



Transcript



Psychosocial Wellbeing in the Workplace: Supporting Healthcare Practitioners

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Prof Mark Creamer (00:00:02):

Hello, and on behalf of MHPN and Comcare, welcome to this webinar on psychosocial wellbeing in the workplace supporting healthcare practitioners. Warm, welcome to all of you who've joined us for the live activity tonight. We've got an amazing number of registrations, but a warm welcome also to those of you who are watching or listening to us later on the record. Before we start, I would like to acknowledge the traditional custodians of the lands across Australia upon which our panellists and our participants are located and I'd like to pay our respects to their elders past, present, and emerging. My name is Mark, Mark Creamer. I'm a clinical psychologist with a long background in public and private sector mental health as well as in research and policy. And my area of interest is trauma, mental health effects of trauma. And so this area tonight, this area of looking after ourselves and our colleagues, it's something that's very close to my heart and so I'm looking forward very much to hearing what our experts have to say about the topic. So without further ado, let me introduce them. First we have Jordan Jackson. Jordan is the assistant director psychosocial regulation at Comcare. He's got a particular interest in suicide prevention as well as in trauma-informed practise in the workplace. Welcome, Jordan.

Jordan Jackson (00:01:21):

Thanks for having me. Mark,

Prof Mark Creamer (00:01:24):

Are you able to tell us just a little bit about what interests you about this area of psychosocial welfare in the workplace?

Jordan Jackson (00:01:32):

Yeah, absolutely. In a nutshell, it all started when I used to work on the mines and I used to talk to these big burly lads that asked the right questions, would just break down and tell you all of the things that were happening in their lives. And then I went ahead and got my masters of Suicidology and yeah, really keen on how workplaces can influence positively and negatively someone's overall psychological health.

Prof Mark Creamer (00:01:59):

That's very interesting and when you talk about that population, I can't help thinking about the military

Jordan Jackson (00:02:04):

A hundred percent. Yeah.

Prof Mark Creamer (00:02:06):



Transcript



Thank you. Jordan. Katherine, Dr. Katherine Petrie is a postdoctoral research fellow at the Black Dog Institute and University of New South Wales. She's researching mental health and suicidality and particularly in high risk workplaces and poor Katherine has had a few tech problems tonight. So we're keeping our fingers crossed for you, Katherine, but welcome.

Dr Katherine Petrie (00:02:27):

Thanks very much. Mark,

Prof Mark Creamer (00:02:29):

Let me ask you the same question. Where did this interest come from? What's your interest in psychosocial wellbeing?

Dr Katherine Petrie (00:02:37):

So this has been a longstanding interest for me. I've spent the last 12 years of my research career looking at the intersection and the interaction between work, mental health and suicide. And over the last four years I was completing my PhD, which investigated a common mental disorder and suicidality among Australian doctors. So this subject is very close to my heart.

Prof Mark Creamer (00:03:03):

Oh, absolutely. And our case example of Anna is very important for you there, which we'll talk about a bit more in a minute. Our third panellist tonight is Steve Meyer. Steve's a psychologist with over 15 years experience in clinical educational and organisational settings, and he's got a particular interest in reflective practise as a tool for building thriving workplace cultures, which sounds like a fascinating area, Steve. But welcome. Thanks for joining us.

Steve Meyer (00:03:29):

Thank you very much.

Prof Mark Creamer (00:03:31):

So finally, let me ask you as well, it's any particular reason why you have an interest in this area?

Steve Meyer (00:03:37):

Look, I think right throughout my career and even right up to my work now, it's a tool that can transform not just of what we do but the how as well. And it can generate all of these solutions to these wicked problems that we face in our professions. And if it's introduced well, we can bring people on board with new ways of thinking who might not necessarily appear like they'd be up for it, but it has an incredibly protective effect for those of us who work in really impactful settings. And I think I'm a living, breathing example of reflective practise and how that can improve our health and what we deliver for our patients and clients as well.

Prof Mark Creamer (00:04:18):



Transcript



Good. And so we'll be hopefully building on that tonight as we go through the webinar and we'll be coming back to our panel in just a minute because they are going to each give us a brief five minute presentation which will kind of set the context for us as we go into the rest of the webinar. We've given them a case which I just mentioned actually a case study, Anna, which you've also had the chance to read. I hope that you have and have some thoughts about. And the idea is that the panellists can use our case study of Anna as a kind of jumping off point. The idea is not that it will constrain them or the discussion that we have tonight, but rather it's simply it's a good kind of starting point

(00:05:07):

Be driven by Anna, but they may

(00:05:08):

We'll take in other areas before we end up with our closing comments. In terms of what we want to achieve in this webinar, you've all seen the learning outcomes I suppose in terms of what, and I think there's a slide for them coming up, but in terms of what I'm interested in, first of all I'm interested in identifying the common factors that influence wellbeing in the workplace. So what are the risks, what are the factors that determine wellbeing in the workplace? I think the second is to recognise the impact that those factors have on us as individuals and on the workplace more broadly. And thirdly, I'd like us to understand the evidence-based interventions that can be used to help individuals and teams in terms of psychosocial wellbeing. Okay, so that being said, let's get on with our five minute presentations and the first cab off the rank tonight is going to be Jordan. So I'm going to hand over to you Jordan for five minute presentation.

Jordan Jackson (00:06:14):

Excellent, thank you very much. I've got \$10 writing on the fact that I can make this in under five minutes, so let's see how I go. Okay, so I wanted to start, if we could go to that first slide. Thank you. Discussing basically what is the psychosocial hazard, what are the risks and what do we mean by that? So a psychosocial hazard really is talking about anything in the workplace that could cause psychological injury and can also include physical injury. When we have a look at things like violence and aggression, we've got a heap of legislation that governs this. I work in under the federal jurisdiction and for the most part I believe yourselves would be governed by whatever state or territory you're in. However, they are all very similar except for Victoria, which operates with the same intention, just slightly different wording. So we're going to get straight into it.

(00:07:15):

The code of practise here that I've got there, we talk about 17 of the common psychosocial hazards that we regulate. And when I say we regulate, that means us. That means that the employer has a positive duty to ensure the health and safety of their workers with regard to these hazards and how they might crop up and how they are controlled, identified and eliminated if possible. So we've got the 17 there for Anna's situation, these are the ones that I picked out reading through that scenario. I won't read you all of the words on the screen, otherwise I'm never going to make my 10 minutes, but those are the big ones that we're sort of going to look at tonight or myself will at least. Next slide please. What we know about psychosocial hazards is that while each of them individually is a risk and can present a risk of psychosocial harm, what we tend to find is that they will be cumulative. So me having and having poor support in isolation is tricky and might present a hazard, but we tend to find that the risk increases as



Transcript



these things combined and build on each other and that's where we're going to lead to the incident or the injury with the main ones in the psychosocial space, we focus on being burnout, suicidal behaviours and that interpersonal conflict, whether that be a verbal falling out between colleagues or physical aggression as well. Next slide please.

