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**FROM SAFETY TO HEALTH:
THE NEW ZEALAND LEGAL RESPONSE ON
WORK-RELATED PSYCHOSOCIAL HARM**

A thesis presented in partial fulfilment of the requirements for the degree of

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Luzanne Oosthuizen

10131170

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Abstract

Despite the widespread international acknowledgement that psychosocial hazards are an important health risk for workers, work-related psychosocial harm still remains relatively unexplored in New Zealand. The limited research within this field continues to focus on the potential underlying reasons for regulation difficulties. A portion of this field that has received considerably less attention is how psychosocial harm at the workplace is recognised in law.

Therefore, this research aimed to explore the legal response in New Zealand to work-related psychosocial harm. This was undertaken by examining 24 court case transcripts retrieved from the New Zealand Legal Information Institute (NZLII) database. This unique and valuable data source provided information on cases that would otherwise be challenging to access. The data were selected from the year 2003 onward following the enactment of the Health and Safety in Employment Amendment Act (HSE Amendment Act) 2002. Transcripts were limited to the Employment Relations Authority (ERA), the Employment Court, and the New Zealand Health and Safety in Employment Decisions in which work-related psychosocial hazards were integral to the case being heard.

The qualitative study's findings, developed using the framework analysis methodology, demonstrated alignment with the regulatory requirements of sections 36, 44 and 45 of the Health and Safety at Work Act (HSWA) 2015. Further, findings uncovered the interrelated influence the Person Conducting a Business or Undertaking (PCBU), the officer (director, partner, or a person occupying a position comparable to that of a director), and the worker have in meeting legislative duties and contributing towards a healthy workplace.

The study has concluded that, through analysing court case transcripts, sufficient evidence is available for the New Zealand regulator, WorkSafe NZ, to investigate and assess psychosocial harm at the workplace with the current legislation. Although amendments to the HSWA 2015 may be beneficial, it is not deemed essential for work-related psychosocial harm court prosecutions.

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Glossary

ACC	Accident Compensation Corporation
Applicant	A person who applies to a court for an order, direction, or decision.
Case Number	CN
DoL	Department of Labour
EAP	Employee Assistance Programme
ERA	Employment Relations Authority
ERA 2000	Employment Relations Act 2000
ESENER-1	Management of psychosocial risks at work: An analysis of the findings of the European survey of enterprises on new and emerging risks
ESENER-2	Management of psychosocial risks in European workplaces: evidence from the second European survey of enterprises on new and emerging risks
EU	European Union
EU-OSHA	European Agency for Safety and Health at Work
FAE	Fundamental Attribution Error
GRWM Regulations 2016	Health and Safety at Work (General Risk and Workplace Management) Regulations 2016
HSE Act 1992	New Zealand Health and Safety in Employment Act 1992
HSE Amendment Act 2002	New Zealand Health and Safety in Employment Amendment Act 2002
HSWA 2015	New Zealand Health and Safety at Work Act
ILO	International Labour Organisation
MBIE	New Zealand Ministry of Business, Innovation and Employment
NZLII	New Zealand Legal Information Institute
OHSBoK	Occupational Health and Safety Body of Knowledge
OSH	Occupational Safety and Health

PAS 1010:2011	Publicly Available Standard: Guidance on the management of psychosocial risks in the workplace. British Standard Institution
PCBU	Person Conducting Business or Undertaking
PRIMA-EF	The European Framework for Psychosocial Risk Management
Primary Intervention	Preventing exposures to hazards that can cause disease or injury
Respondent	The person against whom an application to the court is made (or the opposing party to an appeal)
Secondary Intervention	Responding to disease or injury that has already occurred, aiming to reduce the impact
Tertiary Intervention	Improving the quality of life and reducing the symptoms of a disease
WorkSafe NZ	WorkSafe New Zealand' primary workplace health and safety regulator
WHO	World Health Organisation

Chapter One: Introduction

1.1 Research Orientation

There is widespread acknowledgement that work-related psychosocial harm is an important health risk for workers (WorkSafe New Zealand, 2019c). In recent decades significant changes, closely linked to the organisation and management of work, have taken place in the world of work (Leka & Jain, 2010). The European Agency for Safety and Health at Work (EU-OSHA) recognises work-related psychosocial harm as an emerging work-related safety and health risk (Brunand & Milczare, 2007). Following global trends, the New Zealand Government recognises that psychosocial hazards must be minimised, and health and safety legislation enforced within our workplaces to reduce psychological harm and promote mental health for all New Zealand workers. In fact, it is argued that there is a requirement for workplace interventions towards work-related psychosocial hazards to reduce psychological harm (WorkSafe New Zealand, 2016). The New Zealand regulator, WorkSafe NZ, implies a lack of awareness and prioritisation of psychosocial hazard management within New Zealand (WorkSafe New Zealand, 2019c). The court case prosecution summaries provided by WorkSafe NZ indicates the majority of court hearings under the HSWA 2015 to be central to physical, ergonomic, chemical, and biological hazards. There are limited court case prosecutions within New Zealand where work-related psychosocial hazards were identified as the cause of harm to the worker (WorkSafe New Zealand, 2019d), which is a worrisome omission by WorkSafe NZ.

There is an overall lack of research within New Zealand into the regulatory aspects of work-related psychosocial harm as it is a relatively new field and is considered challenging (Chen, 2016). One focus of the current research was the underlying reasons for regulation difficulties. A recent study suggested that “Despite recent reforms, WorkSafe NZ still does not have the legislative tools or the regulatory standards needed to be able to properly address the problem of stress-related illnesses” (Duncan, 2018, p. 14). In a previous study, Duncan (2016) proposed “legislative reform is needed to begin to tackle the growing challenge of chronic work-related harm problems in New Zealand” (Duncan, 2016, p. 88). Based on the limited research within New Zealand, potential reasons for the lack of work-related psychosocial harm enforcement is due to the perception that there is a need to reform the Health and Safety at Work Act 2015 (Health and Safety at Work Act [HSWA], 2015) or to provide additional regulatory tools (Duncan, 2016, 2018). It is troubling that WorkSafe NZ

does not prosecute psychosocial harm cases due to the impression that legislative reform is needed before charges can be laid.

The New Zealand HSWA 2015 is largely based on the Safe Work Australia Model Work Health and Safety Laws (Safe Work Australia, 2011), but with changes (attached as [Appendix A](#)) to accommodate the differences between the New Zealand and Australia working environments (WorkSafe New Zealand, 2019a). Therefore, comparisons can be drawn between the HSWA 2015 and the Australian Model Work Health and Safety Laws. The Occupational Health and Safety Act 2004 section 21 (1) is part of the Safe Work Australia Model Work Health and Safety Laws. The New Zealand HSWA 2015 section 37 (1) and the Occupational Health and Safety Act 2004 have similarities in providing and maintaining for employees a working environment that is safe and without risks to health and safety, so far as is reasonably practicable (The Australian Industry Group, 2016). Court hearings where psychosocial hazards play a significant role in causing harm to a worker are successfully prosecuted under the Occupational Health and Safety Act 2004 (WorkSafe Victoria, 2020). Although the HSWA 2015 does not directly address psychosocial hazards in the workplace, it has the potential to do so in that companies can be held accountable for failing to prevent harm to the physical and mental health of their workers under the duty to provide a safe and healthy working environment. It can be concluded that the New Zealand health and safety legislation is sufficient in providing the regulatory aspects of law enforcement for psychosocial hazards at the workplace and that legislative reform, as recommended by previous studies (Duncan, 2016, 2018), may not be necessary.

The definition of work-related psychosocial risk is another complexity to this field (Leka et al., 2015). Work-related psychosocial risk factors, hazards, and harm are often used interchangeably, contributing to the difficulty of understanding their full meaning. Additionally, differentially experienced psychosocial hazards are, unlike physical hazards, often invisible to evaluate.

Thus, it is imperative to direct efforts toward addressing the issues of not only understanding but also regulating work-related psychosocial harm within New Zealand. This study is a pragmatic approach to qualitative research exploring work-related psychosocial harm court case transcripts before the New Zealand legal system.

1.2 Research Focus

The study aimed to explore the New Zealand legal response on work-related psychosocial harm. The research gap within the area of work-related psychosocial harm and the New Zealand legal response guided the development of the overall research question: “how is work-related psychosocial harm prosecuted under the current New Zealand HSWA 2015?” Transcripts from court cases heard by the Employment Relations Authority, the Employment Court, and the New Zealand Health and Safety in Employment Decisions were retrieved from the New Zealand Legal Information Institute (NZLII). The use of this unique data source provided a rich and contextualised understanding of an individual’s experience at the workplace. To achieve the research aim of exploring the New Zealand legal response on work-related psychosocial harm, four interrelated research objectives (ROs) were formulated.

RO1: Gain insight into work-related psychosocial harm prosecutions

RO2: Explore enforcement under the HSWA 2015 on work-related psychosocial harm

RO3: Explore the employers’ and workers’ influence on psychosocial harm

RO4: Recognise implications on companies being prosecuted

1.3 Research Structure

Chapter two reviews the literature defining work-related psychosocial harm, followed by contextualising work-related psychosocial hazards as an emerging risk, the impact of work-related psychosocial harm on New Zealand workers, the current mitigating factors New Zealand has in place to control work-related psychosocial harm, and the justification for this research. Chapter three details the research methodology using secondary data from court case transcripts and how the framework analysis was applied to examine the court cases.

Next, chapter four describes the results and discussions organised into categories as it applies to different sections of the HSWA 2015. Finally, chapter five includes the overall findings and conclusions. Limitations and future research areas are also noted before discussing this thesis’s contributions to theory, practice, and policy.

Chapter Two: Literature Review

2.1 Introduction

This research aims to explore the New Zealand legal response on work-related psychosocial harm. The concept of work-related psychosocial harm is often misunderstood. There is a lack of agreement within the academic world regarding a true definition of the term psychosocial risk (Leka et al., 2015). Accordingly, this literature review begins with a background exploring the complex concepts of psychosocial risk to create a definition of work-related psychosocial harm specific to the purpose of the study (section 2.2). With this foundation, the following section 2.3 explores psychosocial hazards. This is followed by the impact of these hazards on workers (section 2.4) and the current New Zealand mitigating factors (section 2.5). The last section focuses on the justification, significance, and contributions for further research (section 2.6).

2.2 Work-related Psychosocial Harm: Interpretations

There is a range of difficulties that are encountered when trying to define work-related psychosocial harm. Broadly, the term psychosocial refers to the interrelationships between individuals' thoughts and behaviours, and their social environment. In literature, outside the Occupational Safety and Health (OSH) field, this term often refers to social environments such as family of origin, socioeconomic status, and education level. While it is important to be aware of individual and non-work psychosocial factors, in the OSH context, psychosocial hazards have come to refer only to hazards created by work and the work environment (Way, 2012).

Work-related psychosocial risks, hazards, factors, and harm are often used interchangeably to reflect the same meaning. Potential reasons for the uncertainty of defining work-related psychosocial harm include the differential nature of psychosocial hazards experienced by different workers; the invisibility of psychosocial hazards unlike, for example, physical, chemical or biological hazards; or that several legal requirements and international standards address only risks and do not explicitly mention psychosocial hazards (Leka et al., 2011). For the purpose of this research, it is important that an understanding of work-related psychosocial harm is developed. A clear definition will support the research direction and create a common understanding of words or phrases being used throughout the study. Thus,

the following section will provide insight into the definition of work-related psychosocial harm.

2.2.1 Work-related Psychosocial Harm - Literature Background

The term psychosocial pertains to “the influences of social factors on an individual’s mental health and behaviour” (Vizzotto et al., 2013, p. 102). Since as early as 1951 (World Health Organisation [WHO], 1951), mental health and behaviour have been a topic of interest to the World Health Organisation (WHO) and the International Labour Organisation (ILO).

Both organisations collaborate towards improving workers’ health, safety, and wellbeing (Burton, 2010). The WHO defines mental health as “the capacity in an individual to form harmonious relations with others, and to participate in, or contribute constructively to, changes in his social and physical environment” (WHO, 1951, p. 4). During the 1953 joint ILO and WHO committee meeting on occupational health, the connotation between mental health and the workplace was discussed (International Labour Organisation & World Health Organisation [ILO & WHO], 1953). It was recorded that:

The attitude of work supervisors will influence the mental health of workers under them. In the selection of supervisors, therefore, as much attention should be paid to their capacity for human leadership as to their technical competence. Special training in human relations is important. The objective of mental health activities is to promote the health and happiness of people at work. The most important way to reach this goal, however, is not the provision of psychiatric services, but the planning of work tasks and patterns. (p.11)

This implies the importance of social and work conditions likely to influence workers’ health. Such work conditions include adequate training for workers, supervisors’ attitude towards workers, human leadership capacity, technical competence, the planning of work tasks, and patterns (ILO & WHO, 1953). In a joint committee meeting in 1986, the ILO and the WHO (ILO & WHO, 1986) introduced the concept of psychosocial factors as:

The interactions between and among work environment, job content, organisational conditions and workers' capacities, needs, culture, personal extra-job considerations

that may, through perceptions and experience, influence health, work performance, and job satisfaction. (p. 3)

More recently, the WHO uses terms such as psychosocial factors and common workplace stressors to describe a work environment consisting of boring and repetitive tasks, production pressure, stress, low pay, lack of recognition, organisational change or conflict, career development, or shift work contributing to workers' mental health (Leka et al., 2003; WHO, 2002).

The ILO has also developed international standards in the field of OSH to guide governments in setting national laws and regulations to enforce their application at the workplace. In the most current ILO 2019 report, the ILO recognises psychosocial harm as an emerging work-related safety and health risk. Issues include, but are not limited to employee isolation, socialisation, access to information, representation, new trends in work organisation, and employer liabilities for illness or accidents arising out of work. The report concluded that issues must be addressed to anticipate and shape a preventative safety and health culture in the future. It also implied that the current health and safety laws, policies, and programmes must be reconsidered either in terms of amendments, or improved implementation (International Labour Organisation [ILO], 2019b).

To ensure a holistic approach and background on psychosocial factors, literature other than the ILO and WHO is also considered. The European Framework for Psychosocial Risk Management (PRIMA-EF), published by Leka and Cox (2008), provides a framework of psychosocial risk management and the promotion of mental health and safety at the workplace (Leka & Cox, 2008). It explains psychosocial hazards as the work environment where job content, workload and work pace, work schedule, control, environment and equipment, organisational culture and function, interpersonal relationships at work, role in organisations, career development, and home-work interface can play a role in influencing a worker's health.

In addition to PRIMA-EF, the European Union (EU) also contributed towards the meaning of work-related psychosocial harm. The EU-OSHA provided the Framework Directive 89/391/EEC on Safety and Health of Workers in 1989 (European Agency for Safety and Health at Work [EU-OSHA], 1989). This directive introduces measures to encourage improvements

in the safety and health of workers. It documents employers' general obligations to ensure workers' health and safety in every aspect related to work and includes psychosocial risks as health and safety risks. The directive refers to the work environment, physical or otherwise, to affect a worker's health and safety.

In 2007, as part of the expert forecast on emerging psychosocial risks related to OSH, the EU-OSHA identified psychosocial risks at the workplace as those aspects in the design, organisation, and direction of work and its' social environment which may cause psychological, social or physical health damages in workers (Brunand & Milczare, 2007). During 2012, the first European Survey of Enterprises on New and Emerging Risks Report (ESENER-1) by the EU-OSHA (Staetsky et al., 2012) uses the term psychosocial hazard to describe:

Those aspects of work design and the organisation and management of work, and their social and environment contexts, which have the potential for causing psychological, social, and physical harm. (p. 15)

During the second European Survey of Enterprises on New and Emerging Risks Report (ESENER-2) in 2018, the EU-OSHA (Vandenheuvel et al., 2018) uses the term psychosocial risk management to describe the number of procedures and measures in place to deal with psychosocial risk.

Further to the EU-OSHA, the British Standards Institution (British Standard Institution [BSI], 2011) developed the Guidance on the Management of Psychosocial Risks in the Workplace (PAS1010:2011). This standard explains psychosocial factors as:

The interaction among job content, work organisation and management, and other environmental and organisational conditions, and the employees' competencies and needs. (p. 2)

It describes psychosocial risk as "the likelihood that psychosocial factors have a hazardous influence on employees' health through their perceptions and experience and the severity of ill health that can be caused by exposure to them" (BSI, 2011, p. 2).

The work-related interactions described by the ILO and the WHO (ILO & WHO, 1986) are consistently referred to throughout several other countries, based on language specific to their work environments. South America introduced regulations to prevent and address psychosocial risks in the workplace (Espada, 2019). These risks stem from the workers' job activities, the type of work shift, or the exposure to severe traumatic events or work-related acts of violence. Additionally, the National Standard of Canada for Psychological Health and Safety in the Workplace introduced a government policy to describe "hazards including elements of the work environment, management practices, and/or organisational dimensions that increase the risk to health" (Mental Health Commission of Canada, 2013, p. 5).

[Appendix B](#) provides a summarised table indicating the different guidance, frameworks, and standards used to describe work-related psychosocial harm. The terminology identifies the expressions used concerning psychosocial risk, factor, hazard, or harm; and any other contributing factors such as health, workplace stressors, mental or occupational health. This is followed by the key definition or meaning outlining the language. By analysing the table in [Appendix B](#), similarities in guidance, frameworks, and standards by the ILO, the WHO, the EU-OSHA, and the British Standards PAS 1010:2011 in the use of words to describe social, environmental, and organisational conditions influencing a worker's health were noted.

These similarities could be due to the Robens Report issued in 1972 influencing the European, Australian, and, in turn, the New Zealand health and safety legislation. The Robens Report arose from concern for the coal industry's poor health and safety record during the mid-1900's (Foster et al., 2014). The Robens Report recommendations were adopted worldwide, including by the ILO, to represent the best practice approach to workplace health and safety. The Robens Model remains the universally preferred approach to legislating for health and safety and is reflected in the recently enacted Australian Model Law (Schmidt-McCleave & Shortall, 2016).

In summary, the words psychosocial risks or factors were used to describe a work environment influencing a workers' health (EU-OSHA, 1989; ILO & WHO, 1986; WHO, 2002). This was replaced by the term psychosocial hazard described in the PRIMA-EF (Leka & Cox, 2008). The term psychosocial hazard was also referred to during the first ESENER-1 report (Staetsky et al., 2012). Although the British Standards PAS 1010:2011 still

refers to psychosocial risk factors, the definition carries a similar meaning (BSI, 2011). Australia and New Zealand both refer to psychosocial hazards as the adverse workplace interactions or conditions of work that compromise a worker's health and wellbeing (WorkSafe New Zealand, 2019c; WorkSafe Victoria, 2004). Furthermore, throughout the literature there is discussion around mental or physical health being influenced by these psychosocial hazards. This can be through, for example, high levels of work-related stress developing health-related impairments (such as mental and behavioural disorders, namely exhaustion, burnout, anxiety, and depression); or other physical impairments (such as cardiovascular disease and musculoskeletal disorders) (ILO, 2016). The EU-OSHA implies that psychosocial hazards have the potential to cause psychological, social, and physical harm (Staetsky et al., 2012). Consequently, 'physical, social, and psychological harm' caused by psychosocial hazards are key concepts for further study.

2.2.2 Defining Work-related Psychosocial Harm Specific to the Study

As discussed in section 2.2.1, the current New Zealand health and safety legislation is largely based on the Safe Work Australia Model Work Health and Safety Laws (Safe Work Australia, 2011). Australia uses the term psychosocial hazard which is derived from the PRIMA-EF (Leka & Cox, 2008). Within this definition psychosocial hazards (adapted from Cox, 1993) include the job content, workload and work pace, work schedule, control, environment and equipment, organisational culture and function, interpersonal relationships at work, role in organisations, career development, and home-work interface (Way, 2012). Therefore, the term psychosocial hazard, as opposed to psychosocial risk or factor, is used as part of the definition and, consequently, throughout this study.

The definition of work-related psychosocial harm needs to consider what type of harm these psychosocial hazards can potentially cause workers. As outlined by ESENER-1 report during 2012, "psychosocial hazards have the potential for causing psychological, social, and physical harm" (Staetsky et al., 2012, p. 15). The definitions and meanings of psychosocial hazards gravitate more towards psychological or social ill-health, as opposed to physical harm, experienced by workers caused by psychosocial hazards. The literature uses words, for example, such as burnout and stress reactions (Leka & Jain, 2010), sleep deprivation, over-medication, depression, anxiety, anger, (Burton, 2010), or in extreme cases suicidal ideation or post-traumatic stress disorder (WorkSafe New Zealand, 2019c) to describe how psychosocial hazards can potentially impact a worker. All of these considered, the HSWA is

clear in defining health as “mental and physical health” (HSWA, 2015, s 16). Additionally, the ILO (2016) implies high work-stress levels can contribute to health-related impairments. These may include mental and behavioural disorders such as exhaustion, burnout, anxiety, depression, and other physical impairments such as cardiovascular disease and musculoskeletal disorders (ILO, 2016). Therefore, to ensure a holistic approach that faithfully represents the diverse literature, the potential influence that work-related psychosocial hazards can have on workers will include psychological, social, and physical harm.

The definition of work-related psychosocial harm for the study’s purpose is to be described as ‘mental or physical ill-health where there is reason to believe that work-related psychosocial hazards played a significant role in causing psychological, social or physical harm.’ The term ‘significant’ within this definition refers to a psychosocial hazard central to the worker experiencing ill-health, instead of a minor contributor. This definition is outlined in [Appendix C](#), providing the meaning and description of each element within this definition, supported by the relevant Act or legislation.

The following sections will examine psychosocial hazards likely to influence a workers’ health (section 2.3) and the impact those hazards can have in causing psychological, social, and physical harm (section 2.4).

2.3 Distinguishing Work-related Psychosocial Hazards

In risk assessment, hazard, risk, and harm are central technical terms. A hazard relates to characteristics of the work environment, which have the potential to evoke adverse effects. A hazard with an unacceptable level of probability can be characterized as a threat, danger, or risk to health and wellbeing (Metzlera et al., 2019). A risk is denoted as the probability that harm will occur under the given circumstances.

Psychosocial hazards have been adopted from the ILO and the WHO (ILO & WHO, 1986) definition of psychosocial factors. The PRIMA- EF acknowledges the ILO and the WHO definition of psychosocial factors (Leka & Cox, 2008). However, it adopts a simpler definition of psychosocial hazards as ‘those aspects of the design and management of work, and its social and organisational contexts that have the potential for causing psychological or physical harm’ (Cox & Griffiths, 1995, 2005; Griffiths et al., 2000). The Occupational Health

and Safety Body of Knowledge (OHSBoK) also refers to the PRIMA-EF when discussing psychosocial hazards (Way, 2012). The OHSBoK is a discipline, shared internationally, where collective occupational health and safety knowledge is studied and enhanced. (Occupational Health and Safety Body of Knowledge [OHSBoK], 2017). With New Zealand following in the footsteps of the Safe Work Australia Model Work Health and Safety Laws, it is accepted to also refer to the PRIMA-EF framework when discussing work-related psychosocial hazards during this research (WorkSafe New Zealand, 2019a)

The PRIMA-EF framework for psychosocial risk management describes job content, workload and work pace, work schedule, control, environment and equipment, organisational culture and function, interpersonal relationships at work, role in organisations, career development, and home-work interface as work-related psychosocial hazards with the potential to cause harm (Leka & Cox, 2008). Consequently, Cox and Griffiths (2010) describe psychosocial hazards as those work factors stemming from design, organisation, and management of work in their societal and environmental context, which have the potential to induce physical or psychological harm (Cox & Griffiths, 2010). Table 1 illustrates the psychosocial hazards as described by the PRIMA-EF, adapted from Cox (1993).

