

22 January 2020

Productivity Commission
GPO Box 1428,
Canberra ACT 2601

Inquiry into economic impact of mental ill-health 2019 – draft Report

The draft report is a welcome and comprehensive paper. Thank you for the opportunity to again comment. This is to supplement my previous submission.

My experience, as listed in my original submission, is based on over 30 years' experience in work health and safety (WHS), in operational and policy functions. This includes my role in development of the WHS legislation, as a member of Safe Work Australia and my involvement in mentally healthy workplaces. I offer these comments as an experienced professional with an interest in improving health and safety and in fostering a flourishing community.

I wholeheartedly support the proposed key reforms of

1. prevention, early intervention and maintaining good mental health
2. connecting dots in healthcare services – including improved access
3. investment in a wider range of services, not just clinical health
4. better access to education and work and better systems for retention in education and work
5. improving data and interventions for better care, coordination, governance and funding.

The following comments on the Productivity Commission draft Report¹ are provided in sections

- 1. Structure to achieve proposed reforms**
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¹ *Productivity Commission 2019, Mental Health, Draft Report, Canberra Vol 1 & Vol 2, <https://www.pc.gov.au/inquiries/current/mental-health/draft>, accessed December 2019*

1. Structure to achieve proposed reforms

Key points to assist Governance and Structure include

- a) An independent statutory authority, the National Mental Health Commission (NMHC), with collaborative **structure of committees** funded by government participants through an **intergovernmental agreement or charter**
- b) **Role for NMHC involves nationally consistent communications, accredited training** (using core principles to adapt), **national data, evaluation and research**

A structure for immediate, priority reforms and long-term reforms

I sincerely hope that these aims can be achieved **with collaboration, oversight and comprehensive data and evaluation**. I strongly support the reforms and their goals through an **independent statutory authority, the National Mental Health Commission (NMHC)**.

As well as having a role in coordinating, overarching governance, monitoring and evaluating, as a national independent authority, the NMHC would be well placed to provide **consistent language and national communication for use** across various stakeholders. Some work has already been done. For example; the work of EveryMind/MindFrame on communications and language can be used as a base.² They have noted that

The way mental ill-health is communicated about or portrayed can greatly influence help-seeking behaviour and the prevalence of stigma.

National consistency in communications will also improve coordination and other linkages. Consistency in communication is an important role for the NMHC.

Certainly, evaluation of proposed reforms and some existing approaches will take time but some **data collection and evaluation should begin as early as possible to provide guidance on what works and what doesn't**. We also need early assessment of the success of proposed interventions, such as

- immediate action on strategies to follow up people after suicide attempt
- local interventions that have worked on prevention
- successful cultural/indigenous programmes
- national communication guidance

These are examples of what can be done now to evaluate success and guide any further interventions/programmes and there are others.

² MindFrame guidelines for communicating about mental ill-health * MindFrame is managed by EveryMind and funded by the Australian Government under the National Suicide Prevention Leadership and Support Program.
<https://mindframe.org.au/mental-health/communicating-about-mental-ill-health>
Accessed 14 January 2020

A structure for consultation, governance and unity of purpose

Many stakeholders are involved with mental health and each may well have a different perspective. Whatever the reforms, success will need **collaboration across all the stakeholders** involved, not just government.

For workplaces, strengthening the already established Mentally Healthy Workplace Alliance (MHWA) which is currently under the auspices of NMHC, would be a great start. This structure could apply to other sectors too, an alliance or sub-committee for education, another for the justice sector, one for clinical health and another for community based interventions. Please note: The MHWA is missing from Fig 22.1 in the Productivity Commission's draft report and it's not clear to me how NMHC would formally link with the COAG Health Council.

Nearly everything works better in partnership. A network of subcommittees/alliances from each sector with an overarching member committee that draws on representation from departments or jurisdictions and social partners has worked before (a similar system has been successful for Safe Work Australia). Mental health is a broad, complex and hitherto fractured area. I believe a **collaborative structure**, along SWA lines, can be especially successful for a national approach to mental health.

If an independent NMHC could act as a secretariat for this network, it would be in a position to connect the dots, to harness and make the most of the **shared efforts of stakeholders**. Moreover, if it can use an **intergovernmental agreement style of funding model** (again similar to SWA), it could deliver efficient and effective action. This type of funding model enhances the **shared commitment** and would work well for all the five proposed reforms.

A structure for data and evaluation and commitment

An important function for the new NMHC is the collection of data and the evaluation of mental health and suicide prevention or intervention programmes. This evidence base along with strong engagement and commitment of stakeholders could support a genuinely national approach.

Similar to Safe Work Australia, each of the jurisdictions should have a funding commitment to the independent statutory authority; a unifying base for commitment to a new "nationally" and "across departments" agreed, National Mental Health Strategy.

With this funding commitment, comes the need for each jurisdiction to **evaluate and show progress for the money and other resources invested**. Everyone needs the data. This will engender a strong interest in conducting data collection using standard terms and definitions. This funding model could provide the high level of commitment for a collective appraisal of approaches and reinforce the value of the sharing of information and resources. In turn, this structure and funding model would support a nationally planned approach to much needed research.

With this collaborative structure the commitment and the data and research, the NMHC would thus be well placed to ensure the longer-term reforms happen. I strongly support its **independent and coordinating role and a funding model that inspires commitment from the stakeholders.**

2. Early Identification, Access and Maintenance for good mental health

Key Points for consideration include

- a) **Electronic or digital techniques** for early identification, access and maintenance throughout life has much potential and needs to be explored further.
- b) **A national communications** plan using evaluated proven electronic or digital techniques and promotion of Head to Health should be explored further by the NMHC.
- c) **Building capacity** for community, family and schools and sharing responsibilities for mental health and conversations on mental health
- d) **Professional teacher training** adapted from NMHC accredited training and designing supportive **structures in schools, promoting conversations and use of smart phones for delivery**

A fundamental issue is how to improve identification of people experiencing or at risk of mental ill-health **before** there is an issue, especially our young.

Identification, or self-identification is the first step. The next step is the need for easy access to assistance or services. The statistic quoted in the Productivity Commission's draft Report is that *40% of those with mental ill-health have never accessed mental health services nor seen their GP about their condition, with young people particularly unlikely to seek help.* Improvement actually involves two steps; **identification** of risk, either by others or self-identification, then the second step is **seeking assistance**, either by referral or self-referral.

I suspect that with improved data and less stigma, the current statistic (above) on both identification and seeking assistance or access to services would actually be significantly higher. In the current environment people do not identify with mental ill-health, nor want to seek help.

Indeed, as noted in the Productivity Commission's draft Report³, there is a *reluctance for people to seek helpparticularly in some cultural groups and in smaller communities....*

³ Productivity Commission 2019, Mental Health, Draft Report, Canberra Vol 1 p565 <https://www.pc.gov.au/inquiries/current/mental-health/draft> Accessed December 2019

beyondblue's Depression and Anxiety Monitor ⁴ showed that people with depression and anxiety experience significant levels of perceived prejudice and discrimination:

- *Fifty-one per cent had concealed or hidden their mental health problem from others – which may relate to a fear of discrimination, and*
- *Twenty-six per cent had stopped themselves from applying for work.*

People must feel comfortable to identify their own ill-health, to seek information and to have a conversation, then raise issues, at any age but especially at an early age. **That is, the right environment with the right information and the right responses at the right time.** But this level of comfort, information and access needs to be ongoing through the critical points in life. This is not a one-off; its needed **throughout life.**

Reports show that often, the individual recognises and seeks help too late; indeed, individuals often fail to recognise they need help at all and generally miss the moment when support can be most beneficial. And when they do have concern, access to authorities is not always their first step.

Access to the authorities, or the medical system can be self-directed (although rarely), but initial help-seeking can also occur through family and/or the community. **Family and community need skills to identify and refer and may need access too.** More needs to be done to provide easy access for individuals, for family, for the community. And this must be done in a way that is culturally sensitive, timely and reaches across Australia to small or remote communities.

In a recent paper, Hanisch⁵ notes that

improved knowledge of mental-health problems was shown to have a crucial effect on the ability to recognize signs of mental illness, as well as on supporting help-seeking and accepting treatment

I suspect **a national communications plan using evaluated proven electronic or digital techniques may meet these needs but should be explored further by the NMHC.** Promotion of *Head to Health* will also help.

Alongside consistent communications, keys include education and building skills for individuals, family and community. Schools and community sector do provide opportunities or 'doorways'. Schools can be gateways to reach people – especially the young.

⁴ beyondblue, Depression and Anxiety Monitor, 2014
<https://www.beyondblue.org.au/about-us/depression-monitor> accessed December 2019

⁵ Hanisch, S.E., Twomey, C.D., Szeto, A.C.H. *et al.* The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review. *BMC Psychiatry* **16**, 1 (2016)
<https://doi.org/10.1186/s12888-015-0706-4> Accessed January 2020

Teachers and schools – my experience and apprehension

Early identification of risks in children offers the greatest potential for improving health, social and economic outcomes.

Whilst this is an important part of a teachers' skills, training and professional development, the responsibility cannot reside solely with teachers or schools.

I was a teacher myself (in the distant past). I was required, as part of my training (even then), to report "at risk" individuals. This in itself was fraught, sometimes involving an insensitive process and the outcomes often were negative. It can be quite complex. There also remains the potential for misdiagnosis, especially if this is through an individual teacher. Teachers should not be making a diagnosis. Even an expression of concern or referral can have negative consequences.

