventing and responding to workplace bullying (published 31 August 2016). The 14 June guide confirms that employers are ‘required to manage risks from hazards, including work-related psychosocial hazards, so far as is reasonably practicable’ (p 11), and that this includes hazards arising from ‘workplace bullying, aggression, harassment including sexual harassment, discrimination, or other unreasonable behaviour by co-workers, supervisors or clients’ (p 9).

⁴¹ For example, [Workplace Health and Safety Queensland, Mentally healthy workplaces toolkit](#)

⁴² Paula McDonald, Sara Charlesworth and Tina Graham ‘Developing a framework of effective prevention and response strategies in workplace sexual harassment’ (2015) *Asia Pacific Journal of Human Resources* 53, 41-58, 42.

⁴³ See for example: Australian Human Rights Commission, ‘Everyone’s business: Fourth national survey on sexual harassment in Australian workplaces’ (2018); Australian Human Rights Commission, ‘Working without fear: Results of the Sexual Harassment National Telephone Survey’ (2012); Australian Human Rights Commission, ‘Sexual harassment: Serious business: Results of the 2008 Sexual Harassment National Telephone Survey’ (2008); Human Rights and Equal Opportunity Commission, ‘Sexual Harassment - A Bad Business’ (2002).

⁴⁴ ACTU submission to the 2018 Review of the Model WHS Laws (2018), 50, [102], [103]

<<https://engage.swa.gov.au/32134/documents/78522>>

⁴⁵ Paula McDonald et al, ‘Developing a framework of effective prevention and response strategies in workplace sexual harassment’ (2015) *Asia Pacific Journal of Human Resources* Vol 53, 42

Western Australian Government has recently released a code of practice on mentally healthy workplaces for fly-in fly-out (FIFO) workers in the resources and construction sectors.⁴⁶

The regulation and code of practice making powers in the Model WHS Act provide the flexibility to deal with new and emerging hazards. It is time to use these powers to address the regulatory gap that exists in relation to psychosocial hazards. The ACTU welcomes the Report of the Review of Model Workplace Health and Safety Laws,⁴⁷ released on 25 February 2019, which recommends the urgent development of a new ‘WHS Regulation to deal with how to identify the psychosocial risks associated with psychological injury and the appropriate control measures to manage those risks’, as well as review of the notification provisions to ensure psychosocial hazards are properly captured.

Limitations in data

It is difficult to accurately quantify the problem of psychosocial hazards at work. The Stop Bullying Inquiry recommended an annual update of trends in workers’ compensation data relating to psychosocial health and safety generally, and workplace bullying specifically. In response, Safe Work Australia now produces an annual ‘Statement on Psychosocial Health and Safety and Bullying in Australian Workplaces’. SWA’s latest report shows that while mental stress claims overall have fallen between 2002-03 and 2015-16, the rate for harassment and/or bullying claims has increased over the period, although has been trending downwards from a peak in 2010-11.⁴⁸ For the reasons outlined below (and as noted by SWA) these figures are an ‘approximate measure of the psychosocial health and safety status of Australian workplaces over time and should be interpreted with caution’. This is primarily because the data presented in these statements are drawn only from accepted workers’ compensation claims caused by a psychosocial stressor (such as harassment or bullying, occupational violence or unreasonable work pressure) that has caused an injury or disease. Such claims are known as ‘mental stress claims’. Mental stress claims data is the only data available to assess the nature and prevalence of psychosocial stressors in Australian workplaces, and it is subject to some serious limitations. It only captures accepted claims, and as discussed below, the workers compensation regime fails to respond adequately to psychological injuries, meaning that many psychologically injured workers are not successful in their workers compensation claims, or do not claim workers compensation at all.

What is clear from the SWA data is that while mental stress claims only make up a small proportion of claims, the time lost and cost associated with them are ‘significantly higher’ compared to other types of workers’ compensation claims. Other interesting statistics to note include the fact that by far the

⁴⁶ http://www.dmp.wa.gov.au/Documents/Safety/MSH_MHW_FIFO_COP.pdf

⁴⁷ Marie Boland, *Review of the Model Work Health and Safety laws, Final report, December 2018*, 30-35

⁴⁸ Safe Work Australia, *Psychosocial health and safety and bullying in Australian workplaces: Indicators from accepted workers’ compensation claims*, Annual statement, 4th edition, 2017, 1

largest category of mental stress claims relate to occupational violence, harassment and/or bullying at work, and the frequency rate of claims for harassment and/or bullying made by female employees is almost three times higher than males.⁴⁹