Table 1. Psychosocial hazards (Adapted from Cox, 1993)

Job Characteristics	Nature of Work
Job content	Lack of variety or short work cycles, fragmented or meaningless work, under use of skills, high uncertainty, continuous exposure to people through work
Workload and work pace	Work overload or under load, machine pacing, high levels of time pressure, continually subject to deadlines
Work schedule	Shift working, night shifts, inflexible work schedules, unpredictable hours, long or unsociable hours
Control	Low participation in decision making, lack of control over workload, pacing, shift working, etc
Environment and equipment	Inadequate equipment availability, suitability or maintenance; poor environmental conditions such as lack of space, poor lighting, excessive noise
Organisational culture and function	Poor communication, low levels of support for problem solving and personal development, lack of definition of, or agreement on, organisational objectives
Interpersonal relationships at work	Social or physical isolation, poor relationships with superiors, interpersonal conflict, lack of social support
Role in organisation	Role ambiguity, role conflict, and responsibility for people
Career development	Career stagnation and uncertainty, under promotion or over promotion, poor pay, job insecurity, low social value to work

Job Characteristics	Nature of Work
Home-work interface	Conflicting demands of work and home, low support at home, dual career problems

There is a reasonable consensus in the literature on the nature of work contributing to psychosocial hazards. Aspects of work design, how the work is organised, and how the work is managed can have the potential to cause stress (Leka & Cox, 2008). Therefore, psychosocial hazards are also referred to as psychosocial stressors.

2.3.1 Work-related Psychosocial Stressors

A 2016 British study indicates that psychosocial stressors are the dominant hazards in the work environment and that physical hazards are decreasing in significance, while psychosocial hazards are increasing (Armstrong, 2016). Stressors are defined as those events that are evaluated as harmful or threatening by the individual and that elicit a stress response from the body. Stress affects everyone in different ways; it has an individualistic nature. Worker tolerance to stressors varies considerably. What may be perceived as a stressor by one person may have no effect on another (Blonna, 2012). The manifestation of stress is the result of many different factors. These include but are not limited to an individual's personality type, their ability to be flexible, their understanding and use of avoidance or coping mechanisms, an individual's sleep and behaviour patterns, as well as their cognitive style, and how they learn (Patching & Best, 2014). Stress is characterised by varying degrees of distress and anxiety and associated with high-arousal cognitive states that, if sustained, lead to mental fatigue and sleep disruption. At the physiological level, stress is characterised by metabolic changes that prepare the organism to survive a stressor - notably the mobilisation of the sympathetic nervous system (Lazarus, 1993).

Therefore, not all workers experience organisational aspects in the same way, with workers' needs, competencies, perceptions, and experiences mediating the nature of the health outcome. Figure 1, adapted from Kompier and Marcelissen (1990), illustrates how individual worker characteristics influence the impact on health when exposed to workplace stressors (WorkSafe New Zealand, 2019c, p. 11).

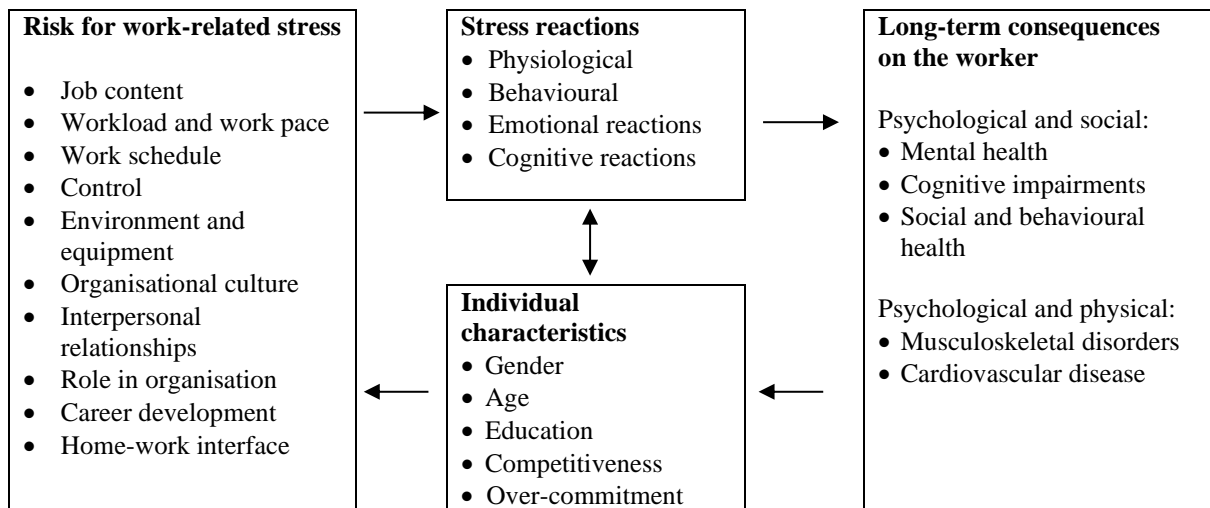


Figure 1. Individual characteristics during the exposure to stressors in the workplace
(Adopted from Kompier and Marcelissen, 1990)

To conclude, when demands exceed a worker's abilities and knowledge, it can pose a threat and result in stress. However, if a worker is able to perceive this as an opportunity to work towards achieving a state of balance, a situation of learning and development may arise (Eurofound, 2007).

Adequate controls should be applied to manage the work environment actively. Although little real scientific evidence is available on stress management's effectiveness at an organisational level, a significant amount of good practice has been described. The commitment of the organisation itself and the involvement of both workers and management appear to be crucial for the success of stress management activities, although other factors are also identified as important (Eurofound, 2007). The lack of effective management at an organisational level and implementation of controls to actively address psychosocial hazards at the workplace could be due to the changing work environments. New forms of work have evolved over time, creating different and challenging work environments (Leka & Cox, 2008). These changes give rise to new hazards which have been labelled emerging risks, discussed in section 2.3.2.

2.3.2 Work-related Psychosocial Hazards: An Emerging Risk

The changing nature of the world of work and the transition of modern work affect workers' health and wellbeing (Leka & Cox, 2008). Psychosocial stressors, or hazards, have been

labelled as an emerging risk. Within the OSH context, an emerging risk is defined “as any occupational risk that is both new and increasing” (Brunand & Milczare, 2007, p. 13).

The EU-OSHA sets up a risk observatory to explore emerging OSH risks. The top 10 emerging psychosocial risks revealed by experts’ forecasts are related to new forms of employment contracts and job insecurity, the ageing workforce, work intensification, high emotional demands at work, and poor work-life balance (Brunand & Milczare, 2007). These 10 emerging risks arise from the restructuring of organisations and organisation of work, where downsizing of organisations is often accompanied with subcontracting and outsourcing and, in many instances, shifting the risk to these providers. Other changes include expectations for workers to accept flexible working arrangements, have a range of skills, and be open to upskilling throughout their working lives. Additionally, workers are exposed to the emergence of working from home, increased use of information and communication technology, and expectations for constant connectivity and immediately responding without delay. Non-standard and temporary employment, jobs with irregular hours such as shift work and demand-driven or insecure jobs, including seasonal work, are likely to proportionally increase and generally involve low levels of job certainty (WorkSafe New Zealand, 2019c). These are only but a few psychosocial hazards emerging from the significant changes in the world of work due to demographic shifts, increased economic globalisation, and rapid technological change (Brunand & Milczare, 2007).

The identification of emerging risks by the European Risk Observatory is aimed at early intervention to prevent any possible negative effects of these risks on workers’ safety and health. Employers have the duty to actively manage and assess psychosocial hazards at the workplace to ensure a healthy and safe work environment. A comprehensive approach by organisations to emerging risks and new prevention patterns is necessary to face the challenges arising from a changing world of work. Failure to manage emerging risks will impact workers’ mental health and wellbeing. The impact of psychosocial hazards on workers’ mental or physical health will be discussed next.

2.4 The Impact of Work-related Psychosocial Hazards

A psychosocial risk constitutes the likelihood of a psychosocial hazard to cause harm (Leka et al., 2015; Metzlera et al., 2019). Harm concerns the type and nature of the impact a risk

may provoke (European Commission [EC], 2016; Leka & Jain, 2010). The EU-OSHA includes psychological, social, and physical harm that can potentially be caused by aspects of work design and the organisation and management of work and their social or environment contexts (Griffiths et al., 2000; Staetsky et al., 2012). This section will consider and discuss the impact of work-related psychosocial hazards contributing to diseases or harm.

According to the WHO, occupational or work-related diseases can be described as any disease contracted primarily as a result of exposure to risk factors arising from work activity (WHO, 2020). Exposure to psychosocial hazards in the workplace is linked to poor mental health (Bonde, 2008; Stansfeld & Candy, 2006), increased health detriments such as increased smoking (Kouvonen et al., 2005), alcohol consumption (Kouvonen et al., 2008), musculoskeletal disease (Bongers et al., 2002; Wei et al., 2006) and poor physical health such as coronary heart disease or even death such as cardiovascular mortality (Kivimäki et al., 2002).

Stress is the second most frequently reported work-related health illness in Europe where 50-60% of all lost working days are attributed to work-related stress. The number of people suffering from stress-related conditions caused or exacerbated by work is likely to increase (ILO, 2019a). According to the EU-OSHA, work-related stress is experienced “when the demands of the work environment exceed the workers’ ability to cope with or control them” (EU-OSHA, 2009, p. 14). Furthermore, the EU-OSHA literature review on work-related stress and psychosocial risks outlines the relationship between work-related stress and psychosocial risks and mental health problems such as depression, cardiovascular disease, musculoskeletal disorders, and diabetes (EU-OSHA, 2014). Psychosocial risks and their associated effects on health will impose a significant financial burden on individuals, organisations, and societies (EU-OSHA, 2009). A recent systematic review on the cost of work-related stress examined quality assessments completed by Australia, Canada, Denmark, France, Sweden, Switzerland, the United Kingdom, and the 15 EU countries. The report indicated that the total estimated cost of work-related stress was considerable, ranging substantially from US\$221.13 million to \$187 billion (Hassard et al., 2017). Productivity related losses are observed to proportionally contribute to most of the total cost of work-related stress between 70 to 90%, with healthcare and medical costs constituting the remaining 10 to 30%. The evidence suggests a sizable financial burden imposed by work-related stress on society (Hassard et al., 2017).

Closely linked to work-related stress is the concept of job strain, which, like work-related stress is characterised by working conditions in which workers face high demands, but have little control or influence over their work environments (Stansfeld & Candy, 2006). Results from the Fifth European Working Conditions Survey found a significant proportion of workers being exposed to numerous job strain. For example, 62% of surveyed workers reported working under tight deadlines, 59% at a fast pace, 51% experienced organisational change, and 24% worked more than 40 hours a week (Parent-Thirion et al., 2012). Job strain, the combination of high job demands and low control at work, is one of the most widely studied definitions of psychosocial stress (Steptoe & Kivimäki, 2012).

The relation between job strain and coronary heart disease was studied using a meta-analysis of published and unpublished studies. This study shows that job strain is associated with a small, but consistent, increased risk of an incident event of cardiovascular heart disease (Kivimäki et al., 2012). Another study reviewing evidence from Europe, the USA, and Japan suggests that work stressors, such as job strain and long working hours, are associated with a moderately elevated risk of incident coronary heart disease and stroke (Kivimäki & Kawachi, 2015). A multicohort study of 90,164 participants suggests individuals with an imbalance towards effort and reward at the workplace have an increased risk of coronary heart disease (Dragano et al., 2017). In addition to coronary disease are musculoskeletal diseases caused by work-related psychosocial hazards. Several studies support an increasing body of evidence, linking psychosocial factors and mental wellbeing at work with an increased likelihood of trouble with the musculoskeletal system (Bongers et al., 2002; Wei et al., 2006).

Within New Zealand, a worker is more likely to die of a work-related disease than a safety incident, such as a fall. Every year approximately 600 to 900 people die from work-related diseases in New Zealand, thus an estimate of 15 people per week (WorkSafe New Zealand, 2016). The number of people who die of a work-related disease is approximately 10 times the number who die from work-related instant trauma. Approximately 5000 hospitalisations each year are due to work-related ill-health (WorkSafe New Zealand, 2017c). Many more cases of work-related illness are unreported. According to WorkSafe NZ, work-related disease is the impact that work can have on people's health. In the past, this has been referred to as occupational health. The Ministry of Business, Innovation, and Employment (MBIE) identifies cancers, cardiovascular disease, respiratory systems disease, mental disorders, and

nervous systems disorders as the main contributors to work-related mortality (Ministry of Business Innovation and Employment, 2018).

Business NZ and Southern Cross Health Society undertook a Wellness in the Workplace Survey, outlining the connections between absenteeism, sickness, costs, and related workplace issues and practices within New Zealand (Business New Zealand & Southern Cross Health Society, 2019). An absent worker typically costs the employer between \$600 to \$1000 per year. Time lost to absence averaged 4.4 days per worker in 2016, increasing to 4.7 days per worker in 2018. WorkSafe NZ acknowledges poor mental health from work-related psychosocial hazards can lead to work-related stress, anxiety, or depression (WorkSafe New Zealand, 2017b).

Stress is often described as being associated with emotions such as anger, anxiety, and depression (Cox, 1978). Evidence suggests that stress, anxiety, and depression are inter-related and contribute to impoverished mental health (Cooper, 2005). Responses may include physiological reactions such as increased heart rate, blood pressure, hyperventilation, or emotional responses such as feeling nervous or irritated. These reactions and feelings are associated with anxiety and depression. It may also result in cognitive responses such as reduced attention or forgetfulness, and behavioural reactions such as aggressive behaviour or making mistakes (Eurofound, 2007).

It can be concluded that there is an inter-relation link between work-related psychosocial hazards and mental or physical health problems. However, this is a relatively new field of study and further exploration of the relationship is needed.

At present, the literature review provides a comprehensive understanding of work-related psychosocial harm (section 2.2), the psychosocial hazards contributing to workers' mental or physical health (section 2.3), and the impact of psychosocial hazards potentially causing physical, psychological, or social harm (section 2.4). The remaining sections will consider the mitigating factors New Zealand has in place to administer work-related psychosocial harm (section 2.5) and, lastly, research in this field and the potential for further study (section 2.6).

2.5 Mitigating Factors by the NZ Government Against Work-related Psychosocial Harm

In 2013 the New Zealand Government appointed WorkSafe NZ as New Zealand's primary work health and safety regulator over workplace health and safety activities. WorkSafe NZ's function as the regulator is to educate, engage, and enforce duty holders to comply with the requirements outlined in the HSWA 2015 (WorkSafe New Zealand, 2018c). Toolkits and resources are published by WorkSafe NZ to support HSWA 2015, for example, the bullying and harassment toolbox (WorkSafe New Zealand, 2018a). The WorkSafe NZ annual report 2018 to 2019 provides insight into WorkSafe NZ's engagement in assessing health and safety practices, investigating events, reviewing concerns, and designing an evidence-based approach to addressing psychosocial hazards at work (WorkSafe New Zealand, 2018b).

WorkSafe NZ has also issued the WorkSafe position on work-related occupational health (WorkSafe New Zealand, 2017e). It sets out the expectations of duty holders in following the work-related health requirements of the HSWA 2015 and the Health and Safety at Work (General Risk and Workplace Management) Regulations 2016 (GRWM Regulations, 2016).

The HSWA 2015 and the GRWM Regulations 2016 strengthen the requirements for Person Conducting Business or Undertaking (PCBU) to provide more focus on protecting the health of workers (WorkSafe New Zealand, 2017d). The difference between mandatory and voluntary duties or activities of a PCBU to prevent work-related harm to workers' health and safety is illustrated using the 'continuum from workplace health and safety protection through to the promotion of workplace health and wellbeing' (WorkSafe New Zealand, 2017c). Wellbeing, health promotion, and health and safety protection all fall within the mandatory spectrum, where WorkSafe NZ may take enforcement action consistent and proportionate to the risk of harm.

WorkSafe NZ's strategic plan for work-related health 2016 to 2026 explains the outcomes needed by 2026 to improve awareness, attitudes, and behaviours around work-related health and better management of work-related health risks and reduced exposures to health hazards. It states that the aims for 2026 are to focus on "encouraging and supporting significant and sustainable improvements in work-related health and health-related safety risk management across the health and safety system" (WorkSafe New Zealand, 2016, p. 23). Relatedly, the

New Zealand Government has introduced a Health and Safety at Work Strategy 2018 to 2028 addressing work-related health, including mental health, as a priority to manage health and safety hazards effectively and proportionately (Ministry of Business Innovation and Employment, 2018).

WorkSafe NZ also expects PCBUs to have effective systems for protecting worker health, both physical and mental, from work-related factors before implementing activities to promote general health and wellbeing. Without enforcement or prosecution under the HSWA 2015, there will be insufficient accountability for PCBUs, limited publicity against duty holders, and inadequate workplace environment improvements addressing psychosocial harm. The WorkSafe NZ prosecution policy, published in December 2019, describes the high-level approach WorkSafe NZ uses regarding prosecution. Each prosecution recommendation will be reviewed by a prosecutor, either within WorkSafe NZ or externally, to ensure that the ‘test for prosecution’ is met. The prosecution test is a two-part process, made up of the evidential test and the public interest test. Both parts of the test for prosecution must be met in order for a prosecution to be commenced (WorkSafe New Zealand, 2019b).

It is the duty of WorkSafe NZ to regulate that PCBUs address physical, ergonomic, chemical, biological, and psychosocial risks. However, since introducing the HSWA 2015, court summaries published by WorkSafe NZ are limited to mainly physical, ergonomic, chemical, and biological risks (WorkSafe New Zealand, 2019d). There is a gap when it comes to the final step of enforcement of psychosocial hazards under the HSWA 2015. The next section will explore that gap for potential further research.

2.6 Further Research

2.6.1 Background of Work-related Psychosocial Harm Research

There has been growing recognition of the influence of work organisation and psychosocial hazards on occupational health and safety (Johnstone et al., 2011). During the ILO Conference in 2003, psychosocial hazards were the main discussion point. It was suggested that the impact of psychological factors on worker safety and health, stress at work, job insecurity, and relations with superiors or colleagues must be considered to create a healthy work environment. It was concluded that undertaking a comprehensive analysis of law and

practice, particularly best practices in this area, would be a prerequisite for assessing possible future ILO standard-setting action (ILO, 2003).

Proving that a psychological illness is work-related can be difficult and compensation claims based on psychological illnesses are more likely to be disputed by employers (Wyatt & Lane, 2017). A qualitative study by Brijnath et al. (2014) was conducted to manage mental health claims and return to work. The results indicate that mental health claims are too complex to manage because of initial assessment and diagnostic difficulties related to the illness's invisibility.

Globally, the research conducted by the ILO indicates several challenges of regulating work-related psychosocial harm. These include the lack of regulator resources such as staff, time or money; lack of appropriate expertise; poor integration at enterprise and policy level; inadequate enforcement of regulation; lack of specific regulations; the sensitivity of the issue; lack of awareness; limited understanding of psychosocial factors and work-related stress (ILO, 2016). An international overview of these regulatory difficulties suggests that causes include challenges for specifying standards; deficiencies in regulation; psychosocial hazards being invisible and difficult to assess; resourcing, recruitment, and training constraints for regulator inspectors; and fears of victimisation amongst workers (Lippel & Quinlan, 2011).

Research into the regulatory aspects of work-related psychosocial harm within New Zealand is challenging and considered a relatively new field, with most research focusing on the underlying reasons for regulation difficulties (Chen, 2016). There had surprisingly been no research investigating how the HSWA 2015 can be applied to prosecuting work-related psychosocial harm. The limited New Zealand research around this is more focused on the shortcomings of the HSWA 2015 than the possible application of the Act. WorkSafe New Zealand (2019) states that “the research record in New Zealand is weak in terms of workplace context and the social and cultural dimensions within which psychosocial harm arises” (WorkSafe New Zealand, 2019c, p. 9). This signals the need to understand the current New Zealand legal response on psychosocial harm at the workplace.

Research on New Zealand's legal response towards work-stress-related illnesses, especially depression and cardiovascular disease (Duncan, 2018), uses a combination of interdisciplinary and applied methods to consider the law in context. Duncan (2018) suggests

that healthy work's regulatory standards need to be established to address chronic work-related harm. The study implies that the “problems are not in the general duties, but rather in the lack of enforcement and regulations sitting beneath those duties” (Duncan, 2018, p. 14). Duncan further states that “WorkSafe New Zealand still does not have the legislative tools or the regulatory standards needed to be able to properly address the problem of stress-related illnesses” (2018, p. 14). By comparing the HSWA 2015 and the Australia Model Work Health and Safety Laws (Safe Work Australia, 2011), as discussed in chapter 2.2, there is reason to believe similar reparation can be sought under the HSWA 2015 without reform. The study aims to investigate how the HSWA 2015 can be applied in handling work-related psychosocial harm cases, as opposed to the potential shortcomings of the HSWA 2015.

2.6.2 Justification for Further Research

There is widespread acknowledgement that psychosocial hazards are a significant health risk for workers (WorkSafe New Zealand, 2016). The New Zealand Government recognises psychosocial hazards must be minimised within our workplaces. In fact, it is argued that there is a requirement for workplace interventions towards work-related psychosocial harm to reduce psychological harm (WorkSafe New Zealand, 2019c). However, since the enactment of the HSWA 2015 the WorkSafe NZ prosecutions summary indicates most court hearings are central to physical, ergonomic, chemical, and biological hazards. There are limited court hearings where psychosocial hazards played a significant role in causing harm to workers while at work (WorkSafe New Zealand, 2019d). Research has explored the potential reasons for the lack of work-related psychosocial harm law enforcement.

Current research, discussed above, implies that the HSWA 2015 does not directly address psychosocial hazards in the workplace and that legislative tools or the regulatory standards needed to be improved to be able to properly address the problem of stress-related illnesses (Duncan, 2018). However, as the HSWA 2015 reflects the Australia Model Work Health and Safety Laws, comparisons in cases can be drawn. Court hearings where psychosocial hazards played a significant role in causing harm to a worker have been successfully prosecuted under the Occupational Health and Safety Act 2004 (WorkSafe Victoria, 2020). The New Zealand HSWA 2015 section 37 (1) and the Occupational Health and Safety Act 2004 section 21 (1) have similarities in providing and maintaining for employees of the employer a working environment that is safe and without risks to health and safety, so far as is reasonably practicable. By drawing such comparisons, it can be concluded that the New Zealand health

and safety legislation, similar to the Occupational Health and Safety Act 2004, is sufficient in providing the regulatory aspects of law enforcement for psychosocial harm at the workplace. This creates an opportunity to be further examined.

Furthermore, the New Zealand health and safety legislation is similar to most European countries where there is no specific legislation on psychosocial hazards such as there is legislation for chemical factors, noise levels, or work equipment. This does not necessarily mean that there is a legal gap within these European countries because, for psychosocial hazards, many preventive and protective measures regarding the health at work are applied by using appropriate legislation concerning general risks in the workplace (Toukas et al., 2015).

Therefore, the research aims to explore this potential by addressing how the HSWA 2015 can be applied to prosecute work-related psychosocial harm, rather than how the Act can be improved to accommodate work-related psychosocial law enforcement.