Training is an important step but rather than a path involving "mental ill-health" perhaps teachers could trigger an exploratory discussion with support staff, parents, and others before embarking on this pathway. **It's not just about teacher training but also about designing the structures to address any concerns – the follow up counts and the initial conversation counts.**

The when and the how for us as teachers were perhaps not well developed in the past. Even raising a disquiet as a teacher needs sensitivity and confidence in trusted and true pathways, with safety nets. Just as those children in care haven't always fared well in our society, **I am wary of trying to achieve what's desired by simply equipping teachers and then raising the expectations that teachers can solve all. There is more to solving this. Teachers can be a part, but it has to be a shared responsibility.**

I do agree with the Productivity Commission's draft Report's statement that

Schools are already funded to provide social and emotional wellbeing programs. However, they face a confusing and disjointed proliferation of poorly evaluated programs and services on child wellbeing

Whilst no doubt nominating a trained person with responsibility for "wellbeing" will provide supports and activities that would be helpful, **I am similarly wary of a mental health and "wellbeing" leader.** I hope this does not devolve into the distracting fruit boxes and yoga that has happened in the workplace. Perhaps dropping "well-being" from the title and establishing a more assisting or supportive title would provide more approachable and better focused support.

I trust that the new NMHC and its education "alliance" would be in a position to ensure the distractions of "well-being" do not happen here. Also, I hope that they evaluate programmes and services for a more focused approach.

Shared responsibility

Schools do indeed provide gateways for students and their families to access help. They are an important part of a community.

Communities themselves need better information, better access to services and more support to reduce stigma. **The community acceptance and environment** for the teacher and the schools can make a difference. But I also believe that often our first port of call for information or even to help with our thinking is a **conversation**.

A teacher can be alert to signs and symptoms of mental ill-health but the first sensitive conversation requires more than skill; it also requires the right framework and follow up and acceptance or involvement from the community. This doesn't just rely on the teacher alone nor the proposed mental health and wellbeing person in each school. Achieving the desired environment can be improved through **accepting a shared responsibility, with consistent communications, skilled conversations, nationally accredited training and electronic supports such as smart phones**.

Conversations, nationally accredited training and smart phones

Having a conversation is a skill, especially a conversation on mental health. There are existing programmes on how to have a conversation, the language to use, the steps involved and the options to utilise. Some work has already been undertaken, for example, on a charter and media communications by EveryMind and beyondblue has good resources for having a conversation, especially at work. Some work has been done on programmes for school-aged children too. An important and effective approach would be to build on the **shared responsibilities and equip key people with skills to have a conversation**.

The new NMHC can investigate the best of these guides and build a **nationally consistent communications plan**. These communications should help establish the same language that can be used by all (not just the media) and improve confidence in taking that first step with a conversation. From the work on nationally consistent communications, the NMHC can then establish some core principles for **accredited training programmes** that can be adapted for the different communities or circumstances. An accredited programme using core principles could then be targeted and used for teachers as well.

These days we are particularly reliant on our electronic devices. Artificial Intelligence is in our hands at all times. Perhaps our **smart phones** are key! My life is on my phone already. I can and would seek information or support, privately and anonymously on my phone and could do so at any time during the day or night. Perfect access, where 'ere you are. Whilst internet delivery is not yet perfect everywhere, its reach is improving. **Internet can already reach far more regional areas, and a wide range of ages and stages. It is the 'go to' for most.**

Our smart phones have the ability to maintain **continued engagement with those with mental ill-health in their own space, at their own pace**. It can refer where necessary to appropriate services and people. It can help create workable linkages between schools and healthcare pathways; and it can raise awareness of mental health in the community. The internet can deliver tried and refined, consistent and sensitive messages too. It is likely this would also work, with the young, very young and with other ages.⁶ Furthermore, electronic 'consultation' allows delivery of consistent, approved and sensitive communication. It is much better controlled than face-to-face, and can help all those assisting including those who may have less experience.

I would strongly encourage the evaluation of electronic devices as the channel to help people identify and access services, thus providing early identification, access and maintenance. Even for those requiring specialist treatment, electronic access and evaluation mechanisms can help them and their carers throughout the therapeutic or life journey. Of course, this does not obviate the need for face-to-face if needed.

So, in schools lets enhance the use of electronic devices, not just train teachers. Let's assist the community around schools and provide more structure and supports for identified individuals, not just provide a well-being person in a school.

3. Notes on the Health Sector

Key points include

- a) **Accredited nationally-consistent training** can be provided across a range of professionals in collaboration with professional bodies. Core principles can be adapted for each profession. A Charter or Partnership Agreement might also help.
- b) **expand CareTrack to assess mental health care and other data collection sources**
Look at **other forms of funding** and resourcing
- c) Explore more **people centric** approaches – in community care, carer supports etc., communications and training
- d) **Include mental health in a checklist as part of the triage system**
- e) Use emergency services (or emergency departments) as a **last resort**

⁶ Prof Maree Teesson, Nicola C Newton, Tim Slade, Cath Chapman, Louise Birrell, Louise Mewton, et al. Combined prevention for substance use, depression, and anxiety in adolescence: a cluster-randomised controlled trial of a digital online intervention, January 2020, [https://doi.org/10.1016/S2589-7500\(19\)30213-4](https://doi.org/10.1016/S2589-7500(19)30213-4), [https://www.thelancet.com/journals/landig/article/PIIS2589-7500\(19\)30213-4/fulltext](https://www.thelancet.com/journals/landig/article/PIIS2589-7500(19)30213-4/fulltext)
Accessed January 2020

Proposal for more mental health nurses and training for other health professionals

The Productivity Commission's draft Report rightly suggests that

Stigma reduction programs, including interactions between health professionals and mental health consumers on an equal footing outside of a clinical setting, should be rolled out in a staged manner, into the initial training and continuing professional development requirements of mental health professionals.

And I would argue this applies also to other health professionals such as GPs, emergency health professionals, nursing, police and other first-responders, and any other professionals that people encounter on their journey.

I recently asked a group of nurses in training what exposure they had had to mental health as part of their course. These were soon-to-graduate nurses. All resoundingly cried "not enough!" They also commented that understanding mental health and their own roles as practitioners is part of their role for every patient and yet mental health is given scant attention. Anecdotal of course, but certainly suggesting that this is worth exploring further for all nurses.

So, this should not be simply about more mental health nurses. Accredited nationally-consistent training can be provided across a range of professionals in collaboration with professional bodies.

We are a culturally diverse society and so, as noted in the Productivity Commission's draft Report I agree that

..... professional training for all should value peers and

*..... should include measures that instill an understanding of how peoples' **cultural background** affects the way they describe their mental health and their compliance with treatment options. (bold added)*

Again, building on the work on nationally consistent communications, the NMHC can then establish some core principles for **accredited training programmes**. This would recognise and be adapted for the different communities or circumstances and different cultures. An accredited programme using core principles could be used for all health professionals as well.

Our clinical health system

From my position outside the clinical health system, it does indeed seem that there is a large service gap. Those who need perhaps only a little support often remain unsupported, and their problems can develop into more serious conditions. Even those with severe and diagnosed ill-health also often need more or better attention.

Effective self-identification is hard. And even when a person acknowledges to themselves that they need help, the individual needs to know when and where to seek help to ensure they connect with the right help at the right time. This is a vulnerable time for the person and the steps in the process have weak points as well. Guidance from new NMHC is vital.

This means ongoing access throughout life and throughout dips and troughs of mental ill-health. At **no point** should there be a gap.

Much could be achieved by guidance from NMHC for all levels of vulnerability, all ages and stages and at all points through life. Resources for self-help can be much improved by consistent messaging (and definitions), across services including any delivered through the internet/electronic devices. This is something the new NMHC can do – consistent national communications, along with an accredited training programme for the various health practitioners.

Again, to quote EveryMind/MindFrame, *the way mental ill-health is communicated about or portrayed can greatly influence help-seeking behaviour and the prevalence of stigma*. EveryMind/MindFrame has published guidance for communications and this could be a useful starting point for all.⁷

There are many suggestions for re-orienting health services towards people who need them. Again, I would hope a nationally coordinated “alliance” through NMHC would evaluate and develop well-considered evidence-based approaches.

Emergency Departments

There are two matters to raise first here:

1. We should be aiming to **relieve** our emergency departments of some of the mental health workload by intervening before presentation at hospital, and by offering more appropriate interventions.
2. Some emergency departments are ill-equipped to manage mental health issues. They can of course be better equipped but other appropriate options can be established for referral.

I was once asked to report on access to the emergency department in a large public hospital. Access to and progress through the emergency department of hospitals can be complicated. It can be frantic. Presentations can be multifaceted. It can involve priority actions or lengthy waiting times. Triage is, as always, a crucial point.

⁷ MindFrame guidelines for communicating about mental ill-health
<https://mindframe.org.au/mental-health/communicating-about-mental-ill-health>.
Accessed 14 January 2020 * MindFrame is managed by EveryMind and funded by the Australian Government under the National Suicide Prevention Leadership and Support Program

Most triage systems are geared to physical emergencies. Inevitably, the triage process limits what can be achieved for someone with an immediate need for mental health treatment. Those involved should have an understanding of the issues involved in presentation, including mental health issues. Other restrictions they must balance are the resources available and emergency priorities.

However, alongside these issues are some opportunities.

