Australian Government

Comcare

Submission Number: 64
Date Received: 13/10/2011

PUTTING YOU *FIRST*

HOUSE STANDING COMMITTEE ON EDUCATION AND EMPLOYMENT INQUIRY INTO MENTAL HEALTH AND WORKFORCE PARTICIPATION

COMCARE SUBMISSION TO THE PUBLIC HEARING

INTRODUCTORY REMARKS

Comcare partners with workers, their employers and unions to keep workers healthy and safe, and reduce the incidence and cost of workplace injury and disease including mental health. We implement the Australian Government's policies in federal workplaces to drive social inclusion and productivity.

Our work in prevention, rehabilitation and compensation affirms the importance of work as a determinant of mental health and wellbeing.[1] The workplace is a source of wellbeing and support for mental health, but can also be a potential source of harm.

One of our top priorities is to improve the mental health, wellbeing and resilience of workers in the Comcare scheme and to tackle the problem of psychological injury arising from job stress. Mental ill health is becoming a major cause of disability in the scheme with serious productivity consequences for employers. The drivers for this increase are as yet unknown but probably varied. Drivers may range from the more positive awareness of mental health issues within the community to changing stressors on the modern family and work-life expectations.

OUR STRATEGIC FOCUS—WORKERS ARE CENTRAL

We place workers at the centre of what we do to ensure they return safely to their families, friends and communities everyday. When workers are harmed, we help with their recovery and support. We deliver a sustainable, fair, reliable, and high-performing Comcare.

Healthy at work, safe at work

Comcare partners with federal workers, their employers and unions, to keep workers healthy and safe at work, so they can return safely each day to their families, friends and communities. Health and Safety Law requires employers to manage risks arising from both the physical and the psychosocial work environment. We expect employers need to give a high priority to the design and organisation of work and manage particular risk factors that contribute to work-related stress such as excessive demands, co-worker relations, critical incidents, change management, and customer-related stressors.

1 There is ample evidence of the benefits of work for people with mental illness and that most people with mental illness want to work. Comcare is a signatory to the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) of The Royal Australasian College of Physicians (RACP) Consensus Statement on the Health Benefits of Work.

Back at work

We support workers in their recovery from injury and help them and their families cope with the change and challenge that result from workplace harm. The *Safety, Rehabilitation and Compensation Act 1988* (SRC Act), is underpinned by the understanding that work in general is good for health and wellbeing. It has a strong focus on an early return to work as part of rehabilitation and recovery from illness or injury. Return to work is not easy with a mental illness. It is not always well understood by managers or colleagues. It is our job to help employers to get this right; providing suitable work and fostering an inclusive supportive workplace that will help reduce the isolation and anxiety of a mental illness and help people to get back to good work.

Scheme at work

We provide a sustainable injury compensation scheme that is fair and responsive for the workers and their families who rely on it, while representing value for money for employers.

MENTAL HEALTH IN THE COMCARE SCHEME

Work related mental stress is of concern in the Comcare scheme, especially in the APS. The number and proportion of worker's compensation claims as well as the cost of psychological injury claims, has increased over recent years.[2]

Over the four-year period to 30 June 2010:

- around 9 per cent of accepted Australian Government premium payer claims were attributed to mental stress; and
- around 35 per cent of total claim costs related to these claims.

However, the impact of mental stress is even greater when secondary conditions are taken into consideration. There are a number of cases where the initial claim was not caused by mental stress, but the injured worker developed a mental disease as a secondary medical condition. Taking these cases into consideration, over the same period:

- around 11 per cent of all accepted claims within Australian Government premium payers involved mental disease as either a primary or secondary condition
- around 43 per cent of the total cost of accepted claims related to these claims.

BARRIERS TO PARTICIPATION IN WORK FOR PEOPLE WITH MENTAL ILL HEALTH

Perceptions of work capacity and provision of suitable duties

Workplace awareness of mental health has increased (according to the latest data from beyondblue). However, whilst we are more aware of mental health problems there tends to be a limited view of the work capacity of people facing these problems. Our workers' compensation experience tells us that employers struggle to find suitable duties for people with a psychological injury claim. Those with a psychological injury do not return to work as quickly as those with claims for non-psychological injures.[3] For example, during 2010–11, 49% of the mental stress claims from employees of Australian Government premium payers that involved 4 weeks lost time from work progressed to 26 weeks lost time. This compares to just 23% of all other claims that progressed from 4 to 26 weeks lost time during the same period.[4] The work engagement needs to move from a deficit approach to one that provides opportunities to recognise and grow people's capabilities and actively support them to put these to use.