2.6.3 Research significance and contributions

The significance of this research is three-fold. Firstly, it addresses the research gap of how the current New Zealand health and safety legislation, without any amendments, can potentially be applied in handling work-related psychosocial harm cases.

Secondly, the research supports the New Zealand regulator, WorkSafe NZ, in guiding work-related psychosocial enforcement.

Lastly, my research strengthens the body of local evidence by exploring the workplace context within which psychosocial harm arises.

Chapter Three: Methodology

3.1 Study Overview

This study takes a pragmatic approach to qualitative research exploring work-related psychosocial harm court case transcripts before the New Zealand legal system. The study aims to explore how work-related psychosocial harm cases provide insight into enforcement under the HSWA 2015.

This chapter will detail the secondary data approach taken (section 3.2) as outlined by Bryman and Bell (2019), including the ethical considerations of secondary data (section 3.3). Next is an explanation of how the secondary data was retrieved from the NZLII and filtered using specific criteria (section 3.4). This chapter ends by describing the framework data analysis procedure (section 3.5).

3.2 Research Design

Both primary and secondary data approaches were considered as different methods to collect information on the sensitive issue of mental or physical health harm cases. Primary data are collected for the specific analysis in question where the questions are tailored to elicit the data that will help with the specific study (Bryman et al., 2019). Primary data's advantage is its validity and credibility as it is designed and carried out for the research's main purpose (Hox & Boeije, 2005). Consideration was given to primary data through interviewing participants, using surveys, or direct observations where workers are exposed to psychosocial harm at the workplace to gain information on their expectations or experience of the legal response. However, the sensitive issue of mental health harm at the workplace could create ethical concerns where participants may experience discomfort, embarrassment, or further psychosocial harm. Another disadvantage is that purposive sampling of individuals with certain characteristics could propose a challenge in finding a suitable number of participants. Therefore, collecting data by means of interviewing, surveys or observation was not deemed a suitable technique.

Alternatively, data can be obtained from "already existing data where the researcher was not involved in the collection of those data for purposes that likely were not envisaged by those responsible for collecting the data" (Bryman et al., 2019, p. 295). It can also be explained as data collected by someone else for some other purpose (Hox & Boeije, 2005). Technological

advances have led to vast amounts of data that has been collected, compiled, and archived, and that is now easily accessible for research (Johnston, 2014).

The most significant advantage of such secondary data is that it has already been collected and is ready to be analysed. Other advantages of secondary data are the high level of accessible information, cost-effectiveness, high-quality data, and the convenience it provides, thus conserving time and resources (Hofferth, 2005). For this study's purpose, employment court case transcripts were sourced as they provide a unique view into the sensitive issue of work-related psychosocial harm. Court case transcripts are published following decisions made by the judiciary, in response to one or more grievances that have been brought by (often former) workers against their employer. The level of detail provided in these transcripts varies, with document lengths varying from only a few pages to dozens. Generally, a balanced account is sought from each party with circumstances around the incidents that lead to grievances outlined in detail.

The secondary analysis disadvantages are that the data were not collected to answer the specific research question and lack sufficient information (Smith, 2008). To overcome this concern, the data were evaluated against the research question criteria while keeping in mind the aim for which they were originally collected.

3.3 Ethical Considerations

Before conducting research, all proposed studies must undergo the Massey Human Ethics application where research, teaching, and evaluation activities which involve human participants are considered (Massey University, 2019). During this process, potential risks relevant to the proposed research are identified and considered by the researcher.

The main ethical concern with using secondary data, following the Massey Code of Ethical Conduct (Massey University, 2017), is around potential harm to individual subjects identified in the original data. The data gathered in this study's context is considered public and available for research purposes, as opposed to personal and private information. The data is freely available on the Internet, and therefore, the permission to further use and analyse it is implied (Tripathy, 2013).

However, to address the above ethical concern, a case numbering system was used for all data collected from the NZLII to mitigate personally identifiable data being brought to the reader's attention. A further measure to protect and respect the court cases' privacy was to replace people's names with their industries, keeping individuals anonymised. These measures ensured adherence to the database's privacy policies and the Massey University Ethical Code of Conduct (Massey University, 2017).

3.4 Secondary Data Collection

3.4.1 New Zealand Legal Information Institute

The New Zealand Legal Information Institute (NZLII) database provides a rich and novel data source of exclusive jurisdiction. It contains the decisions of judges in matters before a court or tribunal. In each decision, the judge recounts the case's facts, the relevant law in the circumstances, and then discusses how it applies to the relevant facts (Adlam, 2017).

To ensure the cases are related to the workplace, only cases from the Employment Court, Employment Relations Authority (ERA), and New Zealand Health and Safety in Employment Decisions were considered. The Employment Court has exclusive jurisdiction to hear and determine proceedings founded on an employment contract and determine challenges against the ERA. The Employment Relations Act 2000 is currently the most commonly utilised statute for workers seeking compensation for hurt and humiliation as a result of the employer's failure to adequately address a bullying-related complaint (Blackwood et al., 2013). It acts through the enforcement of employment standards by giving power to WorkSafe Inspectors, the ERA, and the Courts. Even though the level of detail provided in the court hearings can fluctuate, most cases provide insight into the New Zealand legal framework and offer opportunities to explore enforcement under the HSWA 2015. The court hearings generally question the interpretation of the law; have jurisdiction to address poor health and safety practices; provide insight into the reporting process of psychosocial harm at the workplace; indicate steps followed during prosecution, and record an outcome such as penalties and fines.

3.4.2 Initial Search Using Mental or Physical Ill-health Keywords

To collect relevant data for the study, it is important to ensure appropriate search words are entered when using the NZLII database. This section will explain how specific search words

were selected by analysing the terminology used for mental or physical ill-health globally and within New Zealand.

Health captures a broad concept of an individual's physical, social or psychological health and wellbeing (Mental Health Commission of Canada, 2013). Everyone has mental health in the same way that everyone has health. At various times, the nature of one's mental health can change. This health element can be referred to as psychosocial or psychological health and wellbeing (Caponecchia, 2016). Globally, words such as anxiety or sleep disorders, severe stress, mental distraction, mental illness or harm, fatigue, emotional and mental reaction, or exhaustion are used interchangeably to describe a negative connotation to mental health (Leka & Jain, 2010). The Mental Health Foundation NZ (2020) explains mental health problems as difficult experiences or feelings that go on for a long time and affect our ability to enjoy and live our lives in the way we want to.

The HSWA 2015 defines health as both mental and physical health. Mental ill-health can include adverse health conditions such as fatigue, anxiety, depression, or mental disorders (WHO, 2002). Work-related symptoms of common mental disorders may include depression, anxiety, and burnout (Leka & Jain, 2010). Mental harm could be caused by work-related stress or as a result of mental fatigue, as described in the HSE Amendment Act 2002.

On the other hand, health also includes physical health (HSWA, 2015) where health is defined as both mental and physical health. Physical ill-health or impairments include, for example, cardiovascular disease or musculoskeletal disorders (ILO, 2016).

Search words to describe mental or physical ill-health were entered into the NZLII database using no specific order. The words 'fatigue' and 'burnout' were searched separately with accurate and relevant results. Stress, depression, and anxiety were also entered separately. This resulted in many duplicate court hearings with overlapping keywords. To gain a rich and contextualised understanding of workers' responses when exposed to psychosocial stressors at the workplace, the term work-related stress was further refined. Since fatigue was already used with successful results, stress was used as a search parameter for depression and anxiety. This provided a more concise number of cases without overlapping terms. Mental AND harm (HSE Amendment Act, 2002) as well as psychological AND harm (EU-OSHA, 2012). These 6 searches totalled to 912 (n=912) cases. Additional searches were done using

‘wellbeing’, however no new case transcripts were found, and additional searches did not provide any new results.

During research data collection, theoretical research saturation can be reached. This applies when additional information ceases to be necessary and any new findings do not alter the comprehension of the researched phenomenon (Corbin & Strauss, 2008). Therefore, searches done using the word ‘wellbeing’ were abandoned because of overlapping results of stress, depression, and anxiety. The abandoned search results are attached as [Appendix D](#).

In summary, the following search terms were employed resulting in 912 cases. The search words are illustrated in figure 2, section 3.4.6.

- Fatigue
- Burnout
- Stress AND depression
- Stress AND anxiety
- Mental AND harm
- Psychological AND harm

3.4.3 Data Filter Criteria One - Dates From May 2003 to July 2019

The selected cases (n=912) were further refined by restricting the search to the dates where current legal terminology was being used.

Prior to 2003, under the HSE Act 1992, there was no reference to work-related stress as a potential hazard to harm workers at the workplace (HSE Act, 1992). The HSE Act 1992 was amended to the HSE Amendment Act 2002 (HSE Amendment Act, 2002). Changes included repealing the definitions of the terms of harm and hazard to include work-related stress and mental fatigue. Therefore, only court descriptions since 2003 were considered to explore how New Zealand jurisdiction has addressed psychosocial harm at the workplace through the period since enactment of the HSE Amendment Act 2002 and, more recently, the HSWA 2015.

The data from 2003 refers to work-related stress or mental harm and provides insight into psychosocial harm’s legal response at the workplace. Using the search words as described in

section 3.4.2 and filtering it by dates from May 2003 until the end of July 2019 (at the time of writing), the court case transcripts went from 912 to 788 cases, omitting 124 cases.

At this point, it was noted that duplicate court hearings were present. Duplicate court hearings where cases returned to court for additional hearings (n=35) were removed, leaving 753 cases. It was also noted that the repetition of some cases appeared under different search words. In cases where more than one search word appeared, it was removed from the one group where the search word appeared less and placed with the group where the search word appeared more frequently. All cases (n=753) were verified, and a number of duplicate cases (n=211) were removed. This resulted in a total of 542 cases.

3.4.4 Data Filter Criteria Two – Refine by Keyword ‘Health’

To ensure that the final cases for analysis provided sufficient insight into the legal response under the HSWA 2015 concerning the worker’s health, it was decided to apply a second filter criterion limiting the result to health-specific cases.

As work-related psychosocial hazard or risk is an adverse workplace interaction that compromises a worker’s health (WorkSafe New Zealand, 2019c), the second filter criterion was applied to eliminate cases where the word ‘health’ was not included in the data. This resulted in the removal of 363 cases, which left 179 remaining cases.

3.4.5 Data Filter Criteria Three – Psychosocial Hazards

Consistent with the research purpose, only cases where psychosocial hazards played a significant role were considered. The cases needed to meet the criteria where psychosocial hazards played a significant role in causing mental or physical ill-health. During this filter criteria, the cases were selected where a psychosocial hazard was the main theme to the ill-health and, therefore, using the term ‘significant role’.

After applying the first two filter criteria the cases (n= 179) were read and re-read to ensure one or more psychosocial hazards played a significant role. For example, during CN 20 workload played a significant role where:

‘(Company) had unrealistic expectations and (applicant’s) workload was excessive. (Applicant) expected to work overtime without payment and perform tasks on public holidays. (Applicant) became overwhelmed and anxious every Sunday night at the

prospect of the week ahead. (Applicant) was not sleeping or over-sleeping at weekends and always thinking about work.’ – CN 20

A case that did not meet criteria due to the worker being exposed to physical work hazards at the company, leading to injury and emotional stress, stated:

‘(Company) failed to take all practicable steps to ensure that (applicant) was not harmed (at work). (Applicant) fell and suffered fractures to the humerus bone and left shoulder, together with bruising to other areas of her body. (Applicant) experienced emotional harm as a direct result of the accident.’ Case No 25

In this case, the emotional stress at work was caused by physical safety hazards at the workplace, in example, lack of ventilation, as opposed to mental ill-health hazards such as excessive workloads, job content, work schedule, organisational culture and function, interpersonal relationships at work, role in the organisation, or career development. In these cases, harm was caused by hazards other than psychosocial hazards and, therefore, the cases do not provide insight into psychosocial hazards as the main causes of harm.

After applying this final filter criterion of the definition of work-related psychosocial hazards at the workplace, another 155 cases were removed. The cases reduced from 179 to a final number of 24.

3.4.6 Data - Summary

To retrieve work-related psychosocial harm cases held by New Zealand jurisdiction, cases were selected from the NZLII database using search words in accordance with the WHO, the PRIMA-EF, the HSE Amendment Act 2002, and the HSWA 2015. The cases from the selected search words identified a high number of cases (n=912). To refine and improve more accurate results for the purpose of the study, three search criteria were applied. This is illustrated in figure 2, where the final number of cases for further analysis totalled to 24.

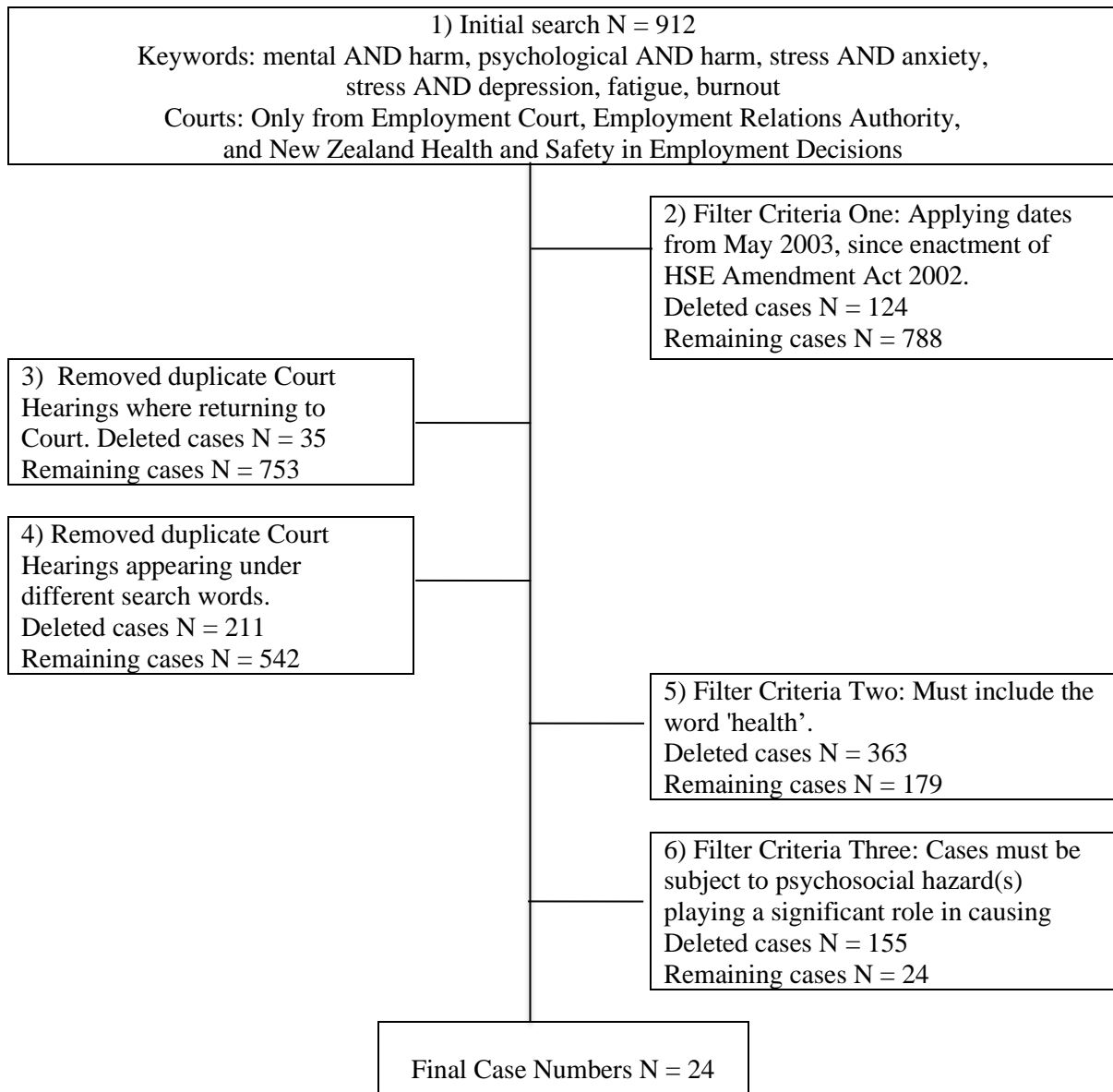


Figure 2. Data selection flowchart

All the selected cases (n=24) have been through full court hearings and include the latest outcomes, with no active cases to be followed. Most of the cases (n=23) fall under the ERA and only 1 under the New Zealand Health and Safety in Employment Decisions. [Appendix E](#) provides full entries of selected cases (n=24) in no specific order. The paper will refer to the cases using a numbering system to address ethical concerns, as discussed in chapter 3.3.

3.5 Data Analysis Procedure

3.5.1 Introduction

While several methods could be used to analyse the selected cases (n=24), the method that was considered most applicable was framework analysis. This method was developed by the National Centre for Social Research in the United Kingdom during the late 1980s to manage and analyse qualitative data. Framework analysis is not aligned with a particular epistemological, philosophical, or theoretical approach. Rather it is a flexible tool that can be adapted for use with many qualitative approaches that aim to generate themes. The tool itself has no allegiance to either inductive or deductive thematic analysis (Ritchie & Lewis, 2003). This analysis is in alliance with the pragmatic approach of the study.

The framework analysis method is relevant to this study, where the 24 cases are explored by category and content. This method allows for qualitative data to be assessed by identifying commonalities and differences, followed by focusing on the relationship between different data parts. Descriptive or explanatory conclusions can be grouped around themes or categories. In this study, categories, as opposed to themes, are used due to personal preference.

The framework analysis's defining feature is the matrix output where rows consist of cases, columns of categories, and the cells of summarised data. This provides a structure into which the researcher can systematically reduce the data to analyse it by case and category. An in-depth analysis of key categories can occur across the whole matrix while the dataset remains connected to the case, therefore ensuring the context is not lost. A case can be an individual, predefined groups or organisations (Gale et al., 2013). This method is most commonly used to analyse semi-structured interview transcripts and textual data, including documents such as meeting minutes, diaries, or field notes from observations (Pope et al., 2000). It is also a popular approach to managing and analysing qualitative data in health research (Dey et al., 2006; Furber, 2013; Gale et al., 2013). The framework method's comprehensive and systematic approach was considered most suited for analysing secondary data from the court transcripts.

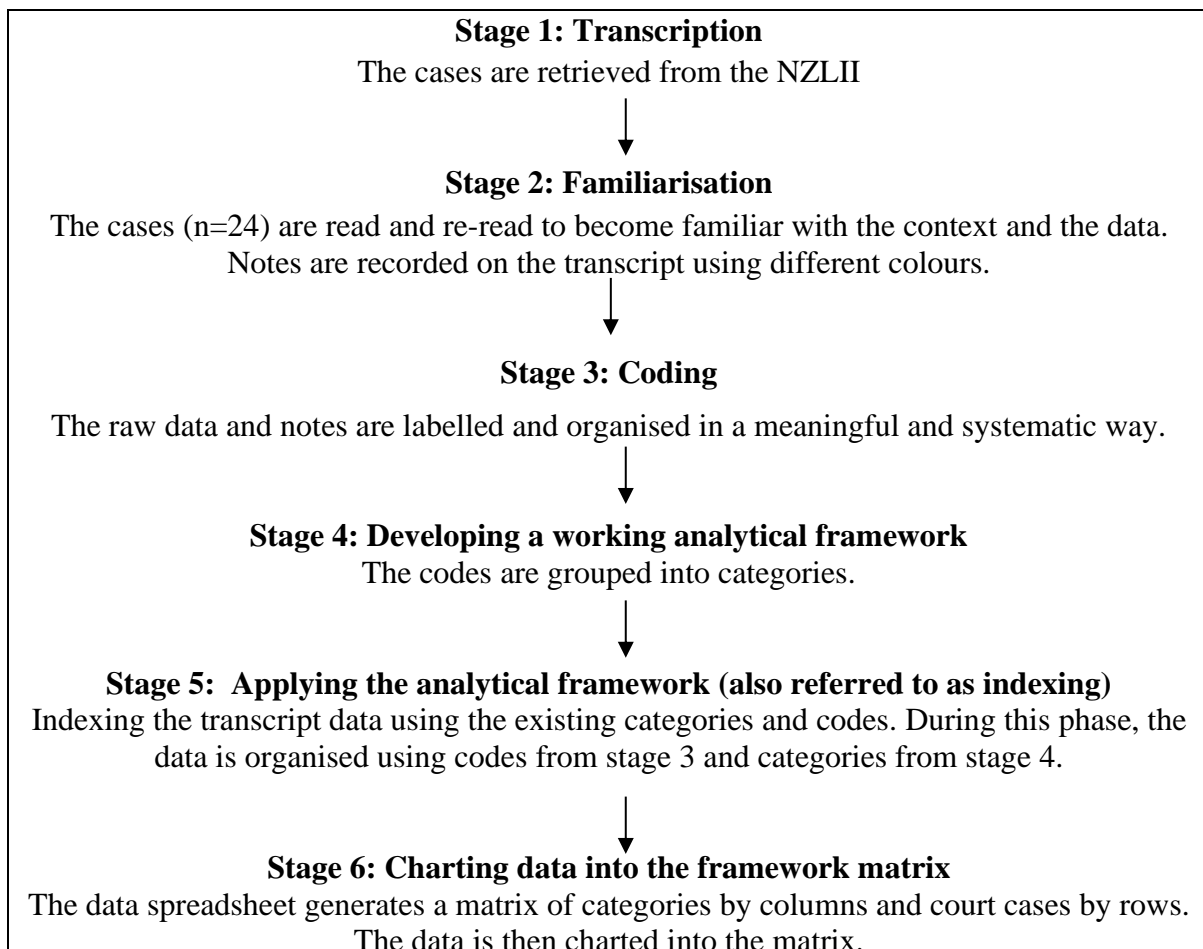
The advantages of the framework analysis method are the ability to easily compare data across many cases as well as within individual cases. The matrix structure is visually

straightforward and can facilitate recognising of patterns in the data (Popay et al., 1998). The systematic procedure is easy to follow and produces highly structured outputs of summarised data. However, there are disadvantages to this method, including that it cannot accommodate data without similar topics or key issues, and it can be time-consuming and resource-intensive (Gale et al., 2013).

It can be concluded that the framework analysis method provides a systematic and comprehensive approach towards analysing potential complex information where the secondary data were not originally recorded for the purpose of the study. The framework analysis provides 7 stages to follow (Gale et al., 2013). These stages will be applied during section 3.5.2.

3.5.2 Applying the Framework Analysis

The 7 stages of the framework analysis are followed to produce highly structured outputs of summarised data, as illustrated in figure 3 below.



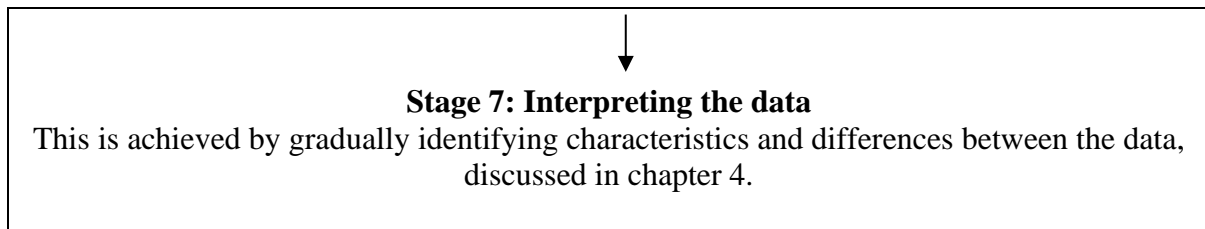


Figure 3. The 7 stages of the framework analysis approach

The first stage of applying the framework analysis is transcribing the raw data, which is already achieved using secondary data.