For example, one of the Reith Lectures by BBC looked at the future of medicine. Dr Atul Gawande used a powerful case to show how introducing a simple checklist in the process, early enough during triage improved the outcome. This was despite resistance from staff involved. It may be that **including mental health in the checklist as part of the triage system**, could prove beneficial. Again, NMHC in conjunction with its stakeholders, could look at available research, share data, evaluate and provide guidance and accredit training for health professionals.

Although the health sector is fragmented and competes for funds, has resource difficulties and issues around quality outcomes, there are opportunities for improvement and fast referral to other avenues can be found.

Even so, we need to find other avenues before emergency services are called upon. **No matter how well coordinated, any emergency service including the emergency department in hospital should be a last resort.** I am concerned that current emphasis is on using the emergency services as a pathway to treatment. Certainly, crisis or emergencies can happen and the responses could be improved at triage and beyond, but the main aim is to first prevent and then refer appropriately and in good time.

A recent paper reviewed the Australian healthcare system.⁸ They note

Public hospitals in Australia face problems like other developed countries, for example, limited resources, a growing demand and pressure to improve the quality and patients' outcomes. Resource allocations and performance improvements are two main issues that policymakers, researchers and healthcare practitioners ought to deal with.

As part of the research they found that

The CareTrack⁹ study revealed that significant improvements were needed to deliver appropriate healthcare in Australia.

⁸ Dixit SK, Sambasivan M. A review of the Australian healthcare system: A policy perspective. *SAGE Open Med.* 2018;6:2050312118769211. Published 2018 Apr 12. doi:10.1177/2050312118769211
accessed 15 January 2019
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5900819/>

⁹ CareTrack: Assessing the appropriateness of health care delivery in Australia. Runciman WB, Hunt TD, Hannaford NA, Hibbert PD, Westbrook JI, Coiera EW, Day RO, Hindmarsh DM, McGlynn EA, Braithwaite J
Med J Aust. 2012 Jul 16; 197(2):100-5.

This research looked at specific physical conditions. A summary of the key characteristics of the Australian, Canadian and French healthcare systems is shown in their paper in Table 7. I believe it would be of value to **expand this work to assess mental health care in Australia.**

In this paper, the review noted that Australia uses Activity Based Funding, and thus, there is scope for looking at **other forms of funding.**

The researchers also make the following recommendations for future research

1. *... a bundled payment mechanism may be used to reduce the costs and improve the quality and patients' outcomes. Bundled payments can also be used to reduce unplanned readmissions.*
2. *...Australia also has private hospitals, the prospects for the pooling of resources and the management of a joint waiting list could be explored. Such a proposal may trigger a public policy debate and raise some legislative issues.*
3. *... the appropriateness of care should be incorporated in the outcomes' measurements of hospitals.*
4. *... patient education and discharge planning strategies should be a part of the performance measurement mechanism.*

Their suggestions for bundled payments, certainly for a joint or shared waiting list, measured outcomes on appropriateness of care and discharge planning strategies could be suitable for our approach to mental health and deserves more research.

Also, timely availability of crisis support services can prevent or reduce emergency department presentations and offer an alternative direction for police and other crisis first responders.

Rather than focusing on emergency services, more emphasis should be placed on developing and enhancing crisis support in the **community**. Encouraging digital technology, improving skills and communications.

Certainly, reforming health sector with more patient focus as recommended in the Productivity Commission's draft Report would be a good step.

4. Contributing Lives

Key points

- a) **Review process** for accommodation (and supply) for those in need, including identification and assessment for those with mental ill-health.
- b) **Education** for all parties including property managers through appropriate professional development and professional associations
- c) Teachers, schools and community have **shared responsibilities**. So, any training and the requisite support pathways should be shared. **Digital technology** has potential for all ages.
- d) **Similar to schools, tertiary institutions can offer a “gateway”, so they can provide nationally consistent information and can promote available services, and provide referrals. Digital technology and programmes like EAPs could be explored**

Homelessness

Improving our capacity to live contributing lives and participate in the community, is a platform for prevention, and a crucial part of the journey to recovery for ill-health.

Many of those with mental ill-health are homeless. Does mental ill-health cause or result in homelessness is not a question that needs an answer here – as a society, we must address homelessness. Many reports show that homelessness clearly aggravates mental health and mental ill-health often results in homelessness.

As with the connection between work and mental ill-health, there is a nexus between homelessness and mental ill-health. As noted by the Productivity Commission,

On one hand, the stresses of homelessness can contribute to poor mental health. On the other hand, mental illness can increase an individual’s risk of homelessness.

Suitable housing can prevent and potentially enhance recovery. We also want to accommodate people in the community rather than in hospitals or institutions. Those who are persistently homeless, should have access to long-term housing and mental health supports as quickly as possible. People with complex, long term mental ill-health would probably benefit from a progressive or staged approach to independently living in the community. How this can be achieved and maintained is the question.

Researchers in UK¹⁰ found that they

did not find clear evidence on the most effective model(s) of mental health supported accommodation.

I feel how to provide accommodation (and funding it) could be more thoroughly addressed.

There must still be a process for assessing if participants are housing-ready and how and when they might engage with support services. Taking out steps or checks may seem to lessen the time or the process but this risks deferring issues or creating new ones.

Perhaps the current process has some weak points. The **process may need review**. Merely removing these attributes and these steps or checks will not, in my view, necessarily improve outcomes. The response cannot be a blanket approach.

Indeed, this seems an urgent task for the new NMHC and a cross departmental committee.

Building positive relationships is important here too - for all those involved. I agree with Productivity Commission draft Report Vol 1¹¹.

State and Territory Governments should develop or scale up existing supported housing programs that integrate housing, tenancy support and mental health services.

I think **it is actually possible to build positive relationships with real estate agents and landlords**, as recommended in the Productivity Commission draft Report. Real estate agents receive training and are licensed; they need to be aware of the implications of any tenancy decision. This can form part of professional development. The Property Council and other professional bodies should be approached for their views.

We are not here talking just about discrimination or stigma. We know that building skills helps break the silence, helps break down the barriers.

We need steps to provide each party with the necessary skills to construct positive relationships, to **identify early signs and to refer to the appropriate service** for the issue at hand in a timely fashion. Identifying vulnerable tenants for example is a skill and using eviction alone without offering other pathways should always be only a last resort. **This is actually about education and skills. The appropriate professional development and professional associations must be consulted about the best way to reach their members.**

¹⁰ Killaspy H et al, Supported accommodation for people with mental health problems: the QuEST research programme with feasibility RCT, 2019 <https://www.ncbi.nlm.nih.gov/books/NBK546971/> Accessed January 2020

¹¹ Productivity Commission 2019, *Mental Health*, Draft Report, Canberra Vol 1 p565 <https://www.pc.gov.au/inquiries/current/mental-health/draft> Accessed December 2019

Because this also holds a risk of misdiagnosis and abuse, none of these parties should diagnose. Instead they should be equipped with the skills to refer to appropriate services such as tenancy support, mental health or suicide helplines.

The aim is to build trust, understanding and awareness by providing some basic skills and options. We also must provide appropriate alternative accommodation.

Contributing Lives - The justice system

I wholeheartedly agree that there is a need for mental health care at all stages of the justice system from initial assessment and, where mental ill-health has been identified, throughout the person's life. This sounds resource-intensive but has the potential to be cost effective.

The NMHC could undertake research on most appropriate times for ongoing assessment of mental ill-health and cost effectiveness of health care where ill-health is identified.

Legal representation is an important protection for all people especially those who face involuntary detention and treatment due to mental illness. I agree that some form of funding should be provided for legal assistance.

Contributing lives - Tertiary Students

Tertiary institutions should provide students with mental illness (and indeed, all students with a disability) timely access to effective support.

At a recent event, one student seeking mental health support from University services reported that they had to wait for three weeks for an appointment. That is three weeks of continuing and often increasing anguish. It seems sensible to provide an immediate electronic service (smart phone access 24/7) with referral to outside services. Of course, timely face-to-face service at the University can also be offered. As with Employee Assistance Programmes (EAPs) in the workplace, Universities can contract to external confidential, accessible assistance. EAPs can also be shared in clusters with other organisations.

University (or other tertiary) life can be undertaken remotely; attendance is not always compulsory. Lectures are accessible on line and assignments submitted on line. I was previously a lecturer in a tertiary institution. Today there is less direct contact and less relationship building. A lecturer or department is less likely to have the opportunity to become aware of issues and so cannot be expected to take responsibility for every individual student's mental health.

However, the tertiary institution can offer a "gateway", so it can provide nationally consistent information and can promote available services, and provide better referral.

On most campuses, international students have access to language support, social supports and inclusion activities. Self-referral and access can be even more difficult for international students. Some institutions have tried mentoring programmes, some have tried language and interpretation services. I am not aware of any robust data on what works. Culturally sensitive programmes certainly need to be explored and evaluated further. Again, electronic devices could be key.

Sufficient private healthcare cover should apply to all students, not just international students. A triage process could be used to help identify if students have cover and if not where they could be directed to obtain cover. For those that can ill afford private cover there needs to be a safety net. A business case could be established for tertiary institutions to explore creation of a fund from existing resources, or shared with community funders or the Alumni, for a safety net to support those in need.

In addition, the application processes for disability funding should be reviewed and simplified, ensuring that a student receives the support necessary to remain engaged in their education – primary, secondary and tertiary. This is an urgent task for the education “alliance” or committee within the new NMHC.

The Individual Placement and Support (IPS) program currently being trialled for youth with less severe mental illness in Australia should be evaluated. Indeed, it is my understanding from colleagues that this has potential. So, depending on the outcomes of the trial, similar services could be established.

