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WHITEPAPER

Beyond the EAP

What actually prevents psychological injury at work. And a straight test for any provider who says they can help.

Prepared for **HR, People & Culture, and operations leaders** at Australian employers

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The conversation that never reached you

A team leader notices her best analyst has gone quiet. Late starts. Missed details that never used to slip. Lunch alone at his desk, door half-closed. There was a hard client incident a few weeks back. She wants to say something. She stops. It isn't her place, she wouldn't know what to do if he opened up, and all she's been handed is a phone number on a poster. So she lets it go. Three months later he's on leave with a psychological injury claim. The first the organisation formally hears of it is the insurer.

None of that was negligent in the ordinary sense. The Employee Assistance Program was in place, working exactly as built. That is the uncomfortable point of this paper: **the EAP did its job. Its job just never included the part that mattered most.**

An EAP does one narrow thing: confidential, short-term counselling for the few who pick up the phone. That is treatment, and it is sold as far more. It was never built for prevention. Yet for most organisations it is the only psychological-health measure in place, so the biggest driver of injury, the way work is designed and led, goes completely untouched, while the organisation believes the problem is handled. This paper sets out what actually prevents injury: work design, manager capability, and clinical care joined across the continuum. It ends with ten questions to test any provider on substance. Us included.

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1 What an EAP is genuinely for, and its four structural limits

An EAP is a confidential counselling service, usually a phone line or a few sessions, that an employer funds so staff can reach out privately when something is wrong. The something can be work or personal: grief, a breakup, money stress, a rough patch. For the handful who call, it can help a little. Private, free at the point of use, a low barrier to a first conversation. But that is a small, narrow service, and it is routinely sold as a whole strategy.

That is the problem. Not just how the EAP is used, but what you are sold: a reactive counselling line dressed up as prevention. It reaches almost no one, touches none of the causes, and leaves you believing the risk is covered. The gap between what it promises and what it actually does is where injuries, and liability, pile up.

THE ONE-LINE DISTINCTION

An EAP helps the people who come forward, after something has gone wrong. Prevention is about the people who never come forward, and the conditions that hurt them in the first place. **Different jobs. Different tools.**

Four limits that belong to the category, not to any provider

These are not failings of a particular vendor. They are properties of what an EAP is. The best-run EAP in the country and a mediocre one share all four, which is exactly why shopping around the EAP market never closes them.

1 Reach is low and self-selecting

EAP utilisation usually sits in the low single digits a year; the 3-5% range is the common industry figure. The people who call are, by definition, the people willing and able to. The colleague going quiet or quietly burning out usually is not. A service built on self-referral cannot, by design, reach the population most at risk.

2 It is reactive, not preventive

An EAP activates once a person is already distressed enough to seek help. By then the hazard has done its work. Prevention happens upstream, in the role, the workload, the roster, the manager, weeks or months before anyone thinks to call a counsellor. The EAP sits at the wrong end of the timeline. It can only respond.

3 It has no lever on work design

The decisive one. An EAP counsellor can help a person cope with a crushing workload, but they cannot change what created it. The workload, the roster, the role conflict, the understaffing, the unaddressed bullying: these are levers only the organisation holds, through how it designs and runs the work. The counsellor works on the worker. The hazard lives in the work. However good the counselling, it never reaches the cause.

4 Disconnected from claims, RTW & the manager

The EAP is a sealed silo by design. It does not see the workers-compensation claim, does not feed return-to-work planning, and, for sound confidentiality reasons, tells the manager nothing. So the leader who spotted the early signs has no way in, and the organisation learns nothing from the pattern of who is calling, and why.

Now your managers can be personally liable

Who can be held legally responsible for psychological injury at work has changed. It used to be a problem for the company; now individual officers, directors and managers can be held personally accountable for failing to manage it. In New South Wales, a positive duty to manage psychosocial hazards sits in the WHS Regulation (the psychosocial provisions introduced in 2022, now consolidated in the WHS Regulation 2025), read with the primary duty of care in the WHS Act and the SafeWork NSW *Code of Practice: Managing Psychosocial Hazards at Work*. The duty: identify psychosocial hazards and eliminate or minimise the risk so far as is reasonably practicable. From 1 July 2026, section 26A of the WHS Act makes approved Codes of Practice enforceable benchmarks. That section is the enforceability trigger, not the source of the duty.