2 Psychological injury claim trends in the Comcare scheme (see Attachment B)

3 beyondblue: 2011 Annual Business and Professions Study

4 Comcare KPI dashboard B1.3 Claims continuance rate—26 weeks (2010–11)

Breakdown in employment relationships

The mental illness itself may be complicated by the fact that those workers who are unwell have been experiencing stress for some time before making a claim and may have withdrawn from the work place over a period of time. In instances where relationships with the work place have broken down (for example where bullying behaviours have been involved), seeking resolution and managing a return to work can be difficult because of a breakdown in trust. Workplaces need to offer people a range of incentives to re-engage, and work options which enable people to return to work with mutual responsibilities and expectations.

Delays in early intervention

In the Comcare scheme, over the period 2006–07 to 2010–11, the median time taken by injured employees of premium paying agencies to lodge a claim with their employer is 19 calendar days following the date of injury.[5] However, mental ill health can be characterised by a slower onset and take longer to be reported to employers. The median time taken by employees of premium paying agencies to lodge a claim with their employer is 51 calendar days (i.e. for claims caused by mental stress).[6] Delays in seeking help may be due to the stigma that injured workers felt was attached to seeking medical treatment and to lodging a claim, or to their belief that they could manage things themselves. Other reasons for delayed support can be the employer's failure to recognise those workers whose circumstances place them at higher risk and early warning signs are missed. Employers also need to improve the time taken to on forward mental stress claims received from their employees to Comcare. For example, during 2010–11, only 43% of mental stress claims received by Australian Government employers were received by Comcare within 10 calendar days of receipt by the employer.[7]

Performance management

There may be times when the productivity of a worker falls below that expected due to health problems. In these circumstances managers play an important role in supporting staff with illness in the workplace through greater use of flexible work arrangements, and reallocating priorities and deadlines. But managers, in turn, need information on how to do that effectively and identify helpful behaviours to support their colleagues. When this is not done well there can be poor outcomes including workers compensation claims.

Common goals are needed

Recent research has emphasised that best practice management of mental ill health includes the early referral to appropriate treatment, particularly Cognitive Behavioural Therapy (CBT), delivered by an appropriately qualified mental health practitioner. The GP has a pivotal role in facilitating this referral.

Comcare, like other compensation schemes, faces considerable challenges in influencing General Practitioners' understanding that early referral to treatment together with a supported return to work can assist recovery, minimize the impact of mental ill health on their patients and reduce work disability. Better support for GPs is needed to promote work resumption following an injury. Optimising return to work needs a partnership, setting goals focussing on return to work developed in collaboration with workplaces, the injured worker and their GP.

---

5 Claim lodgement timeframes for claims received in the period 2006–07 to 2010–11 (see Attachment D)

6 Ibid

7 Comcare KPI dashboard B1.4 Timeliness—claim lodgement by employer (2010–11)

WAYS TO ENHANCE ACCESS TO, AND PARTICIPATION IN, EMPLOYMENT THROUGH IMPROVED COLLABORATION

We are entering a new era for Work Health and Safety in Australia. Harmonised Work Health and Safety Law, taking effect from January 2012, places consistent expectations on all workplaces to manage risks arising from work and prevent physical and mental harm to their workers. There is a greater emphasis on productivity and participation. When employers work in collaboration with workers, they can influence not only the health of their staff, but also the health and productivity of the organisation as a whole. Improving mental health outcomes needs an integrated approach to work health and safety which seeks to prevent sources of harm to health, promote healthy life choices and improve participation in work for those with illness or disability.

Comcare is a signatory to the Royal Australasian College of Physicians Consensus Statement 'Realising the Health Benefits of Work'. The statement recognises compelling international and Australasian evidence that work is generally good for health and wellbeing, and that long-term absence, disability and unemployment generally have a negative impact on health and wellbeing.

