



Submission to the Draft Report from the Productivity Commission's Inquiry into Mental Health

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About CME

The Chamber of Minerals and Energy of Western Australia (CME) is the peak resources sector representative body in Western Australia. CME is funded by member companies responsible for more than 90 per cent of the state's mineral and energy production and workforce employment.

In 2018-19, the Western Australia's mineral and petroleum industry reported a record value of \$145 billion.¹ Iron ore is currently the state's most valuable commodity at \$78 billion. Petroleum products (including crude oil, condensate, liquefied natural gas, liquefied petroleum gas and natural gas) followed at \$38 billion, with gold third at \$12 billion.

The value of royalties received from the sector totalled \$6.8 billion in 2018-19,² accounting for 21 per cent of general government revenue.^{3,4} In addition to contributing 40 per cent of the state's total industry Gross Value Added,⁵ the sector is a significant contributor to growth of the local, state and Australian economies.

Summary of recommendations

CME appreciates the opportunity to provide feedback on the Productivity Commission's Draft Report into Mental Health (draft report) as part of the Mental Health Inquiry (the Inquiry).

The below is a summary of CME's recommendations, categorised according to the relevant section of the draft report. CME notes that the Inquiry also included a number of requests for further information in the draft report, and responses to these requests have been included in the body of this submission.

- CME welcomes the draft report's acknowledgement that a holistic and coordinated approach to mental health in the community is required.
- CME considers current WHS laws appropriately capture psychological health. Further prescription or applying a one-size fits all approach to managing complex mental health issues would not be in the best interests of improved mental health outcomes.
- CME agrees that Codes of Practice play a role in providing guidance to employers on how to manage psychological risks, however recommends the Inquiry acknowledge the need for these to sit within a broader suite of guidance materials and to ensure a risk-based approach to allow flexibility of implementation for employers.
- CME recommends the Inquiry explore the suitability of other bodies, such as the national Mentally Healthy Workplace Alliance, to monitor and collect data in relation to workplace initiatives and assist efforts of WHS agencies in the various states and territories.
- CME recommends the Inquiry specifically recommend the ABS survey, which aims to quantify and assess the prevalence of mental health issues within the Australian community, be repeated to enable a more recent snapshot of the impact and frequency of mental ill health and to inform data-driven decisions by government, community organisations and employers alike.
- CME supports the intent of this recommendation but is concerned this will result in advice from insurance companies, in the absence of sufficient evidence, as to what workplace initiatives are appropriate and effective. This will subsequently drive workplace-practices, and risk a 'one-size fits all' approach to applying workplace initiatives which may not result in improved mental health outcomes.
- CME considers recommendation 19.3 regarding workers compensation schemes is too broad and introduces a variety of implementation risks across all states and territories. Instead, CME suggests that an appropriate body, such as Safe Work Australia, conduct a specific review of the workers compensation system to ensure it can be made more fit-for-purpose for mental health case management.
- CME considers allocating personal leave days as mental health days will not improve mental health outcomes and will not provide a useful data set for presenteeism or absenteeism.

¹ Government of Western Australia, *Latest statistics release: Mineral sector highlights*, Department of Mines, Industry Regulation and Safety, September 2019: <http://dmp.wa.gov.au/About-Us-Careers/Latest-Statistics-Release-4081.aspx>

² Government of Western Australia, *Annual report 2018-19*, Department of Mines, Industry Regulation and Safety, November 2019, p. 77.

³ References hereafter to government refer to the Government of Western Australia, unless otherwise indicated.

⁴ Government of Western Australia, *2018-19 Annual report on State finances*, Department of Treasury, September 2019, p. 8.

⁵ Duncan, A. and Kiely, D., *BCEC Briefing note: WA Economic update*, Bankwest Curtin Economics Centre, November 2019, p. 4.