(00:08:47):

Thank you. So the first thing that the employer needs to do and we'll take the role of Anna's employer in this situation is that we need to identify what the hazards are. How do we know all of these things could present harm to our workers? Consultation with staff is the big one. I probably don't need to tell the majority of you on this call as clinicians that you already know what the issues are with your work, how it functions, what you are exposed to. We want our employers to observe work and behaviours, not through the lens of KPIs and widgets, but as people watch your workers talk to them, observe how they're going, what are the parts that are stressing them out, what are the parts that they're doing really well? What are the barriers to them doing their job effectively? We also want to review any other available information.

(00:09:38):

Do we have patient satisfaction reports? Do we have Google reviews about our practise? Is there any other information in there that we can start to paint a little bit of a picture about how things are going? It isn't dissimilar to how we would manage physical hazards. It's actually very, very similar, but tonight we're going to focus specifically on that. Next slide please. Some of you may or may not be familiar with the hierarchy of controls. We've got a problem and we need to control it. We've got a hazard that leads to a risk, we need to control it. Our regulations are really specific in how we do that. We need to start right at the tippy top and work our way all the way down. I'm sure that you know yourselves, if you had a massive issue within hospitals and healthcare systems of disease and your only control measure was to say to the clinicians here, wear PPE, that's not going to cut the mustard.

(00:10:39):

We want to have a look at ways of eliminating. Can we eliminate patients? Probably not, but there may be ways that we can eliminate their aggression by reducing wait times, doing that kind of thing, substitution. Is there an option for telehealth, engineering the controls out? Is there a way that we can change the layout of the waiting room to make it a lot more hospitable for people so that violence and aggression doesn't peak while they're waiting for their appointments? We use a lot of administration in psychosocial settings. It is good and it is what's most common, but that doesn't mean it's what we want to rely on. But when I say administration, can we change wait times? Can we reduce the number of appointments people have to do within the day? Can we factor in team meetings? And then of course our PPE, and when I say PPE in the psychosocial setting, we sort of want to look at what are those factors of personal control that people that you can give to people. Can we train resilience? Can we train mindfulness? I'm not a huge fan of those personally because organisations sometimes tend to say, this is what we are doing and as I just mentioned, you've got a massive disease outbreak and what you are doing is handing out rubber gloves. It's just not going to cut the mustard. Next slide, please.

(00:12:04):

On that point, and my last point, EAP is an intervention. It's not prevention. So many organisations, and I say this because it is a particular bugbear of mind in my time that I've been doing this, people will say, oh, well we've got the employee assistance programme. That is no more beneficial to somebody who is



Transcript



suffering than giving a cold and flu medication. To me, once I've already got the sniffles, we need to stop the problem before it gets to that. How did I go, mark? Oh, one minute over. I'm

Prof Mark Creamer (00:12:35):

Afraid you've lost your \$10 mate. I'll send you my bank account details.

Jordan Jackson (00:12:41):

Thank you. I did rush through that really quickly.

Prof Mark Creamer (00:12:44):

Anyway, look, it was a lovely talk, John. It was a lovely talk. Can I just pick up quickly, and we do have to do it quickly, but I'm interested in your comment, which I agree with entirely about observing work and behaviours. You talk about employers observing their staff, but presumably we're talking also perhaps about colleagues and supervisors, whatever. But the point I wanted to ask about was we kind of think sometimes we think this is just being a good human being. It's just keeping an eye on your mates kind of thing, and I guess I'm wondering whether we can afford to do that or whether people actually need training in how to recognise when things might be going wrong.

Jordan Jackson (00:13:23):

I absolutely think there is a space for that additional training. There are a number of really good programmes out there that do suicide prevention training and the like, particularly in workplaces, absolutely. But at the end of the day, you don't need a certificate to be able to reach out to somebody. The main things that are going to stop us from offering that help is fear. Fear of what will happen if I'm rejected, what will happen.

Prof Mark Creamer (00:13:52):

I'll stop you there, Jordan, because actually we're going to talk about that a lot with Anna Anna's case, but the point you make is a very good one. I quite agree. I quite agree and it is common sense, but unfortunately common sense is not that common. Thank you very much, Jordan. Okay, Katherine, your opportunity to show Jordan up and get yours in within five minutes. Over to you.

Dr Katherine Petrie (00:14:13):

Thanks very much. Okay, so as you are very much aware, healthcare is a particularly complex, diverse and unique work setting, and within this context there are several psychosocial risk factors that are particularly prominent in exacerbated by or unique to healthcare and mapped out here in the table are some of the psychosocial risk factors that are identified in the literature most prominently across healthcare roles and settings worldwide. I've organised them here according to a prominent framework which classifies psychosocial risk factors as being related to three main categories, job factors, the design and content of the work being conducted, team and operational factors which are related to the environment in which the work occurs and the wider context and culture of the organisation at a systems and policy level. And also in bold, you can see factors that you may remember noticing in Anna's story, which there are a number of risk factors that were evident there, but why are these array of work factors important? Next slide.



Transcript



(00:15:30):

Both Anna's story and the research evidence highlight the critical importance and the potential harmful impact that psychosocial risk factors can have on healthcare professionals mental health and wellbeing. International evidence over the last few decades has found that many psychosocial risk factors influence healthcare workers mental health and are associated with an increased risk of a range of outcomes like these listed below, some of which such as symptoms of stress and concerning, suicidal thoughts we saw in Anna's scenario. Next slide. It's also important to note that psychosocial risk factors can also have broader impact on patient and workforce outcomes down the line indirectly via healthcare worker and mental health. So we know that mental health problems and burnout among healthcare workers can also be associated with poor performance at work, low job satisfaction, which we saw in Anna's case and also higher levels of job attrition and turnover.

(00:16:36):

Another important aspect to note here, which is also born out in the research is that when engineered and managed properly at optimal levels, some of these psychosocial factors can actually be protective or have a positive impact on workers' mental health and performance. So they're not necessarily always risk factors with adverse impact. Many of these factors are on a spectrum and can also contribute to healthcare worker wellbeing and promote a mentally healthy workplace if we create the right systems team and job design around each healthcare worker to support them individually and as a team and also as a broader workforce. Next slide.

(00:17:22):

So what can we do? I can touch on what some of the evidence-based strategies are later on, but what I really want to highlight for everyone here tonight is the importance of help seeking, help seeking as early as possible and always including a professional, is critical when anyone is experiencing mental ill health and particularly in cases of suicidal thoughts or behaviours. Promisingly, we saw that Anna had already considered seeking professional support for her mental health, which is really encouraging because there are some really concerning statistics showing low rates of professional help seeking for mental health among healthcare workers. Some of my research has looked into this and has found that healthcare workers report multiple barriers to help seeking some of which are linked to psychosocial risk factors such as an inability to take time off work due to long working hours and high work demands. Stigma is also another barrier which Anna also mentioned.

