mindseye
Training and Consulting

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Ms Rosie Bartlett

CEO Mindseye Training and Consulting.

Dear Commissioners

Thank you for the opportunity to make a submission to this very important and significant enquiry.

The focus of Mindseye Training and Consulting's submission is on parts of ***Section 3, Skills acquisition, employment and healthy workplaces.*** The chosen parts of that section are in bold and precede our reponses

Mindseye Training and Consulting has been delivering the nationally and internationally recognised Mental Health First Aid (MHFA) training across Australia in the private, NGO and LGA sectors since 2007. In 2018 it was appointed to the SA Health government administered provided panel for MHFA training. It has and continues to deliver to some of Australia's largest corporates and has recently delivered to large retail chains.

Further information about Mindseye Training and Consulting can be obtained at www.mindseyetraining.com.au.

If the Commission wishes to clarify or request further input please contact myself, Rosie Bartlett.

Mindseye Training and Consulting has access to an extensive network covering mental health issues and comorbidities such as addiction. These very frequently present in tandem in the workplace and evidence shows that such impairment can make intervention and helpful responses more complex and resource intensive. Comorbidities are a very real concern and should be included in the agenda as a challenge for workplaces. It is now well known misuse of prescribed medication is a considerably under estimated problem. When misused in the presence of an existing diagnosed or undiagnosed mental health problem it can be regarded as a high risk situation with serious potential harms or mortality for the person.

I would like to congratulate the Commission on giving these matters its attention.

Warm regards

Rosie Bartlett

The Commission welcomes comments on why employers are not investing more in workplace mental health, given the large potential benefits suggested by past modelling. It may be that the modelling does not fully reflect the:

1. **barriers to implementing measures to improve workplace mental health, and their cost**

2. **factors which create uncertainty about the returns to a given employer**

3. **limited extent to which measures which been beneficial for a small sample of businesses, or a particular type of organisation, can be applied more widely**.

Mindseye Training and Consulting response:

It is difficult to separate workplaces/work floor from the whole entity of which they are part and the use of the term workplace can conjure the image of a division between the work floor and higher levels. This can imply that the responsibility for MH starts and stops on the work floor, whatever that may be. As the government has messaged strongly in the community, Mental Health is everyone's concern or problem so it must be an organization wide perspective and attitude that needs to be developed.

The strengthening of the responsibility for mental health and wellbeing across all level of leadership, management and supervision is essential. There can be a tendency to compartmentalise or 'box' this in to the functions of a first aid officer or HR function which again puts it at arm's length and into and Employee Assistance Program (EAP).

Mental Health is still highly stigmatised and for an employer it can be seen as hard work. Popular and stereotyped conceptions of mental health problems are at the acute end of a spectrum, such as 'breakdowns' or psychotic episodes and not the less acute but vastly more common problems of depression and anxiety. Therefore when an employer considers taking greater responsibility, their perception of the burden may be at acute end. e.g "How will we deal with these 'broken' workers and not ' Ok this might be quite manageable as there are quite a few known options.'

Bombardment by the market of wellness products and slick fixes and 'let us take care of this for you' options make choosing for an enterprise difficult. Again the tendency is to look for the 'silver bullet' fix outside and not recognise that the best returns will come from inside the organisation. To this end the allocation of resources and within budgets tends to 'buying and not building'.

The statistical information around such returns is as yet poorly developed. Very general single figure returns of a few dollars are publicised but any breakdown is not clear, well explained nor does it have a comparator tool for industries or organisations to work out their own return. In addition there does not appear to be any tool to help organisations determine what amounts and types of resource

allocations are best made to get a positive yield. In the absence of such supports many are left to steer their own way into what is new and unchartered territory.

It is also unclear how industry sectors and organisation types communicate with each other in mental health and therefore how they learn and spread information about their experiences or the significance of good mental health practices in the workplace. Some organisations identify mental health 'champions' but how that role is defined, developed and enabled across organisations is not known or perhaps not even happening.