Comcare attended the launch in August 2011, by the Hon Nicola Roxon MP—Minister for Health and Ageing, of a Joint Statement of Commitment promoting good health at work. This was an important demonstration of the commitment of the Australian Chamber of Commerce and Industry, the Australian Industry Group, the Business Council of Australia, the Council of Small Business of Australia and the Australian Council of Trade Unions, to ensuring the long-term health and wellbeing of the Australian workforce.

Comcare is collaborating with government and social partners to identify and implement innovative ways of improving workers health and wellbeing.

We have established a *Centre for Excellence in Mental Health and Wellbeing at Work* with research bodies, employees, employers and health practitioners to foster collaboration and facilitate innovation and support for successful implementation. The Centre's Advisory Group have defined what the 21st century workplace would look like to promote and support mental health and wellbeing.[8]

This year we ran a campaign targeting awareness to improve the management and reporting of bullying issues in the workplace—Work Safety Campaign—*Don't be a silent witness*. The campaign included collaborative audits in workplace bullying prevention with employers to review WHS management systems.

STRATEGIES TO IMPROVE CAPACITY OF PEOPLE TO RESPOND TO THE NEEDS OF THOSE WITH MENTAL ILLNESS

Early recognition and mental health literacy

Sickness absence and incapacity can be significantly reduced through the efforts of line managers who also recognise the influence of a worker's family, community and social circumstances. Managers need to enable conversations to understand issues that impact on ability at work, and employ work arrangements to accommodate mental ill health at work. These skills need to be developed through training, supported by clear policy and coached by human resource personnel.

Comcare provides Mental Health and Wellbeing training for employers to build capability and improve on mental health literacy of line managers. The focus is on promoting, supporting and restoring mental ill health. Comcare's website provides resources and tools to assist people at work to understand and promote mental health at work.

8 Comcare's Centre of Excellence in Mental Health and Wellbeing at Work: Defining Success (see Attachment A)

Early response and services

Current workplace based services may include targeted health and wellbeing programs, training to support line managers and case managers to carry out their responsibilities in early intervention, arrangements with Approved Rehabilitation Providers (ARP) for rehabilitation, and provision of more holistic support to address broader determinants of poor health such as family or financial concerns (through Employee Assistance Programs).

Comcare's claims management teams are putting workers at the centre of what they do. There is a team dedicated to return to work outcomes, supported by a clinical advisory panel. Complex case officers are appointed to liaise with different parties and help workers with mental ill health navigate the system. Our Injured Worker Survey is helping us to better understand the experience of injured workers including those with mental ill health. We will learn from this feedback and continue to improve approaches to supporting injured workers and their families.

Comcare provides advice to employers to help them to respond consistently and appropriately to federal workers whose mental health may be at risk. We have also established a Workplace Relationships Resolution Team (WRRT) to review complex cases involving breakdown in workplace relationships, including bullying and harassment and psychological injuries. Cases are managed in line with Comcare's Regulation Policy and the intervention ranges from providing advice, education, and compliance monitoring to investigations.

Proactive case management and coordination

When a worker is off work for a more extended period of time, effective case management is critical to promote collaborative problem solving related to identified issues and to manage risks of delayed return to work. Aligning treatment and return to work goals with evidence based recovery timeframes, and using an exception reporting approach to highlight where cases are drifting into long term incapacity, is important.

Comcare provides practitioner education programs designed and delivered to improve capacity of employers within the Comcare scheme to manage health and rehabilitation. Comcare's national training calendar of programs cover safe workplaces, injury prevention, injury management, work health promotion and mental health awareness. Comcare offers a Certificate IV Government (Injury Rehabilitation Management) for rehabilitation case managers in partnership with the Australian Public Service Commission. Comcare is also member of the Personal Injury Education Foundation providing programs to enhance the range and depth of personal injury management skills in practitioners.

SUMMARY

Success has much to do with the way workplaces are designed, the way policies and culture affect workplace safety, and the employer's response to injury or illness at work. Getting this right means a work environment and management practices which:

- promote worker mental health and wellbeing
- take action to ensure workplace injuries are prevented including the risks arising from the psychosocial working environment
- embrace difference, diversity and disability and promote ability to work
- provide support for injured workers in early stages of sickness absence to prevent longer term or repeated illness
- provide suitable work on return to the workplace
- foster an inclusive supportive culture that helps workers to get back to work and get on with their lives.