(00:18:25):

What's important for everyone to note is that there are variety of sources of support which will differ depending on your level of need and the type of support that you are looking for. And these are not mutually exclusive. You can seek formal professional support and informal support at the same time, and both of these will provide a diverse support network that can provide you with different types of support. What I would highlight is that professional mental health support is essential, especially once as we saw in Anna's story, that your symptoms are starting to compound to impact upon your functioning both at work and at home and are causing growing concern and stress for yourself. So here I've listed a number of supports you can reach out to both at work and outside of work. Next slide. So the three key takeaways is that there are certain psychosocial risk factors that are more prominent in healthcare. These risk factors are incredibly important in influencing mental health of healthcare workers both



Transcript



positively or negatively, and help seeking is critical for healthcare workers who are concerned about their mental health.

Prof Mark Creamer (00:19:36):

Thank you very

Dr Katherine Petrie (00:19:36):

Much. How'd I go with time mark?

Prof Mark Creamer (00:19:38):

Well, I was going to say fantastic content first. I did want to say that first and you ran over by 15 seconds, which let's face it is not bad. I reckon everyone can do that too well tonight. Look, that was great. That was great. I just wonder if we could talk very briefly, and it's potentially a massive area, but it's a really important area about what the evidence says in terms of suicide among healthcare workers in Australia. So just briefly, is there a response to that?

Dr Katherine Petrie (00:20:10):

Sure. Look, suicide's a massive concern in many high risk workforces such as defence and also emergency workers as well as healthcare professionals. We know that healthcare professionals in Australia, one of the studies I recently did looked at coronial data of suicide mortality over the last almost 20 years and found that overall healthcare professionals were at greater risk of suicide compared to other occupations as were nurses and midwives. And also found that suicide rates among female doctors had increased significantly over the last 18 years, which is a really concerning finding.

Prof Mark Creamer (00:21:02):

That is very concerning isn't it? Hugely concerning. Okay, well hopefully we'll talk about what some of the ways of mitigating that might be tonight. Our final speaker is Steve, you've got the floor. Steve, over to you.

Steve Meyer (00:21:15):

Thank you. So just looking at some of the points there on the slide, I think Anna really exemplifies a lot of the challenges that healthcare workers face, even particularly in resource limited settings, but sometimes just if there's not systems and structures in place to support the people working there over the past 18 months and has encountered multiple psychosocial stresses and that includes the sudden death of her mother, increased patient demand and exposure to occupational violence. These events have obviously really impacted her wellbeing and that's led to sleep disturbances, heightened stress and feelings of professional isolation. Anna's clinic also doesn't have formal support structures such as peer meetings or violence management policies, which is heightening her sense of vulnerability and her actual vulnerability as well. I believe this experience highlights that urgent need for systemic interventions that address both the individual and the organisational factors that contribute to psychosocial distress and without that support and that sort of wraparound systems view and looking at the individual people like Anna might face deteriorating mental health but also reduce job satisfaction, which ultimately affects the quality of care that we provide. Next slide please.



Transcript



(00:22:42):

Organisational change really is as we know, essential for addressing systemic factors. And I say obviously because I know that there are going to be many of us where we're working in settings that might be quite dysfunctional for a range of reasons or resistant to change. And so we kind of want to think about the strategy of all of this. Effective support really needs to include those regular team meetings, check-ins, reflective practise of course that time to come up for air to look at what we're doing to celebrate the wins and to also be curious about what we can refine but also manageable workloads, opportunities for professional development and leadership at all levels, really taking that obvious demonstration of supportive behaviours and prioritising staff wellbeing. We can see in Ana's case without those supports that she felt undervalued, isolated, and by implementing these organisational challenges, changes rather that promote communication support and growth.

(00:23:43):

Healthcare practises in a whole range of settings can create environments where professionals feel empowered and valued and these changes don't only improve individual wellbeing and keep us in the work in a sustainable way, but it also means we have better client outcomes and better team cohesion and culture. A sustainable level of practise requires a real commitment at all levels to that continuous improvement and the culture that recognises the importance of mental health individually, Anna might start with altering the way she performs her usual work tasks to make her own work demands a bit more tolerable and sustainable. That could be pacing the day, organising how we see clients and patients, but also smart work design, looking at the bigger picture of even how we do the work, not just what it is that we're doing. And this is an evidence-based approach to really boost positive impacts on individual wellbeing teams and organisational productivity.

(00:24:41):

So we talked a little bit about job crafting there, where we're looking at altering those aspects, but again, something like the smart design model looks at stimulating mastery agency, relational and tolerable demands plenty of information out there and would definitely recommend having a look in. Next slide please. Creating change in organisations as we said can be challenging and there's often professional narratives in healthcare that emphasise individual resilience and self-reliance, which can discourage us from then seeking help when we notice that we're impacted by the work and that perpetuate psychosocial risks, especially when much of the work that many of us do is inherently about psychosocial hazards being exposed to all of these stories, the content and people's experiences that again often involve heightened distress. So we want to reframe those professional narratives to highlight collective responsibility but also where we need to talking about our legislative obligation to manage and address as Jordan was talking about psychosocial hazards.

(00:25:46):

It's not just a nice to have. The landscape has changed in terms of our obligations and expectations. So the other thing is I suppose just to encourage everyone to take that approach where we can draw on including Katherine's research and create the business case for that change. If needs be. As we said, we've got to create a strategy that works, but for Anna's case, she might set lines in the sand as well about when she'd know potentially to recreate circumstances in some way, including looking at alternative employment or creating a transition plan for something that's going to be more sustainable. But I think the thing that we can emphasise here is that we have skill sets that are applicable to so many



Transcript



things. So I guess we're saying that in some level we need to step back and look at our relationship to the work and remember that we are not our job and I think that's a really critical aspect of reflective practise, but also maintaining our own mental health wellbeing. Last slide please. The key takeaways, again, psychosocial safety is a fundamental component of sustainable healthcare practise. Not a nice to have, but it's actually an obligation reflective practise and organisational level support or a key strategies for promoting mental health and resilience among practitioners. And Anna's case really illustrates the real world impact of psychosocial hazards and the urgent need for that systemic change. So I'm going to leave it there actually. And yeah, I'm open to any questions or

Prof Mark Creamer (00:27:16):

Perfect. Thank you very much Steve. Thank you very much. Content, brilliant and not quite as bad as Jordan in terms of echo time, worse than Katherine, but not quite as bad, some great stuff there. So just very quickly, do you think that the health sector should be leading the way in this kind of stuff? How do you think we do in terms of good psychosocial practise in the workplace?

