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# Productivity Commission Draft Inquiry Report: Mental Health

6 February 2020



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Chamber of Commerce  
and Industry

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## Response to Part 3 - Reorienting surrounding services to people: Income support

### **DRAFT RECOMMENDATION 14.1 — EMPLOYMENT SUPPORT ASSESSMENT MEASURES**

Assessment tools for jobactive and Disability Employment Services participants should be more relevant to job seekers with mental illness.

### **DRAFT RECOMMENDATION 14.2 — TAILOR ONLINE EMPLOYMENT SERVICES**

Ongoing development of the New Employment Services should consider the needs of participants with mental illness.

Generally, ACCI is supportive of the recommendations made in the draft report on employment. We qualify this however by noting that there is no significant focus in the draft report on the demand side of employment. The lower than average participation rates for people with mental health disability reflect the challenges in connecting people with disability to employers and jobs. Employment services systems need to be better focused on employers and how to link the supply side managed through publicly funded employment services with the vacancies existing in the job market. This is best done through a whole-of-government approach. Instead, we have people with mental illness who are seeking work being serviced by a range of different government programs including jobactive, DES and NDIS. This issue was raised in our previous submission, and it is disappointing that the draft report did not discuss the inefficiency of these programs operating separately.

The challenges and barriers to employing people with mental health vary according to the health condition and its severity and have not been dealt with significantly in the report as it relates to employment.

In a survey commissioned by the Department of Jobs and Small business in 2018, employers identified that there were significantly more roles deemed as suitable for depression and anxiety than for bipolar disorder and schizophrenia<sup>1</sup>. It also indicated that employers felt more capable of managing some mental health conditions compared with others. This reinforces the need for a better understanding of employers needs, including their confidence in taking on people with more complex disorders and mental health issues.

### **DRAFT RECOMMENDATION 14.3 — STAGED ROLLOUT OF INDIVIDUAL PLACEMENT AND SUPPORT MODEL**

The Individual Placement and Support (IPS) model of employment support should be extended beyond its current limited application through a staged rollout to (potentially) all State and Territory Government community mental health services, involving co-location of IPS employment support services.

The Commission is seeking further feedback on whether this should occur through partnerships between dedicated IPS providers and community mental health services, or direct employment of IPS specialists by community mental health services.

Although the concept that more individualised attention yields better results is generally accepted, the considerable support in the draft report for Individual Placement and Support (IPS) approaches needs to continue to be tested by the evidence.

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<sup>1</sup> Department of Jobs and Small Business (2018) Employer Mobilisation Final Research Report, commissioned on behalf of the Collaborative Partnership for Improving Work Participation.

This more intense service is in keeping with the concept of enhanced services that are part of the jobactive reforms. The challenge in implementing this approach includes its affordability and scalability. With the reform of jobactive there is already a tension in trying to retain the total current investment so that funds can be redirected from the savings arising from digital-first to provide the enhanced services. Within our recommended approach, all people seeking work should be serviced by the one system (jobactive as it is the largest now) and enhanced services for those harder to place who are provided with more individualised support.

## Response to Part 4 - Early intervention and prevention: Workplaces

At the outset we would note throughout Chapter 19 the conflation of psychosocial risk and risk reduction through risk management activities to that of workplace mental health interventions and improvements to the mental health (or reduction of mental ill-health symptoms) of workers at a workplace.

In Chapter 19, the draft report contends that psychological safety and health does not receive the same focus as physical health in the workplace due to its reference only in the general duty of care. The logic is that legislative amendments are needed to give psychological safety and health the same importance as physical safety and health on the assumption that this specificity will lead to greater engagement in risk management activities by businesses and improved “workplace mental health”.

There is very little in the way of evidence presented to warrant legislative change, no articulated cost-benefit analyses nor recognition of the fact that mental health has been for some time a regular consideration of businesses. The difference being that this has traditionally been through a manager, human resource, wellbeing program or anti-discrimination lens. The increased emphasis and expectation that businesses manage mental health as well as psychosocial risks is only relatively recent.

We are disappointed that the draft report did not explore beyond a ‘regulatory’ response and look at other policy levers and contextual barriers to improvement such as business (particularly small business) capability, awareness (including low awareness of the National Guidance by Safe Work Australia), regulator capabilities and activities and professional capabilities (WHS advisers, consultants and psychologists).

We also reiterate key issues for address from our first submission that were not captured in the draft report:

- There is continued debate around work-related psychosocial hazards (ability to identify): research has identified a number of issues in evaluating the risk factors for workplace psychological harm and the academic fraternity remain divided in regards to each hazards health outcome, effect size and strength of evidence.
- There is limited research and tools/resources available for PCBU's to make valid and reliable assessments of psychological risk in their workplace.
- There is little research and evidence for the efficacy of specific controls or interventions for any of the known psychosocial hazards that would apply globally, to a diverse range of business environments, including small and family businesses.
- Professional skills and capacity in this area are underdeveloped and scarce. If businesses were to seek assistance – regulators are still developing capacity and most businesses are reluctant to seek assistance from them. Traditional WHS consultants do not typically have psychosocial risk management skills (the first WHS unit of competency for VET was only developed last year and is yet to be delivered) and organisational psychologists have particular training that operates independently to the WHS framework and principles. Although a number of programs have been developed, almost all lack data on their effectiveness and require assistance to implement and tailor within businesses (which is particularly difficult for SME's).

A legislative response fails to address the core issues restricting improvements: confusion between mental health promotion activities and WHS risk compliance activities, lack of 'how to' guidance SME's can translate to their own context, lack of expertise and training opportunities to assist businesses on WHS risk management approaches (versus public health promotion), too many varying regulator models and a lack of organisational capability.

Lastly, there is limited evidence internationally showing any additional prescriptive legislation results in improved outcomes (see below).

## The effectiveness of Regulation, Standards and Codes in other countries

Australia is not alone in having legislated legal duties for worker's psychological safety and health. The explicit and prescriptive nature of these duties however varies significantly between countries.