5. Workplaces that work for everyone

Key points for workplaces where mental health is a shared responsibility

- a) Psychological health is already a WHS obligation. More can be done to provide **incentives and guidance towards good design** of work practices.
- b) **Businesses** do play a key role, but their responsibilities, and therefore responses, should be confined to **what is under their control**. They can act as gateways.
- c) More research and guidance is needed to produce **evidence for overarching programmes that are effective** and meet obligations.
- d) More could be done nationally to **disseminate, support and understand the SWA Guide; to communicate, educate and train** all levels in the workplace so there is better understanding of the roles and responsibilities.
- e) **Encouraging a good culture and having conversations as early as possible are highly effective mechanisms.**
- f) More can be done to have the **confidence and skills to be respectful, respond and act appropriately**. This requires **skills, education, training and nationally-consistent information**.

There have been valiant efforts to encourage workplaces that are inclusive, that value diversity and retain their workers. The benefits of 'good work' to the individual are extensively reported and substantiated. This is not in question nor is it a solution. Whilst businesses should have social and environmental responsibilities and accountabilities, it is not the prime function of a business to act as a social enterprise.

Evaluation and provision of **guidance on workable successful programmes that encourage and enable inclusion and retention of workers** would be a constructive approach. Indeed, Hanisch et al¹² found

Future research needs to explore to what extent changes in employees' knowledge, attitudes, and supportive behavior translate into increased and earlier help-seeking by affected individuals.

Despite all the promotion on the returns on investment in this area, many businesses remain reluctant. There are barriers. To encourage 'workplaces for everyone' these barriers warrant more attention. More can still be done to highlight the potential and the high returns to employers. **But more needs to be done to establish what works and what doesn't and to provide clarity on what is expected of employers and how they can meet all their responsibilities.**

I don't believe employers are totally oblivious or determinedly obstinate; their concerns need to be addressed and the practical application made clear and easy to apply for small and large businesses. So, let's have more support and guidance for the desired long-term commitment to retain workers, for workers to recover at work and to provide a supportive positive culture.

In fact, **a broad range of factors contributes to an individual's psychological health – not all of them reflect a legal duty on the business.** My experiences with organisations showed some employers were reticent to sign up to the Australian Consensus Statement on the Health Benefits of Work.¹³ It can be difficult for some to recognise that the obvious benefits for the employee translate into benefits for the business, particularly since the former are immediate and the latter, longer term.

¹² Hanisch, S.E., Twomey, C.D., Szeto, A.C.H. *et al.* The effectiveness of interventions targeting the stigma of mental illness at the workplace: a systematic review. *BMC Psychiatry* **16**, 1 (2016)
<https://doi.org/10.1186/s12888-015-0706-4> Accessed January 2020

¹³ Australian Consensus Statement on the Health Benefits of Work. Australasian Faculty of Occupational & Environmental Medicine Position Statement 2010
[www.racp.edu.au > faculty-of-occupational-environmental-medicine](http://www.racp.edu.au/faculty-of-occupational-environmental-medicine) Accessed December 2019

Some of the barriers to adopting these programmes by employers include **confusion on terminology and uncertainty or ignorance about responsibilities and what action is proven to be effective**. For example, one case notes that

*..... steps likely to **reduce the risk of injury to mental health** may be more **debatable in terms of their likely efficacy** than the mechanical alteration of the physical environment in which an employee works.¹⁴*

These uncertainties are a significant barrier. Businesses do play a key role, but their responsibilities, and therefore responses, should be confined to what is under their control. More research and guidance is needed to produce evidence for overarching **programmes that are effective and meet obligations**.

Mental health is a shared responsibility. In the workplace, this is not just a matter of allocating legal responsibilities and then enforcing them. Some commentators in reviewing sexual harassment and discrimination in the workplace note that whilst laws fulfil a role, laws themselves have not shown how to be proactive and preventative. More laws are not the only option; indeed, legislation alone is not the **best way to achieve behaviour change**.

I note that a 2019 survey by SuperFriends¹⁵ (a regular survey) found that; *The most common barrier to achieving a thriving workplace is lack of appropriate skills in managers*. The indicators in this survey cover the *five key domains of thriving workplaces: leadership, connectedness, policy, capability and culture*. More can be done to provide incentives, improve skills and also provide guidance towards good design of work practices.

In my view, businesses' role and responsibilities should include those factors involved in **work-related** psychological health. What a person in control of a business or undertaking (PCBU) needs to know is **'how'**: how to meet their obligations, how to act on the issues under their control, and how best to respond.

A respectful, mentally (psychologically) healthy workplace is one that prevents harm, has good work design, intervenes early and provides appropriate supports, that is has a supportive stigma-free culture.

¹⁴ Hegarty v Queensland Ambulance Service [2007] QCA 366 <http://www.austlii.edu.au/cgi-bin/sinodisp/au/cases/qld/QCA/2007/366.html?stem=0&synonyms=0&query=hegarty> Accessed March 2019

¹⁵ SuperFriends Indicators of a Thriving Workplace 2019 Survey <https://www.superfriend.com.au/further-resources/2019-indicators-of-a-thriving-workplace-survey/> Accessed January 2020

Safe Work Australia (SWA) recently republished its Guide: *Work-related psychological health and safety: A systematic approach to meeting your duties*. January 2019.¹⁶ **I believe more could be done nationally to disseminate, support and understand the SWA Guide; to communicate, educate and train all levels in the workplace so there is better understanding of the roles and responsibilities.** It will deliver a better understanding of inclusive employment, of reasonable accommodation of difference or disability and recovery at work.

Reasonable accommodation and reasonable management are part of the expectations and obligations for work and apply to psychological health as well as physical health. I do not see how this results in treating psychological health as an *exception*. It is however vital to “triage”, to assess and provide appropriate actions as early as possible. As noted by Collie¹⁷ *Screening, early intervention and referral programs may reduce the prevalence and impact of psychological distress.*

Along with **design of good work** (or good design of work), early reporting and early interventions are important. This means encouraging a culture where people are comfortable enough to share and express their thoughts about the effect of work being undertaken or issues that may affect their work. **Encouraging a good culture and having these conversations as early as possible are highly effective mechanisms.** They are not strictly legal responsibilities.

Responsibilities also extend to a person in control of a business or undertaking (PCBU) understanding his/her duty for an **individual’s non-work-related issue that may be affecting their performance (or the performance of others) or affects a person’s safety while at work.** Even in a thriving mentally healthy workplace, there will be mental ill-health from time to time, some brought about by factors outside the control of the workplace; it’s vital that **managers or supervisors do not diagnose, nor act as psychologist or health supporter. They do need to have the confidence and skills to be respectful, respond and act appropriately.**

This requires **skills, education, training and nationally-consistent information.** It requires, not more laws, but the usual four stages - genuine consultation, gaining of consensus, collaboration and then gaining the commitment needed to make a difference.

A person’s general health is the responsibility of the individual. Whilst the community, the health sector and businesses have a role, businesses should not be held to account for an individual’s feeling of **complete “wellness”**. Use of this approach in the past has built barriers and has been counterproductive.

¹⁶SWA Work-related psychological health and safety: A systematic approach to meeting your duties. (January 2019) <https://www.safeworkaustralia.gov.au/doc/work-related-psychological-health-and-safety-systematic-approach-meeting-your-duties> Accessed 17 February 2019

¹⁷ Collie A, Sheehan L, Lane TJ, Iles R, Psychological Distress in Workers' Compensation Claimants: Prevalence, Predictors and Mental Health Service Use. [J Occup Rehabil.](https://doi.org/10.1007/s10926-019-09862-1) 2019 Oct 23. doi: 10.1007/s10926-019-09862-1. <https://www.ncbi.nlm.nih.gov/pubmed/31646415>. Accessed January 2020

As the draft report notes,

determination of whether or not the psychological injury is work related is a 'challenge' as the triggers of mental health conditions are often multi-factorial and difficult to authenticate (Nelson 2019).

In December 2018, A Clinical Guideline for The Diagnosis and Management of Work-Related Mental Health Conditions in General Practice was published. This was to guide the diagnosis and management of patients with work-related mental health conditions.¹⁸ Both the SWA guide for the workplace and the GP guide for General Practitioners need to be promoted and need time to have effect and be evaluated.

Employers desire to reduce workers compensation premiums may actually be an incentive for better performance, not for “fudging” claims. **It is the insurer that makes the decision on a claim.** Premiums are only part of the picture. The allocated category for premiums is also based on the claims experience of the particular industry. The industry category can have a large effect on the premium and applies to large or small businesses. Surely, this can be an incentive for the whole industry to reduce the risks. The insurer is in a good position to encourage good practices and share experiences. It is the government’s contract with insurers that could be strengthened to encourage positive, pro-active, preventative approaches. Indeed, good practices should be rewarded. Is there robust evidence for extensive mismanagement of claims for avoiding premiums?

The intention of the obligations imposed under the WHS legislation is really about the foreseeable effect of work on psychological health. Workers compensation is for when this effect results in work-related harm.

What would specific psychological health regulations actually achieve beyond the guidance provided? Regulations should not be used to replace education and capacity building. How can regulations specific to psychological health be devised and applied? It is not a noise level which can be measured and a number or level enforced. Impact and response can be unique to an individual. I believe there are better ways to encourage good work and good behaviour.

¹⁸ Clinical Guideline For The Diagnosis And Management Of Work-Related Mental Health Conditions In General Practice 2018, www.monash.edu/work-related-mental-health-guideline .