Steve Meyer (00:27:41):

Look, I can only talk to my experience of it and I think a lot of what I've seen is that we don't necessarily get taught to identify which features of our job are a psychosocial hazard when it's just inherent to what we do. So I think we then have such a high threshold for a lot of behaviours that then affects the way that we develop policies or not at all. We tend to approach things from a really individual manner and don't get that time out where we've got business models sometimes, whether it's a clinic or other aspects or service contexts that make us go back to back. So I think we need the opportunity and when we get it, we make the most of it, but it's about how we can introduce narratives to places that might not be quite ready to go there straight away.

Prof Mark Creamer (00:28:27):

Alright, thanks. And we will come back to a fair bit of that stuff I think in question. So let's go there. It's time to open up the discussion now for some broader reflections and questions and so on. Many of you have already submitted questions when you registered for the webinar. You can also submit questions tonight by clicking the three dots in the bottom right hand corner of your video panel and click on ask a question and I'll be monitoring those questions throughout the course of the discussion. While you're thinking about that and perhaps while you're submitting questions, I'd like to welcome some thoughts from a former panellist and a friend of MHPN Associate Professor Antonio dio. So over to you Antonio.

Assoc Prof Antonio Di Dio (00:29:14):

My name's Antonio Dio and I'm the director of the Professional Services Review here in Canberra as well as a practising GP for the last a hundred odd years. Thank you so much for having me here. And hi Mark and thank you for a fantastic and enjoyable session so far. Also allow me to pay my respects to the nana will and bury people here in Canberra. I hope you've all enjoyed looking at the case study of Anna and her working in her small clinic with GPS and other allied practitioners and I hope very much that some of this material is at least familiar or starting to make a coherent pattern.

(00:30:01):



Transcript



Anna means a lot to me because I've been Anna many times and so have been a number of my dear friends and colleagues. A question that I'd really like people to think about is what would you do? What question would you ask? How would you respond to being Anna's work colleague, whether you are reporting to her colleague, her boss, what kind of conversation would you have with her? How would you raise it? How would you enter the space to make it safe to have those conversations with her? What would you ask? What tone would you use? What follow up would you have if you said something along the lines of, Hey, I noticed that you haven't been yourself lately, just checking you're okay. And if you ever needed somebody to talk to, what response do you think that you would get if it was a hostile and negative response?

(00:31:01):

Response, brushing off and saying, I'm fine. At which point, at what time would you like to ask the question or a similar one again, Anna is in a vulnerable place. Anna could quite easily become very depressed and unwell if she doesn't get the kind of understanding and support that she needs. How do we prevent that? How do we stop her from becoming that person perhaps for years before she develops her own understanding and insight and reaches out and needs help? How can we be a great colleague, a great friend to Anna and a great benefactor to the health system overall?

Prof Mark Creamer (00:31:48):

Thanks very much Antonio for those thoughts. There's a lot there, very full provoking and I do hope that our participants at home, as Antonio was talking there, we're able to start answering those questions yourselves about how you might work with Anna. I think we were going to unpack what Antonio was saying there. We've kind of got three main components and the first I think is that issue about would you approach Anna and if so, how would you do it? These things are often sensitive and not easy, but let me throw it out to the panel. Would you raise it with her? How would you go about doing that?

Jordan Jackson (00:32:27):

I'll jump in. Yeah, absolutely. Absolutely. You should approach Anna. As I was sort of alluding to in my rambling last answer to your last question, the things that would stop us from approaching Anna, we really need to sort of stop and be really critical of ourselves. Are we hesitant in approaching Anna because we might negatively impact her or are we worried about what it might happen to us? What happens to me if I say the wrong thing, what happens and that a little bit of ego, a little bit of fear, a little bit of stigma. It doesn't take a clinical psychologist, no disrespect to be able to have a genuine conversation with someone and get that ball rolling. So yes, absolutely and just approach it in an authentic way. The way that you would normally speak to Anna over the water cooler I think is the best and possibly only way to go about it

Prof Mark Creamer (00:33:28):

And not be overly concerned about will I say exactly the right thing or whatever. Would either Katherine or Steve want to come in there? We've got other questions, but I was just going to say actually how important, I think Antonio mentioned this, how important do you think choosing the right time and the right place is? Is that important? If we're going to talk to Anna,

Steve Meyer (00:33:48):



Transcript



I think it's incredibly important and I think partly what we can also focus on is just building a relationship with Anna and not feeling like our first conversation necessarily has to be about what we've observed. But I think there's also the importance of creating a culture first about how it is that we check in with each other and sometimes we need some structure to that. So it could be about creating shared languages, using the window of tolerance, things that gently introduce people into just routinely talking about their wellbeing so that it's not, I think there's something wrong with you and we can all be sensitive to that if someone approaches us.

Prof Mark Creamer (00:34:24):

I think that's crucial. It is the workplace culture one that allows you to actually do that. Okay, so we are going to approach her, as Antonio said, it's a bit difficult to know how she's going to react. What kind of response do you think you might get from Anna? What would you expect to get?

Steve Meyer (00:34:46):

I might jump in if that's okay. I think Please do. Yeah, we can expect all sorts of different reactions and that really depends I suppose on also how well we might know Anna, whether we've had a chance to build a relationship with her and have some context for why it is that we might be approaching. But if there is a hostile response, I think what we can just reassure the person of is that's okay, I'm here if you have a need to chat. This is just I think important for us to all do. And again, reminding that person that you're talking to or Anna in this case, that this is just normal, this is what we do. Again, it's not sort of zooming in on an individual. And then I think in terms of scheduling a follow-up or coming back to that, we might even just ask Anna, look, is it okay if I just check in a couple of days? I just want to make sure that nothing's changed or that if there is anything that you wanted to ask, we can do that. But it's really,

Prof Mark Creamer (00:35:39):

Yeah. Which kind of leads us onto the next part I think of what Antonio was saying, which is how do we stop her sliding down? How do we stop her deteriorating and so on. What kind of follow up, but I take your points, Steve there, that getting permission to follow up, getting permission to say, is it okay if I check in on how you're going in a couple of days or whatever. It's probably important. Anybody else want to add anything there about how we might prevent Anna going down?

Jordan Jackson (00:36:07):

Speaking from MySpace in the work health and safety thing, I think it's important that we look at these systems and we challenge business as usual. If you've had these conversations with Anna and she tells you that she's struggling with those different work factors that the panels identified today, you should have enough confidence and capacity and know that the legislation is backing you up to able to go to your boss and say, the conditions here are having a really negative impact, we actually need you to do that. You can do that respectfully. It doesn't need to be a forceful, you will fix this, but we certainly need to, us as colleagues, particularly given in Anna's situation, would probably only have so much scope to be able to inverter commas do something about it that onus does fall to the employer. So to pick up on those things and be able to push them back uphill where they belong, I think it's a difficult conversation to have, but a crucial one.