In 2016, the National Research Centre for OHS Regulation (NRCOHSR) at the Australian National University examined the effectiveness of the model Work Health and Safety Act and Regulations, model codes of practice and national guidance material for addressing psychosocial risks<sup>2</sup>. The project examined different regulatory and advisory frameworks for managing psychosocial risks at work in Australia and other countries and reviewed the literature relating to these frameworks.

The report found that:

*"Although there are many examples of mandatory legal obligations addressing psychosocial hazards, active inspection and enforcement of compliance with these obligations, and multiple resources intended to support workplace action to address these hazards, there is a dearth of studies evaluating the effect of these different regulatory and advisory initiatives."*

*"There are "limited studies of the effect of psychosocial legal obligations" implemented in Europe generally, Sweden or Canada."*

*"These studies do not enable any conclusions to be drawn about the strengths or weaknesses of particular regimes, but they do suggest that organisational commitment and capacity, including resources, knowledge and skills, are predictors of organisational effort to address psychosocial hazards."*

*"The limited insights and evidence from other countries on legal obligations ... do not allow us to distinguish the relative effectiveness of general obligations (like general duties) and requirements specific to psychosocial hazards. There is also limited evidence about the effectiveness of voluntary standards, guidance materials and tools. For both legal obligations and voluntary instruments, the limited evidence suggests that they only work when certain organisational pre-conditions are met."*

In this context, organisational pre-conditions refer to organisational motivation (senior leadership commitment) and capacity (including financial and personnel resources, skills and knowledge).

In addition, the report noted that *"For voluntary instruments, the most studied are the UK Health and Safety Executive's (HSE) Management Standards for Work-Related Stress, and the resources and methods to support their implementation. The evidence for their effectiveness is equivocal."*

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<sup>2</sup> (2016) Effectiveness of the Model WHS Act, Regulations, Codes of Practice and Guidance Material in Addressing Psychosocial Risks. National Research Centre for OHS Regulation. Canberra. *Unpublished report produced for Safe Work Australia.*

## Learnings from the UK experience: Management Standards

In 2017, the Health and Safety Executive published a position paper by the HSE Workplace Health Expert Committee on Work-related stress and psychological health.

The work-related stress and psychological health paper reviews the effectiveness of the HSE Management Standards for work-related stress. We draw your attention to the following sections of the report:

### **Intervention research**

- Results showed a small intervention effect for one measure of wellbeing (WEMWBS) but no effects on sickness absence, GHQ score or work characteristics.

*“The prevailing consensus was that although the Management Standards are a needed, innovative, simple, and practical overall approach to managing work-related stress, organisations experience problems following through and implementing risk reduction interventions. Thus, there is still work to be done in terms of how organisations can implement the Standards and what skills and competencies are required. Overall, a question was evident related to whether the Management Standards work in practice or in principle. The consensus was that the approach works well in principle but less so in practice. Experts also agreed that the Management Standards approach is generally but not always used as the Health & Safety Executive intended.”*

### **National Survey results**

- A series of annual omnibus surveys conducted between 2004 and 2010, designed to monitor changes in the psychosocial working conditions covered by the Management Standards showed that scores for ‘Demand’, ‘Peer Support’, ‘Role’ and ‘Relationships’ did not change significantly between 2004 and 2010, remaining positive over the period<sup>3</sup>. Scores on ‘Change’ and ‘Managerial Support’ showed an improvement, and scores on ‘Control’ showed a worsening over the period. While the early years of the survey showed a decrease in the number of employees reporting that their job was ‘very’ or ‘extremely’ stressful, levels subsequently returned to their 2004 level. There was little change in the number of employees stating that they were aware of stress initiatives in their workplace or reporting discussing stress with their line manager.

The report concludes:

*“In conclusion, the general picture is of little change in psychosocial working conditions in Britain between 2004 and 2010; employees have largely reported positive conditions over this period. There are signs of improvements in of management support, and improvements in management of change, but a decline in control in the most recent data, which is perhaps expected in light of changing economic conditions and insecurities in the jobs market.*

*The proportion of employees reporting their jobs as extremely or very stressful was lowest between 2005 and 2007, and despite the small decrease in 2010 this remains slightly elevated. It is unlikely that the rise and fall in those reporting their jobs as very or extremely stressful over the survey years is directly related to the Management Standards but impacted by additional factors already discussed in this report.”*

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<sup>3</sup> HSE (2010) Psychosocial working conditions in Britain in 2010. United Kingdom



## Systematic Review of international guidance materials

There has been relatively little research into the effectiveness of guidance materials for work-related psychosocial risks, even less that are specific to Australia.

In 2018, a systematic review was conducted on a range of international guidelines (from Australia, Canada, Denmark, England, New Zealand, Sweden, the Organization for Economic Cooperation and Development and the World Health Organization) that aimed to help workplaces prevent or detect work-related mental health problems<sup>4</sup>. The paper concluded that few guidelines have been developed with sufficient rigor to help employers prevent or manage work-related mental health problems and evidence of their effectiveness remains scarce.

It added that:

*“Few of the guidelines considered the limited documented effect of implementing complex workplace interventions to all organizational contexts. Most guidelines recommended interventions that were not feasible without substantial financial and human resources. Although interventions were recommended to all workplaces regardless of size, lack of resources was not considered as a crucial barrier for smaller enterprises<sup>5</sup>.”*

## Draft Recommendation 19.1 – Psychological Health and Safety in workplace Health and Safety Laws

### DRAFT RECOMMENDATION 19.1 — PSYCHOLOGICAL HEALTH AND SAFETY IN WORKPLACE HEALTH AND SAFETY LAWS

Psychological health and safety should be given the same importance 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.