- Adding a requirement for employers to purchase income protection insurance on behalf of their employees will not improve the level of coverage available to workers, and instead will add to the cost of doing business in Australia with no material improvement to mental health services. CME would instead recommend a review of insurance practices to ensure that there are suitable products on the market for all individuals which adequately recognise and respond to mental health issues.
- CME welcomes the recommendations to re-orientate mental health services and funding models to better serve the needs of consumers in rural and remote areas, including greater transparency of the funding model and how it is weighted for factors such as remoteness, population and socio-economic status. CME would caution that the current draft Recommendation 5.6 calls for the replication of one program which, in our considered view, does not serve the needs of all members of rural and remote communities equally. CME suggests that the recommendation is altered to include the need for implementation agencies to review the accessibility requirements and defined outcomes in the design of future services.

Context

Mental health and suicide are complex issues felt across all facets of Australian society. CME welcomes the focus on these important issues through the current Inquiry. CME notes the draft report is significant, totalling some 1,200 pages and synthesising views from over 500 submissions, demonstrating the importance of the issue widely across Australian society.

The Western Australian resources sector is committed to the mental health and wellbeing of its workforce and companies invest significantly in a range of formal and informal strategies. When it comes to looking after the safety and health of employees in the workplace, there will always be room to improve and it is imperative that we collectively and progressively do so. Our member companies initiatives are regularly reviewed and improved upon as new evidence and effective best practice becomes available.

CME works with our member companies to continue to collectively improve workplace safety and health (WHS) outcomes for all resources sector employees. Our commitment to mental health and wellbeing in this regard is driven from the level of our Board level down, who recognise mental health as a high priority policy and operational focus area. CME's Mental Health Working Group (MHWG) was developed in 2013 to lead industry's proactive response and share best practice in this area. For example, CME launched our Mental Health Blueprint⁶ in 2015 as a common industry framework to drive continuous improvement in mental health strategies. More recently, CME has partnered with Lifeline WA to develop and make accessible a suite of industry specific tools to support organisations to improve mental health outcomes in the workplace. It is intended outcomes will support risk-based and flexible delivery models tailored to the resources sector, and are being designed to be easily accessible and available at reasonable cost.

CME welcomes acknowledgement in the draft report that a holistic approach is required to address mental health issues in society - whereby government, the community and industry all have roles to play. In the context of workplaces, the draft report states that while "providing a mentally healthy workplace is important, it is only one component underpinning the mental health of an individual". The report goes on to note that those risks to mental health in the workplace are just one part of an extensive group of risk factors, including individual factors and broader relationship interfaces at home and in the community. Employers acknowledge they have a role to play in minimising and managing psychological risks at work, but cannot be held entirely responsible for ensuring the complete mental health of employees due to the complex and differing range of factors outside of their control. Therefore, while a mentally healthy workplace is an important component, it is only one factor potentially contributing to the mental health of an individual, and ongoing investment by government and the community at large remains critical.

Given CME's role in supporting our members in the WA resources sector, the below submission largely focuses on the role of employers in this equation as outlined in Chapter 19 of the draft report. CME also notes that the draft report documents the challenges of providing and funding effective mental healthcare resources within Australia's rural and remote communities. Many of CME's members operate enterprises in Western Australia's rural and remote locations, with their workforces often living in, or commuting to, regional communities. Given the sector's experience in this regard, the below submission provides comment on these specific areas of the draft report.

CME welcomes the draft report's acknowledgement that a holistic and coordinated approach to mental health in the community is required.

Mentally Healthy Workplaces

The below section of the submission provides comment on recommendations made in the draft report's Chapter 19 – Mentally Healthy Workplaces with respect to workplace health and safety laws, evidence-based initiatives and the consideration of mental health under workers compensations schemes.

Workplace Health and Safety Laws

The draft report recognises that psychological health and safety should be given the same importance as physical health and safety in WHS laws:

⁶ The Chamber of Minerals and Energy of Western Australia (CME), (2015). *Blueprint for Mental Health and Wellbeing*, available at: <https://www.cmewa.com/images/files/policy/people-and-communities/Mental-Health-Blueprint.pdf>

Draft Report Recommendation 19.1: Psychological Health and Safety should be given the same importance as physical health and safety in workplace health and safety (WHS) laws.