The second stage is to become familiar with the context. Cases (n=24) were thoroughly read and re-read to become familiar with their context and data. Following this, data were organised in a meaningful and systematic way through coding.

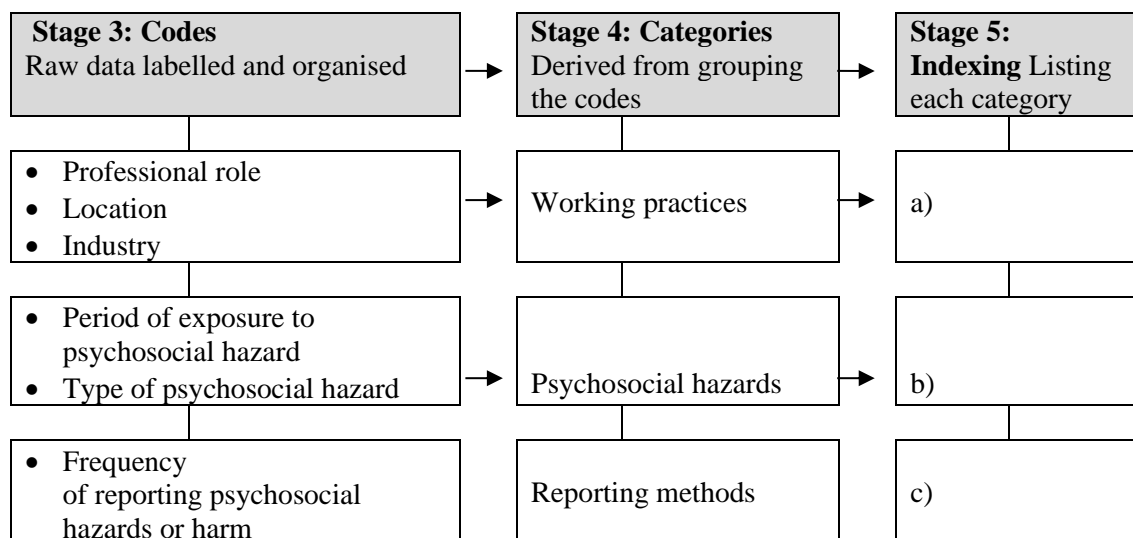
The third stage of coding is the labelling of raw data. Codes can be conceptualised as the building blocks to create categories or themes (Gibbs, 2007). Such codes are more specific than themes. The codes intend to classify all the data to be compared systematically with other parts of the data set. It captures a single idea associated with a segment of data and identifies interest in the data. The coding is done by looking at the raw data holistically, considering the overall impression during each court case. As well as getting a holistic sense of what was said, coding is also done line-by-line to consider that which may ordinarily remain invisible because it is not clearly expressed or does not 'fit' with the rest of the account.

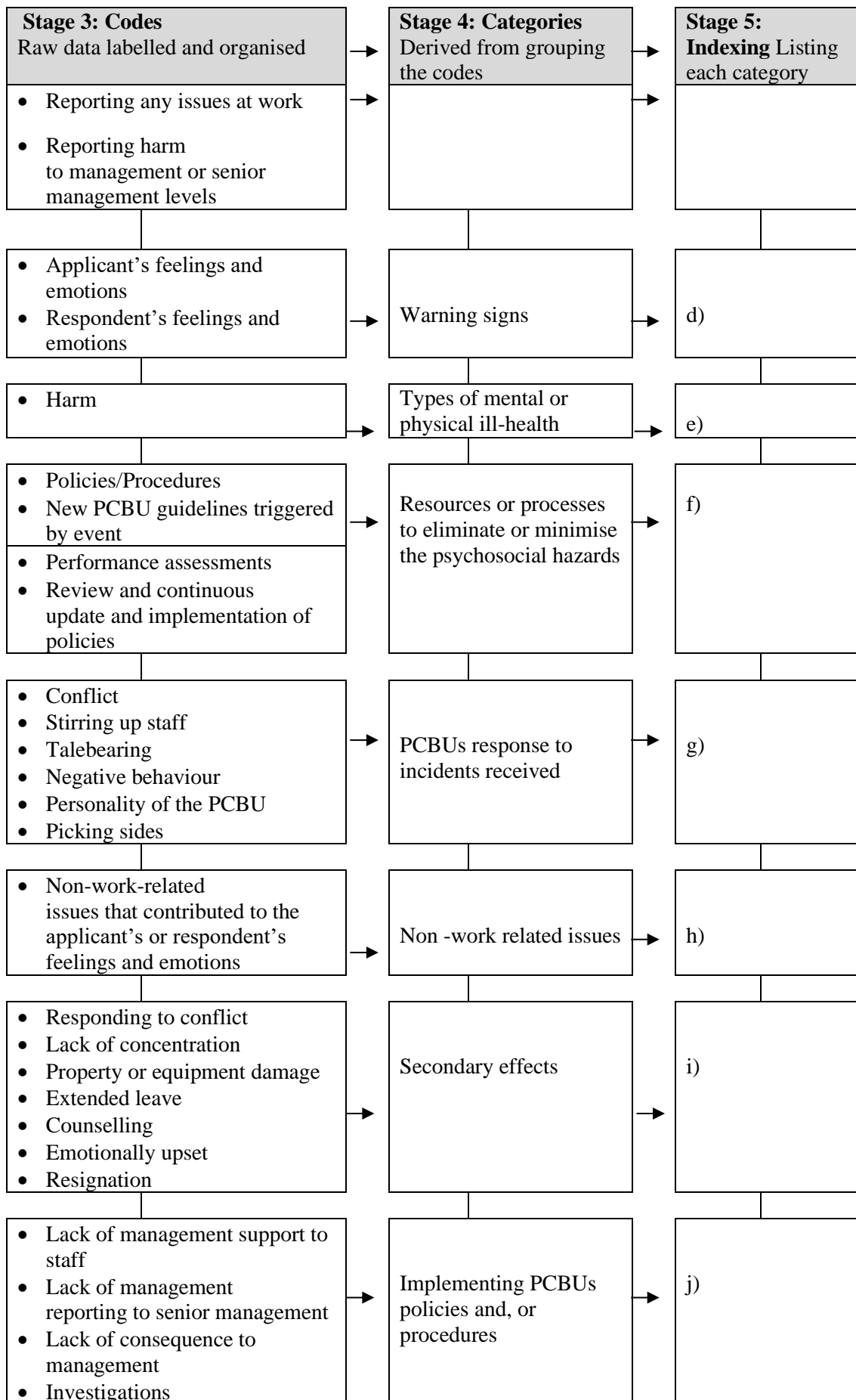
During the third stage of coding, it became apparent that each case had similar topics of discussion. These include, for example, the worker's professional role, the location and industry of work, the type of psychosocial hazards the workers were exposed to, the period of exposure, the method of reporting it to their employer, workers not reporting the harm, feelings of humiliation, confusion, shock, or embarrassment experienced by the worker, the employers' response to the reports received, the potential conflict caused by lack of response from the employer, the changes implemented by the PCBU to improve the workplace, the neglect of improvement within PCBUs, long term consequences, and court penalties. These discussion topics are marked as codes and illustrated in figure 4 (first column) as part of the analytical framework.

After coding, the fourth stage is to develop a working analytical framework. This is developed where codes from the third stage are grouped into categories, which, in turn, are then clearly defined. The categories are formed in relation to the main subject matter shared by several codes. For example, the workers' professional role, location and industry of work are grouped and categorised as 'working practices', labelled a). Next, the codes related to the type of psychosocial hazard exposure and period of exposure are grouped and categorised as 'psychosocial hazards', subsequently labelled as b). The next grouping labelled c), is the category 'reporting methods' where codes included data on the frequency of reporting psychosocial hazards or harm, reporting any other issues at work, or reporting harm to the management or senior management levels. This process is applied to all the codes, mapping the codes into subject matter categories. Several iterations of the analytical framework are required before no additional codes emerged. The analytical framework is only considered final after the last transcript has been coded. The coded data (n=24) are organised to provide 12 categories labelled a) to l). The categories are illustrated in figure 4 (second column) below.

The fifth stage is to apply the analytical framework by indexing the transcript data using the existing categories and codes. Each code is assigned an abbreviation for easy identification. NVivo10 was considered for organising and storing the data. However, due to personal preference written notes were made directly onto the transcripts. During stage 5, the data are organised using the indexing number so that the codes and categories are easily accessible for the analysis process. This is illustrated in figure 4 (last column) below.

Stages 3 (coding), 4 (categories), and 5 (indexing) are illustrated in figure 4 below.





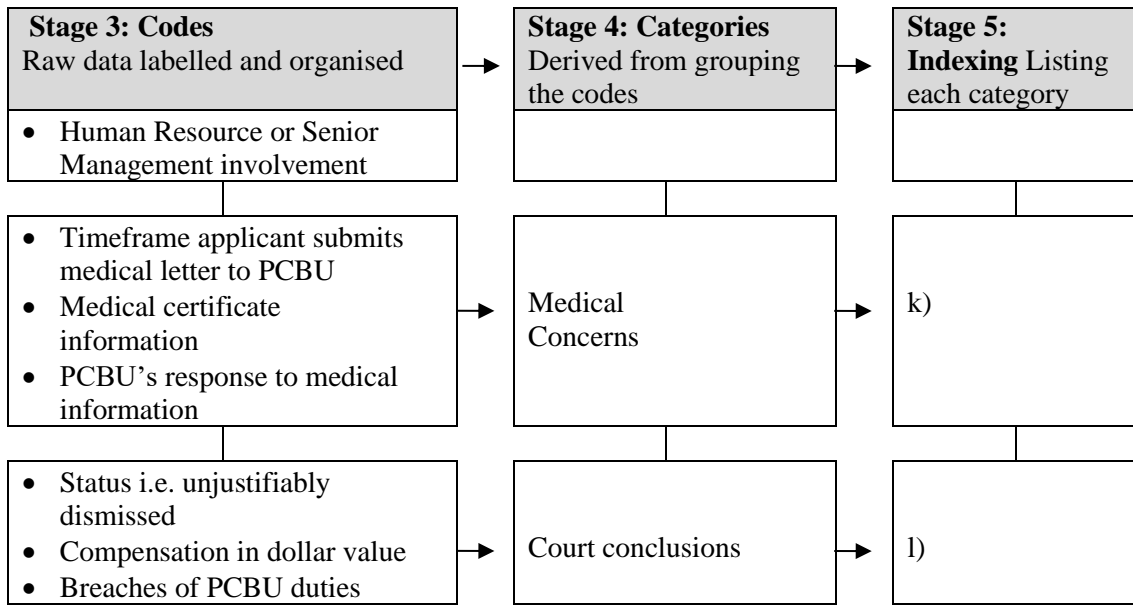


Figure 4. Analytical framework - codes, categories, and index numbers

To review, the codes from stage 3 are grouped into categories creating the analytical framework, stage 4. These categories are numbered, called indexing, in stage 5 for easy identification and application.

Next, the sixth stage of the framework analysis summarises the data by category from each transcript onto a data spreadsheet. The data spreadsheet generated a matrix, called the framework analysis matrix, consisting of cases (n=24) by rows and categories (n=12) by columns. The data is then charted into the matrix. Each data entry is completed using separate cells within the matrix to ensure easy access for further analysis. The data spreadsheet matrix is illustrated in table 2 below. This table is for illustration purposes and, therefore, only includes categories a) to f) and cases 1 to 3.

Table 2. Stage 6 - The framework analysis matrix - Illustration of the format

	a) Working practices	b) Psychosocial hazards	c) Reporting method	d) Warning Signs	e) Harm: Type of mental or physical ill- health	f) Resources or processes to eliminate or minimise the hazards... (continue to l)
CN 1						
CN 2						
CN 3... continue to CN 24						

Charting ensures that researchers pay close attention to describing the data using each case's subjective frames and expressions in the first instance, before moving onto interpretation (Gale et al., 2013). The case data charted, or entered, into the matrix is direct quotes from the cases. Some of the data may be entered into more than one category, for example, a worker diagnosed with anxiety by a medical practitioner falls within the type of mental or physical ill-health, category e), and within the medical concerns, category k). An example of the data spreadsheet is attached as [Appendix F](#). This example only includes data from court cases 1, 2, and 3 due to high volumes of data.

The seventh and final stage of the framework analysis consists of the interpretation of the data. This is achieved by gradually identifying characteristics and differences between the data, discussed during chapter 4 (results and discussion).

3.5.3 Analysis - Summary

In summary, the framework analysis technique is used to provide insight into work-related psychosocial harm cases. By applying the 7 stages of the framework analysis approach (figure 3), the data (n=24) were analysed using the framework analysis where the data were coded and grouped into categories (n=12) labelled a) to l). This is illustrated in figure 4. The 12 categories were then used to establish a data spreadsheet consisting of a matrix with cases (n=24) by rows and categories (n=12) by columns (table 2 or [Appendix F](#)). The cases retrieved from the NZLII database were entered into the applicable cells within the data spreadsheet, creating a clear and concise database.

Chapter Four: Results and Discussion

4.1 Introduction

To recap, this study aimed to provide insight into the New Zealand legal response on work-related psychosocial harm. To achieve this aim, four interrelated research objectives (ROs) were formulated (section 1.2), as outlined below.

RO1: Gain insight into work-related psychosocial harm prosecutions

RO2: Explore enforcement under the HSWA 2015 on work-related psychosocial harm

RO3: Explore the employers' and workers' influence on psychosocial harm

RO4: Recognise implications on companies being prosecuted

Sections 4.2 to 4.6 will address research objectives one to four (RO1 to RO4). Section 4.7 will provide a summary of the overall results and discussions.

4.2 Connections Between the HSWA 2015 and the Analytical Framework

Under the HSWA 2015 any PCBU has a primary duty of care to provide a work environment without risk to a worker's health and safety, so far as is reasonably practicable. WorkSafe NZ, the NZ regulator, expects companies to have effective systems to protect workers' health, both physical and mental, from work-related factors to promote general health and wellbeing (WorkSafe New Zealand, 2017e).

The main purpose of the HSWA 2015 is to provide a balanced framework to secure the health and safety of workers and workplaces, where the term health includes mental harm. The 12 analytical framework categories from figure 4 (second and third columns) were grouped in connection to their relevant sections under the HSWA 2015. This is demonstrated in table 3, where:

- Any PCBU has the responsibility to ensure a safe and healthy workplace for workers (HSWA 2015, section 36). The analytical framework identifies early warning signs (category d) throughout the cases that resulted in mental or physical ill-health experienced by the worker (category e) where psychosocial hazards (category b)

played a significant role, with the potential of leading to secondary effects (category i).

- The employer has a responsibility to ensure their workers' health whilst at work (HSWA 2015, section 44). The cases indicate a trend of employers' effective or ineffective actions in providing a safe and healthy place to work. This is illustrated by the working practices that the employer provides (analytical framework category a), the resources or processes to eliminate or minimise psychosocial hazards (category f), PCBUs' immediate response to incidents (category g), and implementing the PCBUs' policies and procedures (category j).
- The worker has the responsibility for their own health and safety whilst at work (HSWA 2015, section 45). This is illustrated by the method used by the worker to report the incident (analytical framework category c), non-work-related issues that influenced the worker (category h), and any work-related medical conditions (category k).

Table 3. Connection between the HSWA and the analytical framework categories

HSWA	Analytical Framework	
	Number*	Category*
Section 36	d)	Warning signs
	e)	Types of mental or physical ill-health
	i)	Secondary effects
	b)	Psychosocial hazards
Section 44	a)	Working practices
	f)	Resources or processes to eliminate or minimise the psychosocial hazards
	g)	PCBUs immediate response to incidents received
	j)	Implementing PCBUs policies or procedures
Section 45	c)	Reporting methods
	h)	Non-work-related issues
	k)	Medical conditions
Court Conclusions	l)	Court outcomes and compensation

*Extracted from figure 4.

4.3 HSWA Section 36 - Risk of Mental Harm

Section 36 (1)(a) of the HSWA states a PCBU must ensure, so far as is reasonably practicable, the health and safety of workers who work for the PCBU, while the workers are at work. Findings from the framework analysis described in chapter 3 identified four

categories in relation to section 36 of the HSWA 2015. These 4 framework analysis categories included: warning signs (section 4.3.1), types of mental or physical ill-health (section 4.3.2), secondary effects (section 4.3.3), and psychosocial hazards (section 4.3.4). The relationship between mental or physical ill-health and psychosocial hazards will be explored (section 4.3.5), followed by a summary of these findings (section 4.3.6).

4.3.1 Warning Signs

One prominent characteristic that emerged during the framework analysis was the applicant’s feelings or experiences before identifying mental or physical ill-health. The Mental Health Foundation NZ (2020) explains mental health problems as difficult experiences or feelings that go on for a long time and affect our ability to enjoy and live our lives in the way we want to. For the study, these feelings or experiences were referred to as the early warning signs of mental ill-health. As derived directly from the cases, these early warning signs have been grouped in figure 5 by feelings or experiences of being verbally, sexually or physically abused; feeling emotionally upset; experiencing sleep deprivation; experiencing early symptoms such as migraines, headaches, neck or chest pain; or feeling vulnerable or unprotected.

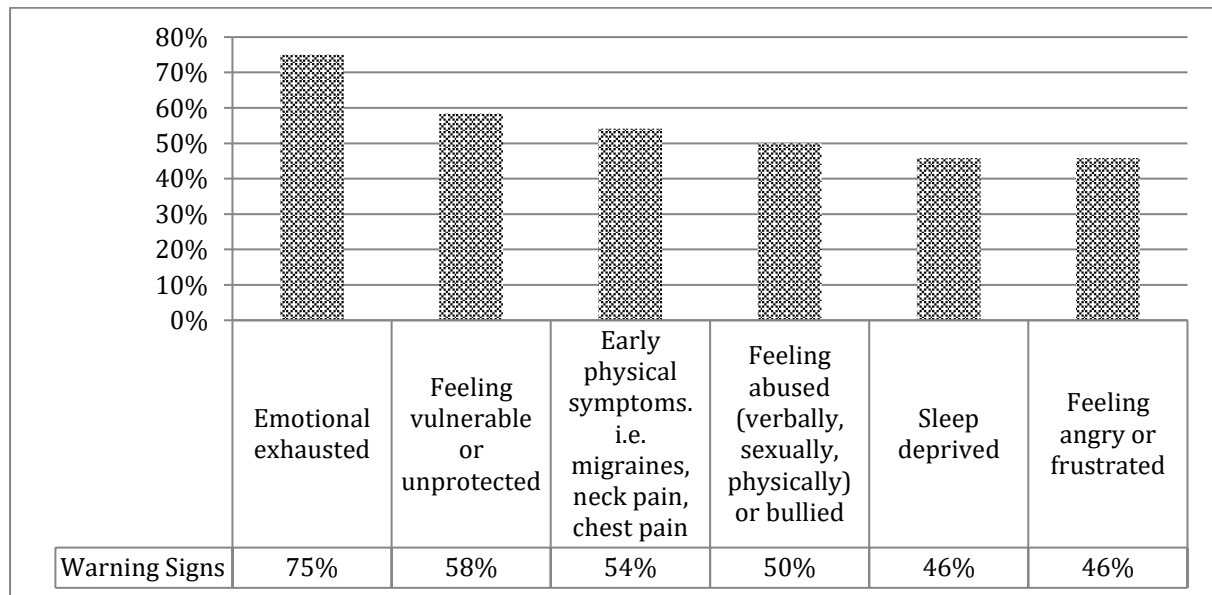


Figure 5. Warning signs

Feelings of emotional exhaustion were the most evident at 75% (n=18). During these cases, it is explained as

‘being in tears during a meeting at which (applicant) talked about the likely impact of it on (applicant’s) mental and physical health.’ - CN 10, or

‘(applicant) having a low mood and tearfulness’ - CN 8.

Emotional exhaustion symptoms include negative feelings towards self and others; feeling pressured and out of time; having strained relationships; feeling angry, irritable or frustrated towards others; having counterproductive work behaviours and feeling unmotivated (Mental Health Foundation of New Zealand, 2020). Feelings of emotional exhaustion being most prevalent may be due to excessive workload, work demand, lack of management supporting workers, not being familiar with the symptoms or effects it can have on them, feelings not being reported or, the employer failing to address such feelings.

The next most frequent early warning sign was feeling unprotected or vulnerable at 58% (n=14). This is defined as being exposed to the possibility of an attack or harm, either physically or emotionally. The cases described it as

‘feeling betrayed and let down.’ - CN 15, or

‘feeling vulnerable, unprotected and sceptical about (company’s) assurance following the second complaint about (applicant’s) future safety and wellbeing.’ – CN 8

These feelings could be due to lack of confidence to raise or address potential health and safety concerns, lack of policies or procedures outlining the method to raise such concerns, lack of open communication at work environments, or reluctance to admit uncertainty around how to get the job successfully done.

Another early warning sign was workers’ physical symptoms such as migraines, neck pain, and chest pain. Physical signs were relatively high during court transcripts at 54% (n=13). This may be due to physical symptoms being easier to identify and characterised by specific signs than the invisibility of psychological experiences.

The next most prevalent were reports of workers being verbally, sexually, or physically abused in the work environment as experienced by half of the workers. This is somewhat unsurprising, given that Statistics NZ report that during 2018, one in ten workers felt discriminated against, harassed, or bullied at work (Bentley et al., 2019; Stats New Zealand, 2019b). WorkSafe NZ describes bullying at work as repeated and unreasonable behaviour directed towards a worker or a group of workers that can lead to physical or psychological harm.

The definition seems to align with the cases

‘feeling harassed and upset, (applicant’s), confidence undermined, and felt hunted.’ - CN 22, or

‘feeling not only bullied in (applicant’s) employment but unsupported, isolated and unheard.’ - CN 24

WorkSafe NZ has introduced several workplace bullying resources in recent years, including the bullying and harassment toolbox (WorkSafe New Zealand, 2018a). With these resources only being introduced over the last 2 years, it could be possible that companies are not yet fully aware, educated, or experienced enough to manage verbal, sexual, or physical abuse at the workplace.

The last warning sign to be addressed was workers feeling sleep deprived. Sleep deprivation affected almost half of the workers at 46% (n=11). It is described as

‘the situation had become a health and safety issue which was impacting on (applicant’s) sleep and increasing (applicant’s) anxiety. It was acknowledged that (applicant) probably could not resume overtime duties until the anxiety was reduced and (the applicant) was sleeping properly’. - CN 4, or

‘having sleep issues, the lack of ability to concentrate on or enjoying anything outside the situation that (applicant) is involved in.’ - CN 22

Out of the 24 cases analysed there was one fatality where the cause of death was

‘fatigue because of extended work hours’ -CN 11

The impact on workers’ wellbeing concerning the level of consequence will be further explored in section 4.3.3.

To conclude, there is a consistent trend of early warning signs experienced throughout the cases, which affected the workers’ ability to work. It could be argued that these early signs presented PCBU’s with an early opportunity to identify underlying issues – for example, those causing the warning signs – and proactively manage them. Yet, based on the evidence, it is concerning that these early warning signs were generally not addressed and subsequently escalated into matters requiring judicial attention.

The next section will explore the mental-ill or physical health following the warning signs experienced by workers.