It is not clear from the recommendation above when read in conjunction with the supporting text, exactly what form the final proposed legislative amendment(s) would take. We note the following additional information provided in “*Productivity Commission Draft Report Volume 2*” that we provide response on below:

- **Model WHS Act – Objectives reference**
  - “Including psychological health alongside physical health up front in the objectives of the model WHS legislation would send a clear signal as to the importance of a psychological health and safety in the workplace.” Page 744

<sup>4</sup> Nexø M, Kristensen J, Grønvald M, Kristiansen J, Poulsen O, 2018; Content and quality of workplace guidelines developed to prevent mental health problems: results from a systematic review, *Scand J Work Environ Health* 44(5):443-457 doi:10.5271/sjweh.3731

<sup>5</sup> Ibid.

- **Incident notifications – notification trigger for psychological injuries**

- *“For example, serious psychological injuries should be notifiable (as serious physical injuries are notifiable). ...the incident notification provisions in the model WHS Act should be reviewed to ensure they provide a notification trigger for psychological injuries.” Page 744*

ACCI does **not support** any legislative amendments relating to new or modified model WHS Act or Regulation psychological provisions.

### Incident notifications – notification trigger for psychological injuries

We do **not support** modification to the incident notification provisions in the Act to provide a notification trigger for psychological injuries.

We are concerned about unintended consequences resulting from the proposal and note that it would be inconsistent with the intentions of the provision. We believe that it would create further confusion when confusion already exists over notification requirements, as well as create a significant burden for regulators and businesses.

Psychological injuries are distinct and subjective in nature and do not, for the most part, translate well to the concept of a specific ‘event’ or ‘incident’.

Feedback from regulators and our network is that in their experience of the current incident notification and site preservation requirements in the model WHS Act, they are poorly understood and often misinterpreted by PCBUs. This results in either over-reporting or under-reporting of particular incidents, both of which impact on regulator and PCBU resourcing.

*Section 35 of the model WHS Act defines the kinds of workplace incidents that must be notified to the regulator.*

*A ‘notifiable incident’ is an incident involving:*

- *the death of a person*
- *‘serious injury or illness’ of a person, which is defined as including an injury or illness requiring a person to have immediate treatment as an inpatient, or immediate treatment for certain identified injuries, or medical treatment within 48 hours of exposure to a substance, or*
- *a ‘dangerous incident’, which exposes a worker or other persons to serious risks to their health and safety from immediate or imminent exposure to the incidents listed in the section.*

*The model WHS laws require:*

- *the PCBU to ensure the regulator is notified immediately after becoming aware a notifiable incident has occurred*
- *written notification within 48 hours of the request if the regulator asks for it, and*
- *the incident site to be preserved until an inspector arrives or directs otherwise.*

ACCI further notes a number of additional technical questions and concerns our member network have in relation to the notion of expanding notification triggers to psychological injuries, these include:

- Are regulators adequately resourced to respond to an increase in notifications and what would be the response protocol given the requirements flagged in section 35 of the model WHS Act?

- How would a psychological “notifiable incident” be defined – the current definition of ‘serious injury or illness’ doesn’t necessarily fit and psychological injuries are more often subjective by nature than physical. Most likely a revision to the definition of ‘serious injury or illness’ would be required.
- For it to be notifiable, would a diagnosis be required? Would this involve using the DSM or admittance as an inpatient to a psychiatric facility for example? Or would a worker expressing “stress” or “anxiety” be sufficient or lodgement of a mental stress claim?
- Who would make the assessment that an “injury” of this nature occurred – PCBU, worker, a GP, a psychologist, a psychiatrist and how would potential time delays be accounted for?

## Draft Recommendation 19.2 – Codes of Practice on Employer Duty of Care

### 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 should be developed to reflect the different risk profiles of different industries and occupations.

**ACCI does not support a Code of Practice to “assist employers meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace” and targeted to reflect different risk profiles of different industries and occupations.**

In Chapter 19, the draft report notes:

*“Codes of practice developed for small and/or medium sized businesses could provide the practical tools these employers need to meet their duty of care.” Page 747*

**ACCI does not support Codes of Practice being developed for small and/or medium sized businesses in relation to psychological safety and health.**

Industry reports that the majority of Codes are not useful to their members. Especially (but not exclusively) for small and medium businesses, we note that:

- SMEs constitute approximately 85% of workplaces;
- The current Codes of Practice are still far too complex for small business; and
- The Codes of Practice need to be practical, user friendly, tested, and concise.

The practicality, capability and limitations of small and medium enterprises need to be understood and taken into account.

To achieve the aim of improvements in WHS in workplaces, there is a significant need for targeted practical guides that people can pick up and use in their businesses.

Industry experience is that for smaller businesses, the best way to improve safety outcomes is to provide clear and practical solutions to common safety issues with strong education and awareness programmes. These can best achieve their aims when partnered with the industry association.

Useful industry-specific guides would simplify compliance. Industry needs specific information that individuals and organisations can relate to, that provides clear and practical guidance to compliance and that properly take into account the diverse nature of workplaces.

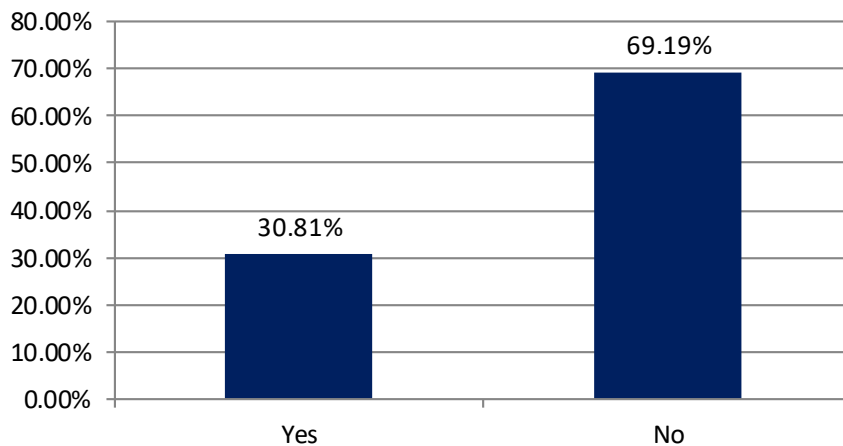
The Safe Work Australia National Guide “*Work-related psychological health and safety: A systematic approach to meeting your duties*” released in late 2018 was a positive step towards increasing awareness of psychological safety and health duties that ACCI and our members supported.

