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WHITEPAPER

The Director's Brief on Psychosocial Risk

The one duty you can't delegate, the claim cost you can't see, and the evidence that protects you.

Prepared for **company officers, boards and risk committees**, directors · CEOs · CFOs · chief risk officers · owner-operators

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A duty with your name on it

Picture the meeting that doesn't happen. A long-serving team leader has gone quiet. Short emails. A missed deadline that would have been unthinkable a year ago. Two Mondays off in a row. Their manager notices, feels a flicker of concern, and does nothing in particular, because there is nowhere obvious to send it and a quarter to close. Four months later, that same person is on a psychological-injury claim that will run the better part of a year. Above all of it sits a board that approved a wellbeing budget, signed an EAP contract, and mistook that for handling the risk.

It was not handled. Under work health and safety (WHS) law, the question that now matters is not whether the company cared. **It is what its officers personally did to manage the risk, and whether they can prove it.** Three things have quietly become true at once: the duty to manage psychosocial risk is now personal to officers and cannot be contracted out; mental-injury claims are now the costliest and longest-running category in the workers-compensation system; and most of that cost is set in the first few weeks, by coordination no director ever sees.

THE THESIS IN ONE PARAGRAPH

The WHS primary duty of care sits with the business (the PCBU). The duty of due diligence sits with its officers, personally and actively. Psychosocial risk now sits squarely inside it. What protects an officer is not a policy on a shelf or a phone line on a poster. **It is dated evidence that you found the risk, controlled it at the source, consulted your people, checked the controls worked, and intervened early**, the kind that survives an inspection, not engagement metrics.

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1 The shift you can't outsource: due diligence is personal

Here is the assumption almost every board holds. It is wrong in a way that costs nothing to fix and a great deal to leave alone: *we engaged a provider, so we're covered.* The EAP is contracted. There's a wellbeing program. HR owns mental health. Every statement is true. Not one of them discharges the duty the law places on an officer personally.

WHS law draws a deliberate line between two duties. The **primary duty of care** (s.19 of the WHS Act) belongs to the PCBU, the company itself. The **officer's duty** (s.27) is separate and additional: an officer must exercise due diligence to ensure the PCBU complies. You are not asked to eliminate every hazard yourself. You are asked to ensure the system that manages hazards exists, is resourced, and actually works, and to stay informed enough to know whether it does.

THE SHIFT

Due diligence is the one duty you cannot outsource, insure, or delegate. Hand off the tasks if you like, the assessment, the program, the EAP, even a clinically-led partner. **You cannot hand off the duty to make sure they work.** It stays on you, personally, and the law judges you by what you knew or ought reasonably to have known. Choosing not to look does not lower the bar.

The officer who reads this brief, asks management three sharp questions, and minutes the answers has done more to discharge the duty than the one who signed off a six-figure wellbeing spend and never asked whether any of it touched how the work is designed. Spend is not the measure. Informed, active oversight is.

Six elements, read against the risk you can't see

Section 27(5) sets out six elements of due diligence. The discipline for a 2026 board is to read each one specifically against psychosocial hazards, the area most officers have the least visibility over, and the area the regulator has signalled it is now watching.

The s.27(5) element	What it requires	Applied to psychosocial risk
1. Knowledge	Acquire and keep up to date knowledge of WHS matters, ongoing, not a one-off induction.	Know the psychosocial duty exists, that a Code applies and becomes enforceable on 1 July 2026, and understand the hazard categories well enough to ask intelligent questions.
2. Operations & hazards	Understand the nature of operations and their hazards and risks, the work, not the org chart.	Know which roles carry high demands, low control, poor support, role conflict, or exposure to distressed clients. The hazards live in work design, not in personalities.
3. Resources & processes	Ensure appropriate resources and processes to eliminate or minimise risk.	Ensure a real psychosocial risk-assessment process, genuine controls (preferably at the source via work redesign), and a funded early-intervention pathway, not just a crisis line.
4. Information processes	Ensure processes for receiving and considering information on incidents, and responding promptly.	Ensure complaints, near-misses, survey results, exit-interview themes and early distress signals are captured, escalated, and answered, before they become a claim.
5. Compliance processes	Ensure processes for complying with duties under WHS legislation.	Ensure consultation genuinely happens, controls are documented, and the approach is benchmarked against the Code (or a demonstrably equivalent standard).
6. Verification	Verify the provision and use of the resources and processes above.	Test whether controls actually operate: review incident trends, audit whether early intervention is offered, demand evidence rather than assurance at board level. **This is where most officers fall short.**