4.3.2. Types of Mental or Physical Ill-health

Psychosocial hazards can cause physical, social, and psychological harm (Staetsky et al., 2012) or, as stated by the WHO (Leka et al., 2003), can cause physiological and psychological effects. The complexity of this topic is evident in a variety of cases where the worker was affected mentally, for example, with anxiety and physically, for example, having difficulty breathing. The selected cases have experienced mental or physical ill-health as the primary work-related harm; however, secondary symptoms may also be present.

As discussed in chapter 2, different words reflect the same meaning and can be used interchangeably. Search words in accordance with the WHO, the PRIMA-EF, the HSE Amendment Act 2002, and the HSWA 2015 were used, in no specific order, to retrieve data from the NZLII. These words include fatigue, burnout, depression, anxiety, mental harm, and psychological harm (figure 6). This section will provide an analysis of these search words.

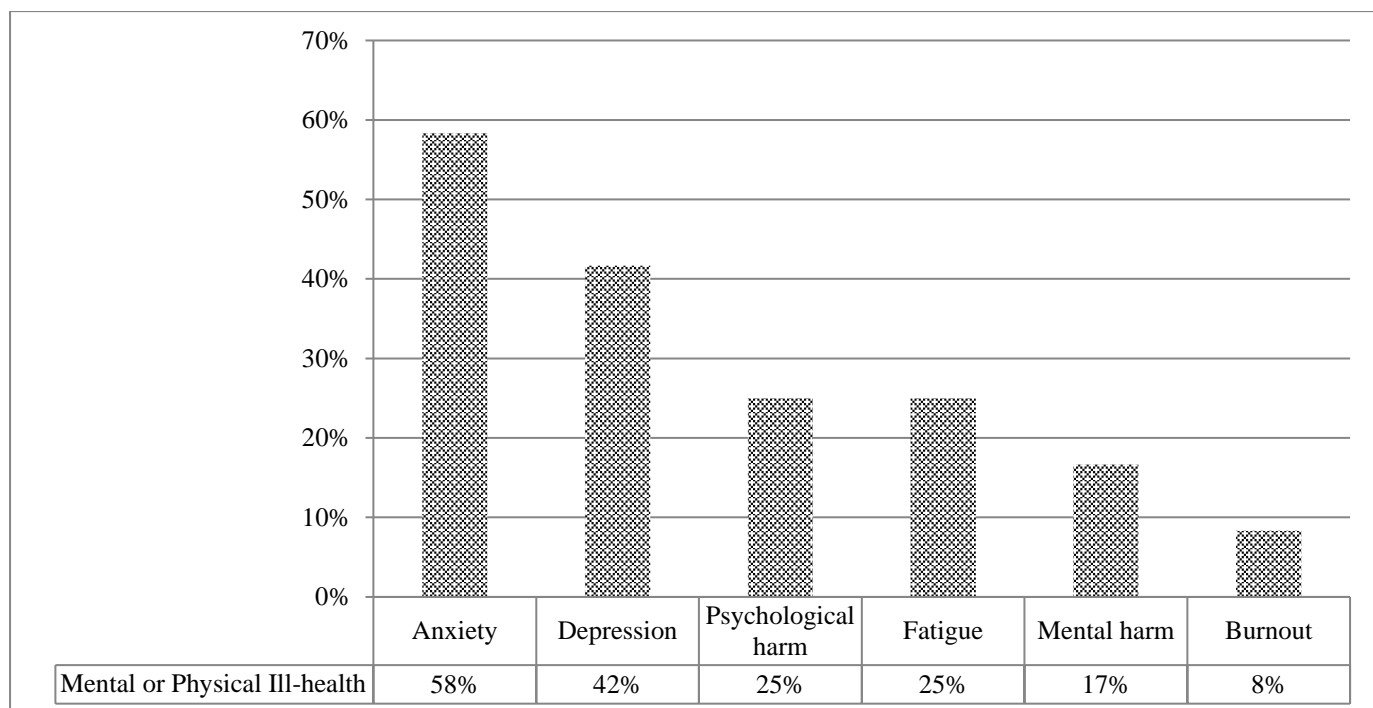


Figure 6. Types of mental or physical ill-health

The prevalence of stress and anxiety at 58% (n=14) and stress and depression at 42% (n=10) was most extensive. These results are aligned with the ILO's findings that in Europe, 50-60% of all lost working days are attributed to work-related stress, anxiety, and depression (ILO, 2019a). The impact of work-related stress on workers may vary (section 2.3.1). It could have

positive effects (Blonna, 2012) or, on the other hand, it could be associated with, for example, anxiety, depression, low productivity, and antisocial behaviours (Department of Labour [DoL] & Occupational Safety and Health [OSH], 2003).

Anxiety was the most prevalent at 58% (n=14). Anxiety is used to describe the lack of control over being worried, often accompanied by restlessness, being easily fatigued, having difficulty concentrating, irritability, muscle tension, and disturbed sleep (Barlow, 2001).

During the cases, workers described anxiety as

‘feeling under pressure to meet targets, feeling unwell, experiencing headaches, migraines and fatigue’ - CN 3.

It could also have physical signs such as chest pain or trouble sleeping (CN 4). A potential explanation for anxiety scoring most prevalent could be that anxiety is a ‘common mental health problem’ where this one term characterises many symptoms.

Following anxiety, depression was the next most prevalent at 42% (n=10). This could be due to nearly one-half of those diagnosed with anxiety also being diagnosed with depression (National Institute of Mental Health, 2017). It is also a commonly used term to describe a mental illness where workers feel sad, miserable most of the time, or experiencing a very low mood (Ministry of Health, 2020). The WHO estimates that by 2020, depression will have become the second leading cause of disability globally. During the cases, depression was described as

‘feeling trapped and experiencing a complete meltdown’ - CN 20, or

‘unable to address concerns’ - CN 21.

The next type of mental or physical ill-health to be considered was fatigue. It is described as a state of physical and/or mental exhaustion, which reduces a person’s ability to perform work safely and effectively (WorkSafe New Zealand, 2017a). Workers experienced fatigue during 25% (n=6) of the cases. Fatigue were experienced as

‘not sleeping or over-sleeping at weekends and always thinking about work’ - CN 20,

or

‘falling asleep at the wheel’ - CN 11.

Additionally, psychological and mental harm are two types of mental or physical ill-health often used interchangeably. Psychological harm or illness can be described as a cognitive or

emotional symptom that impacts a person's life, affecting how they think, feel, and behave. It refers to any work-related stress and associated emotional condition resulting from real or perceived harm (Maguire, 2016). During the cases, psychological harm was used in conjunction with emotional harm:

‘being in tears during a meeting at which she talked about the likely impact of it on her psychological and physical health’ - CN 10.

Mental harm is defined as a clinically significant behavioural, cognitive, or psychological dysfunction (New Zealand Government, 2001) and was only used during 17% (n= 4) of the cases where it was described as:

‘feeling uncomfortable and exposed because of (another worker's) threatening and intimidating behaviour’ - CN 12, or

‘feeling unsafe at work after having been assaulted twice by two different colleagues’ - CN 13,

One of the constraints upon compensability for purely mental harm in common law has been that a plaintiff must have suffered not just adverse psychological consequences from negligence but a ‘recognisable psychiatric illness’ (Frecklelton & Popa, 2018). Therefore, it could be preferred by applicants during cases not to be frequently used.

Lastly, burnout as mental ill-health was experienced during 8% (n=2). The WHO (Leka & Jain, 2010) explains burnout as a state of physical, emotional, and mental exhaustion that results from long-term involvement in work situations that are emotionally demanding. One case described it as

‘psychological pressure caused by disharmony’ - CN 6

An explanation of burnout being less frequently used during the cases could be that it is not a common term within the New Zealand context.

In summary, mental or physical ill-health at work was identified during all of the cases suggesting that companies in the dataset failed to ensure their workers' health, which is in breach of section 36 of the HSWA 2015. Court conclusions stated:

‘(Company) breached their duty when not looking into possible causes of stress and anxiety.’ - CN 3, or

‘It is clear that (applicant) has suffered significant physical, mental, emotional and financial harm as a result of the various workplace issues.’ - CN 13

These medical-ill health terms have not only been self-reported by the applicant throughout the cases but also confirmed by medical practitioners or by the judge during the court conclusions.

4.3.3 Secondary Effects

All 24 cases indicated secondary effects or consequences following their mental or physical ill-health concerns. These were grouped into 6 categories, illustrated in figure 7: sick leave, counselling, resignation, physical assault, major health concerns, and vehicle accidents. Each secondary effect will be discussed independently.

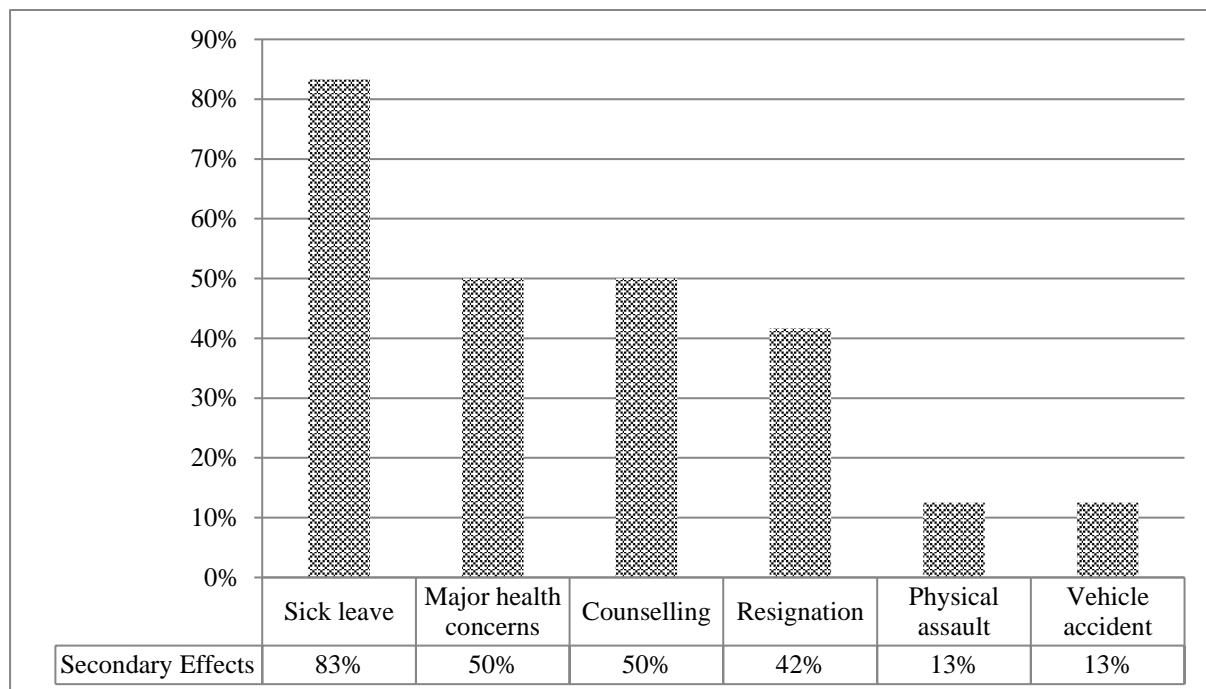


Figure 7. Secondary effects to the worker due to psychosocial hazards

A majority of cases, measured at 83% (n=20), indicated sick leave due to mental ill-health experienced at work. Similarly, research indicates that worker absence cost the New Zealand economy \$1.79 billion in 2018, up from \$1.51 billion in 2016 (Business New Zealand & Southern Cross Health Society, 2019). Furthermore, work-related anxiety, stress, and depression were the cause of absence for 6% of NZ workers during 2016, increasing to 22% during 2018. Sick leave can result from several factors, but the framework analysis identified that 20 cases were specifically caused by psychological hazards at work where the employer failed to ensure a healthy work environment. This high prevalence could be due to PCBU's acknowledging mental or physical ill-health as work-related and, therefore, a legitimate cause of absence.

The next most prevalent secondary effect was major health concerns, or clinical illnesses, experienced by half (n=12) of the workers. Major health concerns identified include, for example, major depressive disorder (CN 3), attention deficit disorder (CN 4), attempted suicide (CN 5), acute adjustment disorder (CN 8), and post-traumatic stress disorder (CN 16). This could be due to the physical environment at work, work characteristics such as shift work, job stress such as high demand or low support, interpersonal conflict, job insecurity, or lack of supportive policies at work.

With similar prevalence to major health concerns, workers attended counselling in 50% (n=12) of the cases. Counselling aims to ease emotional distress and help workers regain normal functioning (Hay, 2012). Employee assistance programmes (EAP) were often used by companies, during court transcripts, as a control to manage hazards at the workplace. According to EAP (n.d.), they provide practical assistance to employees when work issues arise that may impact their ability to do their job or affect their wellbeing. The moderate to high percentage of workers undergoing counselling could be due to companies resorting to this as the main control action for mental ill-health at work, instead of addressing the cause of the mental ill-health and improving a healthy work environment.

Resignation due to mental ill-health occurred during 42% (n=10) of the cases. During the cases, workers resigned due to frustrating work environments where they were not considered during the decision-making process, work overload, interpersonal conflicts with other workers not adequately addressed by management, and lack of trust and confidence between workers and management.

Lastly, physical assault was equally prevalent to vehicle accidents at 13% each (n=3). Even though this number seems low, the impact on the workers and their families was severe. The consequence and impact of secondary effects on workers can be illustrated using a risk matrix.

Risk matrices have been widely promoted in risk management standards and are a practical and easy to use tool which can help demonstrate complex risk data in a concise visual manner (Milosevic, 2003). Risk matrices identify the level of priority for companies to act on managing the risk. The following risk matrix is an example to describe the consequence (rows) and impacts (columns) of potential secondary effects. There are several variations of

risk matrices found in the literature (Duijm, 2015). However, there is limited information and research on the risk matrix categories of impact on worker's wellbeing. Furthermore, limited information from the cases can fully comprehend the severity of the impact on worker's wellbeing. The matrix in figure 8 was created for the study and is specific to the 24 cases at hand.

		Impact on worker's wellbeing			
		Minor Immediate effect	Moderate Immediate or long-term effect	Major Long-term effect	Extreme Immediate life-changing effect
C o n s e q u e n c e	Catastrophic: Physical assault, major health concerns, vehicle accident resulting in criminal charges/fatalities	Critical	Critical	Critical	Critical
	Major: Loss career, resignation	High	High	Critical	Critical
	Moderate: Sick leave, counselling	Medium	High	High	Critical

Figure 8. Risk matrix – secondary effects of psychosocial hazards

The secondary effects from figure 7 are grouped into rows of moderate, major, and catastrophic consequences. The impact of secondary effects was grouped into columns and can be measured against the effect it will have on the worker ranging from minor to extreme life-changing effects. The matrix was divided into critical, high, and medium zones and the risk is scored based on where the consequence meets the impact, which guides prioritisation of risks for PCBUs.

For example, if a worker were exposed to a psychosocial hazard such as interpersonal relationship issues at work, it could cause mental ill-health such as anxiety. The consequence of anxiety could be that the worker attends counselling, which is classified as a moderate consequence. The impact that counselling has on the worker will cause an immediate effect and, therefore, fall within the medium risk score. However, if the counselling becomes long-term, the risk score moves to high.

During CN 3, the applicant experienced fatigue caused by long hours operating a heavy vehicle. The secondary effect of fatigue, in this case, was a road accident causing damage resulting in criminal charges. By applying the risk matrix, the consequence was considered catastrophic. The impact on the worker was major, where the worker's license got revoked, causing long-term effects, and scored as critical. In CN 11, the worker also experienced fatigue caused by long extended hours of shift work. The secondary effect had catastrophic consequences where a road accident resulted in a fatality. The impact was categorised as extreme with immediate life-changing effects, scored as critical.

The 13% of vehicle incidents may well indicate the lowest secondary effects caused by mental or physical ill-health but had by far the most severe impacts. Ensuring workers' health and safety requires that all potential hazards or risks be managed appropriately by the PCBU. Risks can be recorded using a risk register where individual hazards are identified, measured against the risk score using a risk matrix, actively controlled by implementing risk control actions, monitored and frequently reviewed (GRWM Regulations, 2016).

In conclusion, all workers suffered secondary effects caused by mental or physical ill-health. This ranged from sick leave, resignation, counselling, major health concerns, physical assault, and vehicle accidents. A risk matrix, created for the study, measured the consequences against the impact on worker's wellbeing. It illustrated that although a secondary effect (caused by mental or physical ill-health) may occur less frequently, such as fatigue causing vehicle accidents less frequently than anxiety causing counselling, the impact on the worker may be more extreme with long-term or life-changing effects.

4.3.4 Psychosocial Hazards

The psychosocial hazards analysed are consistent with the PRIMA-EF framework (Cox, 1993). Throughout the cases, psychosocial hazards of workload, work pace, work schedule, and work control are used interchangeably and have, therefore, been merged into one category – namely workload and schedule. Career development and home-work interface did not arise as imminent concerns during the cases and were, therefore, not identified as separate categories or discussed as findings. By adapting the categories to suit the information received by the data, a total of 6 psychosocial hazard categories were identified, as illustrated in figure 9.

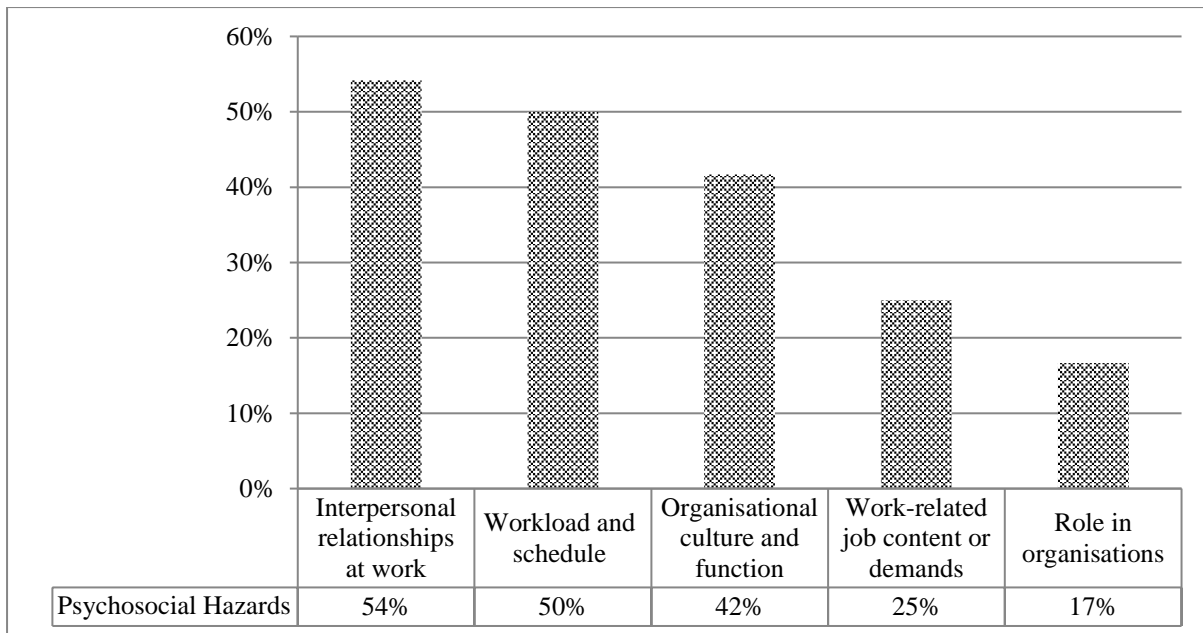


Figure 9. Psychosocial hazards

Interpersonal relationships at work were most frequently identified as a psychosocial hazard during 54% (n=13) of the cases. The PRIMA-EF (Leka & Cox, 2008) refers to a definition by Cox (1993) where interpersonal relationship concerns at work can be defined as physical or social isolation, poor relationships with superiors, interpersonal conflict, and lack of support, for example

‘(Company) failed to take any steps to appropriately manage the working relationship between (applicant) and (co-worker) which allowed ongoing tension within the workplace to continue.’ - CN 13

A potential explanation for interpersonal relationship concerns at work scoring the most prevalent could be due to fundamental attribution error (FAE). FAE can be described as the tendency to underestimate the degree to which behaviour is externally caused (Ross, 1977). During, for example, CN 14 it was assumed that the applicant

‘always gives over 100% and quitting was not an option.’ - CN 14

In other words, people within the PCBU shows a cognitive bias, assuming that the applicant’s actions depend on what kind of person they are, rather than on the social and environmental forces that influence the person such as, in this particular case, workload, and job strain.

Like interpersonal relationship concerns, workload, and work schedule appeared during 50% (n=12). Work overload, or under load, machine pacing, high levels of time pressure, continually being subject to deadlines, shift working, nightshift, inflexible work schedules, lack of control over workload and unpredictable work hours are all examples of workload and schedule psychosocial hazards (Cox, 1993).

CN 20 explained workload concerns where

‘(Company) had unrealistic expectations and the workload was excessive. (Applicant) was expected to work overtime without payment and perform tasks on public holidays. (Applicant) would be called up to ten times a day during some weekends. She said she often worked between 45 and 47 hours per week but was not paid for more than 40 hours. (Employer) responded ‘I don’t know what is wrong with you, I’m running five companies and that was what was expected, and it was not up for negotiation.’ - CN 20

Workload, pace, and schedule could have detrimental effects where, similar to the risk matrix discussed in figure 8, the occurrence could be low, but the impact extreme. A systematic meta-review of work-related hazards for common mental health problems showed a relationship between excessive job demands and negative outcomes for both the individual and organisation. For instance, excessive job demands have been associated with an increased risk of mental health conditions, including depression and anxiety (Harvey et al., 2017). These mental health problems have been associated with higher than average workers’ compensation costs, absenteeism, and turnover (Safe Work Australia, 2019). Other possible reasons why half of the workers in the selected cases experienced mental or physical ill-health where workload, schedule, pace, and control were evident include: unrealistic expectations, lack of adequate resources or training, lack of communication between workers and management, or lack of planning (MacDonald, 2003).

Next, organisational culture and function issues were identified during 42% (n=10). Cox explains organisational culture and function concerns as poor communication, low levels of support for problem-solving and personal development, lack of definition of or agreement on organisational objectives (Cox, 1993; Cox & Griffiths, 2010). It often reflects the attitudes, beliefs, perceptions, and values that workers share in relation to a healthy and safe work environment. This definition supports the evidence in these cases.

During CN 4 the applicant requested to work overtime. The employer stated that this was available, but it was not being offered to the applicant due to

‘(Applicant’s) performance not being at the stage where (applicant) could be trusted to make the right decisions, and there would not be the necessary support during overtime. (Applicant) became angry stating that this decision was unfair. (Applicant) repeated a request she had made previously to move teams....as she could not understand why she was not being offered overtime, and that she needed the extra wages.’ - CN 4

A well-balanced and healthy organisational culture and function could be enhanced by selecting management with human leadership and not only technical competence, creating opportunities for workers to actively participate and engage during setting PCBU objectives, and educating staff on health and mental awareness.

The next psychosocial hazard, namely work-related job content or demand, was experienced by 25% (n=6). Work-related job content or demand could become a hazard where the worker experiences a lack of variety or short work cycles, meaningless work, underuse of skills, or high uncertainty (Cox, 1993; Cox & Griffiths, 2010). This is different from workload or schedule where the employer expects unrealistic goals towards the worker but rather focused on unnecessary work requirements, workers feeling their skills are not best utilised, or work pressures that do not align with a person's knowledge or skills. Under-use of skills following work-related training was illustrated during case:

‘From the time of initial training (applicant) had concerns about the way he was being treated. (Applicant) did not receive his work roster. (Employer)’s response to (applicant) requesting a copy of the roster was sarcastic and threatening.’ - CN 22

Work-related job content or demand could be due to companies’ failure to utilise workers’ skills as best possible, managers not being trained to allocate not only realistic but also necessary workload, and lack of an open communication policy to reduce uncertainty as well as unjustified restrictions.