We have noted however that more efforts are needed to effectively promote the resource and time to assess the take-up by PCBU’s. Producing further regulatory materials before a review of its effectiveness, usability and accuracy would be premature and inconsistent with principles of good regulation.

Although the National Guide has been promoted through conference presentations, webpage updates and news items on the Safe Work Australia website, social media and established media channels it is still relatively unheard of across industry.

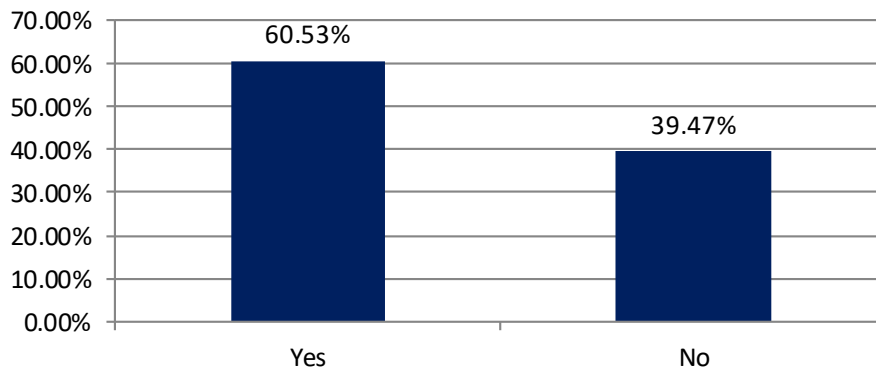
We asked businesses in our member network whether they were familiar with the Safe Work Australia National Guide “*Work-related psychological health and safety: A systematic approach to meeting your duties*”? Only 30% of survey respondents were.

**Figure 1: Response by business – are you familiar with the Safe Work Australia National Guide “*Work-related psychological health and safety: A systematic approach to meeting your duties*”?**



Encouragingly, of those that were familiar with the Guide, the majority found it useful.

**Figure 2: Response by business – if you were aware of the SWA National Guide did you find it useful?**



The predominant rationale for regulation to date is to address concerns from businesses that they needed guidance on “what to do”.

Regulations and Codes are not informative. They don't advise how to conduct the risk management process and implement controls. Businesses would still seek additional resources and support.

Currently there is great confusion between public health preventative measures and psychosocial risk management. There is a significant gap in resources available for the latter. If these resources and support aren't available, there is likely to be significant non-compliance. This is particularly true for small businesses.

Furthermore, clarity would be needed on what regulators consider 'reasonably practicable' and evidence of compliance from SMEs as expectations vary along with regulatory guidance and actions currently experienced by industry.

Time is needed for practical guidance (such as the Guide and materials being developed to support it) to become bedded in WHS practice and understanding, and to evaluate if they address the existing confusion and uncertainty. It would also allow evaluation of the state of knowledge on management of work-related psychosocial risks and how it can be best applied in practice. This would support development of evidence-based actions to improve management of work-related psychosocial risks.

Volume 2, page 747 notes:

*"Importantly, codes of practice could be developed to meet the different risk profiles of different workplaces and occupations. For example, separate codes of practice could be developed for those occupations exposed to greater risks of psychological harm such as for first responders, FIFO workers and/or by sector such as construction and hospitality. (The Western Australian Government recently introduced a code of practice for mentally healthy workplace for FIFO workers in the resources and construction sector (DMIRS 2019))."*

### **The concept of an industry specific Guide has merit as we stated previously, however a Code that is hazard and industry specific is not supported.**

In WA, since the release of the 'FIFO Code' a number of issues have been raised by employers and employees in trying to meet the prescriptive nature of some sections such as working arrangements and shifts. This has resulted in indirect adverse consequences and conflicts with industrial relations legislation and practices.

Feedback has also reflected sentiments noted previously in that the FIFO Code does not provide the "how to" guidance employers were seeking, rather it has resulted in greater confusion and questions particularly as the language and models referenced do not mirror that used in existing national guidance.

Unintended consequences have also been raised due to research references and specific examples. Greater specificity in Codes in particular need to be balanced by the practicality of any examples so that they don't create additional adverse consequences (i.e. proposing shorter roster cycles may result in reduced pay which may negatively impact perceptions of financial security and overall mental health).

### **Management of mental health in the workplace goes beyond WHS**

WHS is just one aspect of workplace regulation and management that impacts psychological health. Workplaces have many moving parts.

The management of mental health in the workplace is a complex area. In addition to the legal risks, there are practical difficulties that come with managing employees who are genuinely not well, and who may not attend work or not respond to reasonable requests and directions.

**In focusing solely on WHS as the applicable workplace regulation relevant to mental health concerns, we fail to give due regard to the broader statutory framework that governs the employer/worker relationship, and the range of regulatory regimes that are potentially triggered when mental health concerns emerge.**

Increasingly, employers are required to manage workplace issues with regard to more than one piece of legislation and in the case of mental health, looking beyond legislation to also have regard to 'good practice'.

These intersecting obligations and expectations add layers of complexity and can make acting in the context of mental ill-health and psychological risk more difficult.

Workplaces not only have to comply with WHS and worker's compensation obligations in relation to psychological health, they must also comply with the Fair Work Act 2009 (Cth), federal and state anti-discrimination laws and the Commonwealth Privacy Act 1988 (Cth).

The duty for employers to make reasonable adjustments is found in the Commonwealth Disability Discrimination Act 1992 (Cth) (DDA). Additionally, the Fair Work Act 2009 (Cth) provides protection for employees with mental illness against adverse action by employers such as dismissal or discrimination. Other relevant legislation that outlines obligations for employers is the Commonwealth Privacy Act 1988 (Cth).