Recommendations

- A new WHS Regulation should be developed in consultation with social partners and experts requiring duty-holders to identify and eliminate or minimise psychosocial risks to health and safety at work, requiring at a minimum:
 - Genuine consultation and engagement of workers and their representatives in the identification, assessment and control of psychosocial hazards;
 - Training to equip HSRs, workers and supervisors to effectively prevent and address psychosocial hazards
 - Workplace policies and procedures that ensure confidentiality for individuals.
- Existing guidance material and laws should be reviewed and amended to address the current problematic definition of ‘bullying’ in workplace law and WHS law, and the confused messages in about the relationship between harassment, violence, discrimination and bullying at work.
- The definitions of ‘notifiable incident’, ‘serious injury or illness’ and ‘dangerous incident’ in WHS laws should be reconsidered and redrafted to require effective reporting in relation to psychosocial hazards.
- The requirements for managing risks to health and safety that are set out in Part 3.1 of the WHS Regulations should apply to all risks and hazards, not just the risks set out in the Regulation.
- WHS regulators in all jurisdictions should be required and supported to develop the appropriate expertise and capacity to effectively address psychosocial hazards at work.
- Unions should have the right to prosecute for breaches of WHS laws.
- Safe Work Australia should conduct research into the influence of systems of work on psychosocial risks and mental health issues associated with workers compensation processes.
- Establishment of a ‘National Workplace Mental Health Hub’ to build capacity in unions and delegates to develop best practice in identifying and eliminating psychosocial hazards from the workplace.

⁴⁹ Ibid, 2

Workers Compensation

Employers in every Australian state and territory are required to have workers' compensation insurance to cover workers who suffer a work-related injury. If a workers' claim is accepted, an employer has various legal obligations to support a worker's rehabilitation at work or return to work following a work-related injury, including providing suitable duties. A worker who suffers a psychological injury in connection with work should be able to access workers' compensation, including paid leave and medical expenses, and if seriously injured, to pursue a common law claim.⁵⁰ However, schemes impose onerous requirements for access to compensation which are too difficult for workers to meet. Eligibility for workers' compensation for psychological injury depends on the way in which each scheme defines an eligible worker, a work-related psychological injury, and the connection between the injury and the employment. Problematically, all jurisdictions deny a worker entitlements if the injury arises from 'reasonable management action'.⁵¹ Litigation arising from these exemptions not only often exacerbates the workers' underlying psychological injury, but wastes resources that could otherwise be directed to supporting rehabilitation and recovery.

Workers also often develop secondary psychological injuries after a physical injury. The system does not respond effectively to such injuries, or the reality that rehabilitation and return to work is as much a 'psychosocial phenomenon' as a medical one.⁵²

While Safe Work Australia has developed guidance material to assist employers and insurers to manage psychological claims,⁵³ the evidence (and feedback from our affiliates) suggests that this is more honoured in the breach than the observance.⁵⁴

As a result, the numbers of successful claims for psychological injury do not reflect the scope of the problem of poor mental health in workplaces. This not only means that Australia's workers compensation schemes are failing to adequately protect workers who are psychologically injured in a workplace context by conduct such as sexual harassment, it also means that employers are not feeling the financial consequences of failing to create workplaces free of violence and harassment, and are not motivated by the cost of rising premiums to change workplace cultures.

⁵⁰ Safe Work Australia, 'Work-related psychological health and safety: A systematic approach to meeting your duties' National guidance material (2018) 25-27

⁵¹ Safe Work Australia, 'Taking Action: A best practice framework for the management of psychological claims in the Australian workers' compensation sector' (2017)

⁵² See the AMWU's submission to this inquiry for more information on secondary psychological injuries; see also [OHS Alert, Workers' comp systems must reflect psychosocial model, 18 February 2019](#)

⁵³ Safe Work Australia, *Taking Action: A best practice framework for the management of psychological claims for the Australian workers' compensation sector*, December 2017

⁵⁴ See for example: [OHS Alert, 'Managers unhelpfully sceptical of mental illness absences', 24 January 2019](#)

Workers compensation regimes in all jurisdictions should be comprehensively reviewed to ensure that they respond effectively and fairly to workers who suffer psychological injuries, including the removal of all ‘reasonable management action’ type exemptions from workers’ compensation provisions in all jurisdictions.