Work Health and Safety (WHS) legislation

Actually, psychological health has always been part of the definition of health. It is and has been part of work health and safety (WHS) or Occupational Health and Safety (OHS) legislation.

Under the [model WHS Act](#), and OHS Acts in Victoria and WA, there is a duty to protect workers from psychological risks as well as physical risks. According to Safe Work Australia, this involves

*designing work, systems and workplaces to eliminate or minimise risks to psychological health; monitoring the health of workers and workplace conditions; and consulting with workers*¹⁹

Employers have these duties under work health and safety (WHS) laws to ensure the health and safety of workers **so far as is reasonably practicable***. This includes psychological health. There are also obligations under Fair Work Act for 'reasonable accommodation'. It should be noted this includes a duty to make sure work is safe, both physically and psychologically, for those returning or recovering after a workplace illness or injury.

As mentioned, the intention of the obligations under the WHS legislation is about the foreseeable effect of work on psychological health. This means a business should focus on managing and minimising **work-related psychosocial risk** and on **prevention of work-related** mental health conditions, so far as is reasonably practicable. The question is how can this best be achieved for the individual, the business and the community.

6. Benefits of good work design

¹⁹ SWA *Work-related psychological health and safety: A systematic approach to meeting your duties*. (January 2019)

<https://www.safeworkaustralia.gov.au/doc/work-related-psychological-health-and-safety-systematic-approach-meeting-your-duties> Accessed 17 February 2019

* Under the section 18 of the Model Act, "reasonably practicable" means

- the likelihood of a hazard or risk occurring
- the degree of harm that might result
- what the employer knows or ought reasonably know about the hazard or risk, and ways of eliminating or minimising hazard or risk
- the availability and suitability of ways to eliminate or reduce hazard or risk
- the cost associated with available ways of eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk

Key points to consider include

- a) More can be done to provide **incentives and guidance towards good design** of work.
- b) More could be done nationally to **disseminate, support and understand the SWA Guide; to communicate, educate and train** all levels in the workplace so there is better understanding of the roles and responsibilities.
- c) More can be done to have the **confidence and skills to be respectful, respond and act appropriately**. This requires **skills, education, training and nationally-consistent information**

Work-related factors in psychological health

In the past, employers have not been clear on how they are to meet their responsibilities specifically for psychological health. To this end, as noted above SWA has recently published nationally agreed guidelines. This includes guidance on the **design of work to avoid issues and safe management of return to work**. SWA states

The Guide describes a systematic approach to managing work-related psychological health and safety, including preventing harm by eliminating or minimising risks, intervening early and supporting recovery.

This guide needs to be widely applied and stakeholders provided with support to achieve its aims. The WHS regulators need to use the range of available tools to ensure this guidance is applied. This guide needs endorsement and promotion. I don't believe time and effort should be spent to change this guide again to a Code of Practice. The evidence is that it is education and incentives that drive commitment; changing to another style of enforcement may not be as successful.

A guide can be used as current knowledge. A code of practice is a different beast. It has particular legalistic attributes. I disagree that it is a more appropriate instrument to gain positive outcomes in the workplace. I would however, wholeheartedly support evaluation of programmes to establish what works best and what doesn't work.

Risk Identification, assessment and control

I don't feel it is useful to directly equate the physical risk management approach with that of psychological health. It is similar but not the same. It is still identification, assessment and "control" or mitigation, but I remain concerned about application of measurement techniques and solutions standard to physical hazards being directly applied to psychological issues in the workplace.

I fear, amongst other things, the misuse of measurement and monitoring. I do not believe it is appropriate to directly apply the control hierarchy for physical hazards on psychological issues and I fear the outcomes for those in need. More research is needed on how psychological risk factors outlined in SWA guidance, interact, how they impact individuals and organisations and what mitigating actions are effective.

We do not need a new army of industrial assessors, measuring mood or psychological state. I am also wary of surveillance and monitoring. There are, no doubt, some approaches and tools that offer much improvement and potential. There has been research on systematic measurement and analysis by Dollard²⁰ and others. Dollard has reported much promise for applications of Psychosocial Safety Climate (PSC). There has also been use of the People at Work²¹ approach. People at Work measures psychosocial hazards and factors through the use of the *People at Work survey*. These approaches have not yet 'excited the marketplace'. NMHC should evaluate further what really works.

Having said that, as I indicated in my original submission, there is a case for assessments for psychological health for nominated high-risk tasks, such as pilots, air traffic controllers etc.

Rather than assessment, compensation, or more law we should be looking at **prevention and sustainable change**. As the Taylor Review notes

*The best way to achieve better work is not national regulation but responsible corporate governance, good management and strong employment relations within the organisation, which is why it is important that companies are seen to take good work seriously and are open about their practices and that all workers are able to be engaged and heard.*²²

²⁰ Prof Maureen Dollard, Tessa Bailey, Dr Sarven McLinton, Penelope Richards, Wes McTernan, Assoc Prof Anne Taylor and Stephanie Bond, University of South Australia, The Australian Workplace Barometer: Report on psychosocial safety climate and worker health in Australia, Commissioned by SWA, 2012, <https://www.safeworkaustralia.gov.au/doc/australian-workplace-barometer-report-psychosocial-safety-climate-and-worker-health-australia> Accessed January 2020

²¹ People at Work Project: An assessment of psychosocial hazards in the workplace - Final report 2016, Queensland University of Technology, The Australian National University, Workplace Health and Safety Queensland, WorkCover NSW, WorkSafe Victoria, Comcare, Safe Work Australia, and *beyondblue*. <https://www.safeworkaustralia.gov.au/book/queensland-managing-psychological-risks> Accessed January 2020

²² Mathew Taylor RSCA; Good Work: The Taylor Review of Modern Working Practices 11 July 2017 (UK) Department for Business, Energy & Industrial Strategy <https://www.gov.uk/government/publications/good-work-the-taylor-review-of-modern-working-practices> Accessed 27 February 2019

7. Funding models other than reforms to workers compensation schemes

Key Points to explore other funding models

- a) Workers compensation is funded by employers and is for claims where **work is a significant factor**. Use the workplace only as a gateway.
- b) Most workers compensation systems are geared towards recovery at work and retention. They provide agreed return to work plans to assist return to pre-injury, pre-event capacity and a scaled approach to treatment and benefits. **improving communication, improving the claims process and providing incentives for the employee to recover at work and employer to practice good recovery at work would be better than a 'no liability' process.**
- c) Rather than encouraging time away from work, its **preferable to build a better approach**. Foster positive engagement and outcomes. Consider a system similar to TAC to fund the programme or an increase to the existing Medicare levy rather than through workers compensation.
- d) **Funding a general health intervention might be more productive than seeking to extend duration or provide no liability for psychological ill-health.**
- e) Consider presumptive legislation that could **fast track** care and return to work in high risk exposure occupations.
- f) Use the learnings and findings from SuperFriend and Safe Work Australia **"Taking Action"** to improve claims management.
- g) **Insurers contractual arrangements** should already include an obligation to assist employers with prevention programmes for both physical and psychological health. Certainly, another incentive could be to **reduce premiums** where employer has demonstrated good performance.
- h) Tweaking one part of workers compensation is not recommended. **Seek changes through SWA Workers Compensation Committee** (all jurisdictions are represented) and use SWA's established process.
- i) **Work-related factors deserve better promotion and encouragement and reinforcement in the workplace**. Indeed, WHS regulators should advise and support employers to implement effective evidence based interventions.
- j) Report serious incidents. A clear definition and simple flow diagram of actions required will be needed
- k) WHS regulators have an important supportive and educative role to play; not just the prescription of regulation and not just enforcement. The best way to effect behaviour change is through education and incentive.

The workers compensation system is important and effective. But it is not a way to prevent or mitigate harm. An individual claims workers compensation after an incident. Of course, overall claims data can provide information for change, but we should be aiming to avoid a claim for a compensable harm in the first place.

Claims for the range of psychological injury are complex. The nexus with work can be more difficult to untangle than for physical injury and the process itself is reported to have potential to exacerbate psychosocial stress.²³

Workers compensation is designed for issues where **work is a significant contributing** factor. It has not been designed for general health concerns. All 11 main schemes in Australia already enshrine a no-fault workers' compensation legislation.

Most workers compensation schemes, even now, provide for immediate support until the claim is determined. This is a worthwhile approach. Despite areas for improvement this rightly remains a core principle of workers compensation. These laws aim to support workers in the event of a work-related injury or illness, including **work-related psychological health conditions**. The Productivity Commission draft Report mentions "features" that delay interventions and treatment. Evaluation should be undertaken to determine exactly what might work to provide recovery at work and identify the factors causing delay because delay can exacerbate the issue.

Premiums are paid by employers and these are used to cover a range of entitlements and services including medical treatment and support for retention and return-to-work (RTW). Return to work is hastened through early identification and treatment of psychological ill-health and physical health too. **Retention at work where practicable is and should be the aim**. If not practicable e.g. for smaller businesses, insurers may be able to find placements in an industry cluster or grouping.

Most systems work towards retention and provide agreed return to work plans to assist return to pre-injury, pre-event capacity. They do not encourage time away from work - nor should these reforms.

Proactive Insurers

In Victoria, the insurer is also required to assist the employer with, not just efficient management of claims and key return-to work (RTW) approaches, but also prevention programmes. Prevention is surely in the interests of insurers too. But not many workers compensation insurers are as proactive as they could be and not many employers know that they are able to seek support from insurers. **Holding these insurers to the contractual arrangement for prevention of physical and psychological health risks would be an important step for reforms to psychological health**. Employers would then have ready access to advice and the funding that they have already paid for through their premiums.