The consequence is blunt. A regulator asking whether you managed the risk looks at what you did about the work: the demands, the control, the support, the relationships, the roles, the way change was led. "We have an EAP" does not answer that, because an EAP touches none of it. It is evidence you offered treatment, not evidence you managed the hazard. And due-diligence duties land on officers personally. The gap between "we provided support" and "we controlled the hazard" is no longer an abstraction on a policy shelf.

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2 The people most at risk will never call

The assumption. Almost every organisation that sees low EAP usage lands on the same fix: awareness. Promote it harder. Put it in the induction pack, the screensaver, the all-staff email, the lanyard card. If people just knew it was there, they would use it, and the risk would fall.

The evidence that breaks it. The people carrying the most psychosocial risk are the least likely to self-refer to anything. That is not a character flaw or a comms gap; it is how strain behaves. As demand outruns a person's resources, the first things to go are insight, energy, and the willingness to be seen needing help. They withdraw. They call it a busy patch. The people who do ring are, on average, the more resourced and self-aware. So a bigger poster recruits more of the already-willing. It barely touches the silent group who need it most.

THE SHIFT

Low EAP utilisation is not a problem to fix. It is the design working as built. An EAP reaches self-referrers, people already willing to seek help. The ones carrying the most risk, the ones who go quiet and will not name it, are structurally the least likely to call. Promoting harder cannot close it, because the barrier is not awareness; it is the nature of the people the awareness is trying to reach. **The reach gap is architectural, not a marketing miss.**

A 4% utilisation rate is not proof your EAP is failing. It may be proof it is working exactly as built, reaching the slice that self-refers, while the design itself has a ceiling no promotion can lift. The right read of a low number is not "publicise it more." It is "this reaches one population, and the population most at risk mostly is not in it. What reaches them?"

The implication. If the highest-risk people will not come to a voluntary service, any strategy that waits for them to come forward has a hole no marketing budget fills. Reach has to be built into the system, not left to the individual. Which means it has to live in things that happen to the work and around the worker, whether or not they put their hand up.

What to do about it. Stop treating utilisation as a score to maximise. Build the two reach mechanisms that do not depend on self-referral. First, **work design**: control the hazard at source and you protect everyone exposed, including the people who would never call. Second, **manager capability**: equip the person who already sees the early signs to start a safe conversation and route it on. An EAP still serves the self-referrers who reach it. The task is to build the rest for everyone it structurally cannot.

ILLUSTRATIVE

A professional-services firm, rattled by 3% EAP usage, ran a six-month awareness push: emails, a wellbeing week, fridge magnets. Usage rose to 5%, almost all of it staff who had used support services before. In the same window, two senior people in an overloaded team went on extended leave with stress-related conditions. Neither had called the line. The campaign moved the metric and missed the risk. The hazard, sustained overload in one team, was never on the EAP's menu. (Illustrative composite; not a real client.)

3 You cannot train a worker out of a work-design hazard

The assumption. Once leaders accept that mental health is a real workplace risk, the usual first move is to invest in resilience: mental-health first-aid, resilience workshops, mindfulness, a wellbeing app. It feels responsible, it is visible, and you can ship it by quarter's end. The unspoken theory: equip people to cope better and they will not get injured.

The evidence that breaks it. It all depends on where the hazard lives. Psychological injury at work is mostly produced by hazardous conditions, not fragile individuals. The **Job Demands-Resources model** splits every job in two:

Job demands

The things that cost effort: workload, time pressure, emotional labour, role conflict, cognitive strain, exposure to distressing material, relentless change.

Job resources

The things that help a person meet those demands and stay well: control over how they work, support from manager and peers, role clarity, fair recognition, the right tools and information.

When demands stay high and resources are too thin to meet them, people deplete. Sustained, that becomes exhaustion, burnout, anxiety, and eventually injury. The key point: **high demands are fine when resources match them, and turn into a hazard when they do not.** The injury comes from an imbalance in how the work is designed and led, not a deficit in the worker. Resilience training builds the worker's capacity to absorb demand. It does nothing to the demand, or to the missing resources.

THE SHIFT

You cannot train a worker out of a work-design hazard, and trying can raise your exposure. If the hazard lives in the work, resilience and first-aid training is the weakest response on the hierarchy of controls. Worse, leading with it documents that you put the load on the individual instead of fixing the source. **"Fix the work, not the worker" is the legal hierarchy, not a values slogan.**

Every WHS professional already applies this logic to physical risk. You do not answer a toxic atmosphere with better masks and a running leak. You fix the leak, then use protective equipment for whatever risk remains. Individual interventions are the PPE of mental health, right for the residual risk after the work is designed as well as it reasonably can be. Lead with them as the only response and you invert the hierarchy. A regulator can now read that inversion.

