Investing in Better Mental Health in Australian Workplaces

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Table of Contents

Summary 4
Introduction: Workplaces and the Mental Health Epidemic 6
Workplaces: Cause and Consequence 8
Review of Regulatory Systems Governing Mental Health and Workplaces 12
The Tiered Framework for Managing WHS Risks 12
International Regulatory Comparisons 15
The Economic Costs of Mental Illness in Australian Workplaces 17
Absenteeism and Reduced Participation 17
Presenteeism 19
Workers' Compensation Claims 19
The Benefits of Preventing Mental Illness in Workplaces 21
The Cost of Workplace Mental Health Injuries: Order of Magnitude 23
Policy Recommendations 26
References 28

Summary

Australian society is experiencing an epidemic of mental illness that imposes enormous costs on individuals with poor mental health, their families, and the broader economy. Even before the COVID-19 pandemic, one in five Australians reported mental health challenges of some sort. And the total costs of poor mental health on Australia's economy, government, and society were estimated by the Productivity Commission (2020) at a staggering $200-220 billion per year. Other research confirms the enormous economic costs of mental illness.[1] The fear, isolation, and insecurity which millions of Australians experienced as a result of the COVID-19 pandemic and resulting recession have undoubtedly made this problem worse. Initial data is already confirming a significant increase in mental health problems since the pandemic hit.

The causes of mental illness are complex and not fully understood. However, some of the factors contributing to mental illness and injury are well-known and preventable. In particular, there is a clear correlation between workplaces and mental health problems in Australia. Workplaces experience significant costs and disruptions as a result of poor mental health. But unsafe workplaces also contribute significantly to the incidence of mental illness and injury. Workplace factors which contribute to mental health problems include unreasonable job demands, exposure to violence and trauma, long or irregular working hours, an absence of worker voice and control, and bullying and harassment. Studies indicate 15% to 45% of mental health problems experienced by employed people are attributable to conditions in their workplaces. This suggests that the costs of workplace-related mental illness and injury are enormous: our estimate (explained below) suggests at least $15.8 billion to $17.4 billion per year in costs arising from workplace-associated mental ill health. Eliminating mental health problems caused by work-related factors and stressors would expand Australian GDP, and reduce government expenses (for health care and other services) by several billion dollars per year.

By modifying workplace practices to eliminate dangerous conditions and prevent psychosocial risks and injuries, a significant proportion of mental ill health could thus be prevented. However, Australian employers and WHS regulators have been slow to respond to the epidemic of workplace mental ill health with the attention and forcefulness this crisis deserves. In particular, Australia's system of work health and safety Laws has been effective in reducing physical injuries and illnesses in workplaces, by imposing explicit and well-enforced responsibilities on employers to systematically

[1] See, for example, Victoria Institute of Strategic Economic Studies (2016).

identify and remove risks from their operations. But an equally rigorous approach has not been applied to reducing workplace mental health risks. The current regulatory system does not specify explicit, enforceable requirements compelling employers to take mental health risks equally seriously – nor does it equip workers, their representatives, and regulators with the tools needed to ensure employers live up to those responsibilities. The tragic result is thousands of lives destroyed by preventable mental ill health, and many billions of dollars in lost output and additional fiscal expenses.

It is past time for Australia's WHS policy-makers to address the mental health crisis in Australia's workplaces head-on. Upcoming decisions regarding reforms to Australia's Model WHS Laws provide a crucial opportunity to modernise Australia's practices, and catch up with other industrial countries – which already treat psychosocial risks in workplaces with the same urgency and rigour as they combat physical health and safety dangers. The economic and fiscal benefits of preventing workplace-associated mental illness and injury are substantial – and would be shared by employers, governments and workers alike. But the human benefits of preventing needless mental health illness and injuries, for affected workers and their families, are priceless.

This report is organised as follows. First, we discuss the two-way relationship between workplaces and mental ill health in Australia: mental illness imposes major costs on Australian workplaces, but unsafe workplaces are also a major cause of preventable mental ill health. Second, we review the overall structure of workplace health and safety regulation in Australia, showing the asymmetry between current approaches to psychosocial injuries and physical injuries. The third major section catalogues several types of economic costs arising from workplace-associated mental illness and injury, highlighting the positive economic return which could be attained by improving the mental health safety of Australian workplaces. Then we develop a broad estimate of the order of magnitude of total costs arising from workplace-associated mental illness and injury. On the basis of published epidemiological research regarding the incidence of work-related mental illness, and previous studies of the total cost of mental illness in Australia, we estimate the total annual cost of workplace-associated mental illness as between $15.8 billion and $17.4 billion per year. This provides governments and employers alike with ample incentive to move forward with ambitious and timely efforts to prevent psychosocial injuries in our workplaces – quite apart from the immeasurable human toll of that preventable disease. Finally, we make several policy recommendations for developing a more serious and systematic workplace mental health regulatory regime.

Introduction: Workplaces and the Mental Health Epidemic

Across Australia, mental illness affects millions of people in their daily lives, including in the workplace. Surveys indicate that about one-fifth of the population experience an active mental health or behavioural condition at any point in time.[2] And nearly half of all Australians will experience poor mental health at some point during their lifetimes.

In 2018-19, a total of $10.6 billion was spent by the Commonwealth Government on direct mental health services, representing 7.5% of all health expenditure.[3] Much more is spent in related government programs and services, and by the state and territory governments. The total economic costs of mental illness are much larger: including lost incomes and productivity, lower labour force participation, and the immense personal costs borne by people with mental illness and their families.

While the epidemic of mental illness plays out in Australians' relationships and homelives, it also has drastic effects in the workplace. People with mental health conditions experience more frequent absences from work, and also the problem of 'presenteeism' (sub-optimal productivity demonstrated while at work). Mental illness interferes with training and skills acquisition, with career paths, and with work-family balance. These costs are borne by both workers and employers – creating a potential shared interest in reducing, and optimally eliminating, mental health dangers from Australian workplaces, and supporting those who struggle with mental health.