²³ Collie, A; Lane, T; Hatherell, L; McLeod, C (2015) Compensation Policy and Return to Work Effectiveness (ComPARE) Project: Introductory report. Research report #: 118-1005-R01

<https://research.iscrr.com.au/recovery/claims-management> Accessed March 2019

Research shows that access to early medical treatment and an expedited claims determination process can have a positive impact on injured workers. It seems that access to treatment is not the main barrier but access to “triage” or accurate screening may be. Changing from early diagnosis and early return to payments to stay away from work seems counter to all that has been achieved already.

A provisional liability (or interim payments or without prejudice payments), payments made (often limited) pending resolution of the claim is not the same as a NO liability system. Nor is it the same as presumptive process outlined in my original submission. The presumptive process for specific deemed conditions or occupations hastens and smooths the process. With presumptive legislation, support payments are automatically made for specified occupations or events.

Reforms should support presumptive legislation for specified occupations or events rather than propose across-the-board no liability. More research is needed to identify “features” mentioned as reasons for delay and I would strongly recommend consultation with Safe Work Australia to evaluate for each scheme. Building positive relationships and responses, building skills and communication may be more fruitful.

Fund provisional liability, but not ‘no liability’

Already under workers compensation, some payments may be made before a decision is made on a claim and/or liability under the relevant legislation. Provisional liability can provide for the payment of benefits and medical expenses under workers compensation schemes. There are different scaled approaches in different jurisdictions for payment of benefits. However, **all this applies only where work is a significant or contributing factor. It cannot be sensible to remove the link between employment and liability in workers compensation arrangements. There are other ways to effectively remove delays.**

The draft report by Productivity Commission notes that

*‘No liability’ medical treatment could be provided for mental health related workers compensation claims **until** the injured worker returns to work or up to a period of six months following lodgement of the claim*

Workers compensation is funded by employers and is for claims where work is a significant factor. Employers paying for general mental health issues, especially with no liability seems to deny natural justice or any right for the insurer to limit access to funds and no right to further investigate a claim. As a colleague noted, this proposal invites, indeed encourages, exploitation of the system; for example, a poor performer who sees the writing on the wall – as soon as they receive their second counselling session, may put in a “stress” claim. Even with ‘reasonable’ management conducted in a ‘reasonable’ way, it can be in the mind of the ‘beholder’ – determining its reality is fraught. Having a no liability approach is inviting trouble, in my view. It works against the desired proactive, positive, co-operative approach.

There must be a **public health funding approach, rather than a Workers Compensation approach.**

Some ideas that have been used in other systems may be worth further exploration. Currently in Victoria the Transport Accident Commission (TAC) pays no liability medical treatment for road accidents. The funds are raised as part of compulsory registration. In Queensland ambulance cover is funded by a levy on a land owner's rates. Queensland also has National Injury Insurance Scheme (NIIS) for workers with a life time statutory entitlement. It makes more sense to me that a system similar to TAC could be used to fund the programme or an increase specific for diagnosed mental ill-health to the existing Medicare levy. Medicare is funded through taxation as well as a levy, maybe there is more opportunity through a mix of tax and levy.

Much psychological ill-health develops over time. A no liability workers compensation approach could be counter-productive.

Ideally, what we really want is to identify as early as possible the factors that can pose a risk; a focus on good work design for example, or identifying signs and symptoms and provide appropriate early interventions. Funding for diagnosed ill-health should remain a general health benefit, either through public funding or mixture of public and private health funding same as it does for physical ill-health.

Early intervention and Early claims processing

Detecting signs early and referring early or enacting a good early intervention program can reduce the frequency or severity of physical injury and certainly also psychological ill-health. Much effective work has been done to date in workers compensation management to reduce the duration of a claim as much as possible.

Under workers compensation the time requirement across Australia for action is, in some cases, 10 days. Why would this be extended?²⁴ For example, in South Australia, the agent is required to make reasonable efforts to make a decision on the claim **within 10 days**. If this is not achieved, interim payments will be made. It is the insurer that makes the decision and they can/could waive any time limits pending circumstances.

Six months is a very long time to wait until a claim is resolved, so 12 months seems far too long before a claim can be resolved; too long to be receiving medical treatment or other benefits but not all the positive benefits of recovery at work, nor good management of claims. This seems counter to aim of recovery at work. I don't believe the threat of extending no liability for psychological ill-health, even though it would be expensive, would **encourage positive preventative action** in the workplace either.

²⁴ Productivity Commission 2019, Mental Health, Draft Report, Canberra Table 19.2: Time requirements on determination of workers compensation claims and provisional or interim payments <https://www.pc.gov.au/inquiries/current/mental-health/draft> accessed December 2019

Most steps in claim process should aim for maintaining good relationships or rebuilding relationships with a claimant. This can be fraught but is especially difficult if there is any dispute. An irretrievable breakdown can derail the whole process and can prevent the worker from returning to their pre-injury role or any workplace. A no-liability process could miss the opportunity, could encourage adversarial approaches, in fact could be totally counterproductive. **Good communication and good relationships are key and reforms should foster positive approaches.**

Accurate diagnosis by a qualified practitioner is important and defines treatment and progress. Establishing good diagnosis at this early stage would also be helpful. It is important to acknowledge that we do **not** want managers or colleagues diagnosing. Inappropriate diagnosis or misdiagnosis can have startling and negative consequences. Also, we want to minimise the risk of secondary psychological injury or aggravation of a condition. The 2018 Guidelines for GPs need time to take effect, be promoted and be evaluated.²⁵

Mental health is complex; it is often caused by multiple factors. More needs to be done to smooth this process even for physical injuries, and of course even more so for psychological ill-health. Creating a hiatus, as proposed in the reforms in the Productivity Commissions draft Report, may reduce the possibility of early interventions, proper communications and other positive interactions. After all, retention at work where ever practicable, is the aim. Actually, reforms should be all the more about processing the claim at the earliest possible time.

I believe its **preferable to build a better approach.**

Funding a general health intervention and using the workplace as a gateway might be more productive than seeking to extend duration or provide no liability for psychological ill-health. It seems to me there are more benefits using a TAC style approach, rather than a workers compensation approach. Some of the best practices of our Australian workers compensation processes could be incorporated into steps developed by this general health (TAC style) approach. Some learnings from overseas interventions can likewise be adapted.

Presumptive legislation- work-related

Some work contains inherent risks to psychological health, for example military service, emergency services and other first responders and health care work. It can be hard and lengthy to prove the nexus between the effect of the work and a poor psychological health outcome.

Rather than no liability, my suggestion is for those such as emergency services personnel, the process should be made easier and smoother. Rather than go through the adversarial process, we can and should recognise and acknowledge a level of psychological distress caused by exposure to work. Let's fast track it. The process for deemed diseases or for certain occupations such as first responders, can be streamlined.

²⁵ Clinical Guideline For The Diagnosis And Management Of Work-Related Mental Health Conditions In General Practice 2018, www.monash.edu/work-related-mental-health-guideline .

This has already been done for exposures to certain chemicals for firefighters. It can apply, not just for a one-off event, but where exposure may accumulate. A presumptive legislation could **fast track** care and return to work, where possible, in these high exposure occupations.

For example, Tasmania is currently considering a Bill that would provide presumptive compensation to *all* public sector workers suffering from Post-Traumatic Stress Disorder (PTSD).²⁶

More work could be done to evaluate this option, where it would apply, to whom and how it would fit with existing compensation processes.

Similarly, if all psychological ill-health was removed from workers compensation and all treated under general health system, the approach would need extensive research and evaluation before implementing. Although, a TAC style system or increase Medicare levy could be explored fairly simply for all psychological ill-health.

Tweaking one part of workers compensation can have unintended consequences. Again, Safe work Australia already has an appropriate committee to consider the most suitable approach. It has all jurisdictions, employers and workers involved already around the table. NMHC needs to work with SWA.

Managing claims better

It is my understanding, from my experience and from the research, that providing early support for a claimant, good communication and good initial responses to physical and psychological conditions make a positive difference to health outcomes. It also helps where all involved recognise the importance of recovery at work, returning back to work as early as possible or where necessary, to transition to a new or modified job; all this whilst bearing in mind the need for reasonable accommodation.

Timely and effective communication between everyone is key. This can be challenging for all parties involved and may vary according to the injury, especially for psychological harm or ill-health. For example, different approaches may be effective for a workplace bullying claim, as against a 'work demand' issue, rostering or shiftwork, fly-in-fly-out work or a first responder with post-traumatic stress.

Improving communication, improving the claims process and providing incentives for the employee to recover at work and for the employer to practice good recovery at work, would be better than a 'no liability' process.