21ST CENTURY WORKPLACES PROMOTE AND SUPPORT—MENTAL HEALTH AND WELLBEING

COMCARE'S CENTRE OF EXCELLENCE IN MENTAL HEALTH AND WELLBEING AT WORK: DEFINING SUCCESS

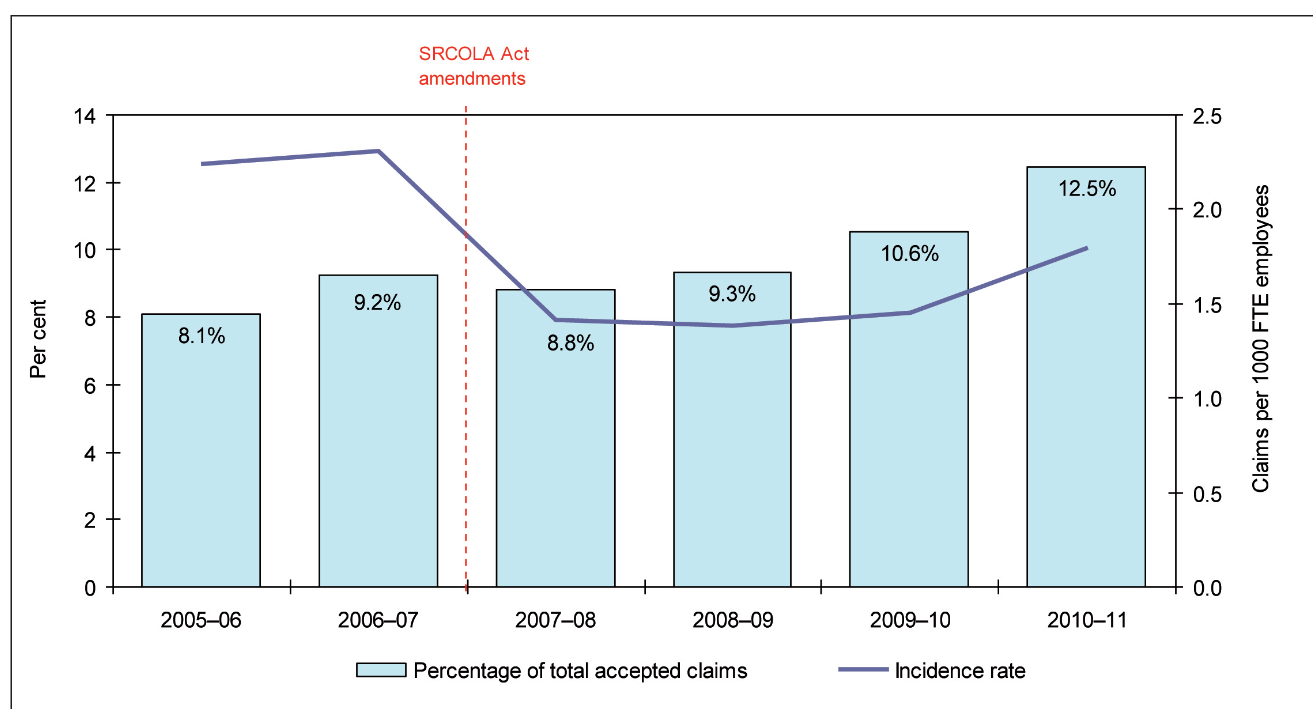
Workplaces deliver the health benefits of good work and promote the health and wellbeing of their workers

1. Workplaces demonstrate a focus on mental health at work by establishing principles that are integrated into work design, people management practices, business processes, leadership and staff development programs.
2. Workplaces assess the risks to mental health and wellbeing and take action to continuously improve culture and systems at work.
3. Managers have capability and support to help workers adapt to challenge and change and are held accountable for this work.
4. The work community is able to recognise early warning signs and people have the confidence and avenues to respond to mental ill health at work.
5. Managers seek to understand issues that may impact on individual's ability to work and make adjustments to accommodate this.
6. People at work are involved in decisions on how their work is undertaken, including changes that affect them directly.
7. People at work have guidelines, tools and support for performance improvement and are accountable for their behaviours.
8. Mental health and rehabilitation service are evidence based, improve functioning and foster participation in work.
9. People with longer term incapacity for work due to mental ill health are offered pathways back to employment.
10. Injured workers experience of the compensation process is supportive and not detrimental to mental health.
11. Injured workers' have access to information and support to optimise their involvement in recovery and return to work