Another psychosocial hazard was the workers’ role in organisations where 17% (n=4) of the workers were affected. Role ambiguity, role conflict, and responsibility for people are examples where roles in organisations caused health concerns for workers. This is illustrated during a case where the

‘(Applicant) became increasingly involved with work organisation issues and attempted procedural change leading to self-imposed additional pressure and stress. (Applicant)’s expectations as to what amounts to an appropriate management style and the mismatch between his perceptions of (company’s) style and his ideal. He set about to effect change and became intensely invested in his proposals for change. He became frustrated, angry and unhappy when his proposals failed to gain traction.’ - CN 3

In this scenario, the applicant experienced role ambiguity by taking on responsibilities outside his framework. This resulted in the applicant suffering from stress and anxiety. It is possible that the lack of clearly defined roles and responsibilities may cause role ambiguity.

Lastly, the physical environment and equipment issues were identified during 13% (n=3). This may include inadequate equipment availability, suitability or maintenance, or poor environmental conditions such as lack of space, poor lighting, or excessive noise (Cox, 1993; Cox & Griffiths, 2010). An explanation could be that most cases where physical environment and equipment issues played a role were due to physical hazards and were, therefore, excluded during the data filtering process. During CN 5 the court concluded inadequate physical environment where

‘(Company) did not meet the staffing ratios for (applicant) prior to the assault on (applicant). By failing to affect the correct staffing ratios (company) failed to take reasonably practicable steps, in the circumstances, to protect (applicant) from a foreseeable risk of harm.’ - CN 5

An assault occurred due to incorrect staffing ratios, which resulted in adverse psychological effects.

In conclusion, interpersonal relationship issues, workload and schedule, organisational culture and function, work-related job content or demand, roles in organisations or the physical environment played a significant role in causing mental or physical ill-health to the workers. This could imply that WorkSafe NZ had the opportunity to engage or investigate companies failing to manage psychosocial hazards. Yet, most of the cases were treated under the ERA and not the HSWA 2015.

During this analysis, it was observed how certain psychosocial hazards were evident during specific mental or physical ill-health. This was further explored by using a comparative analysis.

4.3.5 Comparative Analysis

During case analysis, it was observed that specific psychosocial hazards triggered certain types of mental or physical ill-health. A comparative analysis was completed to further discover the effect of psychosocial hazards on specific mental or physical ill-health at the workplace. During a comparative analysis, two or more things are compared to discover something about one or all of the things being compared (Ploeger et al., 2001). This analysis aimed to compare psychosocial hazards with resulting types of mental or physical ill-health to discover any potential trends.

Mental or physical ill-health experienced during each case was plotted against the psychosocial hazard present in the same case. For example, during CN 1 the worker experienced anxiety and depression in the workplace where organisational culture and function, as well as interpersonal relationship issues at work, were present. This was recorded using a table format where the cases were numbered by rows, the psychosocial hazards by columns, and the types of mental or physical ill-health captured as the data. The format is illustrated in table 4 below, using only CNs 1 to 3 as examples. The completed table with a full list of all the cases is attached as [Appendix G](#).

Table 4. Comparative analysis - court cases measured against work-related psychosocial hazards

	Work-related job content	Workload and schedule	Physical environment and equipment issues	Organisational culture and function	Interpersonal relationships at work	Role in organisations
CN 1				anxiety, depression	anxiety, depression	
CN 2	fatigue	fatigue	fatigue			
CN 3... Continues to CN 24		anxiety, depression, fatigue, burnout, mental harm			anxiety, depression, fatigue, burnout, mental harm	anxiety, depression, fatigue, burnout, mental harm

Once all the data were entered into the table, the types of mental or physical ill-health entries per psychosocial hazards were calculated. The psychosocial hazards were kept by column, and the types of mental or physical ill-health moved to row entries, with the number of cases

measured against the mental or physical ill-health and work-related psychosocial hazard, captured as data. This was illustrated in table 5 below.

Table 5. Comparative analysis - mental or physical ill-health measured against work-related psychosocial hazards

	Workload and schedule	Interpersonal relationships at work	Organisational culture and function	Role in organisations	Work-related job content	Physical environment and equipment issues
Anxiety	6	9	7	4	0	0
Mental harm	6	7	4	3	2	2
Depression	5	5	3	2	2	1
Fatigue	6	2	0	1	3	2
Psychological harm	3	2	1	0	3	1
Burnout	1	0	0	2	0	0

Table 5 was used to create a graph, illustrated in figure 10. The result illustrates the relationship between the types of mental or physical ill-health against psychosocial hazards, where the data reflects the number of cases.

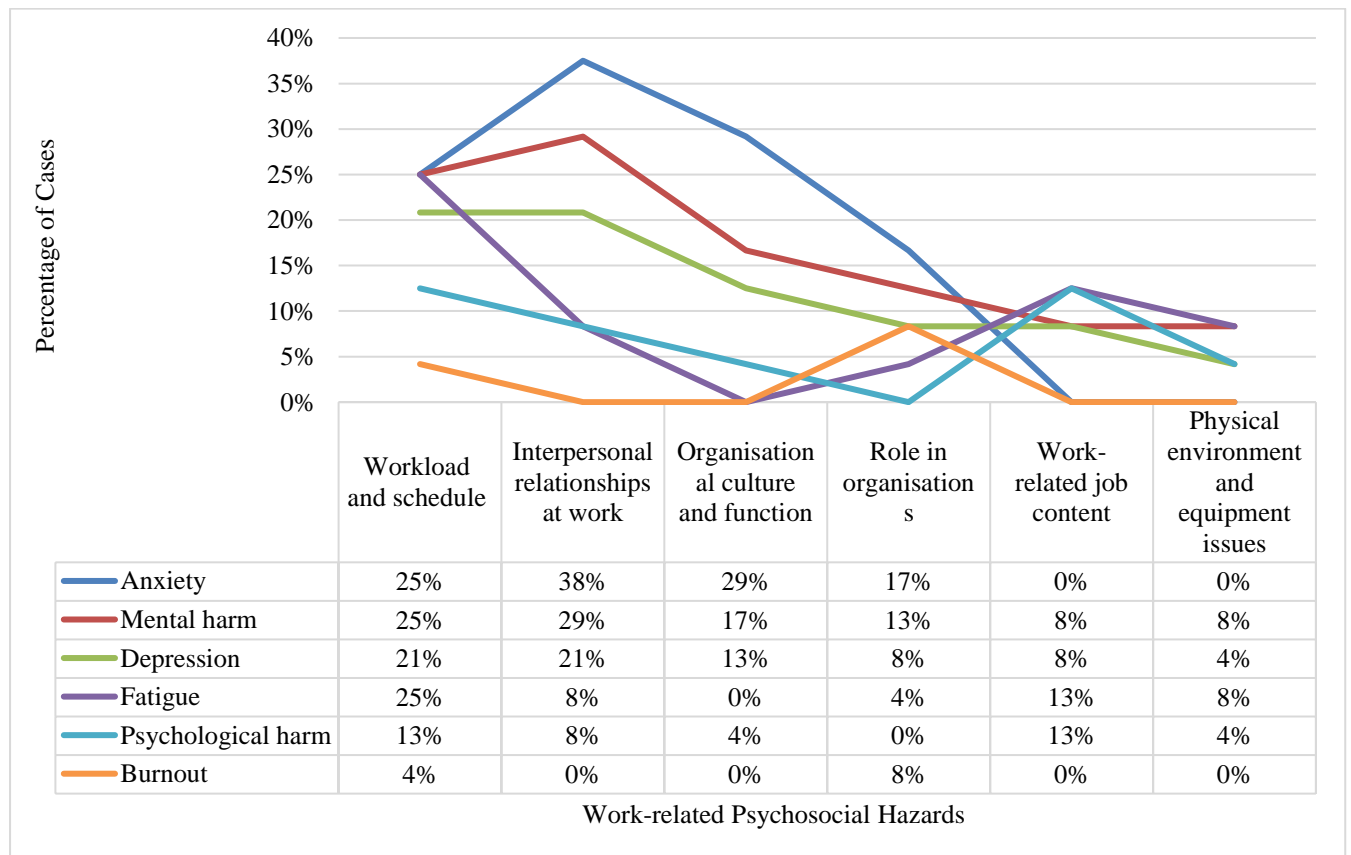


Figure 10. The relationship between mental or physical ill-health and psychosocial hazards

For example, where workload and schedule were identified as a hazard, 25% (n=6) of workers experienced anxiety, mental harm, and fatigue, while 21% (n=5) of the workers suffered from depression. Interpersonal relationship issues at work played a role where 38% (n=9) suffered from anxiety, 29% (n=7) of workers experienced mental harm, and 21% (n=5) depression. Organisational culture and function contributed to 29% (n=7) of workers experiencing anxiety. Where roles in organisations influenced the workplace, 17% (n=4) of workers suffered from anxiety. Work-related job-content contributed to 13% (n=3) of workers suffering from fatigue and psychosocial harm. Physical environment and equipment issues played a role during 8% (n=2) of workers who suffered from mental harm and fatigue.

The comparative analysis findings indicated patterns of mental or physical ill-health influenced by different types of work-related psychosocial hazards. For example, workload or schedule is associated with the potential of causing anxiety, mental harm, depression, or fatigue. Interpersonal relationship issues at work were associated with anxiety, mental harm, or depression. By identifying patterns, associations are implied between the relationship of psychosocial work-related hazards and mental or physical ill-health. Very few studies have assessed whether different types of work-related psychosocial hazards show associations with specific mental or physical ill-health (Yiengprugsawan et al., 2015). Despite the increased awareness of the potentially harmful effects of work-related stress and psychosocial hazards, there has been little emphasis on the effects of detailed psychosocial hazards in terms of work-related illnesses (Clarke & Cooper, 2004).

In summary, the comparative analysis finding is quite unique in suggesting that, firstly, patterns may exist between the type of psychosocial harm and ill-health. Secondly, workload and schedule, interpersonal relationship issues, and organisational culture and function at work may have a relationship with anxiety, mental harm, depression, or workers' fatigue.

4.3.6 Summary

Section 4.3 has discussed evidence from cases where companies were held responsible for their workers' health (section 36 of the HSWA 2015). There are 4 framework analysis categories (section 4.2) in relation to section 36 of the HSWA 2015.

The first category discussed warning signs that were dominant throughout all the cases. The analysis indicated 'things starting to go wrong' (signalled by, for example, emotional

exhaustion or sleep deprivation), providing an opportunity for companies to take proactive steps preventing the escalation of these issues. However, it is concerning that PCBUs did not address these. It could either be due to the worker being unaware of its seriousness, the worker failing to report it, or the PCBUs failing to address it.

The second category discussed the types of mental or physical ill-health. Anxiety and depression were present during almost half of the cases, followed by psychosocial harm or fatigue. Given that these cases presented sufficient evidence during the court hearings under the ERA, it is expected that actions can and should be taken by WorkSafe NZ to prosecute mental or physical ill-health under the HSWA 2015.

The third category discussed secondary effects where all the cases indicated additional harm done to the worker over the short-or-long term following the mental or physical ill-health exposure. By applying a risk matrix, the consequences of secondary effects were measured against the impact of the workers' wellbeing. This indicated that PCBUs are not only in breach of their duties when failing to provide a health and safety work environment but could also be held liable for secondary effects resulting from such ill-health.

The last category explored the type of psychosocial hazards. It is concerning that workload or schedule followed by organisational culture and function was evident during almost half the cases. WorkSafe NZ had the opportunity to practice legislative enforcement where PCBUs failed to manage psychosocial hazards under section 36 of the HSWA 2015. Yet, these were prosecuted under the ERA 2000 and not the HSWA 2015.

In section 4.3.5, a comparative analysis of the 24 cases explored the relationship between mental or physical ill-health and psychosocial hazard where specific psychosocial hazards are related to certain types of mental or physical ill-health.

The next section will address an officer's due diligence concerning health and safety responsibilities (section 4.4).

4.4 HSWA Section 44 - Officers Due Diligence

This section of the report will address section 44 of the HSWA 2015, where officers of the PCBU must exercise due diligence to ensure that the PCBU complies with their duties or obligations under the Act.

To better explain this legislation, an officer is a director, a partner, or a person occupying a position comparable to that of a director. The officer's duty is not the same as the PCBU's duty. Officers do not have to directly ensure the health and safety of the companies' workers. However, officers must exercise due diligence to ensure that the PCBU complies with their duty or obligation without replacing it. The duty is imposed on officers personally and is separate from the duty imposed on the PCBU. Furthermore, it cannot be delegated, modified, or transferred. The due diligence duties for officers include keeping up-to-date with work health and safety matters; gaining an understanding of the nature of the operations of the PCBU and the hazards and risks associated with them; ensuring that the PCBU has appropriate resources and processes to eliminate or minimise risks to health and safety and to manage incidents and hazards (LawLink, 2016).

During the framework analysis, 4 categories were identified relevant to section 44 of the HSWA 2015. Sections 4.4.1 to 4.4.4 explores these 4 categories. This included officer's due diligence to ensure an understanding of the nature and operations of the companies (4.4.1), to ensure appropriate resources or processes to eliminate or minimise the hazards (4.4.2), to ensure appropriate processes for receiving, considering and responding to information regarding incidents, hazards and risk (4.4.3), and to ensure companies' have processes for implementing their policies and procedures (4.4.4).

4.4.1 Nature and Operation of the PCBU

Officers of companies have due diligence to understand the nature of the operations of the PCBU and generally of the hazards and risks associated with those operations. The nature and operations of the PCBUs have been analysed by the industry sectors, the job positions, and the regions throughout New Zealand. These 3 factors will be described separately.

Statistics New Zealand was accessed to identify the industry sectors by business unit classifications (Stats New Zealand, 2019a). The cases (n=24) covered a wide range of

industries including administrative services, agricultural services, air operations, ambulance services, automotive services, child care services, cleaning services, community probation services, education, firefighting services, government administration, nursing services, printing, prison operations, restaurant operation, and transport services. Little can be drawn as there was no clear trend of any business unit classifications indicating a higher or lower number of incidents. Based on this analysis, it can be concluded that psychosocial hazards appear to occur in all industries at the workplace.

The cases also provided information on job positions. Similar to the industry sectors, the job positions did not show a trend where specific jobs were at higher risk than others. Job positions identified include administrator, chef, cleaner, community worker, corrections officer, customs liaison officer, fire risk manager, guillotine operator, locomotive engineer, mechanic, nurse, pilot, restaurant manager, sales accountant manager, ambulance operator, teacher, tractor driver, and truck driver – suggesting that psychosocial hazards at the workplace can exist across a range of jobs.

Analysis by geographic region indicated that the most prevalent number of cases were in Auckland (n=8), Canterbury (n=6), and Waikato (n=4). The remaining court cases occurred at Wellington (n=3), Otago (n=2), and Bay of Plenty (n=1). These findings align with the population base during the 2018 census, where Auckland had the highest population, followed by Canterbury, Wellington, Waikato, and Otago (Stats New Zealand, 2019a).

In summary, the cases did not show any trends concerning industry sectors or job positions. While the number of cases is small, psychosocial hazards at the workplace can potentially affect all industries and job positions. A higher number of cases was identified in Auckland, Canterbury, Waikato, and Wellington, consistent with the 2018 population census data.

Section 4.4.2 will address the resources and processes companies have to eliminate or minimise risks to workers' health.

4.4.2 Resources and Processes to Eliminate or Minimise Hazards

The HSWA 2015 section (4) (c) states that officers have the due diligence to ensure companies have appropriate resources and processes to eliminate or minimise hazards to health and safety from work carried out. A generic model of risk management, called the risk

management paradigm, includes the following steps (Cox & Griffiths, 2010; Griffiths et al., 2000): identification of hazards; assessment of the associated risk; design of reasonably practicable interventions; implementation of interventions; monitoring and evaluation of the effectiveness of the intervention; feedback and reassessment of risk; review of information and training needs of workers.

The GRWM Regulations 2016 outlines the hierarchy of controls to manage hazards. It provides a structure to select the most effective control measures to eliminate or reduce the hazard of certain hazards that have been identified as being caused by the business's operations. The hierarchy of control has 6 levels of control measures. The most effective measure is at the top of the hierarchy, and the least effective is at the bottom. Ideally, companies will start at the top in selecting control measures and work their way down. The hierarchy of control involves firstly elimination (removing the cause of danger completely); secondly by substitution (controlling the hazard by replacing it with a less risky way to achieve the same outcome); thirdly by isolation (separating the hazard from the people at risk); fourthly by engineering controls; fifthly by administrative controls; and lastly through personal protective equipment (PPE).

Although there are many resources and examples available to apply control methods for physical, chemical, biological, or chemical hazards, applying the hierarchy of control to psychosocial hazards is arguably more complex. Workplace interventions for psychosocial hazards are often targeted towards individuals rather than those of organisations (Staetsky et al., 2012). Literature acknowledges the difficulties of using the risk management paradigm for psychosocial hazards (Cox & Griffiths, 2010). Most controls for psychosocial hazards relate to administrative controls. Worker education, comprehensive policies and procedures, and good communication processes are examples of administrative controls (Government of Alberta, 2011). This was evident during the case analysis.

Each case was analysed against resources or processes available to eliminate or minimise psychosocial hazards at the workplace. With resources or processes in place, the cases were identified as compliant, or where resources or processes were not in place, they were considered non-compliant.

PCBUs with resources or processes were evident in 63% (n=15) of the cases. Some of the PCBUs had more than one resource or process and, therefore, calculated to 23 times within these 15 cases. These included health and safety-related policies such as stress and fatigue or bullying policies (n=10); health and safety processes, for example, rest breaks or to resolve health and safety concerns (n=7); EAP including specialist counselling in the event of traumatic incidents (n=4); or contracting a health and safety professional (n=1).

The non-compliant PCBUs measured at 37% (n=9). This could be due to primary, secondary, or tertiary interventions. PCBUs may be placing the focus on, for example, altering unhealthy or unsafe behaviours (secondary interventions) or by encouraging personal strategies to prevent re-injury or recurrence (tertiary interventions), as opposed to preventing disease or injury before occurrence (primary interventions).

Another potential explanation for cases not specifically mentioning resources or processes could be due to the nature of secondary data. The selected cases were not produced specifically for the research aim (to explore psychosocial hazards at the workplace). Therefore, they may have omitted information relevant to this study but not deemed necessary for the judicial process.

In summary, 63% (n=15) had processes to eliminate or minimise the hazard in relation to its operations. This was practiced mainly by applying administrative control actions such as worker education, comprehensive policies and procedures, and good communication processes.

4.4.3 Receiving, Considering and Responding to Information

Section 44 (4) (d) of the HSWA 2015 states that officers have the due diligence to ensure reasonable processes are in place and utilised to receive, consider, and respond to information regarding incidents, hazards, and risks. This section can be split into two elements: companies receiving information and companies considering and responding to the information received, as illustrated in figure 11.

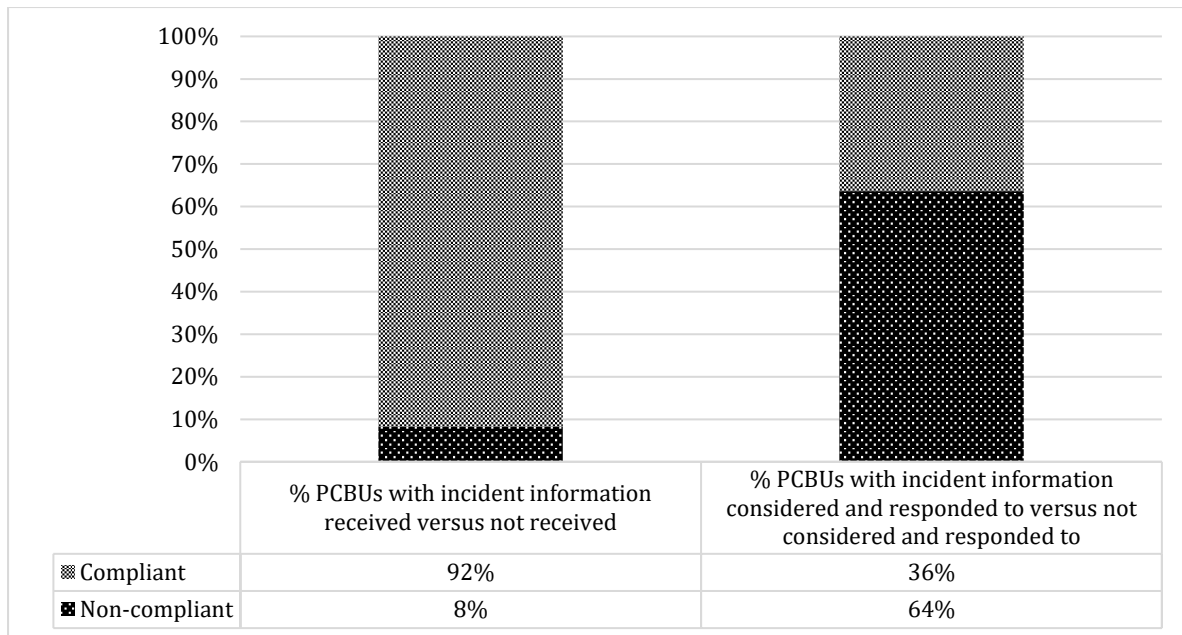


Figure 11. Information received, considered, and responded to

The first element explores PCBUs with adequate processes for receiving information regarding psychosocial incidents, hazards, or risks. These were identified in 22 cases (92%). The processes varied, for example, from workers raising their concern during meetings (CNs 3, 15 and 16), written complaints (CN 6), bringing the incident to the attention of management (CN 8), or having policies in place to deal with the management of workers' issues (CN 9).

The remaining 8% (n=2) was not necessarily PCBUs failing to ensure adequate processes for receiving information, but rather the lack of any such description in these two cases. This highlights a limitation of secondary data which is the possibility of not having data relevant to the study's aim. Therefore, the second element where PCBUs must have processes to consider and respond to information was only measured against the 22 cases where the information was received.

The second element addressed processes in place for PCBUs to consider and respond to information received. Out of the 92% (n=22) of PCBUs where information was received, concerning only 36% (n=8) considered and responded to information received from the worker regarding incidents, hazards, and risks. For example:

'After receiving complaints (company) took all practicable steps to commensurate with its obligations under the HSE Act to ensure the safety of its employees in the

workplace, including taking action on the recommendations made by OSH in 2004/5 to bring its policies and procedures into compliance with the Act.’- CN 3

In contrast, 64% (n=14) of PCBUs failed to consider and respond to the information received, as described where

‘(Applicant) went on leave and once returned to work realised nothing had changed about his workload. No steps had been taken by (company) to address his concerns.’ - CN15

Officers not considering and responding to the information received could be due to their own workload and pressure. For example, the director’s response to worker’s fatigue was

‘I don’t know what is wrong with you, I’m running five companies’ - CN 20

This indicated overload of work schedule and, therefore, not being able to consider the worker’s concern. Another potential explanation is due to a lack of resources or experience, as described where

‘the existing support processes involved no psychological expertise and there was no evidence they were designed to identify or monitor the kind of risk of mental harm posed by (applicant’s) exposure to (the specific risk).’ - CN17

It could also be due to poor company culture or inadequate processes where, for example during CN 16, the person responsible for ensuring processes are in place to consider and respond to information is the same person the bullying complaint was raised against.