THE PATTERN ACROSS ALL SIX

Five of the six elements are about ensuring a system exists and is used; the sixth is about verifying it. Not one is met by good intentions, a wellbeing budget, or an EAP contract, which buys the paperwork of care, not the substance. **Each is met by a process you can point to and proof that it ran.** That is why this brief ends in an evidence map, not a values statement.

The move this demands is small and immediate: stop treating psychosocial risk as a delegated operational matter and start treating it as a standing governance one. Put it on a board or risk-committee agenda. When the answer is an assurance ("it's handled"), ask to see the evidence, and minute both the question and the answer. That record is itself the first piece of due-diligence evidence you will ever need.

2 Why this is now a board problem, not an HR one

Three forces have moved psychosocial risk from an HR concern to a governance one: it is now enforceable, the claims trend has turned hard, and the reputational and coronial exposure is no longer hypothetical. Together they make it a standing risk-committee item.

Enforceability, get the instruments right

Officers are badly served by loose language here. Blurring these instruments is exactly the error that weakens a defence.

Instrument	Status	What it does
WHS Act (s.19 primary duty; s.27 officer due diligence)	Primary law, binding now	Creates the duties. "Health" expressly includes psychological health. Officers must exercise due diligence.
WHS Regulation (psychosocial provisions 2022; consolidated in WHS Regulation 2025)	Subordinate law, binding now	The source of the specific psychosocial duty. Requires the PCBU to identify psychosocial hazards and implement control measures.
SafeWork NSW Code of Practice	Approved Code	Sets out how to comply in practice. Admissible as evidence of what is reasonably practicable. From 1 July 2026 it operates as an enforceable benchmark.
Section 26A of the WHS Act	Enforceability trigger (1 Jul 2026)	Elevates approved Codes to enforceable benchmarks. Follow the Code or demonstrate a control of equivalent or higher standard. The trigger, not the source of the duty.
ISO 45003	Voluntary guidance	Describes "what good looks like". Useful for designing a defensible system; a regulator does not enforce it. A quality benchmark, not a legal one.

THE DISTINCTION THAT PROTECTS YOU

The duty already exists, it arises under the WHS Regulation read with the Act. What changes on 1 July 2026 is the **enforceability** of the Code as a benchmark under s.26A. An officer who says "we'll deal with it when the law changes in 2026" has misread the position: the obligation is live now; 2026 only raises the evidentiary stakes. And mind the verb, aligning to the Code or ISO 45003 *supports demonstration of* due diligence; it does not, by itself, satisfy it. What you actually did still governs.

The claims trend has turned, and it lands on you

Psychological-injury claims are the fastest-growing pressure in the workers-compensation system. Using NSW scheme reporting as context: psychological injuries have risen to roughly one in nine active claims, up from about one in seventeen a decade ago, and are widely reported as the most expensive and longest-running category. That is a structural change in the risk of employing people, and it flows straight to premium and lost capacity.

Reputational and coronial exposure

Regulatory & reputational

SafeWork NSW has signalled active interest in psychosocial compliance. An improvement or prohibition notice, an investigation, or a prosecution, against the PCBU and potentially an officer, carries reputational damage that outlasts any penalty, and is a disclosable and procurement risk.

Coronial

Where a death is connected to workplace factors, a coroner may examine the adequacy of the employer's systems and the officer's oversight. A coronial inquiry is held in public, reads documents forensically, and asks exactly the verification questions in Section 1.