The six categories, in plain English

Australian guidance groups psychosocial hazards into six categories (the HSE Management Standards framework). Map them to the model and the prevention task gets concrete, and the limits of a coping-skills response get obvious.

Category	JD-R type	What it looks like as a hazard, and why training can't fix it
Demands	Demand	Sustained overload, unrealistic deadlines, long hours, heavy emotional labour, exposure to traumatic content. Coping skills raise tolerance; they don't lower the load.
Control	Resource	Little say over how, when, or in what order work is done; rigid process; no autonomy over pace. You cannot teach someone into having control they structurally lack.
Support	Resource	Inadequate manager or peer support; insufficient training, tools, or information to work safely. A workshop is not the missing resource.
Relationships	Resource / Demand	Bullying, harassment, conflict, aggression from clients or the public. Resilience-training a target is close to victim-blaming; the conduct is the hazard.
Role	Resource	Role ambiguity or conflict, competing expectations, accountability without authority. Clarity is a design decision, not a personal skill.
Change	Demand	Restructures, redundancies, and uncertainty handled without consultation. The fix is how change is led, not how stoically staff endure it.

Five of the six are essentially about resources, the very things neither an EAP nor a resilience course can supply. They are design and leadership decisions. They sit with the organisation.

THE CONSTRUCTIVE READ

This is not an argument against building skills. Well-designed resilience and mental-health-literacy programs earn a place, for residual risk and as a complement to a well-designed job. The argument is about **order**: design the work first, then layer individual support on work that is already as safe as it reasonably can be. The same levers that cut injury risk also lift engagement and performance. Prevention and productivity are not in tension. They pull the same rope.

ILLUSTRATIVE

A contact centre with rising stress claims rolled resilience training out to every agent. Claims did not move. The real driver: a workforce-planning change had pushed average handle-time targets up and stripped out the short recovery gaps between hard calls. Textbook demands up, resources down. The training asked agents to absorb a hazard the roster had created. Reinstating recovery time and resetting the targets did what the workshops could not. (Illustrative composite; not a real client.)

4 Your earliest, cheapest sensor is switched off

The assumption. When an organisation gets serious about early intervention, the instinct is to buy more clinical capacity: more sessions, faster access, a bigger panel. The model is that catching things early means getting more people to a therapist sooner.

The evidence that breaks it. By the time a person reaches a therapist, "early" has usually gone. The real early signal shows up weeks before, in one place: in front of the front-line manager. The manager sees the change first, the high performer gone quiet, the creeping lateness, the reliable person now making odd mistakes. They are there, daily, in a way no phone line is. They are the closest thing an organisation has to a live early-warning sensor for psychological risk.

And in most organisations that sensor is switched off. The manager has no training to read the signs, nowhere to escalate if they do, and often no sense they are allowed to ask. So they look away, and the cheapest, earliest, most effective window closes unused.

THE SHIFT

Your earliest, cheapest early-warning sensor is switched off. The front-line manager sees the change first, the withdrawal, the slipping work, the person who is not themselves, but has no training to read it, nowhere to escalate, and often no permission to ask. **The fix is not more therapists. It is a triage pathway that turns the manager into a safe, structured first step into real clinical care.**

The leverage is huge, and mostly free. You already pay these managers. They are already in the room. The signal already reaches them. What is missing is not capacity. It is three cheap things: the literacy to recognise what they are seeing, the permission to act, and a real pathway to hand it to.

The implication, and the trap. The fix is not to turn managers into amateur clinicians. That is the dangerous failure mode at the other extreme. The goal is a manager who can notice, respond like a human, route to the right help, then step back into being a manager. Notice and route sits inside the role. Diagnose and treat never does.

A MANAGER CAN & SHOULD

- ✓ Notice changes in behaviour, performance or presentation, and take them seriously.
- ✓ Open a supportive, non-judgemental conversation: ask how someone is, and listen.
- ✓ Adjust the work where they have authority, workload, deadlines, temporary accommodations.
- ✓ Know the escalation pathway and use it, connect the person to clinical support.
- ✓ Maintain confidentiality, within its limits, and follow up.

- ✓ Fix hazards in their own team's design: clarify roles, resource the work, lead change well.