## The Worker's Compensation System - Response to Part 4 continued

Within the draft report there are a number of references to mental stress claims costs as a driver for recommendations.

**Influencing process and system issues would likely have a greater impact on claims cost and health outcomes than the proposed legislative measures and no-liability treatments.** These proposals in our opinion would not overcome underlying process issues limiting their effectiveness.

International research has identified widespread issues in workers' compensation systems, including inconsistencies regarding claims management practices and access to evidence-based treatment and injury management or rehabilitation that can result in variable outcomes for an injured worker<sup>6</sup>.

Australian Workers' Compensation schemes exist to support workers injured through work. Premiums paid by employers are used to cover a range of entitlements including medical treatment, lost wages and support for return to work. Legislation in each state and territory requires employers to have this insurance and dictates the roles of key stakeholders (workers, employers, nominal insurers, regulators and medical practitioners) and worker entitlements. The legislation provides an overarching framework with key duties but does not dictate or provide how claims are to be managed and the day-to-day operation of the schemes.

Organisations operating in this sector have various levels of maturity in managing workers' compensation claims and more specifically, psychological claims. Recent reviews of insurance schemes and nominal insurers have identified a number of operational issues and current practices that hinder the effectiveness of the schemes and contribute to poor health outcomes for injured workers. These include:

- **Internal issues in developing claims management teams.** This concerns defining the claims manager's role, and the skills and support required to perform it:
  - Team structure has been identified by insurers and agents as a contemporary issue. Two important questions with regard to team structure are: whether or not to create dedicated psychological claims management teams, and
  - How to provide access to expert support and advice for claims managers on medical, psychological, rehabilitation, etc. matters. Options include having expert advisors integrated into the claims team; employing expert advisors in-house but not integrated into the team; or using contracted advisors as required.
- **Poor triaging practices** with limited use of data and little data linkages to other sources. Furthermore the models require validation.
- **A focus on clinical management** and health outcomes, with much **less evidence on vocational rehabilitation and work outcomes.** Clinical improvement does not necessarily improve work participation and productivity; there is poor correlation between the severity of symptoms and work capacity. There is acknowledgement that people with psychological injuries require additional help—over and above symptomatic treatment—to help RAW/ RTW.

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<sup>6</sup> Reavley et al (2016) A synthesis of recent evidence supporting a best practice approach to psychological claims management



- In the workers' compensation sector, insurers are required to pay for both medical treatment and vocational rehabilitation for an injured worker. Our members report very little access to vocational rehabilitation.
- **Poorly developed supports for employers** and small business employers in particular.
- Ensuring that claims managers have ongoing access to information on what is **evidence-based treatment and rehabilitation** for people with psychological injuries.
  - There are two key issues: Evidence for effective treatment and for rehabilitation regimes for psychological injuries are evolving constantly and rapidly changing. Claims managers and rehabilitation consultants need an informed approach to reviewing treatment regimes, and selecting rehabilitation interventions.
  - Inadequate treatment for psychological injuries is common. For example, Australian and international evidence indicates that only about a quarter of people with affective and/or anxiety disorders receive evidence-based treatment. Inconsistency in approach by medical practitioners, a lack of objectivity in reports, and treatment that is inadequate in duration, medication or evidence-base has also been noted.<sup>7</sup>

The Victorian Ombudsman report<sup>8</sup> released in December 2019 highlighted further administrative and process issues. Concerns were raised about **delays in decision making by agents** and the consequent impact on an injured worker's recovery. The concerns primarily centred on the timeliness of agents' approval or rejection of requests for reinstatement of entitlements due to further incapacity or treatment.

- In 2017-18, the ACCS received 856 requests for conciliation for an agent's failure to make a decision regarding a worker's request for treatment. Witnesses to the investigation raised concerns about the impact of such delays on injured workers' recovery, particularly those with a mental injury. For example, one psychiatrist providing treatment to injured workers said:
  - *"Some claims managers do seem to sit on decisions and if I am seeing someone for a second or third time, may have no conclusion reached about the claim. This ... stress can really prolong or create psychiatric disorders or maintain them far past what one would otherwise expect."*
  - Another psychiatrist said since the Ombudsman's 2016 report, their patients were *'still experiencing the same delays in getting approvals and requests for inpatient treatment'* and highlighted that delaying a referral to a psychiatrist or psychologist was *'clinically unsafe'*.
- A number of stakeholders working in the scheme interviewed as part of the study described the process of getting treatments approved as *'onerous'* and highlighted how delays in approvals *'translated directly'* into delays in workers' treatment and recovery.

ACCI member's experiences with claims management practices provide additional insights from an employer's perspective:

- **Claims Management – Lack of employer involvement**
  - Our members have repeatedly commented on the lack of involvement of the employer in the process. Compared to physical injuries, consultation with the employer on psychological

<sup>7</sup> Safe Work Australia. (2018) Taking Action: A best practice framework for the management of psychological claims for the Australian workers' compensation sector. Canberra

<sup>8</sup> Victorian Ombudsman. (2019) WorkSafe 2: Follow-up investigation into the management of complex workers compensation claims. Victoria



injury claims is minimal. Often the nominated treating doctor, rehabilitation provider/psychologist and claims agent/manager drive the progress, and costs, of the claim. One member commented that they had witnessed many scenarios whereby the employer is excluded from case conferences discussing RTW options. It takes a tenacious, well-resourced and informed employer to maintain any sort of presence in claims management and even then there may be reluctance to invite further participation, even to provide relevant and critical workplace information. The employer is a key stakeholder in making reasonable modifications to the work environment and duties to accommodate the workers work capacity and stage of recovery.

## Price Signalling and incentives in the Workers' Compensation system

Throughout the draft report, a number of assertions are made in relation to workers' compensation systems and key drivers of behaviour that we dispute. In particular, we dispute the commentary on premium price signalling and the positive influence on health and safety outcomes.