Mental illness is not distributed equally. Research has shown that the incidence of poor mental health is highest in industries characterised by a combination of high job demands, low job security, and low job control. This combination is particularly acute in sectors like accommodation/food services, manufacturing, retail and administrative services – sectors where nearly one in five workers reports poor mental health.[4] This highlights the importance of working conditions, and in particular the stress and uncertainty associated with insecure work, on workers' mental health.

Official data on the incidence of poor mental health does not yet reflect the daunting mental health consequences of the COVID-19 pandemic and resulting disruptions in workplaces and working arrangements. However, some initial indicators show the

[2] See references reported in AIHW (2020).
[3] AIHW (2019).
[4] Yu and Glozier (2017).

pandemic has constituted a mental health catastrophe for Australians. Between March 2020 and January 2021, almost 11.5 million government-supported mental health services were provided, according to the Australian Institute of Health and Welfare.[5] And calls to the suicide prevention hotline Lifeline rose by 10% in January 2021 compared to the same month in 2020.[6]

The reported rise in mental illness during the pandemic has also been reflected in Australians' experiences in the workplace. COVID-19 has caused a dramatic upheaval in workplace practices: including widespread unemployment and/or reduced hours during the early months of the pandemic, a dramatic shift to working from home in some occupations, and a need to rapidly adjust traffic, screening, and other safety protocols to reduce the risk of workplace contagion. In a survey conducted by Relationships Australia, between 74% and 98% of respondents across all industries reported 'significant changes' to their work since COVID-19 began.[7] And 63% of respondents reported they had experienced changes to their mental health as a result of these changes in working conditions. Similarly, a survey of over 10,000 Australians working from home during the pandemic conducted by the Australian Council of Trade Unions indicated that 49% of home-based workers experienced mental health challenges during the COVID-19 crisis.[8]

While further research is needed on the incidence and consequences of mental health problems in workplaces under COVID-19, it is clear that the pandemic has further exacerbated already-existing problems of mental strain in workplaces.

Preventing mental illness, and providing more support (in services, income, and security) to those suffering mental health challenges, is a critical priority for any compassionate society. But in addition to the intrinsic humanitarian motives for preventing mental illness, there are also demonstrated economic and fiscal benefits from better mental health – including significant dividends to employers from reducing and preventing mental ill health among their workforce, fiscal savings to governments, and macroeconomic benefits from greater participation and employment. Even without these proven economic benefits, Australia should move forward with ambitious and well-resourced efforts to reduce the crisis of workplace-related mental illness. But the economic benefits flowing from prevention and better treatment of mental illness should reinforce the willingness and urgency with which all stakeholders approach this task. The Productivity Commission aptly summarised this perspective:

[5] AIHW (2021).
[6] AIHW (2021).
[7] Relationships Australia (2020).
[8] See ACTU (2021).

> "It is not necessary to quantify the cost of mental illness and suicide to understand the damage that they impose on the lives of individuals and the community as a whole. But quantifying these costs helps to identify where reform efforts should be focused." (Productivity Commission, 2020, p. 9)

WORKPLACES: CAUSE AND CONSEQUENCE

The overwhelming impact and costs of poor mental health are experienced by those who suffer mental ill health. But Australian workplaces also experience major costs and disruptions from the epidemic of mental illness and injury. These workplace costs are experienced through numerous channels: including reduced participation and labour supply; excessive turnover of workers; absenteeism; reduced productivity and 'presenteeism'; impacts on workplace cohesion and cooperation; the costs of health services, insurance, and supplementary employment benefits; and more. Previously published research confirms these economic and workplaces costs are measured in the many billions of dollars per year.

But in addition to incurring these expensive *consequences* of mental illness, Australian workplaces are also a significant *cause* of mental illness and injury. Unhealthy working conditions and practices contribute significantly to the incidence of mental illness and injury, and its costs. Occupational health and related research has identified several dimensions of stress and danger in workplaces that contribute to the epidemic of mental ill health – and which could be avoided with better protections, prevention, and communication. Some of the most important workplace mental health dangers include:[9]

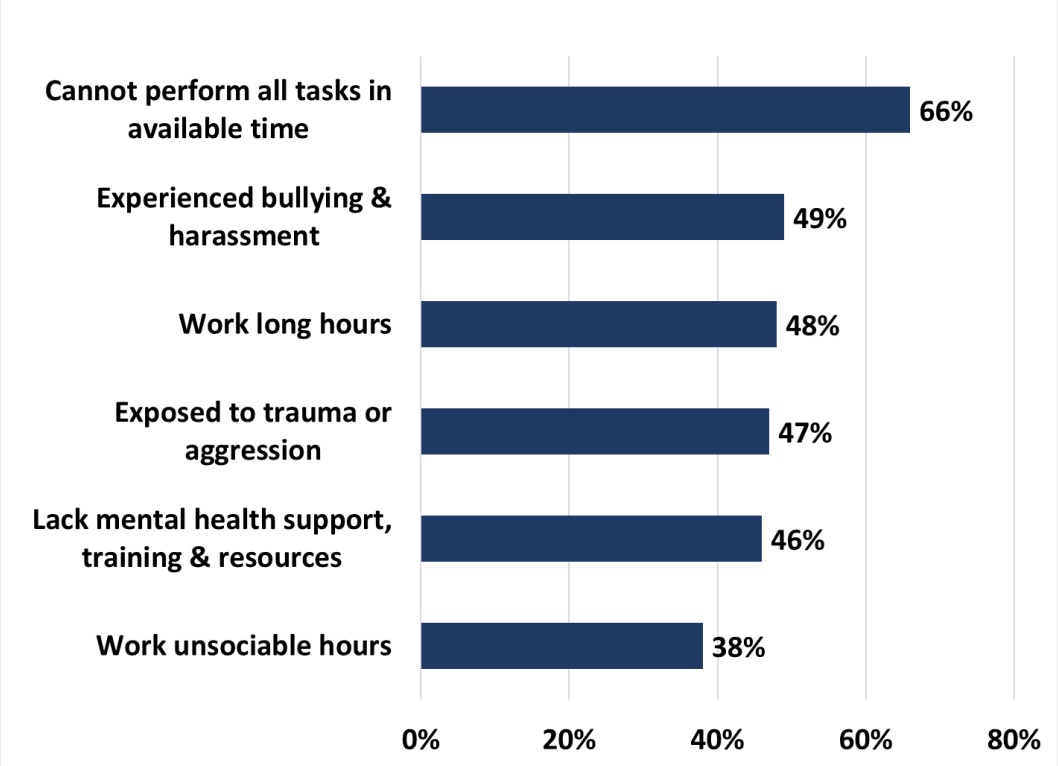
- Excessive workloads, with assignments that cannot reasonably be completed in allotted times.
- Excessive or unpredictable hours of work, including unsocial shifts.
- The coincidence of high job demands with limited worker control over the conditions and organisation of work.
- Exposure to violent or traumatic events on the job.
- Workplace bullying, harassment and assault.
- An imbalance between work effort and reward.
- Insecurity of employment, including precarious and temporary work.