²⁶ Tasmanian Government 2019 has introduced a Bill [Workers Rehabilitation and Compensation Amendment \(Presumption as to Cause of Disease\) Bill 2019](#) The Accessed March 2019

SuperFriend and Safe Work Australia (SWA) jointly published a report in 2017 providing an overview of framework and best practice action areas for claims management. In 'Taking Action'²⁷ they note that

Within the Australian context, there are particular factors that currently inhibit best practice:

- *Delays in notification: people with work-related psychological injuries rarely report their injury within the 6–12 weeks of onset 'window' identified as necessary for early intervention.*
- *The early experience of a PoC* is one of their eligibility being questioned, rather than of trust and immediate support.*
- *Employers sometimes lack the information and guidance they need to support a PoC.*
- *Insurers or agents do not consistently take a proactive approach to addressing any relationship breakdown between an employer and a PoC*
- *The dispute resolution system is slow and may create anxiety for the PoC, which can complicate the claim.*
- *There is a need to improve communication and collaboration between stakeholders involved in the return to work (RTW) process.*

(*PoC is person on claim - See Taking Action Framework p13)

Further they suggest that optimum claims management practice is characterised by the following principles applied *throughout the whole process—from the functions of claims management teams through to the business systems that support them at the organisational level:*

- *greater focus on the PoC as part of a case management approach to handling claims*
- *engaging with the PoC as an active contributor and collaborator in RTW planning*
- *supporting employers*
- *proactive claims management*
- *sophisticated use of data supported by sound governance arrangements, and*
- *active provider management framework.*

²⁷ Taking Action: A best practice framework for the management of psychological claims in the Australian workers' compensation sector, Safe work Australia and SuperFriends, 2017

<http://safeworkaustralia.gov.au/doc/taking-action-best-practice-framework-management-psychological-claims-australian-workers> Accessed January 2020

According to Safe Work Australia's [National RTW Survey](#)²⁸ data, 79 per cent of employees who agreed that their employer responded in a positive and supportive manner were back at work at the time the survey was completed. Whereas, the same survey found 52 per cent of employees who did not agree their employer was positive or supportive were back at work at time of survey²⁹. In other words, people who perceive themselves to have been supported return more quickly to work.

Positive and supportive employer engagement in the return or retention at work process is important. Again, according to the SuperFriends and SWA publication this includes:

- *timely and supportive contact from the employer following the initial injury or claim*
- *the PoC perceiving that their work is valued*
- *management being committed to the RTW effort (finding suitable duties and making reasonable work adjustments), and*
- *support from peers and supervisors on RTW.*³⁰

Research on programs that work, that **promote good work-related psychological health** would give us all more confidence and more positive outcomes. Such programmes are likely to prevent psychological ill-health from occurring and could be more inclusive. **Better work design and better claims management are fundamental.**

In their "Thriving Workplace Survey", SuperFriend³¹ found that there are two key issues:

1. *... Claims managers and rehabilitation consultants need an informed approach to **reviewing treatment regimes, and selecting rehabilitation interventions.***

²⁸ National return to work survey 2018 - Summary report Safe Work Australia October 2018
<https://www.safeworkaustralia.gov.au/doc/national-return-work-survey-2018-summary-report>
Accessed December 2019

²⁹ Wyatt & Lane, Return to Work: A comparison of psychological and physical injury claims; Wyatt, Cotton and Lane, Return to work in psychological injury claims

³⁰ Taking Action: A best practice framework for the management of psychological claims in the Australian workers' compensation sector, Safe work Australia and SuperFriends 2017
<http://safeworkaustralia.gov.au/doc/taking-action-best-practice-framework-management-psychological-claims-australian-workers> Accessed January 2020

³¹ SuperFriend - Indicators of a Thriving Workplace Survey 2019
<https://www.superfriend.com.au/further-resources/2019-indicators-of-a-thriving-workplace-survey/> Accessed January 2020

2. *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.*** (bold emphasis added)

In my experience, WHS and recovery at work (where possible) works best as a team approach. Hallden³² looked at the original intent of workers compensation albeit in the US and notes that

The reality is that positive outcomes depend more on a company's value system, such as whether an organization views its employees as assets rather than liabilities, than on legal protections.

There is also concern about claims process itself and relationships between key players. As Collie³³ et al found

Revision and reform of workers' compensation claims management practices to enhance worker experience and the fairness of procedures may contribute to improved return to work outcomes.

As Kilgour et al³⁴ found

....further research is required to investigate positive interactions and identify mechanisms to better support and prevent secondary psychosocial harm to injured workers.

There is always room for improvement. Signing up to charters or agreements can help e.g. Life Insurance Code of Conduct. We should also look at calculations for premiums or 'normal weekly earnings' (NWE), at improving and building positive engagement at work, and at the initial steps in claims management. All are steps to consider holistically; preferably, with consultation across the stakeholders and through SWA.

³² Hallden J., The original intent of workers' compensation: a team approach. [Work](#). 2014;48(3):435-9. doi: 10.3233/WOR-141909. iospress.com/articles/work/wor01909 Accessed January 2020

³³ Collie A., Sheehan L., Lane T.J., Gray S., Grant G., Injured worker experiences of insurance claim processes and return to work: a national, cross-sectional study. 2019 [BMC Public Health](#). 2019 Jul 10;19(1):927. doi: 10.1186/s12889-019-7251-x. <https://www.ncbi.nlm.nih.gov/pubmed/31291915> Accessed January 2020

³⁴ Kilgour E., Kosny A., McKenzie D., Collie A., Interactions between injured workers and insurers in workers' compensation systems: a systematic review of qualitative research literature. [J Occup Rehabil](#). 2015 Mar;25(1):160-81. doi: 10.1007/s10926-014-9513-x. <https://www.ncbi.nlm.nih.gov/pubmed/24832892> Accessed January 2020

In addition, SuperFriend found that *interventions for psychological claims that add most value are focused on work and are holistic*: Again, noting that

- *There is strong evidence that health and RTW outcomes are improved by work-focused treatments. Cognitive behavioural interventions should be **workplace based and work-focused**.*
- *There is strong evidence that **multifaceted interventions**—those across more than one domain (service delivery, healthcare, work modification)—**are more effective** in reducing time lost than interventions that focus on one domain only. (bold emphasis added)*

Moreover, as pointed out in the SWA Guide *Work-related psychological health and safety: A systematic approach to meeting your duties* in 2018³⁵, work design (e.g. demands of tasks or control over tasks), cultural aspects (e.g. supports provided or sense of justice), relationships at work and work practices, all have an important influence on worker mental health³⁶, and conversely, work-related factors such as high work demand, low control and low support, can pose risks to mental health.

In keeping with the advice from Safe Work Australia, the focus should be on how jobs are designed and how organisations work. **Design of work and attention to other work-related factors can influence individual risk factors for mental ill-health, but addressing these factors, so far as is reasonably practicable, can aid recovery and retain workers.**

So, in my view these aspects warrant further attention. These **work-related factors deserve better promotion and encouragement and reinforcement in the workplace**. Indeed, WHS regulators should advise and support employers to implement effective evidence based interventions.

Boland review and serious incident reporting

I agree that as with physical factors, **serious incidents** of work-related psychological ill-health that are the result of unreasonable, foreseeable, gross unmitigated risk should, like other serious incidents, require notification to the relevant WHS regulator. Such serious incidents could be flagrant defiance of appropriate shiftwork, or a continuing culture of bullying. I agree that criminal acts should be penalised under the relevant existing criminal laws. A 'Serious incident' will need to be well defined and education and support provided to ensure appropriate implementation. Reporting these serious psychological incidents was recommended in the Boland review of WHS legislation in 2018.

³⁵ SWA Work-related psychological health and safety: A systematic approach to meeting your duties. (January 2019)

<https://www.safeworkaustralia.gov.au/doc/work-related-psychological-health-and-safety-systematic-approach-meeting-your-duties> Accessed 17 February 2019

³⁶ Australasian Faculty for Occupational & Environmental Medicine, 2010, Realising the Health Benefits of Work: A Position Statement

The Boland review of the Model WHS laws also recommended that the WHS regulations be amended to specify how to identify the psychosocial risk associated with psychological injuries and the appropriate control measures (Boland 2018). I understand the appetite for regulating poor behaviour but I don't believe this is the best way. I believe more education and support to implement the new SWA Guide must occur and the process evaluated before a new regulation can be justified.

I do believe that the WHS regulators have an important supportive and educative role to play; not just the prescription of regulation and not just enforcement. The best way to effect behaviour change is through education and incentive.

8. Employment – Jobs

Key points include

- a) The form, funding and targeting of employment services **requires extensive consultation** with all parties.
- b) **Strategies need to overcome both the barriers for the individual and barriers perceived by the place of employment.**
- c) Explore other levers, other economic and social interventions that can be applied for a more cohesive package.

Long-term worklessness is one of the greatest known risks to Public Health:
Professor Sir Mansel Aylward (UK)³⁷

Employment can be beneficial to an individual's mental health and often to their recovery both physical or psychological. But this is for **the individual**.

³⁷ Australasian Faculty of Occupational & Environmental Medicine *Australian and New Zealand Consensus Statement on the Health Benefits of Work Realising the Health Benefits of Work*. 2011 [www.racp.edu.au > faculty-of-occupational-environmental-medicine](http://www.racp.edu.au/faculty-of-occupational-environmental-medicine). Accessed December 2019

Research in the US by Kaufmann et al found that economic and education factors were important too³⁸

An estimated 1.7% of unemployed US adults attempted suicide in 2017, compared with 0.4% of those working full-time and 0.7% for those working part-time. Rates of serious thoughts of suicide also differ by socioeconomic status, with such thoughts reported by an estimated 6.1% of those living below the poverty level, 5.0% for those between 100% and 199% of the poverty level, and 3.3% for those over 200% of the poverty level. By level of educational attainment, serious thoughts of suicide affected 4.4% of those with a high school diploma compared with 3.2% of those with a college degree.