THE PERSONAL DIMENSION

The officer duty is one of very few in Australian corporate law that attaches to you personally and is not insured away through the company the way ordinary commercial risk is. A finding against an officer is a finding against a named person, on the public record. **The exposure is yours; so is the protection.**

3 The shift in the numbers: cost is set early, not by severity

To govern psychosocial risk, understand the cost of a single mental-injury claim, and why it behaves nothing like a physical one. Most directors assume a claim's cost tracks the severity of the injury. That is the second thing this brief is here to break.

~3×

Reported lost-time multiple for psychological vs physical claims (SIRA general reporting, directional).

~1 in 9

Share of active NSW claims that are psychological (up from ~1 in 17 a decade ago).

Longer tail

Psychological claims are more likely to turn adversarial and to delay return to work.

Figures above are directional industry context attributed to SIRA / Safe Work Australia scheme reporting, not Unbound data, and not a prediction for any individual claim. Confirm current figures with your insurer or scheme agent.

The first few weeks decide most of the bill

A claim moves through five stages. At each, specific factors push cost and duration up, and at each, a well-organised employer has a lever. Most of the cost is set early, in the window between notification and treatment, by decisions that have almost nothing to do with the eventual size of any lump sum.

Stage	What happens	What drives cost & duration	The controllable lever
1. Notification	Worker lodges a claim; provisional liability may commence.	Delay between injury and notification; an already-adversarial relationship; no early contact.	A respectful, prompt, non-adversarial first response. Early, genuine contact is one of the strongest predictors of a shorter claim.
2. Liability	Insurer determines whether to accept the claim.	Disputes over causation (more contestable for psychological); investigations; a combative experience.	Clear, contemporaneous records of work factors and what was done about them. Avoid reflexive contesting.
3. Treatment	Worker receives clinical care; capacity reviewed periodically.	Fragmented care; mismatched GP/employer/insurer expectations; the worker feeling unsupported.	Clinically-coordinated treatment aligned to a realistic return-to-work goal.
4. Return to work	Worker returns on suitable duties, building back to full capacity.	No suitable-duties plan; a role with the same hazards that caused the injury; a hostile team.	A real suitable-duties plan, into a role where the original hazard has been controlled.
5. Closure	Claim resolves; worker durably back at work, or claim finalised.	Premature closure that triggers relapse; unresolved impairment; lingering conflict.	Durable return confirmed before closure; the underlying work design genuinely fixed.

THE SHIFT

A psychological claim's cost is set in the first few weeks, by coordination, not severity. Two near-identical injuries can diverge by months and tens of thousands of dollars depending on whether the treating GP, the employer and the insurer aligned early on a recovery-at-work plan. **Govern the first fortnight and you have governed most of the cost.**

Why psychological claims cost more, the four mechanisms

Recovery is slower and less linear

Psychological recovery rarely follows the predictable arc of a healing fracture. Capacity fluctuates, setbacks are common, and "fitness for work" is harder to certify cleanly, which lengthens the certified-incapacity period.

The workplace is the site of the injury

When work factors caused the injury, returning to the same workplace can re-expose the worker to the cause. Unless the hazard is controlled, return is fragile and relapse is likely, re-opening a claim that looked closed.

Causation invites the adversarial spiral

Psychological causation is more contestable, so these claims are more often disputed, investigated and litigated. The dispute process is itself harmful, it can deepen the injury and add legal cost on both sides.

Coordination failure, the silent driver

The GP, the employer and the insurer routinely run on different, unstated assumptions. The resulting drift quietly extends duration. It is the most controllable driver and the least controlled.

Most NSW employers above a size threshold are experience-rated: a long, expensive psychological claim carries a multi-year premium consequence. But the insured cost is only the visible part. The uninsured tail, lost productivity, backfill and overtime, management time, team contagion, recruitment, is routinely larger and never lands on the premium invoice.