It is also not clear whether the accounting profession has sought or been informed about such 'soft asset' investments and therefore able to put such considerations on the radar of organisations and enterprises. In charts of accounts it is likely that specific allocations or investments are buried and fudged into areas such as HR, training or EAP costs without clearly identifying resource allocations aimed at establishing and maintaining mentally healthy workplaces.

There does not appear to be any practical based information bank or learning exchange on how enterprises can look at practical experience and thereby reduce effort and risk in creating mentally health workplaces. Each state now has its own Mental Health Commission or equivalent but their ability to create such resources is hampered by funding, state government interference and lack of national coordination. The Federal government could take an active or funding role in this and use strengthen the expectation of state governments to develop their respective Commissions to support such a role.

Small businesses could find it particularly challenging to implement measures to make their workplaces more mentally healthy, given their limited resources and smaller size over which to spread the fixed cost of any initiatives. Of interest, is the extent to which industry associations, professional groups, governments and other external parties can and should assist small, and other, businesses to reduce implementation barriers and costs.

Mindseye Training and Consulting response:

Associations and professional groups have limited resource scope and funding to pick up such a role. In addition to some basic membership fees, many struggle to compete for federal and state funding from one funding cycle to the next. By and large their role tends to centre around advocacy They may also have limited skills, knowledge and experience in providing such support. A more realistic expectation would be for such bodies to have adequately funded partnerships with the Mental Health Commission in their state. These could operate under an umbrella agreement that sets out objectives, targets etc but also adequately resources strategies and approaches on how to engage workplaces on this issue. Just because you build it doesn't mean they will come. This is relatively new turf for workplaces which they would have to engage and which is not cost neutral.

There may also be a case to strengthen the incentives which employers face to make their workplaces more mentally healthy. For example, KPMG and Mental Health Australia (2018) recommended trialling a system to make workers' compensation insurance premiums more reflective of the mental-health risk profile of workplaces. They proposed a trial because an evidence base needs to be developed on whether there is a strong case for such a system.

Mindseye Training and Consulting response:

The term 'incentives' is a curious choice. Many enterprises and industries are likely to see this as the stick and not the carrot. One industry may by the very nature of its activities have a relatively intractable risk profile with out incurring significant costs or loss of profits by creating mentally healthy workplaces. However, the workers and not management in those industries may be the best advocates for change and their collective bargaining or individual agreements may be the leverage tool that works best.

While mental ill-health accounted for only 6% of all workers' compensation claims in 2014-15, they were associated with more time off work (15.3 weeks off work compared to 5.5 weeks for all claims) and higher average claim costs ($24 500 per claim compared to $9 000 for all claims). Moreover, the number of serious claims linked to mental ill-health in 2014-15 was similar to that recorded in 2000-01, whereas claims linked to most other causes had fallen significantly over that period. (Safe Work Australia 2018)

Mindseye Training and Consulting response:

This raises the problematic area of diagnosis which possibly affects the statistics by recording the presenting issue and being less clear on the contributing factors that led to a person being diagnosed with such a condition. For instance, workplace stress and trauma in all probability will lead to mental health problems and may at first not be diagnosed or treated in the spectrum of diagnosable mental illnesses. Yet the very factors that caused the stress and trauma may have their seeds in a very mentally unhealthy workplace and culture.

It should not be any surprise that currently the return to work time period is longer for MH claims than others forms of claim. Firstly the diagnostics are more variable. Second, treatments are less specific and often a bit of trial and error. For example, it is not unusual for a person suffering from depression to be trialled with several medication regimes before the most effective one (with less side effects) is found. Another time factor is that incurred by appointment scheduling with psychiatrists, psychologists or allied health professional. It is highly unlikely that a primary care treating physician will allow a worker to return to the workplace until at least one or two visits with such professionals has taken place. This is in the best interests of the worker and the employer. In South Australia there are over 200 registered

psychiatrists but only 3 work in regional South Australia. The sheer logistics of this access problem is going to bias the statistics is they include workers in country areas. In some regional towns there are only in- reach psychology services which may only visit every 2-3 months. This can significantly lengthen the return to work phase, remembering that recovery can often be 1 step forward and 3 steps back.