A MANAGER CANNOT & SHOULD NOT

- ✗ Diagnose a mental-health condition.
- ✗ Provide therapy or counselling.
- ✗ Assess clinical risk, such as risk of self-harm, on their own.
- ✗ Decide whether someone is "fit" for work on clinical grounds.
- ✗ Keep a serious disclosure to themselves with no pathway forward.
- ✗ Promise a confidentiality that would override a duty to act on a safety risk.

THE NON-NEGOTIABLE

At any sign of acute risk, talk of self-harm, a person in crisis, a serious safety concern, the manager's job is not to handle it alone. Stay with the person. Keep them safe in the moment. Escalate immediately to a clinical pathway, and where life is at risk, to emergency services. **Managers must be told this in advance.** Finding the pathway mid-crisis is too late.

Why the conversation only happens in a safe team

None of this, early disclosure, honest conversations, managers asking and people answering, happens in a team where it is not safe to speak up. The research on **psychological safety** (the shared belief that you can raise a concern, admit a mistake, or ask for help without being punished or humiliated, work associated with Amy Edmondson) is directly relevant. It is what turns a warning sign into a disclosure early enough to act on, instead of a resignation or a claim later. And it is itself largely a product of work design and leadership. Which brings us back to the spine of this paper: the most powerful mental-health intervention most organisations have is better leadership of better-designed work.

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5 The continuum, and why the value is in the handovers

The three shifts land on one conclusion: prevention, early intervention, treatment and recovery are not four products from four vendors. They are stages of one continuum, and the value is in connecting them. People fall in the seams.

Stage	What it is	The right tool	What an EAP-only model misses
1 · Prevention	Stop the injury before it starts.	Work design: identify psychosocial hazards; eliminate or minimise risk via demands/resources changes; consult workers.	**Entirely.** An EAP has no lever here.
2 · Early intervention	Catch the warning signs and act before injury sets in.	Manager capability to notice and respond, plus a clinical triage pathway to escalate into.	**Mostly.** Managers are usually untrained, with nowhere to escalate to.
3 · Treatment	Clinical care for a person who is unwell or injured.	Evidence-based psychological care, with continuity and clinical governance.	**Partly.** Brief counselling suits mild presentations; complex cases need depth an EAP rarely provides.
4 · Recovery / RTW	Help an injured worker recover and return to safe, sustainable work.	Clinically-informed return-to-work planning, joined up with treatment and the workplace.	**Entirely.** The EAP is walled off from the claim and the RTW process.

What actually falls through the gaps

Gap 1 → 2: prevention to early intervention

The hazard audit flags an at-risk team. The finding sits in a WHS report the team's manager never reads. Nothing turns "this team is at risk" into "this manager knows what to watch for, and what to do."

Gap 2 → 3: early intervention to treatment

A manager says "give the EAP a call." The handover ends there. No one knows whether the person called, whether the support matched the need, or whether things are escalating. The thread drops at the moment it matters.

Gap 3 → 4: treatment to recovery

The treating clinician and the return-to-work coordinator are different organisations that never speak. RTW plans get written without clinical input; clinical care proceeds without knowing the work being returned to. Recovery stalls in the seam.

The feedback gap: nothing learns

Because the stages do not connect, the loop never closes. The pattern of who is getting injured, and why, never feeds back into work design. The same hazard keeps producing the same injuries, each treated as an isolated case.

THE DESIGN PRINCIPLE

A psychological-health system is only as strong as its handovers. The value is not a vendor per stage. **It is the stages connected by a single clinical logic**, so a signal at one stage moves to the next, and what is learned at the treatment end flows back to the design end.

Why clinical depth decides the hard cases

Most workplace presentations are mild to moderate and respond well to brief, accessible support. A meaningful minority do not: complex trauma, co-occurring conditions, a worker fighting a contested compensation claim. Those are the cases where the quality and continuity of care decide the outcome.

A roster a worker never meets twice

In a brokered model, a worker may be allocated to whichever contractor is free, then a different one next time. For a complex case this is corrosive: the person re-tells their story to each new clinician, no one holds the whole picture, and the supervision around the clinician is often thin, and invisible to the employer.

A real practice with continuity and supervision

In a clinically-led practice, a complex case can be held by a consistent clinician inside a team with genuine clinical governance, peer consultation, supervision, internal escalation. The person is not starting over each time, and the organisation can trust the care meets a defined clinical standard.