THE GOVERNING ECONOMIC INSIGHT

Prevention is the cheapest path; early, clinically-coordinated intervention is the next cheapest; an adversarial, fragmented, late-coordinated claim is the most expensive path of all. **This is the mental-injury continuum in financial terms**, prevention → early intervention → treatment → return to work, with cost climbing sharply the later you engage.

4 The Return-to-Work Coordination Trap

This is the section a generic EAP or a management consultancy cannot write, because it takes having sat inside real workers-compensation claims and watched them fail. The single most avoidable driver of psychological-claim cost is not the injury. **It is the silent breakdown of coordination between the three parties who must agree for a person to recover at work: the treating GP, the employer, and the insurer, with the worker caught in the middle.**

1 Mismatched expectations, never surfaced

The GP certifies a cautious "no current capacity" to avoid harm. The employer hears "off indefinitely" and stops planning a return. The insurer, seeing no plan, manages the file passively. Three reasonable positions, no shared goal.

2 No suitable-duties plan to certify against

A GP can rarely certify "fit for modified duties" in the abstract, they need to know what duties are on offer. When the employer provides no concrete options, the GP defaults to "no capacity" because it is the safe call.

3 Clinical input that arrives too late

The right assessment at the right moment can unlock a return, but it often comes late. By then the worker has deconditioned, anxiety about returning has compounded, and their identity as a worker has eroded. Time out of work is itself a clinical risk factor.

4 The adversarial IME dynamic

An independent medical examination ordered defensively, framed as a credibility test, can entrench injury. The worker experiences it as the employer disbelieving them; trust collapses; the claim heads for dispute.

THE TRAP IN MOTION (ILLUSTRATIVE)

A team leader develops a work-related psychological injury after sustained excessive demands and unresolved conflict. The GP certifies no current capacity. The employer, with no suitable-duties plan, decides to wait until the worker is "fully better". The insurer reviews the file monthly rather than weekly. At week eight an IME is ordered; the worker experiences it as a challenge to their honesty and disengages. By week sixteen they are deconditioned, the relationship is adversarial, lawyers are involved, and a claim that clinically could have resolved by week six is now a long-tail file. No single party made an obviously wrong call. The coordination failed, and the cost was set by that failure, not by the original injury.

What good, clinically-coordinated return-to-work looks like

The fix is not more goodwill. It is a deliberately coordinated clinical and operational process built around one recovery goal all three parties share:

Early, genuine contact

From the employer, supportive, not surveillance, within days, establishing that the person's role is held and recovery is expected and supported.

A concrete suitable-duties plan

In writing, handed to the GP to certify against, real, meaningful, time-limited modified work, not token "light duties" that signal the worker is unwanted.

Timely, expert clinical input

Aligned to a return-to-work goal from the outset, so treatment and work-recovery pull in the same direction instead of treatment running open-endedly in isolation.

A shared recovery plan

Across GP, employer and insurer, one document, one goal, agreed review points, replacing three private, divergent assumptions. Return into a role where the original hazard has been controlled.

WHY THIS MATTERS TO AN OFFICER

Good return-to-work coordination is at once the most humane response and the cheapest, here, the interests of the worker and the business genuinely align. For an officer, a documented, clinically-coordinated return-to-work capability is also **due-diligence evidence**: it shows the "receiving and responding to information" and "resources and processes" elements of s.27(5) operating in real time.

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5 The shift that flips the board instinct: your strongest defence is your cheapest control

Most boardrooms treat safety as a cost, necessary, but a line item that trades off against growth. On psychosocial risk that instinct is backwards. The highest-order control removes the hazard at its source: a workload made sustainable, a role given clear authority, a manager coached or moved. These are work-design changes, and they usually cost little or nothing. The claim they prevent costs everything.

THE SHIFT

Your strongest legal defence is also your cheapest control. Redesigning work to remove a psychosocial hazard sits at the top of the hierarchy of controls, is the strongest due-diligence evidence you can produce, and often costs little or nothing, while the claim it prevents costs everything. **The board reflex that "safety equals spend" is exactly inverted here.**

The clinically most effective move, fix the conditions that injure people, is also the legally strongest and the cheapest. A risk where the right thing to do is at once the most protective and the least expensive is a rare gift. The catch: it is also the least visible. A claim that never happens leaves no line on any report, so valuing it takes a deliberate governance choice.