In summary, 92% (n=22) of the cases had processes to receive information on work-related psychosocial harm. However, only 36% (n=8) of the companies responded to the information received. This could be due to work overload, lack of resources of experience, or cultural concerns.

4.4.4 Implementing Processes

The HSWA 2015 section 44 (4) (e) states officers’ due diligence to ensure reasonable steps to implement processes for complying with any duty or obligation of the PCBU. PCBUs’ policies, practices, and procedures are discussed by literature (Bentley et al., 2019) as part of a company’s ‘safety climate.’ In the study’s context, the safety climate can be referred to as the ‘psychosocial safety climate.’ This is defined as the “policies, practices, and procedures for protecting workers’ psychological health and safety” (Dollard & Bakker, 2010, p. 580). A

poor psychosocial safety climate is “negatively related to psychosocial health outcomes” (Bentley et al., 2019, p. 22).

Out of all the cases, only 8% (n=2) implemented compliance processes as illustrated in figure 12.

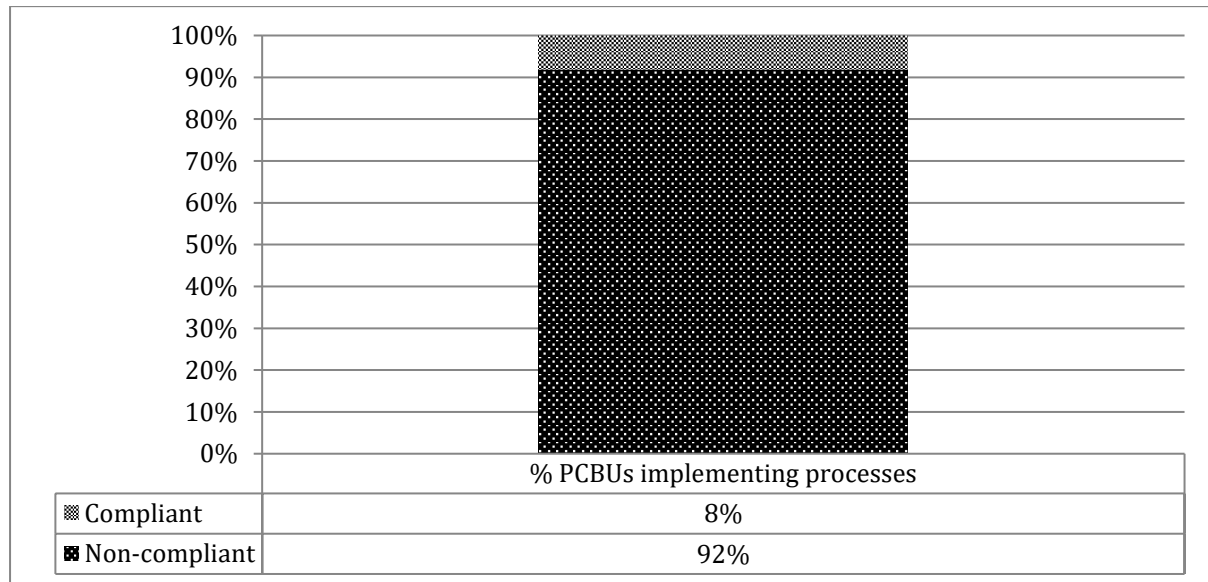


Figure 12. Processes implemented

During case 14, the applicant claimed to have suffered from anxiety caused by stress. The PCBU’s stress and fatigue policy was fully implemented. The court conclusion stated that

‘(Company) took reasonable care and all practicable steps to provide a safe workplace for (applicant). There was not a breach of the duties and obligations that (the company) had towards (applicant) to ensure a safe working environment.’ - CN 14,
or

‘(Company) ensures that all team members are able to achieve rest breaks during their work hours in accordance with the legislation. (Company) provides all staff with fatigue minimisation techniques, including controlled rest, in accordance with their Rest and Meal Breaks Policy.’ - CN 19

The 92% (n=22) remaining cases where processes were not fully implemented could be due to companies not conducting adequate investigations into the health and safety concerns raised by the worker and, therefore, not being fully aware of the seriousness of the incident.

For example

‘(Company) did not take steps to inquire into or explore the health and safety concerns (the applicant) raised during the course of the meeting. Inadequate steps had been taken to explore these health and safety issues. (Company) failed to implement a return to work programme which amounts to a breach of (company’s) health and safety obligations towards (applicant).’ - CN18

Another explanation for companies not fully implementing processes could be due to companies failing to have expert advice, for example, where

‘Despite awareness of the psychological risks and access to expert information and programmes (company) failed to put in place the basic steps necessary to minimise or avoid the ongoing risk to (applicant’s) mental health. - CN17

PCBU culture and values could also play a part in not fully implementing processes. This is demonstrated where

‘(Company) ought to have done more to protect (applicant) from the dangers of excessive working hours fatigue. It did not implement a formal fatigue plan to manage that day. It simply did not do enough.’ -CN 11

This could be explained due to the lack of documenting, communicating, and implementing PCBU culture or values.

The overall low number of cases successfully implementing processes (n=2) could be due to the dataset’s limitation consisting of ‘worst-case scenarios.’ PCBUs effectively implementing processes are less likely to face court proceedings and are, therefore, less evident in this data.

In conclusion, only 8% (n=2) of PCBUs implemented processes for complying with any duty or obligation. Possible reasons include not conducting adequate investigations into the health and safety concerns raised by workers, not being fully aware of the seriousness of the incident, companies failing to reference expert advice, or due to the PCBU’s culture or values. This is a concern considering officers of a PCBU had the opportunity to take proactive steps towards a healthy work environment, yet the majority failed to do so.

4.4.5 Summary

The HSWA 2015 section 44 described officers’ due diligence. Sections 4.4.1 to 4.4.4 explored the 4 relevant framework analysis categories.

The first category addressed the officer's due diligence to ensure an understanding of the companies' nature and operations. There was no evidence concerning industry sectors or job positions, suggesting that psychosocial hazards exist across industries and job positions.

The second category identified that 63% (n=15) of the cases had appropriate resources or processes to eliminate or minimise the hazards, mainly through administrative controls. Companies without resources or processes in place could be due to the primary, secondary, or tertiary interventions focusing on the latter by preventing re-injury or recurrence instead of avoiding disease or injury before occurrence. This could present WorkSafe NZ with an opportunity to engage and educate companies on proactive risk management.

The third category explored officer's due diligence to ensure appropriate processes for receiving, considering, and responding to information regarding incidents, hazards, and risk. During 92% (n=22) of the cases, PCBUs had processes to receive information with only 36% (n=8) responding to the information received. During section 4.3.4, it was observed that almost half of the workers perceived their workplace as a place with poor management commitment and support for psychological health and safety, as well as potentially poor organisational communication with workers about psychosocial health and safety. This is supported by the number of cases (n=14) not responding to information received concerning psychosocial harm.

The last category explored officers' due diligence, where only 8% (n=2) of PCBUs implemented processes for complying with any duty or obligation. PCBUs not implementing their policies or processes could indicate a PCBU's poor psychosocial safety climate with a potential negative impact on psychological health (Bentley et al., 2019).

Overall, officers of the PCBUs had several opportunities to influence the work environment by providing resources for risk management, responding to psychosocial harm reports, or implementing procedures to manage psychosocial harm proactively. It is worrisome that WorkSafe NZ is not actively involved in assessing or investigating such cases.

Workers also carry a responsibility to ensure a healthy workplace for themselves and others. This will be addressed during section 4.5.

4.5 HSWA Section 45 - Workers responsibilities

Section 45 of the HSWA 2015 states that workers must take reasonable care for their own health and safety and must ensure that their actions or inactions do not adversely affect the health and safety of others (WorkSafe New Zealand, 2017d).

The framework analysis identified 3 categories in relation to section 45 of the HSWA 2015 addressing workers' responsibilities. These include the worker reporting psychosocial harm to the PCBU (4.5.1), non-work-related issues (4.5.2), medical conditions raised by health practitioners (4.5.3), followed by a summary (section 4.5.4).

4.5.1 Workers Reporting Psychosocial Harm to PCBUs

Section 4.4 discussed how officers were expected to have adequate processes for receiving information regarding psychosocial incidents, hazards, or risks. This section conversely addresses the responsibility of the worker to engage and participate in using those processes.

During several cases, reference was made to the Christopher John Gilbert versus the Attorney-General (2002) case. This case emphasised that

‘the employee must himself take all practicable steps to ensure his own safety while at work. Foreseeability of harm and its risk will be important in considering whether an employer has failed to take all practicable steps to overcome it. These assessments must take account of the current state of knowledge and not be made with the benefit of hindsight. An employer does not guarantee to cocoon employees from stress and upset, nor is the employer a guarantor of the safety or health of the employee.’ (p.27)

In short, the worker has the responsibility to inform the PCBU of any potential harm. Court conclusions consider the knowledge the PCBUs had in relation to the exposure of potential harm. The court will not consider it the responsibility of the PCBU if they are unaware of the event or situation.

Figure 13 illustrates the percentage of workers reporting harm during the cases.

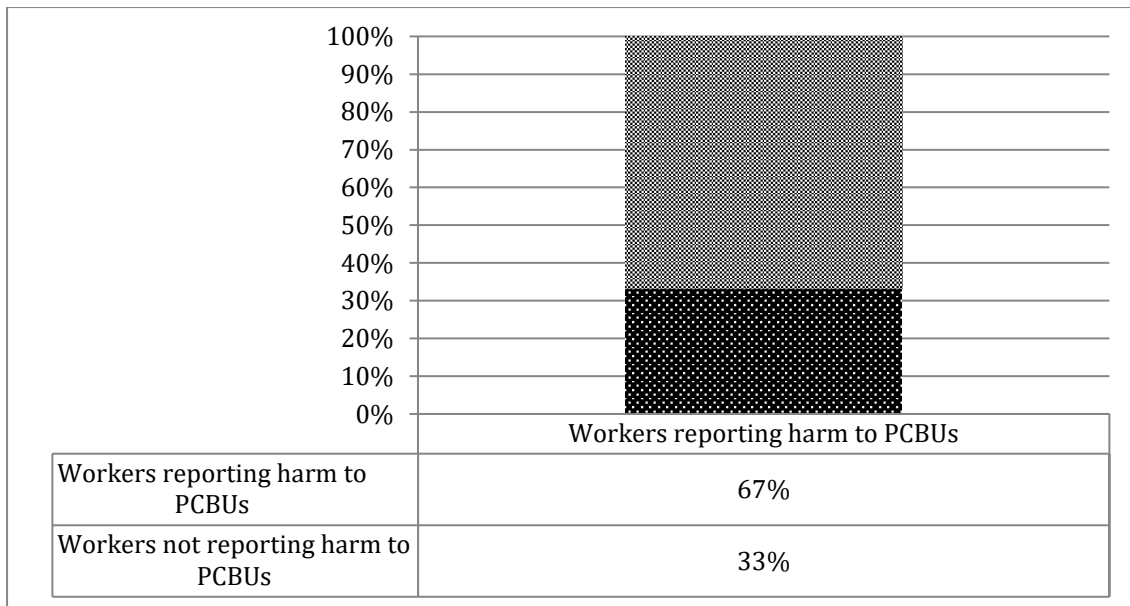


Figure 13. Workers reporting harm

Out of the 24 cases, 67% (n=16) reported psychosocial harm to the PCBU. The remaining 33% (n=8) did not report. An example of a worker not reporting psychosocial harm was where

‘(Applicant) described the situation immediately prior to the assault as being under control and then it changed in a split second and he was assaulted.’ - CN 5

This could be due to the worker not explicitly understanding the potential impact of the hazard. It could also be due to the worker feeling frustrated and not trusting the management style of the PCBU as demonstrated where

‘(Applicant) attempted procedural change leading to self-imposed additional pressure and stress with unfortunate results.’ - CN 3

Where the worker experienced management issues due to other work-related matters, the worker may not trust the PCBU with reporting harm.

Another potential reason for not reporting could be due to the financial situation of the worker. If, for example, fatigue due to long work hours is being reported, the worker may be requested to work fewer hours resulting in less income.

In summary, 67% (n=16) of workers reported psychosocial harm to their PCBUs. Workers not reporting may be due to the not understanding the potential impact of the associated

hazard, the lack of trust in the PCBU, or workers not willing to risk reporting harm for their own benefit.

4.5.2 Non-work-related Concerns

Workers do not shut off all their thoughts and feelings about non-work-related events and issues (Mental Health Foundation of New Zealand, n.d.). The relationship between life inside and outside work can impact workers' wellbeing, job-related attitudes, and job performance. The EU-OSHA (2012) recognises potential situational factors outside of work, having the potential to impact the work environment. For example, family illness, divorce, geographic relocations, or socio-economic level could contribute to how workers deal with psychosocial hazards at work. Non-work-related issues are often discussed as part of work-life balance. EU-OSHA defines work-family balance as the "extent to which an individual is equally engaged in and equally satisfied with their work role and family role" (EU-OSHA, 2012, p. 1).

Figure 14 illustrates the percentage of cases experiencing non-work-related concerns.

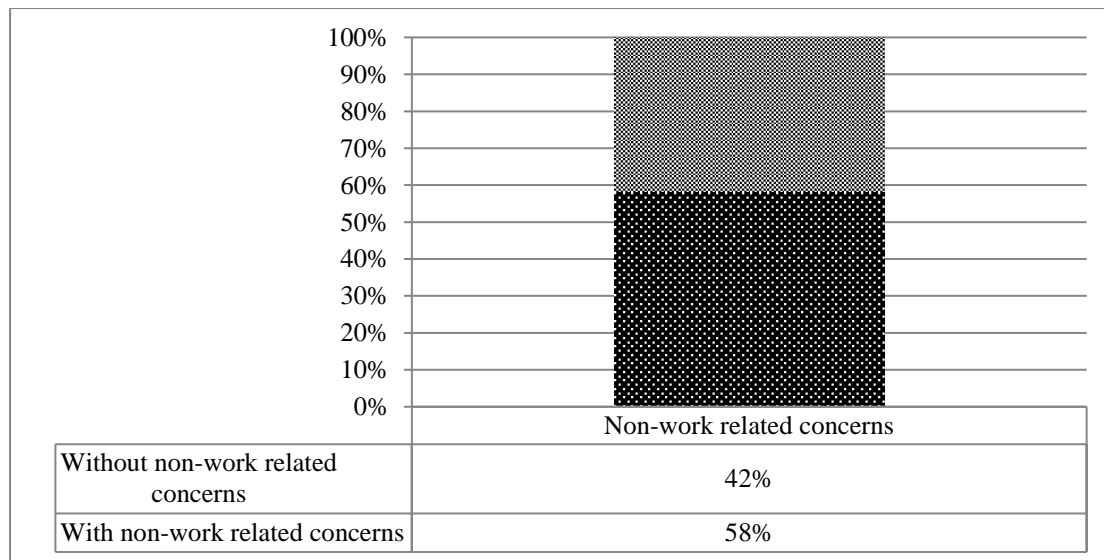


Figure 14. Non-work-related concerns impacting workers

Workers in 58% (n=14) experienced non-work-related concerns that impacted their work. Of this, 38% (n=9) reported it to their PCBUs, as illustrated by figure 15.

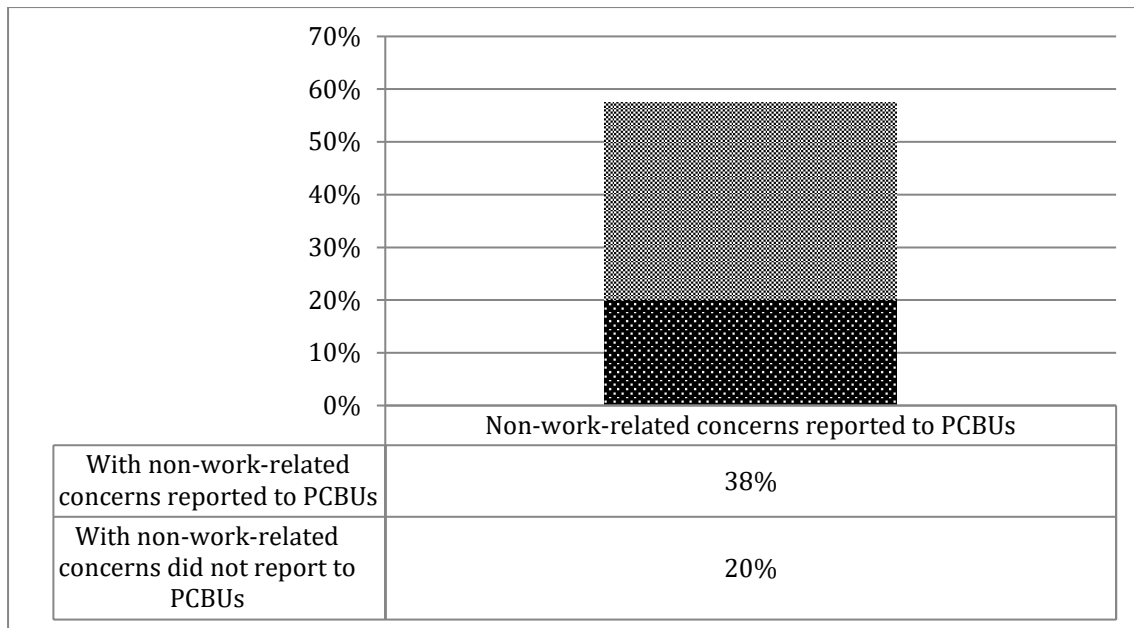


Figure 15. Workers reporting non-work-related concerns to PCBUs

For PCBUs to act and support workers on non-work-related matters, the PCBU must be aware, to some extent, of the workers' situation outside of work. For example

‘(Applicant) had contacted (company) as her mother was gravely ill and she required organising time off from work. (Company) had made the necessary arrangements.’ - CN 16

However, trusting PCBUs with non-work-related issues could have the opposite effect. During for example CN 7, the PCBU was aware of the applicant suffering from a serious incident of psychological domestic violence and argued that the actual cause of mental ill-health was not work-related.

The EU-OSHA (2012) recommends a workplace policy on work-life balance where agreed procedures and policies can help manage exceptions, reduce the number of queries, ensure equal treatment of all workers, and help line managers apply work-life balance policies. Furthermore, worker tolerance to stressors, such as psychosocial hazards discussed in section 2.3.1, varies considerably (Blonna, 2012).

In conclusion, non-work-related concerns contributing to worker's health were experienced by 58% (n=14), with 38% (n=9) reporting it to their PCBUs. This could be due to workers

not trusting PCBUs to provide support, or lack of policies or procedures to manage non-work-related incidents.

4.5.3 Medical Conditions Reported to PCBUs

Medical conditions diagnosed by medical practitioners tend to be one of the last matters submitted as part of the final evidence during cases. In 71% (n= 17) of the cases, workers were diagnosed with a medical condition by an approved healthcare professional. This may or may not have been caused by work-related psychosocial harm, depending on the individual cases. Out of the 71% (n=17) cases, most workers at 63% (n=15) liaised with their PCBUs in response to the recommendations provided by their healthcare professionals. These medical conditions may include, for example, major depression disorder (CN 3), severe psychological effects and anxiety disorder (CN 6), bilateral tendonitis injury, major psychological damage, (CN 15), adjustment disorder with anxiety (CN 18), or post-traumatic stress disorder (CN 24).

During the analysis, an observation was made concerning when the PCBU offered counselling to the worker, which were either before or following the medical diagnosis, or not at all. This is illustrated in figure 16.

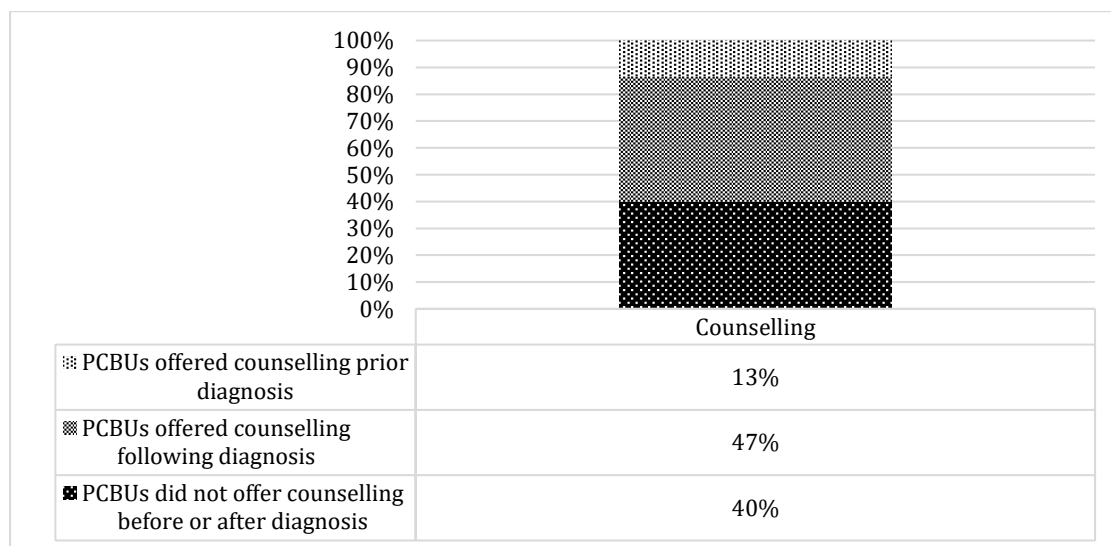


Figure 16. PCBUs offering workers counselling prior to or following diagnosis

Only 13% (n=2) of PCBUs offered their workers counselling before diagnosis. This could be due to PCBUs not considering mental illness as work-related unless the worker voluntarily provides the PCBU with a report from a physician or other licensed healthcare professional.

Counselling offered to the workers following diagnosis was identified in 47% of cases (n= 7). This may suggest that companies feel more confident in providing counselling to workers once a diagnosis is confirmed.

In 40% (n= 6) of the cases, the workers were not offered counselling before or after a medical diagnosis. This could be due to the size of the PCBUs or the funds available. It could also be due to the PCBU perception that employer-funded counselling should only be used to address issues relating to the worker's work life.

In conclusion, 71% (n=17) of the workers were diagnosed with a medical condition by a healthcare professional. In 63% (n=15) of the cases, workers reported their medical condition to the PCBU. Counselling was offered to 13% (n=2) of workers before diagnosis, 47% (n= 7) following diagnosis, and 40% (n=6) were not offered counselling before or after a medical diagnosis.

4.5.4 Summary

Section 4.5 addressed section 45 of the HSWA 2015, where workers have responsibilities towards their own health and safety duties, outlining 3 categories relating to section 45 of the HSWA 2015.

The first category assessed 67% (n=16) workers reporting psychosocial harm to the PCBU. Workers have the responsibility to inform the PCBU of psychosocial harm as the company will not be held responsible for taking reasonable steps if workers failed to report.

The second category described non-work-related issues contributing to a worker's mental ill-health at work. Non-work-related concerns contributing to worker's health were experienced by 58% (n=14), and only 38% (n=9) reported it to their PCBUs. For PCBUs to act and support workers, they must be aware, to some extent, of non-work-related factors contributing to the workers' health.

Lastly, the third category explored 63% (n=15) of the workers making PCBUs aware of their medical conditions (work or non-work-related) diagnosed by health practitioners. Companies offered counselling to almost half of the workers after reporting such medical conditions. Although raising medical conditions may not be mandatory, it could benefit the workers by creating an opportunity for the company to understand better and support their circumstances. However, it also raises a concern where the company may feel it is not their obligation to support the worker if the medical condition is non-work related.