CME has long expressed support for a WHS legislative framework that captures psychological health. As outlined in our 2019 submission the Inquiry, the model WHS Laws do this. The definition of 'health' in the model WHS Laws is explicit in its inclusion of psychological health and, the Department of Mines, Industry Regulation and Safety in Western Australia (DMIRS) has taken a clear position that the state's current Mines Safety and Inspection Act, 1994 should be interpreted in a similar way until the promulgation of the new harmonised legislation, which is anticipated to occur this year. As such, CME considers that the current and expected future legislative environment governing the management of WHS in Western Australia adequately provides for the consideration of mental health by employers.

CME is pleased to see the draft report acknowledge there is an insufficient state of knowledge on what constitutes good practice for the assessment and management of psychosocial risks in the workplace. Whilst the body of evidence regarding best practice in workplace mental health is rapidly growing, prescribing a 'one-size fits all' approach through legislation is unlikely to result in meaningful improvements to individual's mental health and wellbeing given the diversity of workplaces and spectrum of interacting factors that differ from worker to worker. Furthermore, from a practical perspective, any prescriptive approach risks quickly becoming out of date as the body of evidence evolves, which in turn creates unnecessary administrative burden for employers and regulators to follow and update.

CME supports the proposal within the draft report that WHS regulators remain focused on education and assisting employers to navigate this complex area. CME would further suggest that there be a recommendation for WHS inspectorates to avoid a punitive approach to psychological risk assessments. Given the draft report acknowledges that the detection, management and regulation of psychological hazards in the workplace presents a challenge to employers and regulators alike, this growing body of knowledge is best facilitated by a consultative approach - where employees, employers and regulators work together under a risk-based approach to improve workplace practices. A punitive approach may stifle continuous improvement efforts by employers, who may instead revert to a protected compliance approach rather than foster an open, consultative relationship with their employees and the regulator. For example, in instances where reporting of psychological hazards becomes grounds for punitive action by a regulator, this disincentivises employees and employers from openly identifying and addressing psychological hazards in the workplace. This is counter to efforts to de-stigmatise mental health issues in the workplace.

CME considers current WHS laws appropriately capture psychological health. Further prescription or applying a 'one-size fits all' approach to managing complex mental health issues would not be in the best interests of improved mental health outcomes.

The draft report also recommends Codes of Practice be developed to assist employers in meeting their duties under legislation:

Draft Report Recommendation 19.2: Codes of practice should be developed by Workplace Health and Safety Authorities in conjunction with Safe Work Australia to assist employers to meet their duty of care in identifying, eliminating and managing risks to psychological health in the workplace. Codes of practice should be developed to reflect the different risk profiles of different industries and occupations.

CME appreciates that regulators in most Australian jurisdictions have begun steps to create guidance material for employers to assist with meeting their duty of care. For the reasons outlined above, CME discourages a prescriptive, 'one size fits all' approach to managing psychosocial hazards and risks.

Codes of Practice are just one example of appropriate, outcome-focussed guidance in this emerging area. Where used, Codes should take a high-level, risk-based approach, as with any other WHS risk. Codes of Practice which take a risk-based approach enable and encourage employers to tailor and continuously improve their mental health strategies with the specific needs of their workforce and work environments in mind.

Western Australia is already well advanced on this recommendation with the recent development and implementation of the DMIRS *Code of Practice - Mentally healthy workplaces for fly-in fly-out (FIFO) Workers in the Resources and Construction Sectors*. This Code of Practice, developed by the regulator with broad

consultation, takes a risk-based approach. CME is pleased to see the draft report identify this Code of Practice as a positive example.

While Codes of Practice play a role in assisting workplaces meet their duties under legislation, CME considers equally important tools are supporting guidance materials for example guidance notes, fact sheets and online resources. Guidance materials provide more detailed information on the application of regulation and can be easily introduced and updated as required to keep up with the rapidly growing body of evidence. These are useful materials that support Codes of Practice, which routinely exist across other WHS hazards. CME supports acknowledgement within the draft report for a need for the development of guidance materials which are complimentary to Codes of Practice in this regard.