Transcript



Prof Mark Creamer (00:37:05):

The onus is on the employer certainly, but the onus is also on the individual, isn't it? And it takes some responsibility themselves. This is a discussion that I could go on all night about, but it's a good question from Pat actually. Who says, what about clinical supervision? Does that help? Self-awareness really is what she's saying. And I think is it something that we should be looking at in supervision? I think it's really, isn't it? That is part of supervision really. Yeah. Okay. Let's go beyond Anna's case and move on to your questions. We had lots of questions live tonight and I can see 'em still coming in also lots in the registration. We'll do our very best to answer as many as we can, but we have to be realistic. We're not going to get through all of them. So if we don't get to your particular issue, please accept our apologies.

(00:38:00):

I'm going to try and structure the questions a little bit like we talked about before. So we'll look at risk factors and so on. We'll look at impacts and we'll look at interventions. So let's kick it off. I think in terms of the risk factors, our panellists did a great job of running through the kind of standard risk factors around things like overwork, job demands, lack of resources, lack of control, job ambiguity, and I guess these are kinds of things that actually they're factors in any work environment, they, they're not unique to healthcare systems. Anything you would add to the lists that you have already put up or anything we need to consider perhaps especially in healthcare environments.

Dr Katherine Petrie (00:38:53):

I'll jump in there. There are a number of risk factors that are particularly prominent within a number of healthcare professions and roles. Some of those are linked to both the system and the way that the healthcare system is set up, but it's also, so we've got things like long working hours, high job demands, which can push into excessive working hours, excessive working demands. A number of reports, also identify exposure to trauma, both as a witness but also as Jordan had mentioned earlier being the subject of aggression that can come from carers patients. So they're some of the main risk factors that are particularly prominent within the healthcare sector.

Prof Mark Creamer (00:40:02):

And I want to come back to that if we get time, Katherine, to talk about those high risk occupations. But come to you, Steve, because we've got a good question here, which is kind of on what Katherine was saying and also what you mentioned earlier. This is from Julie in New South Wales and she says, how can workplaces move beyond wellbeing initiatives to address the deeper systemic factors, the compromised psychological safety? And as you're saying, if you've got this unrealistic workload, you've got all these other whatever it is, you can do all the wellbeing initiatives in the world and you're still going to be struggling. Do you want to add anything to that, Steve?

Steve Meyer (00:40:39):

Yeah, look, I think it's just about having an approach that embeds wellbeing in existing processes. I think a lot of initiatives float, they don't connect to anything. They're not long-term. They don't have something that we practise in between and then review necessarily. It's something that's just a session that might be delivered or something that's not embedded in how we do our entire HR life cycles, how it is that we look at our patient care, all of those sorts of things we can really transform, I suppose. But it is



Transcript



also being clear about, again, which of those systems most impact the way that we address psychosocial hazards and thinking about the strategy of how we can do it better based on our context people we're supporting and where we're at as healthcare practitioners.

Prof Mark Creamer (00:41:28):

If I could just come back to what you were saying, Katherine, about certain workplaces, and of course it's an issue for Jordan as well in Comcare where you have occupations that we know independent of work demands and lack of resources, all these other things independent of that. These are high risk workplaces and of course we think of the military, we think of our first responders, but within the health sector as well, of course, there are a number of situations that people are working in. We're at high risk of exposure to death and suffering or risk for themselves in emergency or whatever. So I'm just wondering, Katherine, if you've got any ideas about what we can do in that sense to mitigate those kinds of risks, if anything, or indeed, Jordan?

Dr Katherine Petrie (00:42:11):

Yeah, I think if we look back at the COVID era, I guess, and we almost use that as a learning opportunity. What are the things that we didn't do? What are the things that we could build on and adapt? I think the key is prevention, that's the most important, and not both prevention at an individual level. So equipping individual healthcare workers with healthy coping strategies, improving their resilience, but it's almost not ethical in a way to do that without supplying and optimising the job, the team, the organisational, the system level structures around that person to support them in those really high risk situations. One of the key things we learned through COVID was PPE, low resources. That stress of isolation was massive. And also that fear of the fear of infection, both of yourself and then of your family. So all of those things we can learn from and move forward to take into how we can be better prepared for situations like that next time, both prepared at an organisational level and at an individual level.

Prof Mark Creamer (00:43:52):

Yeah, sure. Oh, I was going to say something then I've lost it. Oh, I know. I was going to say, I do think, and there'll been a lot of people out there who disagree with me, but I actually think that some of our high risk professions like the military and our first responders, the organisations are doing their very best to try and improve psychosocial support for their workers. As I kind of alluded to Steve, he responded that I'm not quite so convinced about the healthcare sector per se, whether we're doing quite so well there. And perhaps Jordan, if I can ask you, we've got a question from Russell, which is asking about how realistic, well, I put the word realistic for individual workers to engage with management and the organisation about ongoing risk factors that are impacting their wellbeing. Is it reasonable to expect workers to be able to engage management in that?

Jordan Jackson (00:44:43):

Absolutely. Absolutely. It's reasonable. You as a worker, you've got rights under the Work Health and Safety Act. You've got codes of practise to back you up. You've got all sorts of things. So how you might go about this, it depends on the size of the organisation, lean on your health and safety representatives. If you do have them have capacity to do that, put it to your supervisors. If you're not getting the answers



Transcript



that you need, go one up. I know in healthcare, I've got a few friends in healthcare, so I know how career limiting it might seem to go and step outside of the hierarchy. One of the other things that you can do if you are really concerned work health and safety regulators such as myself and WorkSafe wa, safe Work Queensland, we wouldn't necessarily get involved in individual grievances, but as you said, if the risk factors are ongoing and they're impacting your work and your colleagues, there are channels that you can use to go directly to the regulator and say, this isn't right. We are at severe risk of psychosocial harm. We need something to happen. I can't promise that it will. But that way those things can get escalated and somebody external may be able to stick their head in and say, Hey, you need to fix this.

Prof Mark Creamer (00:46:06):

However well we do, we are not going to solve all the problems in a particular workplace. And we got a question from Tony in Queensland who says, how do we manage when the person has to stay in a workplace that has caused them harm? And I suppose our advice might be, well get out, it's a toxic environment, get out of it, but it's not always that easy. So how do we manage when the person effectively has to stay there?

Steve Meyer (00:46:31):

If I could jump in there, because that's absolutely been me, and I've also absolutely been in Anna's shoes in many environments, but I think we have to make a transition plan sometimes. It's not always about jumping straight out of where we are to something else. In my circumstances, I had to plan out next steps to actually diversify what I was doing. So in my case, I did training and use just where I was at as a temporary thing and was able to look at drawing a line in the sand about, okay, I've got an out, it doesn't have to happen straight away. And again, I think it's just about really needing to remind ourselves about where those lines in the sand are and when we be prepared for that change. But again, it takes planning. We might sometimes need to speak about that in clinical supervision, for example, or professional coaching if we want to get that sort of career focus. But again, think about transitions because, and you have an incredible skill set to offer.