[9] ACTU (2019) and Productivity Commission (2020, Chapter 7) catalogue numerous workplace factors contributing to mental illness and injury.

- Organizational inequality and injustice, and a lack of ability for workers to have their opinions or concerns 'heard' in the workplace.

A self-selected online survey of Australian workers conducted by the Australian Council of Trade Unions (2019) suggests that a shocking proportion of Australian workers have experienced one or more of these workplace mental health challenges. The most commonly cited mental health dangers in workplaces, according to this survey, are summarised in Figure 1. Across all of these contributing factors, the ACTU survey indicated that 61% of respondents have experienced mental health problems associated with their jobs and working conditions. Of these workers, over one-third had missed some work as a result of those stresses and injuries.[10]

Figure 1. Exposure to Workplace Mental Health Stressors



Source: ACTU (2019).

Epidemiological and occupational health research has established a strong connection between the presence of these dangerous workplace conditions and the incidence of

[10] Based on results attesting to the distribution of lost work time among respondents to the ACTU survey, a weighted average of about 2.7% of all work time was lost as a result of workplace mental health problems. If extrapolated across the entire Australian workforce, this result suggests that an incredible 65 million working days per year are lost to workplace-associated mental health absences, worth $25 billion in total lost wages and salaries.

mental health problems, such as depression. LaMontagne et al. (2008) surveyed a large random sample of workers in the state of Victoria, and found that about 15% of reported depression was attributable to 'job strain' (a combination of work-related stresses and insecurity). This is broadly consistent with Finnish research regarding the prevalence of workplace factors in cases of suicide (Nurminen and Karjalainen, 2001). A New Zealand study found that 45% of depression incidents among young workers were associated with workplace problems (Melchior et al., 2007). D'Souza et al. (2005) also documented a robust correlation between job strain and depression among middle-aged Australian workers. Stansfeld et al. (1999) found similarly compelling evidence of workplace conditions and psychiatric disorders among workers in the U.S. These researchers, and many others, conclude strongly that problems in the workplace are an important – and avoidable – contributor to the scourge of mental illness and injury which has swept Australian families and communities. Some of the more blunt conclusions arising from this research are summarised below:

> "Work stress appears to precipitate diagnosable depression and anxiety in previously healthy young workers. Helping workers cope with work stress or reducing work stress levels could prevent the occurrence of clinically significant depression and anxiety." (Melchior et al., 2007)

> "Estimated proportions of depression attributable to job strain among working Victorians indicate that job stress is a substantial public health problem. Findings also show that job strain and associated depression risks are inequitably distributed, with workers in lower skill level jobs most likely to be adversely affected, particularly among males. Both in Victoria and in industrialised democracies internationally, poor mental health is disproportionately prevalent among those in lower status occupations, and with lower educational attainment and lower incomes. Our findings suggest that job strain may be an important contributor to these mental health inequities... We would argue that the impact of *all* psychosocial working conditions on depression would be higher than the estimates we have presented, and corresponding estimates for *all* affected mental health outcomes would be higher still." (LaMontagne et al., 2008)

> "Exposure to insecure and high-strain jobs is likely to rise as economies and labour markets respond to globalisation and political change. High status may not protect employees from either exposure or impact, thus widening the population health consequences of adverse work conditions." (D'Souza et al., 2005)

> "This meta-analysis provides robust consistent evidence that (combinations of) high demands and low decision latitude and (combinations of) high efforts and low rewards are prospective risk factors for common mental disorders and suggests that the psychosocial work environment is important for mental health." (Stansfeld and Candy, 2006)

> "Low social support at work and low decision authority, high job demands and effort-reward imbalance were associated with increased risk of psychiatric disorder … adjusting for age, employment grade, and baseline. Social support and control at work protect mental health while high job demands and effort-reward imbalance are risk factors for future psychiatric disorder. Intervention at the level of work design, organisation, and management might have positive effects on mental health in working populations." (Stansfeld et al., 1999)

In sum, there is a strong connection between work and mental health in Australia – and that connection works in both directions. The performance of Australian workplaces is clearly hampered by the prevalence of mental illness and injury, and by the failure of our health and support systems to adequately address that epidemic, and help Australians heal. At the same time, unsafe and exploitative practices in Australian workplaces are a major contributor to the incidence of preventable mental health problems. By addressing a significant part of the problem at its source, Australian workplaces can play their part in preventing mental ill health – and then reap a share of the economic rewards associated with a healthier, happier workforce.