In Volume 2 on page 756 the report states:

*“Some workers compensation schemes in Australia have weakened the price signal provided through premiums paid for certain businesses by removing or limiting claims experience as an input into setting workers compensation premiums.”*

ACCI strongly disputes the notion of “weakening incentives” through discounted premiums or premium's calculated without or with limited claims experience.

A number of research reports on compliance and interventions commissioned by Safe Work Australia have indicated that the main drivers of behaviour and improved health and safety outcomes are: compliance with the law and moral obligations to staff, not a reduction in premiums.

For decades, stakeholders have assumed as fact this notion of a link between ‘price signalling’ and everyday business behaviours, however there is no evidence that we are aware of that this has been substantiated.

The National Research Centre for Occupational Health and Safety Regulation explored this concept in its paper “The prevention of occupational injuries and illness: the role of economic incentives” noting:

*“First, there is agreement upon the fact that experience rated premiums do have an impact upon workers' compensation claims. However, this is a different matter to a demonstration that such a pricing approach has a significant positive impact upon accidents, injuries and illnesses.”<sup>9</sup>*

*“Academic approaches that attempted to measure the influence of experience rated premium systems upon workplace health and safety emerged from the mid-1970s, and particularly the 1980s. Even in terms of their own methodology, these studies have shown variable results, ranging from a significant impact, through to no effect and even to an adverse impact upon workplace health and safety. However, more fundamentally, there are some significant methodological issues concerning*

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<sup>9</sup> Clayton, A, 2002, WP 5 - The prevention of occupational injuries and illness: The role of economic incentives, National Research Centre for OHS Regulation, Canberra

*the nature of data and of variables that are controlled for in the regression analysis undertaken which have the effect of rendering quite problematical the purported conclusions of these studies.”*

The author notes in addition to the absence of such evidence a number of reasons why experience rating has inherent limitations as a mechanism for reducing injury or illness.

*“The essence of experience rating is that of sending a price signal to employers that will result in remedial action. If that is to operate then this signal must be of sufficient volume as to attract attention and to demand action, particularly when there is a range of other incoming signals relating to other business costs.”*

For small businesses in particular, the author notes that an assessment of ‘true risk’ would take an enormous period of time given the incident rates tend to be lower (estimates average one incident per several years). Even with larger businesses impacts can vary.

There is no dispute that experience-rating does not affect behavioural change however the evidence suggests the change is in relation to the manner in which claims management is conducted.

*“It is not contested that experience-rated premiums do have an effect upon compensation claims. However, claims statistics are simply a proxy for injury and illness statistics. What is contested is the facile assumption that experience-rated premiums result in action to achieve safer workplaces that is a reduction in accidents, injuries and illnesses rather than simply a reduction in claims.”*

Further in the draft report there is an assertion that *“For those employers with premiums impacted by previous claims experience there is an incentive to deny liability, particularly for those claims where there may not be a clear causal link to employment. ... These incentives to deny liability can be strengthened where employers are faced with having their premium reflect their actual claim costs as well as an estimate of the future cost of these claims.”*

The above is not an accurate statement and contrary to the reality of most employers (except in theory for self-insurers who are both employer and insurer). It is not within the power of the employer to determine liability, rather it is the insurer’s decision. In some instances, and following best practice, a determination may be made after consultation with the employer, however the ultimate authority is with the insurer.

In our network’s experience, insurers are typically risk-adverse and more often accept a mental stress claim or settle against employer’s wishes rather than proceeding with expensive medical investigations or potential arbitration.

Many small businesses (which account for the majority of employment in most jurisdictions) would not be sustainable if penalty premiums were applied. Their ability to invest in the manner suggested is also very limited by cost and resources. This is the role of the regulators – to assist and educate small business to achieve sound levels of compliance with WHS duties, not penalise them retrospectively through a complimentary scheme.

## Draft Recommendation 19.3 – Lower Premiums and Workplace Initiatives

### 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.

**ACCI supports in principle premium reductions for those who implement initiatives and programs designed to reduce psychosocial risks.** However, we qualify this by noting that this is typically already considered in premium pricing as any WHS programs are factored into the premium calculation as a measure that further reduces the risk profile of a business.

Reduced risk profiles typically result in discounted premium rates, its good insurance practice. As long as employers can provide evidence of psychological risk management strategies this should be sufficient.

In addition, we note concerns that this emphasised approach to premium pricing may result in insurer practices whereby the focus is on those who do not demonstrate initiatives being penalised. There could also be an unintended consequence of a shift to focusing on psychological interventions and claims management at the expense of a holistic WHS risk management approach, good claims management and return to work practices in an effort to seek a discount.

Workers' compensation schemes should be explicit in stating that discounted premiums will be available to employers who implement initiatives and programs that reduce WHS and organisational risk and where these programs and initiatives are more comprehensive than those ordinarily expected of a duty holder to discharge their relevant duties under WHS law.

**We do not support the part of the recommendation that WHS authorities should prescribe or 'consider' which initiatives and programs are acceptable for any discounts to apply.**

Chosen programs may not be evidence-based or may result in a tick-and-flick response similar to what was seen when this approach was undertaken for use of EAP's. WHS authorities do not currently 'consider' general WHS risk management initiatives and the application of premium discounts in conjunction with insurers so we question the varied approach to psychological initiatives. We note that approaches to applying a discount could significantly vary across jurisdictions and insurers and flag that this may result in unintended consequences such as a disincentive for novel initiatives (those that are disputed due to questions around their effectiveness or that cannot be clearly measured as yet (pilots)).

## Draft Recommendation 19.4 – No-Liability treatment for mental health related workers’ Compensation claims

### 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.

**ACCI does not support the recommendation to provide clinical treatment for all mental health related worker’s 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.**

Workers’ Compensation schemes are insurance schemes based on the assessed work-relatedness of injuries and illness and associated liability. Where there is no liability, other insurance and public health systems are in place to assist injured workers. Employers should not have to pay for private or public health expenses.

Additionally we note that this proposal singles out psychological injuries above and beyond other types of illness, injury and disease where claims cost drivers and liabilities may signal more urgent treatment such as with MSD claims or dust diseases.