It should be acknowledged there is already a wealth of information currently available to employers through a vast number of sources. The feedback from CME's members supports the commentary in the draft report that employers currently experience "information overload" with little distinction given between scientifically validated approaches and anecdotal ideas. CME supports the idea of developing centralised repositories of validated information to assist consumers, employers, and healthcare providers to navigate the plethora of information and supporting tools available in the mental health space. CME agrees that WHS authorities, such as regulators, have a role in providing Codes of Practice, guidance and resources to assist employers to select and implement validated workplace initiatives.

CME agrees that Codes of Practice play a role in providing guidance to employers on how to manage psychological risks, however recommends the Inquiry acknowledge the need for these to sit within a broader suite of guidance materials and to ensure a risk-based approach to allow flexibility of implementation for employers.

Evidence-Based Workplace Initiatives

Acknowledging a need to grow an evidence base as to the effectiveness of workplace interventions, the draft report recommends increased monitoring of these initiatives:

Draft Report Recommendation 19.5: WHS agencies should monitor and collect evidence from employer-initiated interventions to create mentally healthy workplaces. They should then advise employers of effective and appropriate interventions.

CME has long advocated the benefits of a collaborative relationship with WHS regulators, and agrees that there is a role for WHS agencies to perform an education and guidance role for employers. CME further agrees that there is an ongoing need to build an evidence base for mental health programs and initiatives and reiterates regulators should remain focused on education and assisting employers to navigate this complex area.

It is important to acknowledge that data collection (i.e. to build the evidence base) and ongoing assessment and reporting of initiatives by employers is a multi-faceted challenge. It will be important to understand how the data is proposed to be used and shared by WHS agencies, who are also regulators. CME members invest significant efforts in establish strong reporting cultures within their organisations and it is important that to build continued trust in transparency in this area, whilst being mindful of unintended consequences. Without an understanding of how the data will be used by regulators, companies may fear formal actions or prosecution where details of workplaces initiatives inadvertently point to current or previous gaps with regards to psychosocial risk management. This may impact reporting culture. Additionally, adequate privacy would need to be ensured for evidence that involved analysis of the features of an individual's mental ill health case management - such as length of time off work and costs of treatment.

CME recommends that the Productivity Commission considers the role of other organisations, such as the Mentally Healthy Workplace Alliance (the Alliance), be involved in the monitoring and collation of information regarding workplace mental health initiatives. The Alliance shares the view that Australian employers are overwhelmed by the quantity of information already provided by governments, non-government organisations and private enterprise. Additionally, the workplace feedback collated by the Alliance thus far indicates that many employers are looking for direction and guidance to achieve a culture supportive of all employees' health, which goes beyond the minimum legislative obligations.

CME recommends the Inquiry explore the suitability of other bodies, such as the national Mentally Healthy Workplace Alliance, to monitor and collect data in relation to workplace initiatives and assist efforts of WHS agencies in the various states and territories.

The draft report also acknowledges there has been no data captured to assess the mental health of the current workforce since the 2007 National Survey of Health and Wellbeing by the Australian Bureau of Statistics (ABS).

ABS data is often relied upon to estimate the incidence and severity of mental health issues in the workplace, and as a comparison group. CME holds concerns that this data is out of date given the significant changes in the employment landscape over the past decade and the substantial evolution of the public discussion on mental health across society. For example, there have been significant positive steps to destigmatise mental health issues over the past decade, which will not be reflected in the incident representations within the 2007 ABS data.

Having contemporary, reliable information of the incidence of mental health issues within the Australian population is a fundamental baseline from which better evaluation of workplace psychological risk management strategies should occur. It would also support a more relevant calculation of the return on investment of recent workplace mental health initiatives, which is identified in the draft report as being a problematic area currently.