Review of Regulatory Systems Governing Mental Health and Workplaces

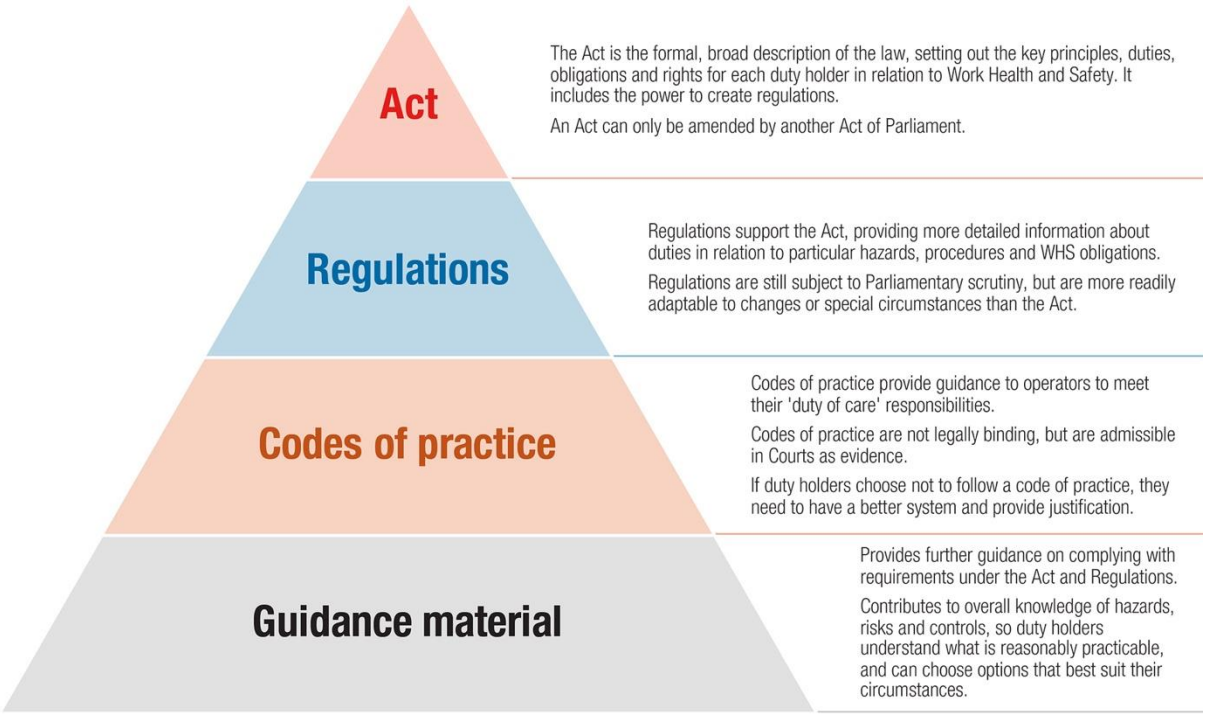
Workplace health and safety is the responsibility of state and territorial governments in Australia. However, since 2011 Australia has developed a system of harmonised health and safety laws covering WHS policy in most jurisdictions. With the exception of Victoria and Western Australia, each state and territory has adopted a set of Model Work Health and Safety laws developed among participating state, territory, and Commonwealth governments.[11] And while Victoria and Western Australia have not yet adopted the Model WHS system, they nevertheless follow a similar structure and framework – and generally adopt similar or even superior regulations, codes and guidance materials.

THE TIERED FRAMEWORK FOR MANAGING WHS RISKS

The Model WHS Laws encompass a tiered framework which requires anyone conducting a business or undertaking to comply with a general duty to ensure the health and safety of anyone working on that undertaking (not just employees). This duty is set out in a broad-based statute, the *Model Work Health and Safety Act* (implemented in 2011-2012). The provisions of the Act are supported by standards set out in regulations, that require 'duty holders' (those conducting the undertaking) to follow prescribed procedures to specifically identify and control specific hazards. This is supplemented by a third tier specifying codes of practice meant to provide practical guidance to both duty holders and workers on how to manage and prevent specific hazards and risks. Finally, regulators often produce general guidance materials informing and supporting workers and duty holders in how to address specific hazards.

[11] For an overview of the history and practice of the Model WHS laws, see Safe Work Australia (2020a).

Figure 2. The Tiered Structure of WHS Regulation



Source: Adapted from Wood et al. (2010).

This approach to strengthening occupational health and safety practices in Australia has achieved significant benefits. Firstly, the obligation on duty holders to ensure safe working conditions was extended in this model beyond the narrow employer-employee relationship (unlike other areas of employment law, which typically only to employees). Instead, the duty of care in WHS issues is taken to also apply to contractors, customers and even visitors who interact with the business or undertaking. Secondly, the primary responsibility of the duty holder to ensure the health and safety of workers and others is also broadly defined: in particular, health is defined as both the physical and psychological health of workers and others. Thirdly, the model is heavily focussed on prevention: it requires duty holders to regularly and pro-actively assess work for hazards and risks to the health of workers and others, and then apply controls to eliminate and mitigate the risk of injury. Finally, this approach also sets out a consultation obligation on duty holders to participate with workers (and their health and safety representatives) in identifying and controlling risks. All of this is supported by an enforcement regime that sets out penalties for non-compliance, and provides an inspectorate to undertake compliance and enforcement activities.

This overall framework has been effective in steadily reducing the incidence of serious injury and death in Australian workplaces. The framework, by specifying the legal responsibility of duty holders to prevent and eliminate risks, has driven down rates of

exposure to physical hazards and consequent injuries.[12] This success is largely attributable to the explicit regulatory requirements in the system directing how duty holders must identify and control specific risks.

However, it is in this dimension that an important and concerning distinction between physical and psychological health emerges in the operation of the Model WHS system. While the model laws define health and safety inclusively to include the psychological as well as physical health of workers, its practical treatment of psychological and mental health risks is not symmetrical with the proven success of its approach to physical dangers. Unlike numerous very specific regulations regarding prevention of physical hazards at work (in specific areas such as manual handling, working at heights, working in confined spaces, hazardous chemicals, and others) there are no specific standards and procedures directing duty holders in how to identify and control psychosocial workplace hazards. This means that other than the broad 'primary duty' (namely, "to ensure health and safety, so far as is reasonably practicable, by eliminating risks to health and safety"[13]), there are no explicit and legally binding requirements on duty holders to address and prevent the underlying causes of psychological injury in the workplace.[14] Not surprisingly, then, even as workers' compensation rates for physical injury have declined consistently across jurisdictions, rates of psychological injury are growing. The absence of specific regulation to compel employers to reduce and eliminate psychosocial risks is contributing to this failure, and is deeply concerning.