PSCYHOLOGICAL INJURY CLAIM TRENDS

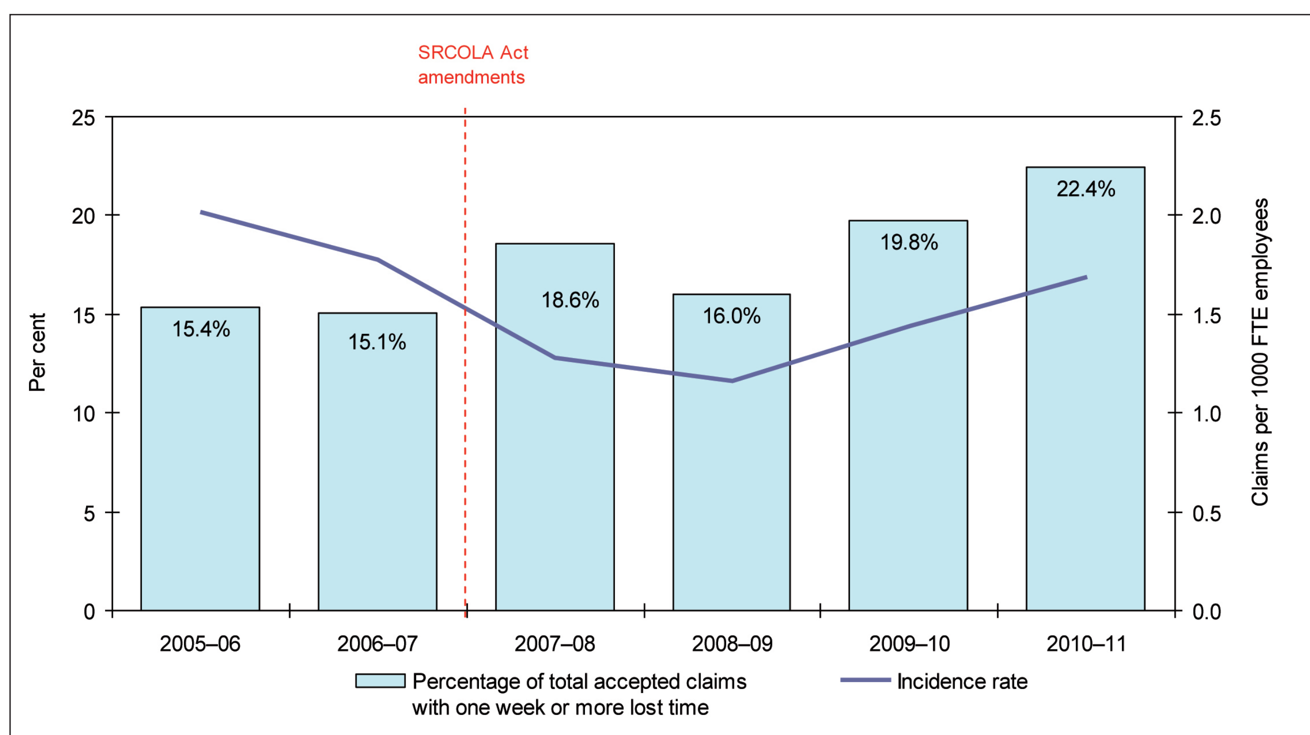
- The incidence and cost of psychological injury claims amongst Australian Government premium payers resulting from work-related mental stress has increased markedly over the period 2008–09 to 2010–11.
- There has been a recent increase in the incidence and cost of mental stress[9] claims for Australian Government premium payers
  - the incidence of mental stress claims has increased from 1.4 accepted claims per 1000 full-time equivalent (FTE) employees in 2008–09 to 1.8 claims per 1000 FTE employees in 2010–11—a 30 per cent increase
  - the total estimated claim cost of mental stress claims has increased from $53m for claims accepted in 2008–09 to $70m in 2010–11.
- While mental stress claims for Australian Government premium payers represented 9.3 per cent of all accepted claims during 2008–09, this has increased to 12.5 per cent during 2010–11 (see Figure 1). In 2008–09, 262 claims were accepted for mental stress, compared to 348 during 2010–11.