CME recommends the Inquiry specifically recommend the ABS survey be repeated to enable a more recent snapshot of the impact and frequency of mental ill health and to inform data-driven decisions by government, community organisations and employers alike.

Mental Health and Workers Compensation

The draft makes a number of recommendations as to how workers compensation schemes can better accommodate mental health:

Draft Report Recommendation 19.3: Workers Compensation Schemes should provide lower premiums for employers that implement workplace initiatives and programs that have been considered by the relevant WHS Authority to be highly likely to reduce the risks of workplace related psychological injury and mental illness for that specific workplace.

CME sees the benefit of this recommendation in principle, however, has concerns with how this might be implemented in practice.

The lowering of insurance premiums in return for implementing hazard control strategies is a well-established practice in relation to physical health and safety risk. However, CME has concerns regarding how this would apply in practice for mental health initiatives given the relative immaturity of the evidence regarding efficacy in this emerging area of workplace practice. Indeed, a section of the draft report itself outlines the current limitations of the scientific evidence surrounding workplace mental health initiatives and programs and includes a citation from a researcher stating that “there have not been enough well conducted studies of workplace interventions to conclude with certainty what is, and what is not effective in improving workers mental health”.

Considering the concerns with methods of analysing the effectiveness of workplace interventions, CME contends that it will be difficult to implement this proposed recommendation in practice. For example, how will the relevant WHS authority define what is considered an appropriate and effective initiative? How will the rating criteria enable suitable programs to be rated as “high likely”? How would the assessments criteria account for the fact that a program may be highly effective in one industry, but entirely inappropriate in another? Further, there could be an inefficiency and dilution of purpose in establishing WHS authorities as a gate keeper, whereby insurers, brokers and employers must submit details of their proposed mental health programs and then wait for feedback or endorsement.

Chapter 19 of the draft report outlines the diverse guidance currently available from state-based WHS authorities and highlights that there is already a lack of consistency about what constitutes a ‘highly’ effective approach to psychosocial hazard management. Recognising that both the academic research and supporting industry guidance material provided by WHS authorities is in its infancy, the recommendation as written may inadvertently pass authority to insurance companies to take the lead on determining what constitutes good practice. Premature advice from insurance companies in this area has the potential to have unintended consequences by driving workplace practices and possibly a ‘one-size fits all’ approach to mental health management. Whilst not dismissing the potential positive contribution by the insurance companies in supporting workers with mental health claims, it should be recognised also that insurance

companies may have a vested interest in minimising their liability and reducing the costs of mental health related claims which doesn't necessarily incentivise the desired traits of mentally healthy workplaces for employers.

CME supports the intent of this recommendation but is concerned it will result in arbitrary advice from insurance companies, in the absence of sufficient evidence, as to what workplace initiatives are adequate or effective. This will subsequently drive workplace practices. A 'one-size fits all' approach to applying workplace initiatives in this space will not result in improved mental health outcomes.

The draft report recommends no liability treatment by provided for mental health related workers compensation claims:

Draft Report Recommendation 19.4: Workers Compensation Schemes should be amended to provide clinical treatment for all mental health related workers compensation claims, regardless of liability, until the injured worker returns to work or up to a period of 6 months following lodgement of the claim

As outlined in the draft report, there are a diverse number of compensation systems currently in use, each with differing funding sources which result in unique levers that incentivise or discourage various practices. With this context in mind, CME considers this recommendation in its current form is too broad to drive successful implementation across all states and territories.

A detailed review of the workers' compensation system and how it can be made more fit-for-purpose for mental health case management is needed. Given the complexity of this issue, rushed reform in this space may have unintended consequences. Safe Work Australia (SWA) as a national body is considered well placed to conduct a more detailed review and make specific recommendations with respect to apportioning liability under various schemes.

By way of illustration, some states have schemes which are entirely government funded (e.g. Queensland). Funding of the extended no-liability treatment in this context may make sense, as the cost is borne by the government in any case (be it from the scheme or from medicare funded services). However, those states or territories which are entirely underwritten by private insurers stand to be most disadvantaged by this recommendation, as the eventual costs will have to be covered by the premium-paying employer. A rise in premiums, not associated with actual risk, may potentially disadvantage employers and limit funding available for initiatives.