In response to the rising incidence of psychosocial injuries in Australian workplaces, Safe Work Australia and state-level WHS regulators have developed guidance material to assist workplaces in managing those risks (corresponding to the lowest tier in Figure 2 above).[15] Additionally, some WHS regulators have commenced work on a code of practice for managing psychosocial hazards to provide more explicit guidance to workplaces on this issue.[16] Unfortunately, to date this work has not extended to the higher tiers of the regulatory framework described above. It thus fails to explicitly specify enforceable standards requiring the identification and control of psychosocial hazards and risks – and empowering workers, their health and safety representatives,

[12] Australia's experience is consistent with international experience, which shows that robust and systematic prevention and hazard-elimination requirements have strong impacts in reducing the incidence of occupational injury and disease; see the extensive survey of findings by Tompa et al. (2016).

[13] Model WHS Act, Section 19; see also Safe Work Australia (2016), p. 7.

[14] In Queensland and Victoria Codes of Practice can be enforceable on duty holders.

[15] See Safe Work Australia, (2019b).

[16] See, for example, Safework NSW (2020).

regulators and inspectors with sufficient tools to ensure that best practices are being followed.

INTERNATIONAL REGULATORY COMPARISONS

In most countries, WHS laws traditionally covered chemical, physical or biological hazards, without comparable attention paid to psychosocial occupational risk factors. However, regulatory reforms are moving forward around the world, as WHS advocates and regulators become more aware of mental health risks in workplaces, and develop appropriate tools to prevent and eliminate them. In an analysis of worldwide WHS laws relating to psychosocial hazards, Chirico et al (2019) found that close to two-thirds of industrial countries now include some form of mandatory psychosocial risk assessment and prevention within their WHS national legislation; three-quarters of industrial countries also have WHS provisions relating to workplace violence.

While the trend toward formal recognition and regulation of workplace mental health risks continues to gather momentum, unfortunately Australia remains one of the minority of industrial countries to not yet implement WHS regulations that specifically address psychosocial hazards and workplace violence. In Europe, almost all EU-member countries now recognise psychosocial hazards in the workplace, and provide guidance and regulations through legislation compelling employers to reduce and prevent these risks to employees.

For example, Finland's legislation on workplace psychosocial risks addresses workload factors, lone working, night work and work pauses, as well as harassment and occupational violence. Denmark's legislation came into effect in November 2020, and directs employers with enforceable guidelines to prevent undue stress from:

- large workloads and time constraints
- vague and conflicting requirements at the workplace
- high emotional demands in social work
- offensive behaviour (including bullying and sexual harassment)
- work-related violence

Belgium's laws on workplace mental health date back to 2002, and are some of the most extensive of any industrial country; they were expanded in 2014 to cover any type of psychosocial burden at work. The Belgian regulations define a 'psychosocial risk at work' as the probability of one or more workers being at risk of, or exposed to, some aspect of environment or behaviour that creates an objective danger over which the employer has some control. Employers are obliged to appoint special prevention advisers specialised in psychosocial issues, and implement five-year action plans to

reduce those risks in consultation with workers. The law also states that during the six months after a complaint of a psychosocial nature is made, the employee who makes the complaint cannot be made redundant.

These international measures have proven effective in reducing the incidence of workplace-related mental illness and injury, and thus reducing the economic (and human) costs of mental illness. It is past time for Australia to learn from, and emulate, these global best practices.

The Economic Costs of Mental Illness in Australian Workplaces

The economic, employment, and fiscal costs of workplace-related mental ill health in Australia are diverse, far-reaching, and expensive. They fall into several major categories, including: absenteeism, excessive turnover, 'presenteeism', reduced productivity, impacts on cohesion and cooperation in workplaces, workers' compensation claims, impacts on self-employed Australians, and others. Below we summarise existing research on the scale of economic costs experienced within some of these categories.

ABSENTEEISM AND REDUCED PARTICIPATION

Australians with mental illness are less likely to participate in the labour market (in either employment or active job search). Mental illness has a powerful negative impact on labour force participation and employment: research on Australian workers by Frijters et al. (2014) found that a one-standard-deviation deterioration in mental health reduces an individual's likelihood of employment by a shocking 30 percentage points. Similarly, even for those who manage to retain employment despite their mental illness, absenteeism is a major problem – with the cost borne by employers and employees alike. The Productivity Commission estimates the economic cost of reduced participation as between $12.2 and $22.5 billion per year, and the costs of absenteeism at $9.6 billion per year.[17] The National Mental Health Commission estimated in 2014 that the impact of mental health-related absenteeism (not considering broader participation effects) was $4.7 billion per year.[18]

According to a Safework NSW report, workers with moderate mental ill health took on average 0.5 extra days of personal leave in the surveyed four-week period compared to non-ill people – equivalent to around 6 additional sick days per year.[19] This increased to an extra 0.9 days of personal leave per four-week period (or about 11 days per year) for workers with severe mental ill health. Another study of UK workers found that poor mental health manifested in work-related stress, depression or

[17] Productivity Commission (2020).