Figure 1: Accepted mental stress claims—Australian Government premium payers



- There has also been a pronounced increase in the incidence and proportion of mental stress claims involving one week or more lost time
  - in 2010–11, the incidence of mental stress claims involving one week or more lost time was 1.7 claims per 1000 FTE employees, compared to 1.2 in 2008–09
  - in 2010–11, mental stress represented 22.4 per cent of all claims involving one week or more lost time compared to 16.0 per cent in 2008–09 (see Figure 2).

Figure 2: Accepted mental stress claims with one week or more lost time—Australian Government premium payers

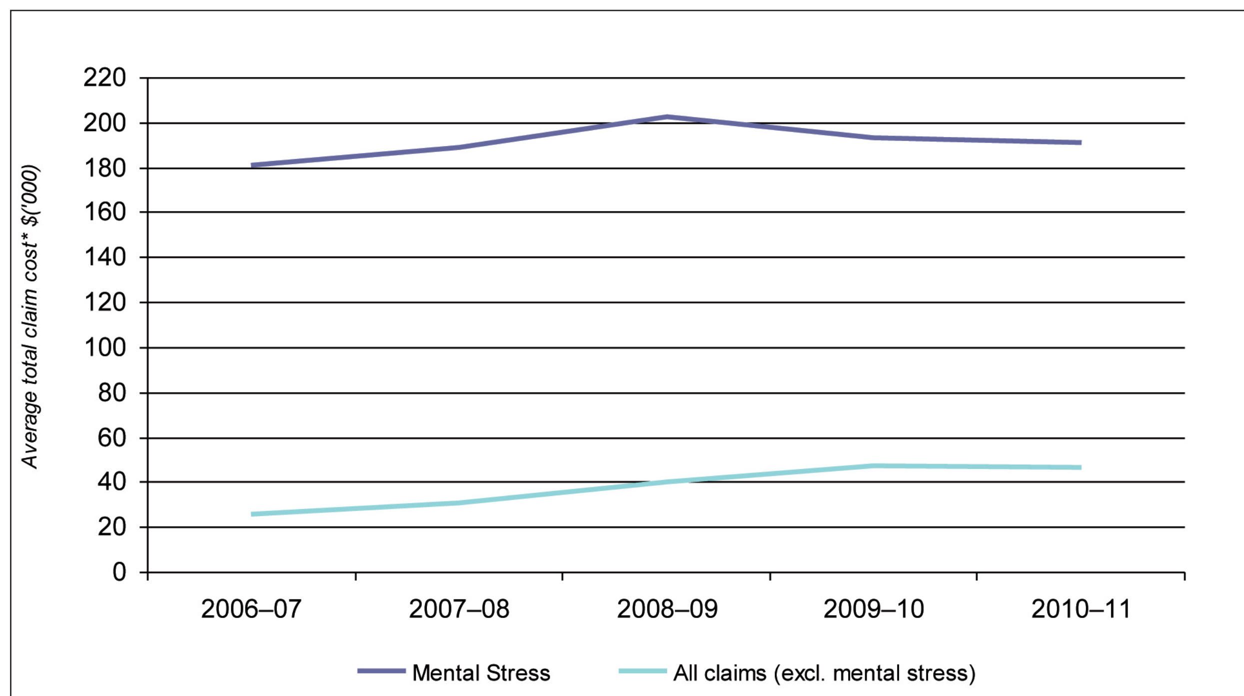


- > The SRCOLA Act amendments of April 2007 strengthened the required relationship with work for a disease claim to be compensable. The impact of the amendments was realised through a reduction in the incidence and cost of mental stress claims in 2007–08
  - the incidence of mental stress claims fell from 2.3 to 1.4 accepted claims per 1000 FTE employees over the period 2006–07 to 2007–08
  - the total estimated claim cost of mental stress claims fell from $77m to $51m over the same period.
- > Since the SRCOLA amendments were enacted a number of matters involving the reasonable administrative action (RAA) exclusions have been subject to appeal at the AAT. The AAT's interpretation and approach to the RAA exclusions has evolved with varying outcomes, which in turn has influenced decision making processes and the acceptance rate for mental stress claims
  - in 2005–06, prior to the SRCOLA Act amendments, Comcare's acceptance rate for Australian Government premium payers' mental stress claims was 60 per cent. This has increased slightly from 49 per cent in 2008–09 to 53 per cent in 2010–11.
- > Mental stress claims are most commonly attributed to *work pressure* and *work related harassment* and/or *workplace bullying*. During 2010–11 mental stress claims associated with work pressure and work related harassment and/or workplace bullying accounted for 81 per cent of all accepted mental stress claims and 83 per cent of total estimated claim costs associated with mental stress for Australian Government premium payers. Of the two key causes of psychological injury claims, current data shows bullying and harassment accounts for 44 per cent (up from approximately 40 per cent), while work pressure accounts for 37 per cent (down from approximately 40 per cent). The changes may relate more to the impact of greater knowledge and 'labelling' of cases.
- > The incidence of mental stress claims amongst Australian Government premium payers is currently around six times higher than the incidence of mental stress claims amongst licensees (self insured employers licensed under the SRC Act). The reasons for this difference are not clear, but many relate to a combination of work demands, organisational, and cultural factors. It is of note that time taken to lodge claims is substantially longer for premium payers (see Attachment D).

AVERAGE TOTAL COST OF MENTAL STRESS CLAIMS—(AUSTRALIAN GOVERNMENT PREMIUM PAYERS)

Latest estimates indicate that the average total cost of mental stress claims accepted during 2010–11 was approximately $191 000, compared to around $47 000 for all other claims.