ACCI is supportive of the objective, that is, seeking to improve early intervention and return to work outcomes however we believe the focus should be on addressing the process and system issues identified earlier in this paper as well as exploring greater cross-sector opportunities as outlined below.

The Cross Sector Project<sup>10</sup> identified a number of opportunities for early intervention that looked across various health care systems and schemes.

The project mapped ten major systems of income support in Australia, including Employer Provided Entitlements, Workers’ Compensation (short-tail and long-tail schemes), Motor Vehicle Accident (MVA) compensation (lump sum and statutory benefit schemes), Life Insurance (income protection and total and permanent disability schemes), Defence and Veterans Affairs compensation and pension, Superannuation withdrawals, and Social Security (Youth Allowance, NewStart Allowance, Sickness Allowance and Disability Support Pension).

*“One important assumption of the public health model is that early intervention is likely to produce the greatest benefits for the individual and also at a community level. This is also a commonly held view in many of the income support systems.”*

Opportunities for improvement were identified through intervening early in the upstream systems in ways that would then benefit downstream systems. Some of the examples provided include:

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<sup>10</sup> Collie, A., Iles, R. and Di Donato, M.F. (2017) The Cross Sector Project Mapping Australian Systems of Income Support for People with Health Related Work Incapacity. Insurance Work and Health Group, Faculty of Medicine Nursing and Health Science, Monash University.

- Early identification of people with complex health conditions or risk factors for delayed recovery or return to work in workers' compensation systems (sometimes called claims 'triage');
- Providing access to rehabilitation for people in the waiting period of a life insurance claim;
- Providing access to condition specific healthcare to people when they first apply for access to social security benefits, for example Cognitive Behavioural Therapy for people with Anxiety or Depression; and
- Providing resources to employers to help them identify employees with health conditions who are still working, but who may be at risk of leaving the workplace.

The report concluded that *"There are likely to be many such opportunities for earlier intervention. For the cross-system approaches to be effective a better understanding of cases likely to proceed / transfer onto other systems will be required."*

Feedback from our member network indicates a need for tools and targeted resources for employers to facilitate effective early intervention strategies and return to work for injured workers and the provision of resources to employers to easily identify support services and referral pathways (beyond workers' compensation) for workers throughout the workers' compensation claims process.

## Provisional liability and interim payments

### INFORMATION REQUEST 19.1 — HOW SHOULD THE TREATMENT BE FUNDED?

*How should the clinical treatment for workers with mental health related workers compensation claims (irrespective of liability) be funded until return to work or up to a period of six months?*

The draft report states:

*"Some workers compensation schemes provide support for all workers compensation claims — not just mental health related claims — prior to liability being determined: the **New South Wales scheme refers to these arrangements as provisional liability, South Australia as interim payments and the Tasmanian scheme as 'without prejudice' payments (table 19.2).***

*"However, there is an issue as to who pays for the initial treatment and any other benefits (such as for loss of income) where the psychological injury or mental illness is determined not to have arisen as result of employment.*

*"Given that there are significant problems around removing the link between employment and liability, another approach to provide early intervention and treatment to promote recovery and return to work would be to have **workers compensation schemes fund medical treatment on a provisional liability or without prejudice basis until liability is determined — within a specified period to avoid delay.***

ACCI members with experience in these state and territory schemes note that interims are not often required. Where liability is undetermined and interims offered, workers sometimes will refuse interims due to the risk of recovery if the claim is rejected. In these cases, Medicare provides basic cover and, where workers have them, health and income protection insurance is available. We dispute the suggestion that all interims are

recovered – interims don't have to be recovered, it's a discretion and recovery is seldom if ever pursued by a self-insurer for example in order to avoid further damage to the worker as well as on cost-effectiveness grounds.

Ultimately employers fund medical treatments and payments within the workers' compensation schemes. Any costs are passed onto employers through premiums as part of the operational models of nominal insurers.

**We fundamentally oppose employers paying for treatments (directly or through a levy or tax) before liability is determined if operating within the workers' compensation scheme.** Some employers support workers outside of the scheme with established support programs and no-liability or 'without-prejudice' payments which is their business decision based on their operating circumstances.

**We do not oppose Governments providing funding for early intervention treatments** however suggest that these actions and resources be linked to claims where determination of liability is pending and operating simultaneously but not dependent on this (a workers' compensation claim).

This returns us to the earlier point that a number of compensatory systems exist and greater facilitated movement between the systems as well as early intervention across these systems would be a more effective approach than to only focus on the workers' compensation system, changing core and long-established liability and payment mechanisms.

Mental health is a broad community responsibility that reaches far beyond the workplace. There are other compensation schemes and income supports beyond workers' compensation that need to be considered in a holistic approach.

## Draft Recommendation 19.5 – Disseminating Information on Workplace Interventions

### 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 healthy workplaces 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.

**ACCI does not support the recommendation that WHS agencies should monitor and collect evidence from employer initiated interventions and advise employers of effective interventions that would be appropriate for their workplace.**

Singling out WHS agencies for this work is a disservice to the other important workplace mental health stakeholders and other business, professional and community stakeholders already actively involved in collaborating on creating mentally healthy workplaces. Collaboration between a range of stakeholders for monitoring and promoting effective interventions is required to achieve best practice.



WHS agencies are not the appropriate body for this work. There are a number of other stakeholders (peak bodies, industry associations and unions) and workplace professionals beyond WHS agencies such as allied health professionals (organisational psychologists, rehabilitation providers) that are skilled to research, design, support and deliver effective workplace mental health advice and programs.

**ACCI proposes two alternative recommendations for consideration:**

**The Mentally Healthy Workplace Alliance be recognised as the most appropriate ‘body’ to coordinate the monitoring and collection of examples of employer programs and provide advice and case studies to employers** (as it is their role and they are funded to do this). We note that the Alliance believes that a collaborative approach incorporating WHS agencies along with industry, unions, not-for-profit organisations, other government agencies and relevant professions in delivery of its National Workplace Initiative will ensure the best outcomes for workplace mental health promotion and practice.