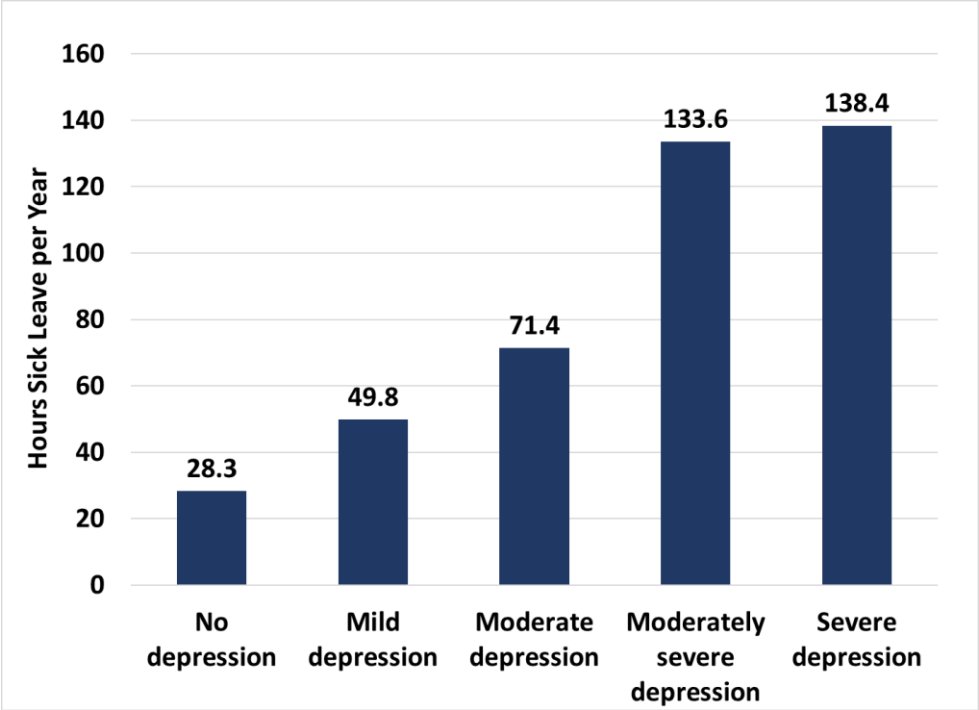
[18] National Mental Health Commission, Beyond Blue, PWC (2014).

[19] Yu and Glozier (2017).

anxiety caused 11.4 million working days to be lost per year in that country – or 27.3 working days per affected worker.[20]

In Australia, a study examining the links between productivity and depression also noted a strong positive correlation between depression and absences from work due to sickness. People without depression recorded 28.3 hours of illness-related absence from work per year. That nearly doubled (to 49.8 hours per year) for people with even mild depression – and 138 hours for those with severe depression (see Figure 3).[21] The difference in lost time between those without depression, and those experiencing severe depression, was up to 110 hours per year, or almost 3 standard weeks of full-time work. Evaluated at current average weekly earnings in Australia, that translates into almost $5000 of lost income for a worker with severe depression[22] – and roughly twice as much foregone output for the employer.[23]

Figure 3: Sickness Absence for Workers with Depression



Source: McTernan, Dollard and LaMontagne (2013).

[20] Knapp, McDaid and Parsonage (2011).

[21] McTernan, Dollard and LaMontagne (2013).

[22] In some but not all cases that lost income will be at least partly offset by paid sickness or personal leave.

[23] Evaluated at average full-time ordinary earnings of $1711.60 in Australia in November 2020; since the share of labour compensation in total output is less than 50%, lost wages on average account for less than half the total value of lost output for any period of work.

For workers without access to personal or sick leave (including those who have exhausted their annual leave, casual employees who do not receive paid leave, or self-employed workers and contractors without paid leave), the immediate financial burden of mental health-related absences can be overwhelming. In a 2010 study for VicHealth, 29% of employees who reported mental health symptoms over a twelve-month period did not have access to paid sick leave entitlements.[24]

Mental ill health is consistently rated as one of the primary causes of absenteeism. Absence from work is a significant drain on productivity and income. Some of these costs are borne by employers (in sick pay and reduced output), and some by workers (via lost income and personal hardship).

PRESENTEEISM

'Presenteeism' is defined as attendance at work, but under sub-optimal conditions which result in reduced productivity. Although presenteeism has multiple causes, poor mental health is a major factor in presenteeism. According to the Productivity Commission, this dimension of mental illness costs the Australian economy $7 billion per annum.[25]

For workers experiencing mental ill-health, rates of presenteeism are generally significantly higher than that of workers without a mental health condition. Therefore, presenteeism caused by mental ill-health is a significant cost for employers.

Research in NSW estimates that the cost of higher presenteeism among employees experiencing mental ill-health is substantial: $3,401 annually for each employee experiencing moderate ill health, and $5,305 per year for employees with severe mental illness (Yu and Glozier, 2017). The National Mental Health Commission estimated in 2014 that the impact of mental health-related presenteeism on workplaces alone was $6.1 billion.[26]

WORKERS' COMPENSATION CLAIMS

Official statistics regarding successful workers compensation claims are not an accurate indicator of the true impact of mental health problems in workplaces, for several reasons. Many workers choose not to pursue workers' compensation for their psychosocial injuries, fearing dismissal, retribution, or stigma. Of those who do pursue

[24] LaMontagne, Sanderson and Cocker (2010).

[25] Productivity Commission (2020).

[26] National Mental Health Commission, Beyond Blue, PWC (2014).

claims, a much larger proportion is rejected than for claims of physical injuries – due to the more harsh treatment of these claims by workers' compensation authorities. So the number of successful compensation clams should be seen as just the tip of the iceberg of the true extent of workplace mental illness. The ACTU's *Work Shouldn't Hurt Survey* (2019) found that as many as 90% of workers who experienced mental ill health related to their jobs did not even attempt to make a workers compensation claim.

Nevertheless, even workers compensation data confirms that the economic and fiscal costs of workplace mental illness and injury are growing rapidly, and that mental illness is becoming a more significant component of total workers compensation costs. Data from the National Dataset for Compensation-Based Statistics indicate an increase in compensation claims for both mental stress and workplace bullying and harassment since 2015.[27] The frequency of claims is likely to increase further in the wake of the COVID-19 pandemic.

And mental health claims have grown steadily both in share and frequency (claims per million hours) of all serious accepted compensation claims in Australia's various (state-run) workers compensation agencies in recent years. By 2018, mental health claims accounted for close to 8% of all accepted claims,[28] amounting to around 8000 major claims accepted per year. Once again, that is just a fraction of the total incidence of workplace-related mental health illness and injury. A high proportion of initial claims for mental health compensation are rejected by the relevant agencies: close to 50% of claims are rejected in most jurisdictions, compared to less than 10% of non-mental-health claims. This naturally discourages workers from submitting claims – as does the risk of reprisal from employers or stigma in the workplace.

Despite the artificially suppressed number of claims, total lost time associated with mental health claims is much longer than for physical injuries. On average, mental health claims were associated with close to 18 weeks per claim in 2018 – three times longer than average lost time for all claims. And the average length of mental health claims has been growing, whereas the overall average length of claim has been steady. Hence the expense of mental health claims is much larger as a share of total payouts, than their share of total claims, and that cost is growing even as other workers compensation claims are reduced.