Part 4 - Support for working parents and carers

Appropriate workplace support for workers with parenting and caring responsibilities is crucial for the health and wellbeing of both the carer and the person or persons being cared for. Existing regulation is failing to meet the needs of working parents and carers. It is not disputed that unpaid caring work (particularly that associated with the care of children) is substantial and continues to fall disproportionately on women, to the detriment of their connection with the labour force. Parenting and caring responsibilities have a consistently negative effect on employment and earning patterns. The evidence shows that female unpaid carers have significantly lower rates of workforce participation and are more likely to be working part-time and in casual employment than fathers and male carers.⁵⁵ Men’s and women’s labour force participation is relatively equal until childbirth, when there is a dramatic divergence in employment. The majority of women work part-time until their children are school aged, whereas men’s employment remains steady, with very high rates of full-time employment compared to their wives and partners. This divergence has serious ramifications for women’s lifetime earnings, culminating in financial hardship and poverty in retirement.⁵⁶

A 2014 report by the Australian Human Rights Commission found that discrimination against mothers in the workplace is ‘pervasive’: Thirty six per cent of women who returned to work after parenthood reported discrimination related to family responsibilities when returning to work, with half of those reporting discrimination when requesting flexible working arrangements,⁵⁷ and one in ten mothers still on parental leave could not find work, or could not negotiate return to work arrangements.⁵⁸

Our failure to adequately support working parents and carers during their working lives is damaging the mental health of families and negatively impacting on the national economy. There is an urgent need for structural reform to improve support for parents and carers over the life cycle.

⁵⁵ Australian Human Rights Commission, *Investing in care: Recognising and valuing those who care*, 2013, p 18

⁵⁶ Australian Human Rights Commission, *Accumulating poverty? Women’s experiences of inequality over the lifecycle*, 2009, pp 5-7; David Hetherington & Warwick Smith, *Not So Super, For Women: Superannuation and Women’s Retirement Outcomes*, July 2017, p 6

⁵⁷ Australian Human Rights Commission, *Supporting Working Parents: Pregnancy and Return to Work National Review*, 2014 at p 29.

⁵⁸ Ibid at 47.

There are a number of reforms that are needed, including improved access to quality, affordable early education and care, and tax reform. This submission focuses on two key workplace reforms: access to paid parental leave and access to family friendly working arrangements.

Paid Parental Leave

It is well established that an appropriate period of absence from work after birth is of the ‘utmost importance’ to the physical and mental health of both parents and their children. It supports the growth and development of the child, facilitates bonding between parent/s and child, and allows the mother to recover. It also positively impacts on the financial security of women, relieving income pressure in the period after birth and supporting women’s return to the workforce. The Australian Government’s 2014 review of the Paid Parental Leave (PPL) scheme found that PPL is associated with an ‘improvement in mothers’ and babies’ health and wellbeing and work-life balance’, particularly for mothers without employer funded parental leave, and those with least financial security due to precarious employment.⁵⁹ The Productivity Commission’s 2009 Inquiry found ‘compelling evidence of child and maternal health and welfare benefits from a period of absence from work for the primary caregiver of around six months’ and considered research showing ‘a positive relationship between the length of maternity leave and maternal health and wellbeing’. The Productivity Commission noted that ‘maternal recovery can be prolonged and an early return to work may increase the risk of depression and anxiety.’⁶⁰ The Productivity Commission found ‘compelling evidence’ that exclusive parental care for at least 6 months fosters improved developmental outcomes, and ‘a reasonable prospect’ that a period of up to 12 months could also be beneficial, and that taking into account the evidence, ‘the average desirable duration of postnatal absence from work would be around six to nine months.’

Australia’s full-rate equivalent weekly parental leave payment is one of the lowest in the OECD.⁶¹ Australia currently provides only 18 weeks paid leave at the federal minimum wage, relying on parents to self-fund and/or access employer funded schemes to top up to the optimal amount of time off work at their full-time wage. WGEA statistics show that less than 50% of employers (47.8%) provide primary carer’s leave in addition to the Federal Government’s paid parental leave scheme, and only 41.8% provide secondary carer’s leave (WGEA 2019, Data Explorer). This means that many Australian employees are having to dip into their own pockets to fund the optimal period of parental leave.

⁵⁹ https://www.dss.gov.au/sites/default/files/documents/06_2014/paid_parental_leave_scheme_review_report.pdf

⁶⁰ Productivity Commission Inquiry Report, Paid Parental Leave: Support for Parents with Newborn Children, No. 47, 28 February 2009 at 4.1, 4.2, 4.14

⁶¹ [Workplace Gender Equality Agency, Towards gender balanced parental leave: Australian and international trends Insight paper](#), pp 6-7

The amount of parental leave should be increased to at least 26 weeks, topped up to the employee's full-time wage, with superannuation on both paid and unpaid portions of parental leave. The 'primary' and 'secondary' carer concept should be abandoned, because it simply entrenches problematic gender roles, and instead the leave should be available in full to either parent/carer to take in amounts that suit the family. This change is important to foster a more equal division of unpaid care and paid work and improve the family work-life balance and support the mental health of Australian families.