To support discussion regarding Recommendation 19.4, the Productivity Commission put out a request for further information regarding the funding of its proposed recommendation for 6 months of no liability clinical treatment:

Information Request 19.1: With respect to the above recommendation 19.4 regarding no liability treatment for mental health workers compensation claims. How should the clinical treatment for workers with mental health related workers compensation claims (irrespective of liability) be funded until return to work or up to a period of 6 months?

Being privately funded, Western Australia's workers compensation scheme (scheme) would experience a significant impact from this proposed change. This is because the Western Australia's system is largely implemented by private enterprise insurers who determine liability and fund the costs of treatment and lost wages. There is an existing incentive for Western Australian employers to proactively prevent work-related mental health illness and to have effective return to work programs in place to recovery and mitigate against recurrence, thereby keeping direct and indirect costs low and reducing their individual premiums. The Western Australian scheme would be particularly vulnerable to the proposed change to allow no liability treatment, as the cost recovery burden would fall on employers. This is one example of why the proposed changes in this space need to be carefully considered in detail. Therefore, before this recommendation is finalised, CME suggests a full review of this proposed change to the workers compensation scheme is carried out to ensure there are no unintended consequences and to provide confidence that it can deliver improved outcomes for individuals experiencing mental health issues (and involved in work-related claims).

The draft report includes an alternative option for funding of the no liability treatment through the government placing a tax on employers. This tax is suggested to be levied based on the number of employees, the

industry they operate in and their risk profile as measured on various metrics to indicate the mental health of their workplace. CME strongly cautions against this proposal. Employers currently absorb many aspects of mental ill health in the community both through paying premiums for their work-related mental health case management, and through lost productivity and reduced performance of individuals suffering non-work related mental health issues. Further, CME is concerned about the suggestion in the draft report that industries which are dealing with higher mental health hazards be subjected to a higher tax. There are many complications with this approach. For example, additional taxes would directly reduce the internal funding available to put in place proactive, preventative measures to reduce the incidence of mental health in the first place. Taxing workplaces with higher mental health hazards in an environment of limited evidence will not encourage proactive risk-based approaches to mental health.

Whilst the suggestion for no-liability treatment seeks to alleviate the burden of treatment cost, it does not address a key issue that often presents with psychological workers compensation claims. In a typical work-related mental health claim, the individual may be certified unfit for work by their treating doctor for extended periods. Whilst the claim liability is determined, the individual uses personal leave entitlements which can be quickly exhausted. In addition, there is often no payment of weekly wage entitlement while the claim is pending. Therefore, while this recommendation seeks to have treatment funded by either employer or insurer, this would not alleviate the financial burden on individuals who may be without a source of income during this time.

Throughout Chapter 19 of the draft report, CME acknowledges that thorough and balanced discussion regarding the challenges of using the Australian workers compensation regimes in their current form. It is further acknowledged that much is expected of these schemes to effectively manage mental illness, including determining the contribution of work related factors, balance the high costs of claims with the disadvantages to injured/ill workers who can experience delayed treatment, long durations out of the workplace and varied return to work experiences. Given the significant implications and complexities associated with this recommendation CME considers a more in depth review of the mental health workers compensation landscape is essential.

CME considers that this recommendation is too broad and introduces a variety of implementation risks across all states and territories. CME instead suggests that an appropriate body, such as Safe Work Australia, conduct a specific review of the workers compensation system to ensure it can be made more fit for purpose for mental health case management.

Response to Requests for Further Information

The report also included a number of further information requests in relation to personal care days and income protection insurance. CME member feedback on these is outlined below.

Personal care days

Information Request 19.2: Would designating a number of days of existing personal leave as 'personal care' to enable employees to take time off without medical evidence to attend to their personal care and wellbeing improve mental health and information on absenteeism due to mental illness?