What evidence actually protects you

Due diligence is demonstrated by evidence, not intention. The right evidence *supports demonstration of* due diligence against each element of the duty, it does not "guarantee compliance", but it moves you from assertion to proof.

Due-diligence element	Evidence that supports demonstration
Knowledge	Board/officer training records; a dated note that the s.26A change and the Code were considered at board level; briefings retained.
Operations & hazards	A psychosocial risk register identifying hazards by role/function, dated and reviewed; evidence the assessment drew on real operational knowledge.
Resources & processes	A control plan showing controls at the source where practicable; budget allocated; a funded early-intervention pathway.
Information processes	Consultation records; complaint/near-miss logs with response and timeframe; survey results and what changed because of them.
Compliance processes	Documented alignment to the Code (or a written equivalent-standard justification); policy with version control; defined accountabilities.
Verification	Board reporting cadence with psychosocial risk as a standing item; review/audit evidence; trend data over time; minuted decisions closed out.

THE CONTEMPORANEITY RULE

Evidence persuades in proportion to being dated, routine, and created before the event. A risk register drafted the week after an inspection notice carries almost no weight. The same register, reviewed quarterly for two years with minuted board discussion, is close to decisive. **Build the cadence now.** The value is the audit trail it leaves behind.

Five disciplines that make the evidence hold

- [ ] **Version-control everything.** A control plan with a change history beats an undated PDF every time.
- [ ] **Minute the questions, not just the decisions.** A board recorded asking "show us the verification, not the assurance" is itself evidence of due diligence.
- [ ] **Retain consultation, not just policy.** Policies prove intent; consultation records prove the duty was actually discharged with workers.

- [ ] **Track trends, not snapshots.** The same survey over time, with documented responses, shows a functioning system.

- [ ] **Hold the evidence centrally and durably** so it survives staff turnover. Due diligence that walks out the door with a departing HR manager was never institutional.

FRAMEWORK A

Twelve questions every officer should be able to answer

A board-level due-diligence question set. If you cannot answer one, or cannot point to the evidence behind the answer, that gap is the exposure. Illustrative governance guidance, not legal advice.

#	The question	What a good answer looks like
1	Do we have a current register of our psychosocial hazards, by role or function?	"Yes, reviewed [date]; it identifies hazards including high demands in X and low control in Y." Not "HR handles wellbeing."
2	Which of our roles carry the highest psychosocial risk, and why?	A specific, work-design answer naming roles and the hazard category, not "it depends on the person."
3	What have we actually changed about the work to control these hazards?	Concrete source-level controls, not only resilience training or an EAP.
4	How do workers raise a psychosocial concern, and what happens when they do?	A named pathway, a response timeframe, and evidence concerns were actioned, not "my door is always open."
5	How and when did we last consult workers on psychosocial matters?	Dated consultation with records, and the changes that resulted, not an annual survey nobody acted on.
6	What is our early-intervention pathway before a claim?	A funded, accessible clinical pathway distinct from crisis support, not a shrug toward the EAP.
7	Do we know our psychological-claim trend year on year?	Actual numbers and direction, with commentary, not "the insurer has that."
8	When someone is injured, who coordinates the return to work, against what plan?	A named owner and a written suitable-duties process the GP can certify against.
9	Do we return people into roles where the original hazard has been fixed?	Yes, with the control documented, not back into the conditions that caused the injury.
10	How is psychosocial risk reported to the board, and how often?	A standing agenda item with trend data and minuted decisions, not "it comes up if there's an issue."
11	How do we verify our controls are working, rather than assume they are?	Review/audit evidence and trend monitoring, answering the sixth element of s.27(5).
12	If SafeWork or a coroner asked tomorrow, what could we put on the table?	A short, dated, contemporaneous evidence pack. If the honest answer is "not much," start there.