Prof Mark Creamer (00:47:34):

Okay, good. It's an interesting question, but actually several people have asked this kind of question, so I'm going to combine it into one, which is probably not the right thing, but they're asking about what are the particular challenges we face when we're trying to implement good psychosocial wellbeing for people from different identities and experiences. And some of the people have asked questions about gender diversity, sexuality, ageism, neurodiverse, clients, Aboriginal Torres Strait Islander people, others from cold backgrounds. The last thing I want to do is kind of lump them all together. And I understand, I don't want to be disrespectful for a second in doing that, but we could spend the whole webinar just taking those apart. In general where you have someone from a diverse or a minority kind of community. Is that a particular challenge, do you think, for social wellbeing?

Steve Meyer (00:48:28):

Absolutely. If we're looking at intersectionality as well, and the experiences of many folks who might be marginalised or experience discrimination both in and outside of work, I think it comes down to also



Transcript



understanding how we can articulate all of our experiences in the workplace as communication preferences and styles, and really trying to get that shared understanding of the diversity that's inherent in every single workplace. And also understanding for ourselves too, how is it that we can build and design our work in a way that's sustainable for us? And being aware of what works over time individually. And again, being able to capture that and communicate that to the people who can help to change our work environment aside from the changes we make ourselves. And so that way we get that shared understanding rather than having our D diversities as issues in the workplace or something that has to be addressed by a strategy, we actually flip it into celebrating the differences and what that brings to our work

Prof Mark Creamer (00:49:27):

In an ideal world. I agree. Tally Jordan. Katherine, do you want to add anything to that? You don't have to. Just want to give you the opportunity if you want. Okay. Let's move on then and talk about the next area, which was the impact of these risk factors that we've been talking about. And I think, again, you all did a pretty good job in your presentations about beginning to look at this area of impact. And we've talked about things like sort of diagnosable and semi diagnosable conditions about people getting depressed and anxious and perhaps PTSD and sleep problems and so on. And clearly they are a factor. But I wonder if I could go beyond that in just a couple of ways. One, I want to go physical and behavioural, but let's talk physical first. Do we expect these things to influence people's physical health and wellbeing? It's a no brainer in it, but anyway, who wanted to take it? Really? Katherine, you were nodding there. Do you want to say anything about that?

Dr Katherine Petrie (00:50:26):

Yeah, I guess it is a no brainer, but it can be often as well, mental, physical, mind, body, they're all interconnected as well. And we take what happens at work, we often take it home back and forth, and so it can get quite complicated, but I think things like your stress hormones, cortisol, noradrenaline can impact your sleep. It can also impact your general physiology, endocrinology and also cardiac. We know that there's been a lot of research into shift work and impact of that on cardiovascular health and adverse outcomes in that sense. And also things like the indirect impacts on your physical health. So if you're exhausted emotionally at work and you are working incredibly long hours, then you're not likely to have that energy to take yourself out for a quick walk around the block, even just to disconnect yourself or more structured things like going to the gym or playing a team sport. Those things can actually be really important. Healthy coping strategies and also important sustainability factors to help keep your mental health as well as your physical health. But if we're struggling emotionally, it can be incredibly difficult to take care of ourselves physically as well.

Prof Mark Creamer (00:52:10):

But isn't that, this is my topic really, that physical exercise, aerobic exercise is so important for both our physical and mental health, isn't it? And I think more and more evidence coming out all the time if you can get people doing regular exercise, but I'm interested in the physical symptoms, and I wonder, Jordan, whether this might be something that your minors that for some people it's easier to acknowledge a physical health problem. So they'll go to their gp, they'll talk about the tummy upsets and their headaches and the back aches and so on and so forth without any reference whatsoever to



Transcript



any stress that they're under, perhaps because it's easier, perhaps because they don't really have the insight to know what's behind it. Does that make sense, Jordan?

Jordan Jackson (00:52:53):

Absolutely. Absolutely. Physical and mental health literacy is not anywhere near the level I would like it with adults in Australia. It's so much easier to go, I'm exhausted, I have a stomach ache. And even describing symptoms, I've spoken to workers that would talk about having bugs under their skin or ringing in their ears and all of these things, when you drilled right down to it was a specific stressor that they were under, and that was the physical reaction, but all they could do was explain that to their gps. And with the ringing in the ears, we're starting to look at things like tinnitus. The hearing was fine, but it was just such a tight level of stress when presented with this particular, let's call them a transient supervisor that would come in sometimes, but they could not even correlate that. So it's so important to understand how those physical symptoms might actually be masking something a lot more major going on in the head and in the workplace.

Prof Mark Creamer (00:53:59):

Absolutely. And as Katherine said this, what was it? Cartesian dichotomy between the mind and the body or whatever. We realise, we know it's completely rubbish, that it really is not the case at all. They're intricately interconnected. Let's just talk quickly about behavioural, and I think one of you, Katherine, probably on the slides, had some good stuff about the impact on things like productivity and on absenteeism or presenteeism and these kinds of things which are going to impact the organisation. I just wanted to come back to you, Steve, because I really like what you said. Well, I think it's really important that you mentioned doing a business case that we need to be able to have a way of explaining to people, this is actually going to save you money. This is good business practise to be addressing this stuff. Is that right, Steve?

Steve Meyer (00:54:43):

Absolutely. I think it's connecting to the priorities and the language that people in different positions who are in management or whatnot, what is it that they're focused on? What are they trying to achieve and how is it that we can language some of these wellbeing beyond an initiative, but strategies that are in our day to day in a way that motivates people to take it up or at least explore it more deeply?

Prof Mark Creamer (00:55:06):

Yeah. Okay. We've got to move on. Not surprisingly, perhaps the biggest group of questions that we've had is what do we do about it? And a lot of people have asked for very practical advice on tools and strategies. So we've got one from Alejandro, which I hope I pronounced it right. I'm learning Spanish, so that's the best I can do, Alejandro, and he or she says, one of the best tools to help people stay psychologically well in the workplace, the best tools, and Eloise from South Australia. What are some of the strategies and resources to support health practitioners in building psychological resilience? People want tools. I'm going to throw it to you, Jordan, or in fact to you, Katherine Blackdog. But Comcare must have some tools, must they?

Jordan Jackson (00:55:55):



Transcript



Yes. No, we do have some things. If you head to our website, it'll be part of the package. There are a variety of different tools, and I can't even think of the right words I'm looking for because you've got tools stuck in my head now, mark. But there is a variety of things that people could do from all walks of life to boost not only their mental health broadly, but also mitigate some of the things that might be going wrong in the workplace. The only caveat I'll put on that, and I sort of said it earlier, and it's the hill that I will die on as being the regulator. I dramatically encourage people to look after their own mental health and to develop their own resilience, but systematic problems within the workplace aren't necessarily going to be fixed. The most resilient person in the world if pushed far enough by factors that they can't control, will eventually crumble. So absolutely condone everything else on the panel, everything everybody else on the panel has been saying. But also just keep in the back of your head there that it isn't on you to fix systemic problems within your workplace.