If so, what would be needed to make this provision effective?

CME appreciates the challenges outlined in the draft report with regards to accurate measurement of absenteeism and presenteeism. CME further acknowledges that the paucity of data able to be collected for these measures in turn impacts the ability to accurately calculate of return on investment figures for mental health initiatives. Whilst this proposal may allow the collection of additional data, CME does not agree that this data would be suitably representative to provide for reliable analysis. There is no guarantee that employees would choose to use available personal care days for the intended purpose, and, some workers may require more than the designated number of days and therefore continue to use their other personal leave days in addition. In both cases, the data is skewed and would not represent a true picture of absenteeism.

Designating an allocation of personal leave days as "personal care" or "mental health" days would not substantially improve mental health. Such an allotment may encourage individuals to self-diagnose and self-manage their treatment rather than accessing professional help. Additionally, the stigma faced by those experiencing mental health issues is frequently quoted as a barrier to accessing the various mental health

supports in the workplace, including Employee Assistance Programs (EAP) and peer support programs. Therefore, there may be individuals in the workplace that will not take leave that is identified as being for mental health reasons due to this perceived stigma.

CME considers it would be more effective for workplaces to implement cultural initiatives that reduce the stigma to ensure that workers feel comfortable accessing relevant mental health support services, and sharing their health status. This would improve the performance of the existing personal leave system, whereby access to personal leave is via negotiation between workers and management. For many of CME's members access to personal leave (outside of minimum defined annual and sick leave) is currently agreed on a case-by-case basis in accordance with the health needs of the worker and the policies of the employer. This is appropriate and allows flexibility for the leave to be allocated and used as deemed most appropriate to support the worker's mental and physical health and the operational requirements of the employer.

CME considers allocating personal leave days as mental health days will not improve mental health outcomes and will not provide a useful data set for presenteeism or absenteeism.

Income protection insurance

Information Request 19.3: Are there any barriers to employers – in sectors where there is a higher risk of workers developing a work-related psychological injury or mental illness – purchasing income protection insurance including for loss of income relating to mental ill-health) for their employees on a group basis to enable their employees to access this insurance at a lower cost?

CME acknowledges the challenges faced by those experiencing mental illness with accessing and utilising income protection and life insurance products, as identified within the draft report. However, CME suggests that it is beyond the remit of the employer to navigate selection and access to these products on top of their various existing employment obligations. For individuals with a specific health concern, be it physical or mental in nature, the selection of the right insurance products is a vital personal choice and an employer negotiated policy may still fall short of meeting their needs.

Whilst some employers do choose to offer payment or discounts for health insurance or other insurance products as an 'employer of choice' service, it should not be mandated or expected. This could add substantial cost and administrative burden to organisations, particularly small to medium enterprises. CME suggests that the draft report include an alternative recommendation to further review insurance practices to ensure that mental health issues are adequately considered and fairly handled. This would go further to address the concerning statistics regarding lack of coverage and claim rejection.

Adding a requirement for employers to purchase income protection insurance on behalf of their employees will substantially add to the cost of doing business in Australia with no material improvement to mental health services. CME would instead recommend a review of insurance practices be undertaken to ensure that there are suitable products on the market for all individuals in the community.

Health services in rural and remote Australia

CME's members operate across some of Western Australia's most remote locations, with their workforces often living in, or commuting to, regional communities. Given the sectors experience across this spectrum, the following section provides commentary on Part II – re-orienting health services to consumers in rural and remote Australia.

CME considers the draft report accurately summarises the challenges faced by rural and remote consumers in accessing timely and effective mental health services. The findings in the draft report regarding waiting times for GP appointments and lack of access to professional psychology/psychiatry services in these areas resonate with the feedback CME has received from its member companies. CME welcomes the recommendations made in Parts II and III of the draft report to address these issues through a thorough review of (amongst other factors) the structure of funding models, the capability and capacity of skills of practitioners, and mental health facilities, and effectiveness of service area coverage.