In addition, **Governments may direct or work with scheme insurers to undertake an analysis of known, existing and real-life employer interventions and the resulting impact on the insurance premiums and other objective and measurable datasets for that workplace, disseminating these case studies to employers as a way to encourage similar strategies.**

## Information Request 19.2 – Personal Care Days for Mental Health

*INFORMATION REQUEST 19.2 — PERSONAL CARE DAYS FOR MENTAL HEALTH*

*Would designating a number of days of existing personal leave as ‘personal care’ to enable employees to take time off without medical evidence to attend to their personal care and wellbeing improve workplace mental health and information on absenteeism due to mental ill-health? If so, what would be needed to make this provision effective?*

Australia has a strong safety net for illness, mental or physical, with paid time off. The existing safety net of personal leave has evolved over more than 80 years, and helps Australians encountering personal mental illness and distress, or seeking to manage it within their families. It arises from major arbitrated cases over more than 80 years, including both extensive evidence and agreed settlement of matters by the Australian Council of Trade Unions and employers.

Under the current law, employees are entitled to ten days paid personal / carer’s leave each year.<sup>11</sup> This accumulates, meaning the balance at the end of each year carries over to the next year. This can be taken for any form of personal injury or illness, including mental illness.<sup>12</sup> It can also be taken to provide care or support to a member of their immediate family or household, because of a personal illness or injury, again including for reasons to do with mental illness. This means that personal leave can already be taken by an employee to attend to their personal care.

Allocating a designated number of days for a specific purpose may have the unintended effect of disadvantaging employees who may need to take personal leave for another purpose they would have ordinarily been entitled to take leave for. This includes, for example, if an employee is hospitalised with a serious physical injury or illness and needs to use a significant amount of their personal leave for that physical

<sup>11</sup> *Fair Work Act 2009*, s.96.

<sup>12</sup> *Fair Work Act 2009*, s.97.

reason. It also includes if an employee wishes to take leave to care for their sick child or parent, for example. It is important that the system remain flexible so that employees can use their personal leave as they best see fit, and can choose how to best manage their health and wellbeing needs.

It is unclear what the purpose designating a number of personal leave days as 'personal care' would serve. The current system also does not require an employee to disclose the type of illness or injury for which they take personal leave. Many employers implement practices and cultures to ensure workers feel safe to divulge mental health issues where they feel comfortable to do so, and offer appropriate support. Some workers may choose to disclose mental health issues to employers and divulge the reason they are taking personal leave. However, others, for whatever reason, may choose not to disclose the reason for taking personal leave to their employer. This includes if the employee fears the risk of stigma around mental health. Disclosing the specific type of injury or illness constituting the employee's reason for taking leave should remain a personal choice of that employee. The current system is flexible to personal circumstances and priorities, and there is no evidence that the status quo is insufficient.

In relation to medical evidence, under the Fair Work Act, an employer is entitled to request evidence that would substantiate that the employee was genuinely entitled to the leave, such as a medical certificate or statutory declaration.<sup>13</sup> This generally does not specify the particular reason the person is taking leave, with medical certificates frequently simply stating that the person is "unfit for work due to a medical condition", meaning that even where medical certificates are requested, the specific reason is kept private.

In practice, employers already use common sense and discretion in asking for medical evidence around personal leave days, with many employers opting to provide significantly more flexibility than the strict requirements otherwise required under the law. For example, many employers will only require a medical certificate after two or more days off. This means that employees can and do already take days off to care for their mental health, and many without the need for evidence, with many employers not questioning single day absences. This, however, should remain at the discretion of the employer. There are a number of factors that may impact on the employer's approach, such as the nature of the work, and any patterns of questionable absence, for example too many Mondays or days after long weekends. It is crucial that the right balance is maintained between supporting employees with their health/work problems, and ensuring accountability/protecting against improper use of personal leave.

**Dedicating a number of existing personal leave days as personal care days for mental health will likely not be effective at improving workplace mental health, and ACCI suggests there are other methods more suitable at addressing this important issue, as outlined above.**

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<sup>13</sup> *Fair Work Act 2009*, s.107.



## Response to Part 5 - Pulling together the reforms: Monitoring, reporting and evaluation

### Draft Recommendation 25.2 – Routine National Surveys of Mental Health

*In the long term (over 5 – 10 years)*

The Australian Government should support the ABS to conduct a National Survey of Mental Health and Wellbeing no less frequently than every 10 years. The survey design should enable consistent comparisons across time, and aim to routinely collect information on:

- prevalence of mental illness
- service use by people with mental illness, and
- outcomes of people with mental illness and their carers.

The survey design should ensure that it adequately represents vulnerable population sub-groups who may have diverse needs. Opportunities for linking the survey data with other datasets should be considered.

**We support this recommendation.**

## About the Australian Chamber

The Australian Chamber of Commerce and Industry is the largest and most representative business advocacy network in Australia. We speak on behalf of Australian business at home and abroad.

Our membership comprises all state and territory chambers of commerce and dozens of national industry associations. Individual businesses are also able to be members of our Business Leaders Council.

We represent more than 300,000 businesses of all sizes, across all industries and all parts of the country, employing over 4 million Australian workers.

The Australian Chamber strives to make Australia the best place in the world to do business – so that Australians have the jobs, living standards and opportunities to which they aspire.

We seek to create an environment in which businesspeople, employees and independent contractors can achieve their potential as part of a dynamic private sector. We encourage entrepreneurship and innovation to achieve prosperity, economic growth and jobs.

We focus on issues that impact on business, including economics, trade, workplace relations, work health and safety, and employment, education and training.

We advocate for Australian business in public debate and to policy decision-makers, including ministers, shadow ministers, other members of parliament, ministerial policy advisors, public servants, regulators and other national agencies. We represent Australian business in international forums.

We represent the broad interests of the private sector rather than individual clients or a narrow sectional interest.

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