Prof Mark Creamer (00:57:13):

I think it's a good point, and we always used to say, and I'm sure we still do actually about work is good for your mental health, which I think is a general rule. It is. Unless you happen to be working in a toxic workplace, in which case it's not good for your mental health. So what you can change, you change what you can't. Katherine, do you want to say anything about resources? You don't have to speak on behalf of Black Dog, but anything there?

Dr Katherine Petrie (00:57:41):

Yeah, actually Black Dog has a great online, I think they call it if it's called the Essential Network or 10, if you put that in, that's a whole heap of resources. There was both general and profession specific to all sorts of healthcare workers, allied health professionals, doctors, nurses, and there's a whole heap of tools and resources there that you can use that look at various things, general wellbeing, sleep, physical health, as well as obviously mental health. And I think just to pick up also on what Jordan said, the research does support that you need both individual and organisational level interventions at the same time, those multilevel interventions are the most effective in creating a mentally healthy workplace. It's not just the individual and not just the organisational, it's both at the same time addressing different areas.

Steve Meyer (00:58:52):

Can I jump in there really quickly, mark? Just to build on that point, good work design, and I'm doing a bit of a Sprick for Care's learning management system here, but is a really great solution to offer management to say, here is a solution to how we design our work. We've got to be careful not to try to make an unsustainable way of working inherently, for example, multiple clients back to back, not much control over your schedule, et cetera. And how do we wedge and shoehorn in some moments to come up for air, but actually to step back and get in touch with that sort of, if we want to phrase it this way, contemporary practise where we design the way that we approach the whole role so that it's sustainable beyond ourselves and our own individual capacities and experiences. We're creating roles for people who are going to come into it in the future. So we've got to also think about leaving something better than what we may be walked into, but thinking at that bigger level.

Prof Mark Creamer (00:59:44):



Transcript



Absolutely. It touched on a question that has just appeared from Andy, which is about making organisations accountable. How can you make organisations accountable for this kind of stuff? And I suppose it often comes down to things like work cover claims, doesn't it? If you get enough work cover claims, well maybe you should do something about it. I dunno. And Concicare are big on this. They would be monitoring claims, wouldn't they?

Jordan Jackson (01:00:08):

Yeah, absolutely. We do. It forms one branch of our regulatory activities. It's not my branch, but I am fully aware of it and that psychosocial claims are on the up and up. But one of the things about accountability is a lot of organisations, I'm still finding even this far down the track we are looking at, they just do not understand. They do not understand the risk, they do not understand the impact, and they do not understand why their staff turnover is so bad. So increasing that accountability that what Comcare is focused on more than using the stick and prosecuting organisations is just that education. People need to be aware of what the hazard is, what the risks are, what the risks are, not only to their staff retention, but to their bottom dollar and what will happen to their reputation if one of their workers was to, God forbid, take their own life. Understanding is half the battle, and I just don't think that we're all the way there yet. So the more we can push education, have these seminars, talk through these things up at the higher levels in the boardrooms, I think that's going to make people actually stand up, take accountability and make some positive changes.

Prof Mark Creamer (01:01:25):

Yeah. Great. Great whole lot of brilliant answers there. I would just remind us, we actually started that about useful tools and resources, so I just want to let participants know that there will be on the page for this episode, a list of resources that our panellists will put links to. We've had a whole lot of questions, perhaps not surprisingly, from people working in rural and remote areas. So we've got one here from Ali. How do you handle reaching for support in small or regional communities where you may have external relationships with all the available providers? And I've never really lived in a very small community, but I have very good friends who do, and they say exactly the same thing. They the gps, their friend, they see down the pub, they play golf with them. And then you have to go in and talk about some fairly intimate detail. I dunno, have you got any ideas about what advice we give to people in small rural areas?

Steve Meyer (01:02:18):

This is a big feature. Our work at the moment, actually, we've got quite a dispersed workforce in the organisation I'm working in. And I think what a lot of the folks that we've got working in those communities tell us is it's about sometimes having, what do we use telehealth for? Which appointments, which services, which needs, might I go outside of the community for just to kind of keep that level of separation. And there might be things that we're more or less comfortable sharing. Some of us might have deep cultural obligations and connections to community as well if we're from that place. And then it's about saying, well how do I meet those needs for connection then? And sort of looking at taking a bit of a multifaceted approach. So not everything has to be drawn from the community if there's that vulnerability there.



Transcript



Prof Mark Creamer (01:03:04):

Okay, great. There's a question here about support networks. What support networks are available for health professionals? And the first thing I must do, they don't pay me to do this, but I'll do it anyway, is to give a plug for MHPN, because that's what the N in MHPN stands for. It stands for networks. And they do a fantastic job at linking people together. And it comes back to the question of rural and remote. So people in rural and remote areas who can perhaps link in with, I dunno, groups in the next town or whatever. So do, if you're feeling isolated and you're feeling you need some support, get in touch with them HPN or go through their website to find a network in your local area. But anyone have other ideas about how people get support? Well, we know about the importance of social support in psychosocial wellbeing. Any ideas for how people can access it?

Steve Meyer (01:03:59):

If I could jump in really quickly and just put in a plug for regularly, if you're part of an organisation or clinic, make routine meetings, standups. It could be little moments just to connect and talk about what you've got on the plate and just, you've got to be quite deliberate, especially if you're dispersed or not necessarily working with colleagues all the time. You've got to create those rituals of connection and points where you are really deliberately creating opportunities to connect with each other, whether it's through networks, professional development could be wellbeing, activities that you do with people. It's got to be really sort of scheduled, I suppose.

Prof Mark Creamer (01:04:35):

Important point, isn't it? And it sort of comes back to a point we've alluded to several times through here, and that is that we all have to take responsibility to a certain extent for our own mental health. You can't just blame it on the employer. And part of that is, as you say, is making a point of getting these social contacts. And I would argue also making a point, getting some exercise and doing some enjoyable activities and all those kinds of things that we know are important. Excellent support networks. Yeah. Okay. There were a number of questions about organisational change. Jackie, for example, I've asked about how we support individuals during organisational change. And if anyone's got anything to add there, that'd be great. But it's probably stuff that same kind of stuff we've been covering already. Does anyone want to say anything about that

Steve Meyer (01:05:22):

Communication? We've got to up it. We've got to make sure there's clear visible leadership support and often leadership need really direct guidance on examples of language to use. If they themselves haven't necessarily learned how to do that, or for whatever reason they're not, there is often quite a bit of guidance needed. But the key is absolutely communication and the narrative that we create about the change

Jordan Jackson (01:05:46):

Consultation and transparency from leadership. You need to bring everybody along for the journey. Otherwise it's just going to create distress and uncertainty. So consultation, transparency, this is what



Transcript



we're doing, this is how we're doing it. What do you think? Even if you don't necessarily accept or act on your workers' feedback, it's important to be inclusive in that process.