Notwithstanding this, CME notes that draft Recommendation 5.6 suggests that mental health agencies look to replicate a program known as the Practitioner Online Referral Treatment Service (PORTS), which has been implemented in rural Western Australia. The draft report states that this program was successful in improving accessibility and effectiveness of online mental healthcare treatment options. CME has several member companies who operate in the Pilbara region where PORTS was implemented. Feedback from these members raised concerns with the program's suggested success. While arguably successful for those accepted to the program, stakeholders have been critical that the service has high barriers to entry – for example, being only available to those with a referral from a GP or another health professional, above the age of 16 and able to demonstrate genuine financial hardship.

Whilst CME does not dispute that online/phone-based triage and treatment options such as that offered by PORTS can be an effective support to traditional face-to-face treatment options for regional communities, there is also need for such services to be available to a wider section those communities. For example, the mental health services available to individuals who are ineligible for PORTS are inadequate and extremely difficult to access. CME suggests that while many aspects of the PORTS program are suitable to be replicated, the access restrictions should be carefully reviewed prior to future replication and implementation.

CME is supportive of funding models that effectively distribute funding for mental health services to rural and remote areas, and notes that the draft report contains recommendations to improve equitable access to effective mental health services for these communities. To illustrate this, the CME, WA Primary Health Alliance, WA Country Health and the WA Mental Health Commission recently conducted a review of 2016/17 data pertaining to payments for MBS psychologist items in Western Australia. When contrasted against population data for various regional centres, a “payment per person” figure was able to be calculated which represents the average spend on MBS psychologist items per person. This research collaboration discovered an inequity between the state average and the Pilbara region in terms of payments per person on MBS psychologist items. Where \$17.72 per person was paid on average for each Western Australian adult, in the Pilbara region the spend per person was \$1.80. CME considers that this figure demonstrates either a concerning barrier in accessing services for those in need, or the potentially material under-servicing of the Pilbara community. In either example, greater clarity on how remoteness, population and socio-economic status is weighted is required to provide industry and the community confidence in how funding resources are allocated by State and Federal Government.

The draft report acknowledges that more funding doesn't automatically translate into improved mental health outcomes for regional communities, and the delivery of these services must be effective and actively encourage utilisation which caters for remote and transient areas. CME supports this view and adds that it is important the particular needs of the community are at the forefront of any service provision and funding strategy. Whilst using local resources, ideas, values and services is encouraged, the Inquiry should consider how these services are funded, branded, marketed and endorsed to ensure there is not a fragmentation of services or confusion of options for people in need. The draft report highlights the current fragmentation of services and the confusing methods by which the services are funded, and CME supports the recommendations in the draft report which highlight the need to simplify, streamline and more effectively market the available services for regional communities.

CME welcomes the draft report's recommendations regarding a re-orientation of mental health services and funding models to better serve the needs of consumers in rural and remote areas, including calling for greater transparency of the funding model and how it is weighted for factors such as remoteness, population and socio-economic status. CME cautions that the current draft recommendation 5.6 calls for the replication of one particular program which in isolation does not serve the needs of the remote communities equally. CME suggests the recommendation must be altered to include the need for implementation agencies to review the accessibility requirements in the design of future services.

Conclusion

CME is appreciative of the opportunity to provide feedback on the draft report and broadly considers the reform areas identified stand to make meaningful change to the Australian mental health landscape – which constitutes one of the most significant societal challenges of our time.

The management of mental health in the workplace is a complex area, and the Western Australian resources sector remains committed to implementing best practice psychological risk management and promoting the mental wellbeing of its workforce. As a large employer of workers who live in or commute to regional and remote locations, the sector also considers that funding for and provision of accessible and effective mental health services these areas is critical to enable these communities to thrive.

If you have any further queries regarding the above matters, please contact Terri-Ann Shilcock, Policy Adviser – People, Health and Safety, on 0419 712 053 or via email at t.shilcock@cmewa.com.

Authorised by	Position	Date	Signed
Robert Carruthers	Director – Policy & Advocacy	07/02/2020	
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