AN HONEST WORD ON ACCESS

Continuity is not the same as speed, and we will not pretend it is. A clinically-led model prioritises the right clinician with continuity over the fastest available appointment. For genuine crises the answer is always an immediate safety pathway and emergency services. Be sceptical of anyone promising both unlimited speed and deep continuity for complex care; those goals pull against each other.

FRAMEWORK A

The work-design control rubric

A reusable framework for translating a psychosocial hazard into controls at each level of the hierarchy. Worked examples are illustrative, not client data.

HOW TO USE IT

For any identified psychosocial hazard, work down the hierarchy and ask at each level: "what control is reasonably practicable here?" The discipline is to exhaust the higher-order, work-design controls before defaulting to individual support. The worker-support row is where an EAP and resilience training belong: valuable, but last, for residual risk.

Level	What it means for psychosocial risk	Generic example of a control
Eliminate	Remove the hazard entirely.	Stop a harmful practice altogether, e.g. cease an out-of-hours on-call expectation that has no operational justification.
Substitute	Replace the hazard with something less harmful.	Swap a high-exposure task for a lower-exposure alternative, e.g. rotate a distressing duty so no individual carries it continuously.
Engineer / isolate	Change the system, process, or structure of the work.	Redesign the workflow, staffing model, or roster so demand and capacity are matched by design, not by individual heroics.
Administer	Change rules, training, and ways of working.	Clear policies, role definition, manager training, consultation processes, escalation procedures, workload caps.
Worker support	Help individuals cope with the risk that remains.	Counselling (EAP), resilience skills, peer support, accommodations, the weakest controls, used last, for residual risk only.

Worked example, Hazard: sustained high workload in a service team

Level	Control (illustrative)
Eliminate	Cease low-value reporting and meetings that consume capacity without operational benefit; remove duplicated work.
Substitute	Automate or simplify repetitive high-volume tasks so the same output takes less sustained effort.
Engineer	Match staffing to demand: adjust headcount, redistribute load, build surge capacity so peaks don't fall on the same few people.
Administer	Set and enforce realistic workload expectations; train managers to monitor load; build workload review into the team's rhythm.
Worker support	EAP and individual support for residual pressure, not the primary control.

FRAMEWORK B

Manager triage & escalation matrix

An illustrative framework to equip front-line managers to respond safely. It deliberately keeps managers in a notice-and-route role, not a clinical one. Adapt thresholds and contacts to your organisation.

Signal the manager observes	Appropriate manager action	When / where to escalate	Who holds it next
Early / low-level. Subtle change: quieter than usual, minor dip in performance, looks tired.	Open a supportive check-in. Ask how they're going; listen. Adjust workload where you can. Note and follow up.	No formal escalation yet. Re-check within a defined window (e.g. 1-2 weeks).	Manager, with self-referral options (incl. EAP) made known to the person.
Emerging / moderate. Persistent decline, increasing absence, visible distress, withdrawal.	Have a more direct, supportive conversation. Name what you've noticed, kindly. Actively offer the clinical pathway.	Escalate to the clinical / early-intervention pathway and to HR. Don't sit on it.	Clinical pathway (triage by a clinician) + HR; manager stays engaged.
Significant disclosure. Discloses a mental-health issue, a serious crisis, or that work is making them unwell.	Listen without judgement. Don't diagnose. Reassure, maintain confidentiality within limits, connect them promptly.	Escalate to the clinical pathway promptly (same day where possible) and to HR per policy.	Clinical pathway holds the clinical response; HR holds the employment response.
Acute risk / crisis. Any indication of self-harm, a person in acute crisis, an immediate safety concern.	Do not manage alone. Stay with the person; keep them safe; do not leave them. Use your crisis pathway now.	Immediate. Activate the clinical crisis pathway; where life is at risk, contact emergency services (000).	Clinical crisis pathway / emergency services. Notify HR/WHS afterwards.

READ THIS BEFORE DEPLOYING THE MATRIX

A triage matrix is only safe if the escalation destinations actually exist and answer. The most dangerous version of this tool tells a manager to "escalate to the clinical pathway" when there is no clinical pathway to escalate to. **Building the pathway is the precondition for handing managers this tool at all.** It is precisely the connection an EAP-only model lacks.

THREE RULES TO TRAIN INTO EVERY MANAGER

1. Your job is to notice and route, not to diagnose or treat. **2.** Never promise a confidentiality that would stop you acting on a safety risk; be honest about the limits up front. **3.** When in doubt, escalate. Over-escalating a concern is safe; under-escalating a crisis is not.