Prof Mark Creamer (01:06:10):

Yeah, yeah, absolutely. And of course a lot of organisations are going through a lot of change, I suppose over the last recent times. Okay. We have had a lot of questions related to how those of us who are clinicians should work with individuals who are health workers who are experiencing stress. It's very, very important area. But I feel it's probably beyond the scope of this webinar where we're talking about creating psychologically healthy workplaces per se. But if it is an area you want to come back to, by all means, stick it on the feedback form and see if you can get MHPN or Comcare to run another one specifically on clinically working with this population. But I'm going to leave you with a final question before we move on. Sort of tie things back together. I dunno who it's from actually, but it is an important one. And it says, given the manpower constraint, I would say person power in this day and age. But anyway, given the person power constraints at most workplaces, how can we protect our own mental health and wellbeing without compromising the service being delivered to our clients and consumers and so on? And that is obviously a delicate balance that I guess we have to draw all the time. Do you want to comment on that?

(01:07:27):

Not really. Okay.

Steve Meyer (01:07:30):

I keep jumping in. I feel like I'm, yeah, no, you do. Sticking it up. I think really the key is that reflective practise piece. How is it that we actually make time, structured time to pause and think about our work? And that is essential to actually creating and sustaining positive patient outcomes. But as we know for many of us, even that our professional ethical code state that it is unethical to just continue to work without ever examining the way in which we're approaching our practise. So just the simple act of social connection, pausing, integrating our thoughts, being curious about our experience sustains us, helps us to metabolise our experience as clinicians and generate new ways to approach the work. Whether it's how we understand it and connect to it, the meaning we give to it so that it is more sustainable and effective both for us and for our patients and clients.

Jordan Jackson (01:08:24):

I'm not a psych mark, so I'm sure that you, smart people have a word for this, but particularly in the suicide prevention space, I've noticed an absolute trend of people barreling towards burnout because my problems aren't as big as the consumers I'm trying to help. And so we just push that down because the next person's got way bigger problems than I. And so I'll put to you, how good are you to anybody if you hit burnout and you are laid out on the couch for three months, barely able to move, and all of your patients and your clients aren't able to help. So it is a absolute conundrum, but it falls right back on that you are no good to anybody if you can't be good to yourself.

Prof Mark Creamer (01:09:11):

That's such an important point. It your first responsibility is to look after yourself. Only then can you really look after other people. So yeah, absolutely. I think we can't say that often enough. I've got to



Transcript



finish, but who was finished with EAP? I think it was Jordan. So I have mixed views about EAP, but there is a question here from Andy asking really about whether they can take a more proactive role in the organisation. We don't just use 'em to refer someone when the wheels are falling off, but we bring them in perhaps and we get them to do education sessions and whatever. Is that a reasonable model, do you think worth thinking about?

Jordan Jackson (01:09:51):

Absolutely. And one of the things that EAP services can provide, and I have checked the legality of this, is generalised feedback. The numbers of people that are engaging with your service to what degree they are. Is it a one and done phone call or do they need continued sessions? What are the major areas of concern for the people in your organisation that are doing this? And it's actually, so in this field, it can be quite difficult to get quantifiable data and as a really nice source of quantifiable data that EAPs can provide back to the organisation. And it often isn't done because organisations don't understand this and they're worried about confidentiality and those kinds of things. That de-identified data is sitting there, right, for the picking and should absolutely be taken advantage of.

Prof Mark Creamer (01:10:47):

Okay. Thank you very much to all of you. There's some fantastic stuff there. We could go on easily for another hour. And I do apologise to participants who haven't had their question directly answered, but I do think we've covered a lot of ground, so hopefully you won't be too disappointed. But it is unfortunately time to wind up now. And so before we finish, I would just like to invite our panellists if they wish to just say a very brief few closing words in terms of take home messages or reflection. So maybe I'll go to you first. Jordan, any final closing comments?

Jordan Jackson (01:11:22):

Oh, final comments, yes. I know that I push the agenda of it is the employer's responsibility because that is the space that I sit in. But as the panels pointed out, time and time again looking after yourself, the employer, looking after yourself and the employer looking after you go hand in hand that you cannot sit and be completely angry at the employer without doing some proactive work yourself. I think it's critical. Great.

Prof Mark Creamer (01:11:52):

Thanks, Jordan. Thanks, Katherine. Any quick take home messages?

Dr Katherine Petrie (01:11:57):

I think as everyone has alluded to it, is that it is both your individual responsibility, but you can also prompt that collective and organisational responsibility as well to ensure that you have a support network and also the optimised job design around you.

Prof Mark Creamer (01:12:23):

Great. Thanks Katherine. And Steve, any final comments?



Transcript



Steve Meyer (01:12:27):

Yeah, just to start small, you don't have to achieve all of these changes straight away. And just to leave everyone with a question, even what is just one change that you can make tomorrow to support psychosocial wellbeing in your team and individually? Just one thing.

Prof Mark Creamer (01:12:43):

Nice idea. Without necessarily saying this is what they should do, they should do this, what can we do? That's a very good point. Okay. Thank you so much to all of you for your time today. If people would like to know more about Jordan, Katherine or Steve or indeed, even me, if you go to the landing page for this episode on the MHPM website, you can find their full bios and also on the landing page, you'll find the resources that we mentioned earlier. You'll find links to various kinds of resources, and you'll also find a very short feedback survey. And I really would encourage you to fill it in. Just let us know what you thought about tonight's webinar and also any other ideas you'd like to get MHPN to do. But for now, I think that's it. Thank you very much again to my panel. Thanks very much, Jordan.

Jordan Jackson (01:13:31):

My pleasure. Mark, I'll email you that \$10.

Prof Mark Creamer (01:13:35):

Thank you. I'll hold you to it. Katherine. Yes. Thank you very much to you, Katherine.

Dr Katherine Petrie (01:13:41):

Thanks so much, mark. Thanks everyone else.

Prof Mark Creamer (01:13:44):

Thanks. And finally, to Steve. Thank you very much, Steve. Thanks for having me. I'm afraid if Jordan owes 10, then you're up for at least eight. No, you all came in pretty close to time. So thank you so much to all of you. Also, thank you very much to all of you, our webinar participants for joining us tonight. I hope you enjoyed it. I hope you found it valuable and enjoyed it as much as we have, please keep an eye, the MHPN website for future webinars and podcasts and various other offerings. But in the meantime, thanks very much again to everybody and it's bye for now. Bye.