Figure 1: Average total cost* of mental stress claims (Australian Government premium payers)



Average total claim cost* $(`000)—Australian Government premium payers					
	2006–07	2007–08	2008–09	2009–10	2010–11
Mental Stress	181.3	189.0	202.9	193.7	191.0
All claims (excl. mental stress)	25.8	31.0	40.1	47.7	46.8

*Average total cost is the cost to date plus estimated outstanding liability

CLAIM LODGEMENT TIMEFRAMES FOR CLAIMS RECEIVED IN THE PERIOD 2006–07 TO 2010–11 PREMIUM PAYING AGENCIES AND LICENSEES

Delay in lodgement of claims to the relevant determining authority (i.e. Comcare or licensee) can negatively impact on early intervention. Delays can be experienced across each of the following as shown in the table below:

> time taken to lodge a claim with the employer by the injured worker (25 days median for premium payers and 9 days for licensees)

> time taken to lodge a claim with the determining authority by the employer (10 days median for premium payers and 4 days for licensees).

	Premium payers	Licensees
Injury claims		
Median calendar days between:		
Date of injury and date employee signed claim	14	6
Date employee signed claim and date employer received claim	1	0
Date of injury and date employer received claim	*19*	*8*
Date employer received claim and date claims manager received claim	*10*	*4*
Date claims manager received claim and date claim registered	2	0
Disease claims		
Median calendar days between:		
Date of injury and date employee signed claim	29	13
Date employee signed claim and date employer received claim	1	0
Date of injury and date employer received claim	*35*	*16*
Date employer received claim and date claims manager received claim	*11*	*4*
Date claims manager received claim and date claim registered	2	0
All claims		
Median calendar days between:		
Date of injury and date employee signed claim	19	7
Date employee signed claim and date employer received claim	1	0
Date of injury and date employer received claim	*25*	*9*
Date employer received claim and date claims manager received claim	*10*	*4*
Date claims manager received claim and date claim registered	2	0

Notes:

> includes claims received by Comcare or licensee claims manager in the period 2006–07 to 2010–11

> the employer received date is the date the employer indicated that the claimant submitted the claim form

> for Comcare, the claims manager received date is the date that Comcare imaged the claim form

> excludes

- deleted claims
- takeover claims
- claims where the employer received date precedes the date the employee signed the claim
- claims where the claims manager received date precedes the employer received date.

CLAIM LODGEMENT TIMEFRAMES FOR CLAIMS RECEIVED IN THE PERIOD 2006–07 TO 2010–11 PREMIUM PAYING AGENCIES AND LICENSEES—MENTAL STRESS/ NON MENTAL STRESS

As shown below, there are significant differences in the time taken to lodge claims involving mental stress compared to all other disease claims:

> time taken to lodge a mental stress claim with the employer by the injured worker (51 days median for premium payers and 26 days for licensees)

> time taken to lodge all other disease claims with the employer by the injured worker (29 days median for premium payers and 14 days for licensees).