HOW TO USE THIS

Run it as an agenda item at one board or risk-committee meeting. Score each question **green** (evidenced), **amber** (partial), or **red** (gap). The red and amber answers are your priority work plan, and the act of running the exercise, minuted, is itself due-diligence evidence under elements 1, 5 and 6.

FRAMEWORK B

Mental-injury claim: cost-driver & controllable-lever map

A consolidated reference for the risk committee. Directional industry context only; not a prediction for any individual claim.

Stage	Primary cost / duration drivers	Controllable lever (and s.27 element it evidences)
Notification	Late notification; pre-existing adversarial relationship; no employer contact.	Prompt, supportive first contact. Evidences: information processes (4).
Liability	Causation dispute; investigation; combative experience for the worker.	Contemporaneous records reduce dispute; avoid reflexive contesting. Evidences: compliance + verification (5, 6).
Treatment	Fragmented care; mismatched expectations; worker unsupported.	Clinically-coordinated treatment tied to a return goal. Evidences: resources & processes (3).
Return to work	No suitable-duties plan; return to the unchanged hazard; hostile team.	Written suitable-duties plan into a hazard-controlled role. Evidences: resources & processes (3); operations & hazards (2).
Closure	Premature closure and relapse; unresolved impairment; lingering conflict.	Confirm durable return; fix the underlying work design. Evidences: verification (6).

THE ONE-LINE TAKEAWAY FOR THE BOARD PACK

Every controllable lever in this table sits upstream of the lawyers. By the time a claim is adversarial and litigated, the expensive decisions have already been made. **Govern the first weeks, not the dispute.**

FRAMEWORK C

The one-page officer due-diligence evidence map

The artefact to keep beside the board calendar. Illustrative template, adapt to your structure and confirm with WHS counsel.

Evidence artefact	What to retain	Review cadence
Psychosocial risk register, hazards by role/function, rated, with controls.	Dated versions with change history.	At least quarterly; on material change.
Control plan, controls at the source where practicable; owners; status.	The plan plus evidence controls were implemented.	Quarterly against the register.
Consultation records, how and when workers were consulted; what changed.	Minutes, survey instruments, response logs.	Each consultation cycle; min. annually.
Early-intervention & escalation pathway, the documented pathway; usage.	The pathway document; de-identified usage data.	Annually; after any serious incident.
Return-to-work capability, suitable-duties process; who coordinates.	The process; de-identified claim/RTW data.	Quarterly trend review.
Board reporting, standing psychosocial-risk item; trend data; decisions.	Board/committee minutes and papers.	Every board/risk-committee meeting.
Knowledge & training, officer WHS training; Code/s.26A considered.	Training records; dated board note.	Annually; on regulatory change.
Verification / audit, evidence controls were tested, not assumed.	Audit reports; action close-out records.	At least annually.

*A worked risk-register row (illustrative): **Hazard**, sustained high job demands + low control in a front-line client-facing team. **Exposed**, client-services team; team leaders. **Rating**, High. **Source-level controls**, caseload caps; rostering review; decision-authority delegated; manager capability uplift. **Lower-order controls**, early-intervention clinical pathway; EAP for acute support only, a low-order control that proves nothing about prevention. **Owner/review**, Operations lead; reviewed quarterly by the risk committee. Note where the EAP sits, that ordering is itself part of the defensibility.*

How Unbound Work can help

Unbound Work is the workplace mental-health arm of Unbound Minds, a multi-site Sydney clinical psychology practice with **32+ employed psychologists**. Because there is a real clinical practice behind us, we work across the whole mental-injury continuum: prevention, early intervention, treatment, and clinically-coordinated return to work.

For officers and boards, we help build the parts of the system that demonstrate due diligence: psychosocial hazard identification, source-level control design, early-intervention pathways, and return-to-work coordination that holds the GP, employer and insurer to one recovery plan, **producing evidence that would survive an inspection, not engagement metrics.**

Pressure-test your posture, book a call →