This strongly emphasises the need for prevention and early intervention.

It is curious to know what criteria the Productivity Commission or reporting body is using to distinguish between serious MH claim and 'not so serious' or 'vanilla' claims. Mindseye Training and Consulting believes such loosely chosen distinctions are not helpful.

It is not clear what measurement or factoring there is of those workers who do not return to work but either finish up on extended sickness benefits, disability income, long term unemployment benefits as a result of mental illness. Employers are not in a position to capture such data but this may be worth pursuing with Human Services or a research body.

What types of workplace interventions do you recommend this inquiry explore as options to facilitate more mentally healthy workplaces? What are some of the advantages and disadvantages of the interventions; how would these be distributed between employers, workers and the wider community; and what evidence exists to support your views?

Mindseye Training and Consulting response:

Mindseye Training and Consulting is currently developing a pilot and tailored training program for a large enterprise of 600 staff delivering a range of services across many sites, with some of those services and work roles having high stress profiles.

The training at this stage consists of 2 modules. One targets the front line workers and the other targets a leaders and managers group. The content differs in as much as the front line workers need practical skills tools and knowledge and the management group will explore issues of culture, supervision and policy setting as well as how to integrate such work demands into staff performance development programs.

What are some practical ways that workplaces could be more flexible for carers of people with a mental illness? What examples are there of best practice and innovation by employers?

Mindseye Training and Consulting response:

This is a highly individualised matter both for the worker and for the enterprise policy setting. How or what are you expecting the carer to do to support the worker in their role? At what phase in a workers recovery is this more appropriate or needed? Does the employer carry any liability for the actions of the carer? If the worker is needing

some intense carer support while in the workplace, would they in fact be back at work? Is the knowledge or occasional presence of a carer something that may stigmatise a worker or raise issues with workmates?

It may be plausible to suggest that at this point in time the Australian 'workplace' generally may not be ready for any such extensive arrangements. . However, each state has a Carers peak body and a direct consultation with these would be recommended.

Another factor which could influence the adoption of measures to facilitate mentally health workplaces is the regulation of workplace health and safety (WHS) by the Australian, State and Territory Governments. Such regulation sets requirements on how the wellbeing of employees is protected in workplaces. However, identifying, assessing and addressing risks to mental health in the workplace is likely to be more complex than for physical health because many of the risk factors — such as job demand and control, imbalance between effort and reward, and bullying and harassment — are not as easily identified and addressed (Harvey et al. 2014).

What, if any, changes do you recommend to workplace health and safety laws and regulations to improve mental health in workplaces? What evidence is there that the benefits would outweigh the costs?

Mindseye Training and Consulting response:

Regulation as a constructive tool may be limited in such matters. It can place and enterprise on a 'red alert' footing and manage risk by avoiding the issue of mental health or recruiting people who may have had lived experience of mental health.

However, reinforcement of positive evidence based practices should be encouraged. Workplace safety committees could have mental health wellbeing as a standing agenda item after appropriate training.

One possible regulation, as a starting point, could be that ratio is expected of x number of staff with Mental Health First Aid (MHFA) training to Y number of staff is implemented. This ration can be adjusted is the enterprise sits in an industry sector with a history or profile of high stress and claims.

A further possibility may be to set a requirement for incorporated bodies and organisations report in annual reports what mentally healthy workplace programs have been funded and delivered and to which staff cohorts. This may encourage enterprises to develop good policies and take a more inclusive approach to people with lived experience.

*The development of a 'peer worker' in place concept would be a positive move and cold be encouraged by government bodies.*Kind regards
  Rosie Bartlett