	Premium payers	Licensees
Disease claims—Mental stress		
Median calendar days between:		
Date of injury and date employee signed claim	43	21
Date employee signed claim and date employer received claim	2	2
Date of injury and date employer received claim	*51*	*26*
Date employer received claim and date claims manager received claim	*12*	*4*
Date claims manager received claim and date claim registered	2	0
Disease claims—Non Mental stress		
Median calendar days between:		
Date of injury and date employee signed claim	23	11
Date employee signed claim and date employer received claim	1	0
Date of injury and date employer received claim	*29*	*14*
Date employer received claim and date claims manager received claim	*10*	*4*
Date claims manager received claim and date claim registered	2	0

Notes:

> includes claims received by Comcare or licensee claims manager in the period 2006–07 to 2010–11

> the employer received date is the date the employer indicated that the claimant submitted the claim form

> for Comcare, the claims manager received date is the date that Comcare imaged the claim form

> excludes
- deleted claims
- takeover claims
- claims where the employer received date precedes the date the employee signed the claim
- claims where the claims manager received date precedes the employer received date.

EMPLOYEE CLAIM LODGEMENT TIMEFRAMES FOR CLAIMS RECEIVED IN THE PERIOD 2006–07 TO 2010–11 PREMIUM PAYING AGENCIES

	No. of claims	% of claims	Cumulative % of claims
Injury claims			
Date of injury to date employer received claim:			
2 weeks or less	4058	41	41
2 weeks to 6 weeks	3448	35	76
6 weeks to 12 weeks	1195	12	88
12 weeks to 26 weeks	667	7	95
more than 26 weeks	518	5	100
Disease claims			
Date of injury to date employer received claim:			
2 weeks or less	2624	26	26
2 weeks to 6 weeks	3013	30	56
6 weeks to 12 weeks	1598	16	72
12 weeks to 26 weeks	1243	12	84
more than 26 weeks	1665	16	100
All claims			
Date of injury to date employer received claim:			
2 weeks or less	6682	33	33
2 weeks to 6 weeks	6461	32	65
6 weeks to 12 weeks	2793	14	79
12 weeks to 26 weeks	1910	10	89
more than 26 weeks	2183	11	100

Notes:

- includes claims received by Comcare or licensee claims manager in the period 2006–07 to 2010–11
- the employer received date is the date the employer indicated that the claimant submitted the claim form
- excludes
  - deleted claims
  - takeover claims
  - claims where the employer received date precedes the date the employee signed the claim
  - claims where the claims manager received date precedes the employer received date.

EMPLOYER CLAIM LODGEMENT TIMEFRAMES FOR CLAIMS RECEIVED IN THE PERIOD 2006–07 TO 2010–11 PREMIUM PAYING AGENCIES

	No. of claims	% of claims	Cumulative % of claims
Injury claims			
Date employer received claim to date claims manager received claim:			
1 week or less	3645	37	37
1 week to 2 weeks	3116	32	69
2 weeks to 4 weeks	2113	21	90
4 weeks to 8 weeks	765	8	98
more than 8 weeks	247	2	100
Disease claims			
Date employer received claim to date claims manager received claim:			
1 week or less	3448	34	34
1 week to 2 weeks	3338	33	67
2 weeks to 4 weeks	2197	22	89
4 weeks to 8 weeks	817	8	97
more than 8 weeks	343	3	100
All claims			
Date employer received claim to date claims manager received claim:			
1 week or less	7093	35	35
1 week to 2 weeks	6454	32	67
2 weeks to 4 weeks	4310	22	89
4 weeks to 8 weeks	1582	8	97
more than 8 weeks	590	3	100

Notes:

- includes claims received by Comcare or licensee claims manager in the period 2006–07 to 2010–11
- the employer received date is the date the employer indicated that the claimant submitted the claim form
- for Comcare, the claims manager received date is the date that Comcare imaged the claim form
- excludes
  - deleted claims
  - takeover claims
  - claims where the employer received date precedes the date the employee signed the claim
  - claims where the claims manager received date precedes the employer received date.