Family friendly working arrangements

The incompatibility of full-time hours with parenting and caring responsibilities has a negative effect on the nature and quality of labour force participation, as well as the well-being of workers, and the impact on women is particularly profound.

Similar to paid parental leave, access to quality, secure flexible working arrangements for carers, particularly for parents returning to work after having a child, are crucial for both financial security and mental well-being: 'The chronic work-life strains and pressures consistently reported by working carers of children, and others such as elders and individuals with a disability, are likely to have implications not only for the health of individuals and their families, but are also likely to affect carers' inclination to participate in paid work in general, and to commit the substantial time required in particular for full-time work.' And by contrast: 'Access to flexible work arrangements supports employee health, wellbeing and work-life outcomes, as well as positively affecting workforce participation.⁶²

However, the current regulatory framework does not provide access to quality, secure flexible working arrangements for all employees who need them. While employees have a 'right to request' flexible working arrangements under s 65 of the Fair Work Act, an employer's refusal is not subject to appeal. This results in a significant gap in the safety net regarding flexible working arrangements. About 1 in 5 employees makes some kind of request for flexible working arrangements.⁶³ While the majority of these requests for flexible working arrangements are granted, there is a significant minority of workers whose requests are rejected, in part or in full, and a large number of people (including many men) who do not ask at all, even though they require a flexible working arrangement, for reasons including that they feel the workplace is hostile to flexible work and fear reprisals.⁶⁴ Even when a

⁶² Skinner N & Pocock B (2014), The Australian Work Life Index 2014: The Persistent Challenge: Living, Working and Caring in Australia in 2014, Centre for Work + Life, University of South Australia, at pp 5 and 45

⁶³ [Family Friendly Working Arrangements \[2018\] FWCFB 1692](#), [273]

⁶⁴ Skinner N, Cathcart A & Pocock B (2016), 'To ask or not to ask? Investigating workers' flexibility requests and the phenomenon of discontented non-requesters', Labour and Industry, Vol. 26, No. 2, pp. 103–119

flexible working arrangement is granted, it may involve ‘occupational downgrading’ in the form of less secure and lower status work.⁶⁵

While many Australian employers recognise employees’ needs to accommodate their parenting and caring responsibilities, too many workers depend on goodwill and luck for these rights. The Fair Work Commission recently found that: ‘Workplace culture and norms can play an important role in the treatment of requests for flexible working arrangements. Individual supervisor attitudes can be powerful barriers and enablers of flexibility’ and that ‘there is a significant unmet employee need for flexible working arrangements’. The Fair Work Commission also accepted evidence showing that a lack of access to working arrangements that meet employees’ needs is associated with ‘substantially higher work-life interference’. The Commission found that the accommodation of work and family responsibilities through the provision of flexible working arrangements can provide benefits to both employees and their employers, and that access to flexible working arrangements ‘enhances employee well-being and work-life balance, as well as positively assisting in reducing labour turnover and absenteeism.’⁶⁶

Lack of support for workers suffering from mental health issues

In addition to the regulatory or legislative issues outlined above, there is a general cultural issue with the treatment of workers who are suffering from mental health issues. This manifests in a number of ways, including difficulty accessing sick or personal leave for mental health issues or poor employer attitudes to making accommodations or providing flexibility for workers who are experiencing poor mental health. Perhaps the clearest example of this attitudinal issue is the status of ‘resilience’ training as the most common type of mental health training that employees are likely to receive. Resilience training puts the impetus on workers to ‘resist’ the poor mental health environment of their workplace rather than requiring employers to provide a mentally healthy workplace. It also shifts blame to employees when they experience poor mental health as it is seen as a failure of resilience rather than the result of poor management or risk mediation.

The reality of these issues is reinforced by the emergence of a number of unfair dismissal cases before the Fair Work Commission relating to the treatment of workers suffering from mental health issues.

Recommendations

- The Fair Work Act should be amended to provide for a guaranteed, enforceable right to flexible working arrangements for parents and carers, with a right to revert to former hours

⁶⁵ See for example: Connolly, S. and Gregory, M. (2008). "Moving down: Women's Part-Time Work and Occupational Change in Britain 1991-2001", *The Economic Journal*, 118(526): F52-F76.

⁶⁶ [Family Friendly Working Arrangements \[2018\] FWCFB 1692](#), [392]

once caring responsibilities have ceased with disputes about access to these arrangements to be resolved by the Fair Work Commission.

- Paid parental leave should be increased to a minimum of 26 weeks at full-pay (accessible to either carer in any amount) in the minimum employment standards, with superannuation paid on paid and unpaid periods of parental leave.

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