Ten questions to evaluate any workplace mental-health provider

A genuinely provider-neutral evaluation framework. Use it on anyone, an EAP, a consultancy, a clinical practice, or us. Where a provider's honest answer is "that's not what we do," that's useful information, not necessarily a fault.

#	The question	Why it matters / what a strong answer shows
1	Where does your offering sit on the prevention-to-treatment continuum, and which parts do you not cover?	Tests honest scope. Be wary of anyone claiming to do everything, and warier of anyone who blurs prevention and treatment.
2	What can you actually do about work design, the demands and resources that cause psychosocial risk?	The prevention question. "We provide counselling" is honest, and tells you prevention isn't covered.
3	Who delivers the clinical care, what are their registrations, and what are your clinical governance and supervision arrangements?	Tests clinical depth and safety. Governance is what protects quality when a case is hard.
4	How do you ensure continuity of care for a complex case?	Tests whether a worker sees a consistent clinician who holds the whole picture, or starts over each time.
5	How does your service connect to workers-compensation claims and return-to-work?	Tests for the silo problem. Disconnection here is where recovery stalls and claims drift.
6	What evidence and measurement do you provide, and would it survive scrutiny in an inspection?	Tests substance over optics, measurement tied to risk, not just engagement metrics like log-ins.
7	How do you support managers to notice, respond, and escalate safely?	Tests the missing middle, real manager capability and a clinical pathway, not a poster with a phone number.
8	What is your escalation and crisis pathway, and how fast does it actually respond?	Tests safety under load. Vagueness here is a red flag regardless of the provider.
9	How do you handle data, privacy, and consent, and how is individual confidentiality protected?	Tests trust and compliance, what's collected, who sees it, how aggregate insight is shared without identifying anyone.
10	Where are your conflicts of interest, and how does your commercial model align with our outcomes?	Tests candour. Ask whether they earn more when you use more services, or when your people get and stay well.

HOW TO SCORE IT

No single answer disqualifies a provider, this is a fit test, not a pass/fail gate. If you need a confidential counselling line, an EAP answering honestly on questions 3, 8 and 9 may be exactly right. If you need to prevent psychological injury and demonstrate due diligence, questions 1, 2, 6 and 7 carry the most weight. The aim is to buy with your eyes open.

Where this leaves you

Go back to the team leader on the first page, the one who noticed and had nowhere to send what she saw. Nothing she lacked was clinical. She needed three things this paper is about: work designed so the hazard was smaller to begin with, the literacy and permission to start a conversation, and a real clinician on the other end. None of those is an EAP's job. All of them are the job that actually prevents injury.

So the argument is simple. A counselling line can help the few who call, but it is the last and weakest link in the system, and it is sold as the whole chain. Put it where it belongs: a minor, residual support sitting at the very end of a system whose first job is to design and lead work so fewer people are injured in the first place. Bought as anything more, it is a false reassurance, and a liability dressed as a safeguard.

Upstream

Prevention sits in work design, before any counselling line can help.

Connected

The value is in the handovers, held by one clinical logic.

Defensible

Evidence that survives scrutiny, not engagement metrics.

How Unbound Work can help

Unbound Work is the workplace mental-health arm of Unbound Minds, a multi-site Sydney clinical psychology practice with **more than 32 employed psychologists**. Because there is a real practice behind us, we can join up the continuum this paper describes: psychosocial hazard and work-design assessment, manager capability with a clinical pathway to escalate into, and clinical care delivered with genuine continuity and supervision, not a contractor roster a worker never meets twice.

If this paper is useful, use the ten questions on whoever you are considering, us included. No pitch, a conversation about what good would look like for your organisation.

Book an intro call →

Regulatory currency. In NSW, the duty to manage psychosocial hazards arises under the Work Health and Safety Regulation (psychosocial provisions introduced in 2022, now consolidated in the WHS Regulation 2025), read with the primary duty of care in the WHS Act and the SafeWork NSW Code of Practice: Managing Psychosocial Hazards at Work. From 1 July 2026, section 26A of the WHS Act makes approved Codes of Practice enforceable

benchmarks, it is the enforceability trigger, not the source of the duty. ISO 45003 is non-binding international guidance. References to the six psychosocial categories follow the HSE Management Standards framework. Statistics on EAP utilisation are cited directionally as general industry context. Confirm all regulatory references with qualified WHS counsel before relying on them.