[27] Safe Work Australia (2020b).

[28] All data in this paragraph as reported by Productivity Commission (2020), Volume 2, pp. 308-312.

THE BENEFITS OF PREVENTING MENTAL ILLNESS IN WORKPLACES

Employers benefit from a healthy workforce in both social and economic terms. While the social and health benefits of good mental health speak for themselves, the economic benefits to employers are also substantial, and experienced across all sectors, occupations, and sizes of business.

The economic costs of mental illness to employers are diverse and significant. The Productivity Commission estimated that the direct economic costs to employers from mental illness include $9.6 billion resulting from excess absenteeism, and $7 billion due to 'presenteeism'.[29]

By the same token, therefore, the benefits to employers to preventing psychosocial risks and achieving better mental health outcomes are also substantial. The return on investment to employers, and to all of society, from investing in preventative mental health have been modelled extensively, by both Australian and international researchers. The findings are clear: employers that invest in eliminating psychosocial risks, and supporting the mental health of their employees, receive a healthy return on those investments through multiple channels: including better retention, reduced turnover and training costs, reduced sick leave, higher productivity, and lower workers' compensation claims.

For employers who invest in improving the mental health of their employees, including by identifying and controlling risk factors that damage workers' mental health, employers capture significant positive returns through retention, productivity, and attendance.

For example, a Deloitte study of employer investments in workplace mental health in the UK found that the return on investment for a simulated series of mental health prevention and support programs averaged over £4 for every £1 spent. That 'payoff ratio' ranged as high as 8:1 for early stage support and prevention initiatives.[30]

Australian studies also suggest significant positive returns on investment across a range of workplace mental health prevention and promotion initiatives.[31] For example,

[29] Productivity Commission (2020), p. 11.

[30] Deloitte (2017).

[31] See NMHC (2016); NMHC, Beyond Blue, and PWC (2014); and Mental Health Australia and KPMG (2018) for sample analyses.

research by Beyond Blue and PWC indicates a range of strong and positive returns to preventative interventions to reduce mental illness in workplaces:

> "Mental health conditions present substantial costs to organisations. However, through the successful implementation of an effective action to create a mentally healthy workplace, organisations, on average, can expect a positive return on investment (ROI) of 2.3." (National Mental Health Commission, Beyond Blue, and PWC, 2014, p. 17)

That 2.3 return on investment reflects the broad average payoff to employers of across seven different types of preventative or supportive workplace measures, adjusting for size of firms (payoffs tend to be higher for smaller firms) and industry. In some cases, rates of return are much higher – up to 15-to-1 depending on the size of firm, the specific intervention, and the industry involved.[32]

In short, there are many initiatives that employers can undertake to prevent mental ill health and psychosocial injuries among their employees. In addition to avoiding painful and often tragic damage to workers and their families, these investments generate proven economic returns to employers. Preventing workplace-related mental health illness and injury is the right thing for employers to do: both morally and economically. But most employers require a 'push' to recognise and capitalise on this opportunity – and that is why progressive, specific regulations and guidance on this matter are so vital to reducing the incidence of this pervasive but preventable workplace danger.

[32] National Mental Health Commission, Beyond Blue, and PWC, 2014, p. 18.

The Cost of Workplace Mental Health Injuries: Order of Magnitude

The economic costs of Australia's epidemic of mental health problems are enormous. As documented in the scientific literature reviewed above, a substantial proportion of mental illness is clearly attributable to events, accidents, and stresses experienced in the workplace. Thus the potential economic benefits – not to mention lives saved, and enormous personal and familial costs avoided – achievable by improving mental health and safety at work are very substantial.

Given the heterogeneous nature of mental illness, and the wide range of factors which contribute to it, it is impossible to estimate the precise share of total mental illness that is associated with workplace problems, stresses and injuries. However, a broad order of magnitude attesting to the economic scale of the resulting costs can be developed on the basis of the epidemiological and economic evidence cited above. By combining estimates of the correlation between workplace conditions and the incidence of mental ill health and injury, with estimates of the overall economic costs of mental health problems in general, an approximate sense of the costs of workplace-associated mental health problems can be developed.

A path-breaking Australian study (LaMontagne et al., 2008) directly measured the correlation between job strain (defined as a combination of stress, degree of control, and insecurity at work) and incidence of depression among a large random sample of employed people in Victoria. The research indicated that 13.2% of depressive episodes among employed men were attributable to job strain, and 17.2% of those experienced by women. This implies that a weighted average of just over 15% of all depressive episodes among working people (of both genders) is attributable to workplace conditions. This estimate is conservative for a number of reasons, including:

- It does not include workplace-related depression among Australians who are no longer employed.[33]
- It does not capture the extent to which mental illnesses initially caused by other factors may be exacerbated by stressful workplace situations.

[33] Such as individuals whose mental illness was caused or exacerbated by workplace factors, but are unable to continue working.

- It does not directly measure the incidence of mental health problems other than depression.

Nevertheless, this finding that 15% of the incidence of depression among working Australians is attributable to the working conditions they experienced is a useful (and likely conservative) benchmark for contemplating the overall costs of work-associated mental health injuries and illness. Note that other research (such as Melchior et al., 2007) report even higher correlation between mental illness and workplace factors.

Table 1
Aggregate Cost of Workplace-Associated Mental Illness

Australian population (2020, 000's)	25,683
Australian labour force (2020, 000's)	13,550
15% of labour force	2,033
As proportion Australian population	7.9%
Total cost of mental illness ($bil/yr)	$200 - $220 billion
Due to:	
Mental illness	*122.0*
Suicide and self-inflicted injuries	*28.8*
Healthcare and related services	*15.5*
Informal and family care	*15.3*
Lower participation	*12.2 – 22.5*
Income support payments	*10.9*
Absenteeism	*9.6*
Presenteeism	*7.0*
Workplace-attributed ($bil/yr)	$15.8 - $17.4 billion
Due to:	
Mental illness	*9.7*
Suicide and self-inflicted injuries	*2.3*
Healthcare and related services	*1.2*
Informal and family care	*1.2*
Lower participation	*1.0 - 1.8*
Income support payments	*0.9*
Absenteeism	*0.8*
Presenteeism	*0.6*

Source: Authors' estimates from LaMontagne et al. (2008), Productivity Commission (2020), and ABS data, as described in text.