We have not yet found an employment and support programme that effectively works for all involved. Job Active has had success and has flaws; apprenticeships have been successful and flawed. Incentives for all parties that overcome barriers for such employment need to be found. We need an approach that **overcomes both the barriers for the individual and barriers perceived by the place of employment.**

Some guidance to overcome barriers is available from various organisations, such as beyondblue, The Black Dog Institute and many more. These need review to provide confidence and encourage evidence-based programmes; programmes that better match employee and employer. Some use a Charter for example LifeinMind.³⁹ to sign up and *demonstrate commitment to reducing stigmatising language and promoting help-seeking and help-offering behaviour*. Or, as in the 2019 Review of National Disability Insurance Scheme (NDIS) the Participant Service Guarantee ⁴⁰

Matching the individual and the employer with the employment services may well play an even more vital role for people with a mental illness than for other job applicants. The form, funding and targeting of employment services **requires extensive consultation** with all parties.

One such employment programme worth considering, is Individual Placement and Support (IPS). Rolling out IPS programme on a staged basis is a promising concept. The proposed *rapid job search with a 'place-train' focus, ongoing support from case workers after employment* and good communication between everyone may well be effective.

³⁸ Kaufman JA, Salas-Hernández LK, Komro KA, *et al* Effects of increased minimum wages by unemployment rate on suicide in the USA *J Epidemiol Community Health* Published Online First: 07 January 2020. doi: 10.1136/jech-2019-212981 <https://jech.bmj.com/content/early/2020/01/03/jech-2019-212981> Accessed 14 January 2020

³⁹ The Charter by Life in Mind has been developed and is managed by Everymind. Life in Mind is supported by funding from the Australian Government, Department of Health, under The National Suicide Prevention Leadership & Support Program. www.lifeinmindaustralia.com.au/the-charter Accessed January 2020.

⁴⁰ David Tune, The 2019 Review of the National Disability Insurance Scheme Act 2013 report. December 2019. [National Disability Insurance Scheme Act 2013 report](#) Accessed January 2020

I support the proposed approach by the Productivity Commission in the draft report that *Depending on the final outcomes of the youth trial, the IPS youth focused services should be established and co-located within community mental health services.*

Either way employers and employees will need incentives to warmly welcome such programmes. They can learn from successful apprenticeship programmes, but would also benefit from extensive consultation with employer associations on policy.

Whatever the proposals, overcoming barriers for both the individual and employers needs to be considered and addressed, not just one or the other.

Proposal for Income protection insurance

I believe employers could be prepared to provide information on or access to income protection insurance on an industry basis. In other words, would act as a gateway.

Perhaps there are other levers, other economic and social interventions that can be applied but all need to be considered in a more cohesive package. A good role for the consultative committees of NMHC.

9. Income support is an important safety net

Key points to consider

- a) Income support is an **important safety net.**
- b) Other models need to be explored, it may be that a change to a **minimum wage** might be helpful.
- c) The form, funding and targeting of income support **requires extensive consultation** with all parties (including National Disability Insurance Scheme) and **more research is needed. The impact of wait times for income support also needs review.**
- d) **A national research strategy is strongly encouraged**
- e) I don't believe a mental health day/s would be as constructive as **building positive relationships in the workplace**

Disability Support Pension, the Newstart Allowance or Youth Allowance, Carers Payment, Disability Support Pension or Age – all types of income support, provide an important safety net. Many of the recipients will have a diagnosed mental illness and, perhaps many more, an undiagnosed mental illness.

A recent paper by Kaufman et al⁴¹ notes that

Suicide is often associated with financial stressors such as job loss, debt or financial hardship, but less is known about how economic interventions such as minimum wage policies could ameliorate these risk factors.

Kaufman et al looked at state minimum wages and suicide rates from 1990 through 2015 in US. They estimated that

...among adults aged 18 to 64 with a high school diploma or less, each \$1 increase in the minimum wage was associated with a 3.5% reduction in suicide risk. The association between higher minimum wage and lower risk was strongest when unemployment was high.

This work suggests it might be useful to look at **minimum wage** and assess its potential for mitigating mental ill-health.

Kaufman et al concluded that

Our findings are consistent with the notion that policies designed to improve the livelihoods of individuals with less education, who are more likely to work at lower wages and at higher risk for adverse mental health outcomes, can reduce the suicide risk in this group. Our findings also suggest that the potential protective effects of a higher minimum wage are more important during times of high unemployment. While the minimum wage can serve as a population health intervention, it is important for society to provide other buffers between financial status and health, so that low education and economic insecurity do not increase the risk of mental illness and death.

A National Research Strategy

Has the research been done? Do we have the evidence or data to answer the following questions?

- Do the income support systems in place recognise mental illnesses and have flexibility to deliver appropriate support? Is it geared to recognise the early symptoms of mental ill-health before they become more serious or is it only diagnosed mental illness? And is this done for each of the listed types of income support?
- If you get one form of support does it negate the other, and for how many? Do any of them work well for those with mental ill-health? Is it difficult to change from one type of income support to the other?

⁴¹ Kaufman JA, Salas-Hernández LK, Komro KA, et al
Effects of increased minimum wages by unemployment rate on suicide in the USA
J Epidemiology Community Health Published Online First: 07 January
2020. doi: 10.1136/jech-2019-212981
<https://jech.bmj.com/content/early/2020/01/03/jech-2019-212981> Accessed 14
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- What positive relationships are built with each of the parties involved? What steps are taken to build positive relationships?
- Would extending the time for changes to their job plan and greater flexibility provide positive outcomes? And on which type of support or which age group or which form of mental ill-health?
- How does anyone ensure personalised job plans that go **beyond compliance** for job seekers with complex needs?

These questions need to be answered before a programme or intervention can be devised.

Certainly, it seems a sensible suggestion for Carer Payments and Carer Allowances to provide more flexibility for the carer in undertaking their own economic and social activity, including flexibility with their studies or their work. In my view, monthly checks are more sensible than weekly checks on hours of work.

Again, I feel that **more research needs to be undertaken along with extensive consultation. A national research strategy is strongly encouraged.**

A Mental Health Day

Designating a number of days of existing personal leave as 'personal care' without medical evidence is not necessary. Many awards and contracts enable a set number of days for ill-health. A "sick" day is the colloquial term often used. Commonly 5-6 days is available. There is no need to further stigmatise mental ill-health. -We should instead encourage having a conversation about mental ill-health or concerns

Quietly slipping off for a day may actively discourage conversations or early identification or early intervention. The use of employee assistance programmes for each and every employee is designed to be confidential and easily accessible. **More should be done to encourage conversations with colleagues, employers and to encourage employee assistance programmes.**

Communication, education and skills would be far more likely to produce positive outcomes. Such a day labelled in this way would risk being totally counterproductive.

10. Suggestions for the draft report

1. Please note in Productivity Commissions draft report Vol 1 page 44 Table 2 Proposed government responsibilities in mental health could be modified to include justice systems, work, community, social inclusion. (All the sectors as mentioned on p125). I'm not sure why only selected few are represented.
2. *Employer Assistance Programs* are actually *Employee Assistance Programmes* (EAPs). These services are provided to employees (not employers). They are confidential and are often the initial point of contact for an employee seeking assistance for a mental health or other problems. Employers may pay a retainer or subscription to have the services available to any employees at any time or may enlist services for a defined period of time.
3. There should be more on the need to plan for the effect of natural disasters on individuals, communities and wider populations and the inclusion and coordination of assistance on mental health as part of planning and recovery. A useful delivery mechanism would be national digital platforms through local organisations, national communications plan and nationally accredited training.
4. The data collected by Australian Institute of Health and Welfare (AIHW) could include mental health data from emergency department presentations. E.g. Table 4.2: Emergency department presentations, by triage category and arrival mode, states and territories, 2017–18⁴² The Household, Income and Labour Dynamics (HILDA) survey in Australia could also be adapted to include mental health data collection.

⁴² Australian Institute of Health and Welfare (AIHW) Emergency department care 2017–18 Hospital Statistics, December 2018
<https://www.aihw.gov.au/reports/hospitals/emergency-department-care-2017-18/formats> Accessed January 2020

Note: Between 2013–14 and 2017–18, the number of presentations to public hospital emergency departments increased by 11% overall—or by 2.7% on average each year. This was greater than the average growth in population over the same period, with an increase of 1.1% in the number of presentations per 1,000 people.

11. Summary

The Productivity Commission's draft report is wide ranging and draws together many of the disparate stakeholders and thinking. It is an important and positive step in determining what we can do to reform mental health in Australia.

I support the Commission's vision for a system that is oriented to people's needs, adapts as these needs change and provides comprehensive clinical and non-clinical support. And I support reforming the funding arrangements in the health system, but I am uncomfortable about the proposals for workers compensation and indeed some aspects of reform suggestions for the workplace. I fear that some proposals may be counterproductive for all involved and will not enhance integration across sectors.

I strongly support the reforms and their goals through an independent statutory authority, the National Mental Health Commission (NMHC) with consultative structures and commitment from government participants through an IGA or charter.

I favour the rebuild model that includes other linked attributes such as drugs and alcohol.

I would be keen to see any of the final proposed reforms outlast the government of the day and commit State and Territory Governments to comply with new monitoring, reporting and evaluation as part of a whole-of-government approach.

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***Note: Findings for Victoria include**

The top three prioritized recommendations included expanding state and national suicide prevention frameworks, aligning nursing home life with community living, and improving residents' access to mental health services.

The Australian Industry Group, Implementing mental health initiatives in Australian business – triggers, facilitators and barriers, January 2020.