We assume further that the proportion of mental illnesses other than depression that can be associated with workplace practices and conditions is similar to the finding above. We then apply that 15% ratio to aggregate Australian labour market indicators and the Productivity Commission's estimates (cited above) of the total economic costs of mental illness. The results are summarised in Table 1.

The preceding methodology suggests that about 8% of total mental health costs in Australia are attributable to workplace stresses, injuries, and conditions experienced by employed Australians. Again, that is a conservative estimate, for several reasons: it only considers the incidence of mental ill health among currently employed people, it only relates that incidence to one dimension ('job strain') out of the myriad of potential workplace-related causal factors in mental illness, and it does not include the extent to which non-workplace-related mental ill health among working people could be exacerbated by factors in the workplace. On the basis of Productivity Commission (2020) estimates of the total cost of mental illness in Australia (pegged at $200-220 billion per year), this logic implies costs of $15.8 billion to $17.4 billion per year arising from workplace-associated mental illness and injury. The direct costs borne by the victims of mental illness and their families constitute the largest component of these costs (including personal suffering, reduced life expectancy, and others). But the strictly economic costs are also very substantial: including combined costs of reduced participation and productivity of $3.5 billion per year, and fiscal costs for healthcare services and income supports of over $2 billion per year.

This analysis suggests an order of magnitude for the consequences of workplace-related mental health problems that should spur policy-makers into quick and forceful action. Economic output could be enhanced by $3.5 billion per year from effective prevention of workplace-related mental illness. Fiscal expenses by government could be reduced by another $2 billion per year. And the catastrophic impact of preventable mental ill health for hundreds of thousands of Australian workers and their families could be avoided.

The costs of workplace-caused mental illness and injury experienced by workers and former workers and their families cannot be adequately measured in monetary terms. But the spillover impacts on participation, employment, productivity, incomes, and government budgets are quantifiable and substantial – and they are borne by all Australians, not just those suffering from these conditions. The economic arguments in favour of prompt action to reduce the risk and incidence of workplace mental health dangers are powerful. And the human and moral motivations for doing so are even more compelling.

Policy Recommendations

Mental illness is a complex, devastating and widespread crisis in our society. Many of its causes, consequences, and potential remedies are not fully understood. But some of the key factors causing mental illness are identifiable and well-understood – and are also indubitably preventable. Working conditions that are dangerous for mental health are known to cause a substantial proportion of total mental illness and injury. Preventing workplace-determined ill health, and supporting workers in recovering from mental illness (whether caused in the workplace or not), are crucial avenues for Australian workplaces to contribute to better health outcomes throughout society. These actions would also generate significant economic and fiscal benefits – and these benefits are shared by employers, experienced via reduced turnover, higher attendance, and stronger productivity.

Despite the significant benefits to employers from investing in safer workplaces and supporting mental health among their workers, many nevertheless neglect their responsibility to ensure safe workplaces and safe practices. This resistance may stem from a short-sighted focus on minimising immediate costs, old-fashioned attitudes that mental health injuries are not 'real', and/or an unwillingness to formally commit to standards and practices (including reporting, communications, worker voice, mental-health-friendly hours and schedules, job design, and other obvious reforms) that reduce employers' power to control the workplace in their own interests. For all these reasons, employers must be pushed to take necessary steps to reduce mental health risks in workplaces, and undertake sensible, proven measures to improve mental health outcomes. They, too, will benefit from those changes – but as is often the case with investing in safer, fairer workplaces, employers do not always act on those incentives of their own accord.

Specific initiatives and policy reforms to improve workplace mental health have been reviewed and considered in detail elsewhere.[34] The most immediate and important measures to address the mental health crisis in Australian workplaces include:

- Occupational health and safety legislation, workers compensation policies, and other labour regulations must recognise explicitly that workplace mental health risks are just as important as risks to physical health and safety. Regulations must compel employers to respond and eliminate or minimise those risks.

[34] See specifically Productivity Commission (2020, Chapter 7); National Mental Health Commission et al. (2014); Mental Health Australia and KPMG (2018); and ACTU (2019).

- Employers must have an explicit duty of care to identify and control mental health risks in their workplace, in the same manner and with the same levers of legal requirement and enforcement as they face with regard to physical safety risks.
- The recommendations of the Boland review regarding improvements to the management of psychosocial risks in workplaces must be fully implemented by state, territorial and Commonwealth governments. Specifically, this should include the development of appropriate regulations that set out the obligation to identify and control psychosocial risks, as well as Codes of Practice that provide practical guidance to duty holders and workers as to how to implement changes.
- Forceful measures to reduce the incidence of workplace bullying, harassment, and assault – a key cause of workplace mental health injuries – must be implemented, including relevant recommendations from the Respect@Work report regarding sexual harassment and assault.
- Workers compensation authorities must reform their current procedures and practices to ensure that victims of workplace mental health injury have their claims assessed fairly and consistently (with equivalent treatment to physical injury claims). The victims must be provided with immediate income support and necessary health services in a timely and accessible way – irrespective of liability issues. It should be noted that some jurisdictions have already moved to implement provisional liability provisions which, on anecdotal evidence, appear to be significantly reducing the time to rehabilitate and return to work from mental health injuries.

Ignoring the role of workplaces in causing and exacerbating mental illness, and abandoning victims of mental ill health to address and manage their conditions on their own (without proper health or income supports), will only further increase the human and economic toll from mental illness that Australia already incurs. Employers and governments, as well as workers, will benefit from safer, more supportive workplaces. It is well past time for Australian policy-makers to move forward with obvious, evidence-based measures to effectively combat this harmful, preventable epidemic. Making workplaces safer for mental health is an obvious place to start.

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