Overall, workers could influence their work environment by reporting psychosocial harm, non-work-related concerns, or medical conditions. It could be implied that WorkSafe NZ has the regulatory duty to support companies in providing guidance and tools for workers to understand the importance of reporting.

Section 4.6 will investigate the court outcomes discussing the conclusions (section 4.6.1) and compensation (section 4.6.2).

4.6 Court Outcomes

Lastly, this section will explore court outcomes separated into the court conclusions (4.6.1) and the compensation (4.6.2).

4.6.1 Court Case Conclusions

During each case, the court findings described the court outcomes and compensations. There was a total of 92% (n=22) convictions and 8% (n=2) non-convictions. Out of the 92% convictions 88% (n=21) were prosecuted under the ERA 2000 and 4% (n=1) under the HSWA 2015. This is illustrated in figure 17. The convicted cases will be discussed, followed by non-convicted cases.

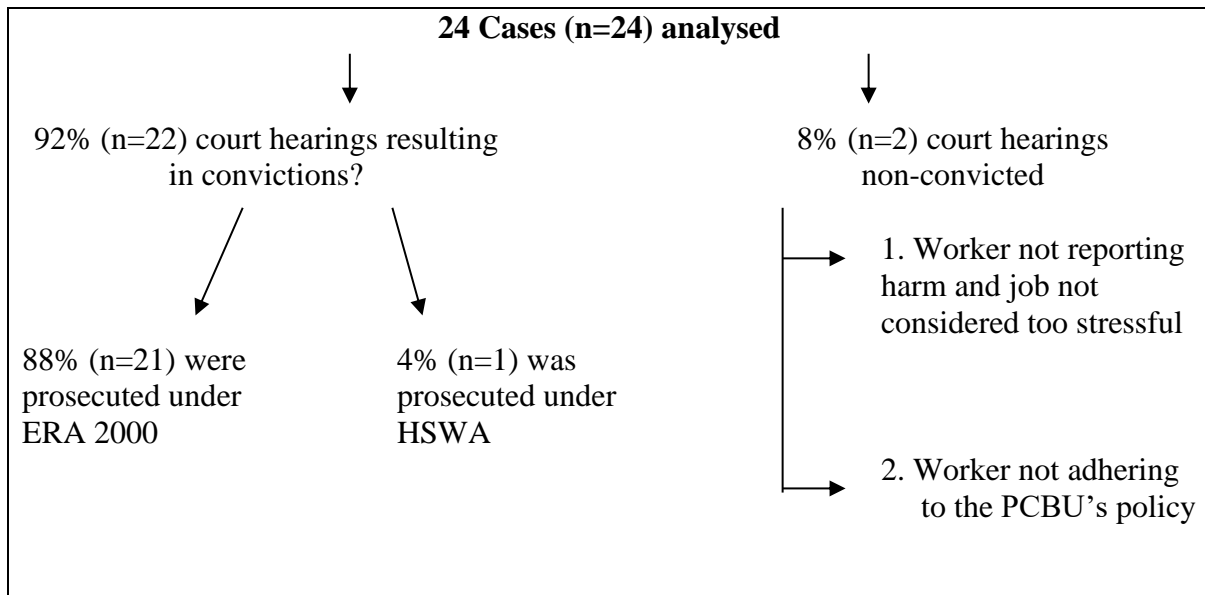


Figure 17. Court outcomes

Research suggests that the challenges of regulating psychosocial hazards in the workplace under the HSWA 2015 lie in the particular nature of psychosocial hazards such as their complexity, uncertainty, value, and power divergences (WorkSafe New Zealand, 2016). Therefore, psychosocial hazards resemble ‘wicked problems’ typically characterized by unclear cause-effect relationships and uncertain solutions (Jespersen et al., 2016). While aware of psychosocial hazards, labour inspectors often deem prosecution as problematic due to limited training, resourcing constraints, deficiencies in regulation, and victimisation fears amongst workers (Lippel & Quinlan, 2011).

It was also suggested for New Zealand to ‘develop a new set of enforcement tools’ to regulate working conditions that lead to poor worker health (Duncan, 2016). WorkSafe NZ has issued their position on work-related occupational health in 2017 (WorkSafe New Zealand, 2017e), explaining the importance of regulating work-related health. It sets out the expectations of duty holders in following the work-related health requirements of the HSWA 2015 and the GRWM Regulations 2016, which both strengthen the requirements for PCBU’s to protect the health of workers.

During this study, 88% (n=21) of the cases, prosecuted under the ERA 2000, had sufficient evidence to confirm that work-related psychosocial hazards significantly influenced workers experiencing mental ill-health.

The judge concluded, for example, that

‘(Company) failed to comply with the applicable obligations to maintain a safe and healthy work environment.’ - CN 4,

‘(Applicant) was not provided with a safe working environment.’ - CN 12,

‘The actions of (Company) constitute a serious breach of the duty to provide a safe place of work and not to be abusive to an employee.’ - CN 7, or

‘An employer is obliged to meet its obligations under the HSE Act 1992 to take all practicable steps to ensure a safe workplace. I am satisfied that (Company) was in breach of these requirements.’ - CN 15

Therefore, it is reasonable to suggest that the cases convicted under the ERA 2000 reveal sufficient evidence for Work Safe NZ regulators to investigate, inspect, or assess.

Out of the 92% (n=22) convictions, the only case not prosecuted under the ERA 2000 was CN 11, where a fatality due to psychosocial harm at the workplace triggered WorkSafe NZ regulators to investigate. The case does not specify whether processes were in place to manage hazards, specifically long work hours and fatigue. It does, however, confirm that the employer practiced due diligence to monitor the worker’s fatigue. The judge concluded that fatigue in the workplace is not well understood, and it would be too simplistic to conclude that the number of hours worked equate to a particular degree of fatigue. The judge further acknowledged that the hours worked were high but not unusual or excessive when viewed in the industry context. It is worth noting that the only prosecution under the HSWA 2015 where psychosocial hazards significantly influenced the worker was for a fatality. This highlights the importance of WorkSafe NZ regulators being actively involved during psychosocial harm cases to eliminate such detrimental outcomes.

The non-convicted cases (8%, n=2), CNs 14 and 19, were also prosecuted under the ERA 2000. CN 14 was not successfully convicted, where the applicant’s dismissal was justified, and the PCBU was not in breach of their duties. The judge concluded that the applicant failed to directly notify or give any clear indication to the employer that their mental ill-health was due to workload. The judge further stated that

‘Psychological pressures are inevitable in all jobs, although greater in some than in others. But it is rather more difficult to identify which jobs are intrinsically so stressful that physical or psychological harm is to be expected more often than in other jobs. Some people thrive on pressure and are so confident of their abilities to

cope that they rarely, if ever, experience stress even in jobs which many would find extremely stressful. Others experience harmful levels of stress in jobs, which many would not regard as stressful at all.’ - CN14

The reasons for the PCBUs not being found guilty were two-fold: one being the worker not reporting the symptoms directly to the employer, and two the judge not considering the job as overly stressful. The impact of different interpretations of jobs being ‘too stressful’ could signify a key challenge in regulating psychosocial hazards.

The other case not successfully convicted was CN 19, where the worker claimed that the PCBU failed to manage fatigue and minimising health and safety or productivity concerns. In defence, the PCBU provided evidence that a rest and meal break policy was available. The court concluded that there was no conspiracy from the PCBU to keep the policy from the worker. Therefore, it falls under the worker’s responsibility to ensure adherence to the policy during shift work.

In summary, the 92% (n=22) were successfully convicted; 88% (n=21) under the ERA 2000 and 4% (n=1) under the HSWA 2015. Convictions under the ERA revealed sufficient evidence for Work Safe regulators to investigate. The one conviction under the HSWA 2015 was for a fatality. This highlights the importance of WorkSafe NZ getting actively involved to prevent similar outcomes.

The 8% (n=2) non-convictions were due to the court concluding that the worker failed to directly report harm to the PCBU. The job position was not considered too stressful, and the worker had access to policy concerning rest and meal break but failing to adhere to it.

4.6.2 Compensation

Each case concluded with an outcome and compensation costs. The average determination costs of all the cases (n=24) were \$20,000.00 per case. This excluded wages, court costs, or any additional costs such as medical or travelling. Employment NZ provides a compensation and cost award table from July to December 2019 (Employment New Zealand, 2019). This table illustrates 68 cases where the compensation was awarded under the ERA 2000 for humiliation, loss of dignity, and injury to the workers’ feelings. Compensation below \$10,000 was awarded to 34% (n=23) of cases; compensation between \$10,000.00 and \$14,999.00 was

awarded to 25% (n=17); compensation between \$15,000.00 and \$21,000.00 was awarded to 28% (n=19); and 13% (n=9) was awarded compensation above \$21,000.00.

As calculated above, the penalties under the HSWA 2015 are considerably higher than the average fines under the ERA 2000. WorkSafe NZ describes the most serious offences under the HSWA 2015 are for failures to comply with health and safety duties under sections 36 to 46 of HSWA 2015. These cover the duties of PCBUs, officers, workers, and other persons at the workplace. Penalties start at \$50,000.00 and may go up to \$3 million (WorkSafe New Zealand, 2015). During CN 11, the starting point of prosecution under the HSWA 2015 (for the loss of life) was within the region of \$600,000.00 to \$800,000.00. Considering the mitigating factors, the end fine was \$325,000.00.

It is important to note that the drive behind prosecution is not only for higher compensation but also for the impacts derived from the publicity influencing the reputation of the PCBU. Furthermore, it could contribute to the overall improvement of health awareness of PCBUs. The accountability on PCBUs through the increased HSWA 2015 penalties could also be more of a deterrent.

4.6.3 Summary

Most of the work-related psychosocial harm cases were successfully prosecuted under the ERA 2000. There was adequate evidence to prompt further WorkSafe NZ investigations. The WorkSafe NZ prosecution policy, including the evidential test and public interest test, was published during August 2019 (WorkSafe New Zealand, 2019b). Further study to understand these requirements could be of benefit.

4.7 Summary - Results and Discussion

The study aimed to explore the New Zealand legal response on work-related psychosocial harm. The analysis in chapter 4 was carried out corresponding to each of the four research objectives:

RO1: Gain insight into work-related psychosocial harm prosecutions

RO2: Explore enforcement under the HSWA 2015 on work-related psychosocial harm

RO3: Explore the employers' and workers' influence on psychosocial harm

RO4: Recognise implications on companies being prosecuted

The thesis progress, with research objectives, are outlined in figure 18 below.

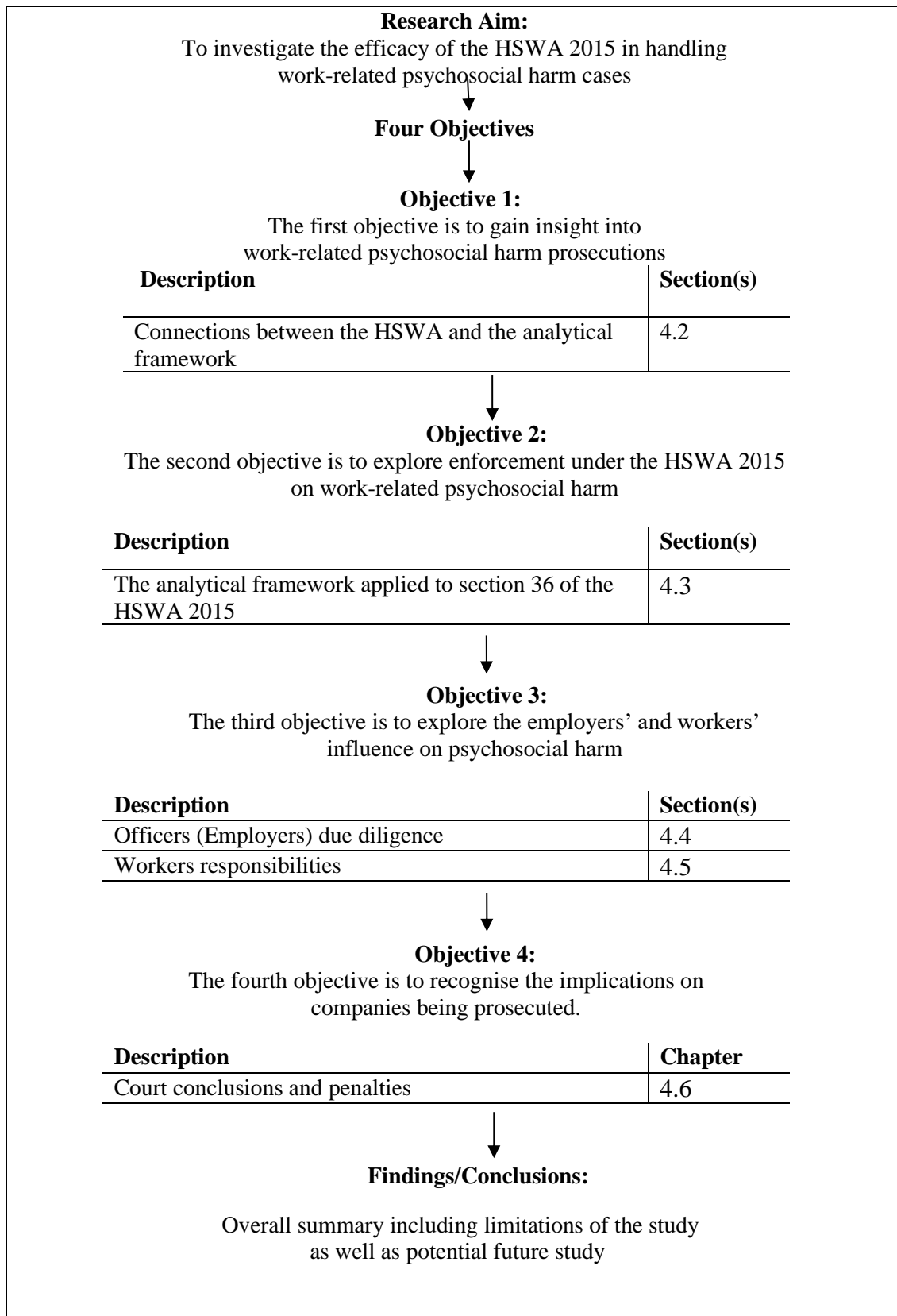


Figure 18. Thesis progress, with research objectives indicated

Section 4.1 outlined the secondary data approach (Bryman et al., 2019) to retrieve court case transcripts from the NZLII. The filter criteria applied to the select 24 cases (n=24) for further study.

Next, section 4.2, addressed the first research objective (RO1) ‘to gain insight into work-related psychosocial harm prosecutions’ by grouping psychosocial harm characteristics, identified during case analysis, into analytical framework categories. These categories were arranged in connection to sections 36, 44, and 45 of the HSWA 2015 (table 3). This section provided knowledge on how events (incidents, injuries, illnesses) where psychosocial hazards played a significant role at work are currently prosecuted under the ERA 2000 and not the HSWA 2015, even though sufficient evidence is available for WorkSafe NZ to intervene.

During section 4.3, the second research objective (RO2) ‘to explore enforcement under the HSWA 2015 on work-related psychosocial harm’ was addressed. This was done by analysing the categories connected with section 36 of the HSWA 2015 where the PCBU must ensure, so far as is reasonably practicable, the health and safety of workers who work for the PCBU, while the workers are at work. The analysis indicated that early warning signs such as emotional exhaustion, feeling vulnerable or unprotected, or experiencing physical symptoms (section 4.3.1) were present during all the cases leading to different mental or physical ill-health (section 4.3.2). During all the cases, mental or physical ill-health were identified but not necessarily addressed, resulting in secondary effects (section 4.3.3). These included workers taking sick leave, participating in counselling, experiencing major health concerns, resigning, or suffering from a physical assault or vehicle accidents. Psychosocial hazards were evident during all the cases (section 4.3.4). It was observed that, by applying a comparative analysis (section 4.3.5), relationships exist between psychosocial work-related hazards and mental or physical ill-health. This section explored how, during all the 24 cases, the PCBU failed to provide a healthy work environment for the worker and, therefore, delivered sufficient evidence to practice enforcement under the HSWA 2015. However, 23 out of the 24 cases were prosecuted under the ERA 2000.

Section 4.4 explored the first part of the third research objective (RO3), namely ‘the employers’ (officers’) influence on psychosocial harm at the workplace.’ This was achieved by investigating officers’ due diligence to ensure a healthy workplace, as described by section 44 of the HSWA 2015. Case analysis suggested work-related psychosocial harm is

experienced across various industries or job positions and all geographic regions (section 4.4.1). The analysis indicated that only over half of the cases had resources or processes to influence work-related psychosocial hazards (section 4.4.2). Most cases received information regarding incidents, hazards, and risks providing an opportunity for employers to influence the outcome of the incident (section 4.4.3). Yet, the cases illustrated that under one-third considered and responded to the information received. Lastly, an overall low number of cases successfully implemented policies and processes (section 4.4.4). This section outlined how officers failed to meet their mandatory due diligence of influencing a healthy work environment, yet, without any repercussions under the HSWA 2015.

Section 4.5 explored the second part of the third research objective (RO3), namely ‘the workers’ influence on psychosocial harm.’ This was achieved by investigating how workers should take reasonable care for their own health and safety, as described by section 45 of the HSWA 2015. During more than half of the cases, workers reported psychosocial harm to their companies (section 4.5.1). Only half of the workers reported non-work-related concerns likely to impact their work. This may imply that workers are not aware of the potential effect of non-work-related issues on themselves and others. Lastly, almost three-quarters of workers made companies aware of their medical conditions - work or non-work-related (section 4.5.3). Counselling was offered to only less than half of the workers with such medical conditions. This section demonstrated that workers have the opportunity to influence the work environment for themselves and others. However, workers frequently failed to report or liaise with their employer concerning matters that may impact their own health and those of others. This section outlined how workers failed to comply with the legislative requirements of taking reasonable care for their own health. Yet, there is a lack of engagement, education, or supportive tools provided by WorkSafe NZ on this matter.

Section 4.6 addressed the fourth research objective (RO4) ‘to recognise the implications on PCBUs being prosecuted.’ This was addressed by analysing the court case conclusions and compensations. Only one case was convicted under the HSWA 2015, with the remaining 88% (n=21) being convicted under the ERA 2000. The average determination costs of the cases (n=24) were \$20,000.00 per case. This is considerably different from penalties under the HSWA 2015, starting from \$50,000.00 and may go up to \$3 million fines (WorkSafe New Zealand, 2015). The 2 non-convicted cases, also prosecuted under the ERA 2000, were

for the worker failing to report directly to the employer, the judge not deeming the work environment too stressful, and the worker not adhering to the policy.

To conclude, 23 out of 24 cases provided sufficient information for court hearings under the ERA 2000, where the PCBU, the officer (employer), and the worker play a role in influencing the psychosocial harm at the workplace. Therefore, it can be implied that sufficient evidence is available to prompt WorkSafe NZ to investigate psychosocial harm at the workplace under the HSWA 2015.

Chapter Five: Main Findings and Conclusions

5.1 Introduction

The ILO 2019 report (2019b) recognises psychosocial harm as an emerging work-related safety and health risk (section 2.3.2). Issues include, but are not limited to, employee isolation, socialisation, access to information, representation, new trends in work organisation, and employer liabilities for illness or accidents arising out of work (Brunand & Milczare, 2007). Following global trends, the New Zealand Government (WorkSafe New Zealand, 2019c) recognises that psychosocial hazards must be minimised within workplaces. Furthermore, there is a requirement for workplace interventions to reduce psychological harm and promote mental health for all New Zealand workers.

The definition of psychosocial harm at the workplace is complex and different terminology is used to describe its meaning. The language used by the WHO, the ILO, the EU-OSHA, the PAS 1010:2011, the HSE Amendment Act 2002, and the HSWA 2015 are evaluated to create a definition specific to this study. By using keywords from the literature (section 2.2.2), work-related psychosocial harm is defined as ‘mental or physical ill-health where there is reason to believe that the work-related psychosocial hazards played a significant role in causing potential psychological, social and physical harm to the individual.’

Research into the regulatory aspects of work-related psychosocial harm within New Zealand is challenging and considered a relatively new field (Chen, 2016). Most of the research (Duncan, 2018) focuses on the underlying reasons for regulation difficulties. WorkSafe NZ published a research and evaluation document in 2019 stating that ‘the research record in New Zealand is weak in terms of a workplace context and the social and cultural dimensions

within which psychosocial harm arises' (WorkSafe New Zealand, 2019c, p. 9). This study explored the New Zealand legal response on work-related psychosocial harm. Four interrelated research objectives to support the research aim were formulated:

RO1: Gain insight into work-related psychosocial harm prosecutions

RO2: Explore enforcement under the HSWA 2015 on work-related psychosocial harm

RO3: Explore the employers' and workers' influence on psychosocial harm

RO4: Recognise implications on PCBU's being prosecuted

The first research objective (RO1) was to gain insight into work-related psychosocial harm prosecutions. This has been achieved by creating an analytical framework matrix consisting of coded data grouped into 12 categories measured against sections 36, 44, and 45 of the HSWA 2015 (section 4.2).

The second research objective (RO2) explored enforcement under the HSWA 2015 on work-related psychosocial harm by analysing the cases against section 36 of the HSWA 2015, where PCBU's have the duty to ensure a healthy and safe work environment (section 4.3). Sufficient evidence during the cases suggests that PCBU's failed to comply with such duties, yet there is a lack of action by WorkSafe NZ to investigate or prosecute these cases.

The third research objective (RO3) explored the employers' and workers' influence on psychosocial harm by analysing cases against section 44 of the HSWA 2015. Officers have the due diligence to ensure a healthy place of work (section 4.4). Case analysis suggests that officers have the opportunity to influence psychosocial harm at the workplace by implementing resources or processes to eliminate or manage the psychosocial hazards, and to receive, consider and respond to information regarding incidents, hazards or risks. The evidence further suggests that although officers have sufficient opportunities to influence work-related psychosocial harm, there is an overall lack of proactive effort to prevent physical or mental ill-health.

Additionally, as part of the third research objective (RO3), workers are responsible for taking care of their own health while at work, as described by section 45 of the HSWA 2015 (section 4.5). Case analysis suggests that workers can influence their workplace by reporting

physical or mental ill-health, by acknowledging and reporting non-work-related concerns or other medical conditions to their PCBU. This could imply that WorkSafe NZ has the opportunity to engage or provide supportive tools to workers on reporting and, therefore, improving a healthy work environment for self and others.

The fourth research objective (RO4) was to recognise implications on PCBUs being prosecuted. This objective is achieved by analysing each case's court outcome and penalties (section 4.6). It was concluded that sufficient evidence was available to prosecute the cases under the ERA 2000, yet only one was investigated under the HSWA 2015. Furthermore, case analysis supports the Employment NZ statistics (Employment New Zealand, 2019), where court penalties under the HSWA 2015 are significantly higher than prosecutions under the ERA 2000.

The next section will consider the main findings of the study.

5.2 Main Findings

Numerous findings were outlined throughout this study. However, only those most relevant to the research objectives will be discussed during this section.

5.2.1 The Framework Analysis

During the framework analysis (section 4.2) similar work-related psychosocial harm characteristics were observed throughout all the cases. Although the cases only represented a small percentage and 'worst -case scenarios', it could be presumed that similar attributes are also to be found at other workplaces. These 'similar characteristics' created the evidence and opportunity for the NZ regulator, WorkSafe NZ, to play an active role in engaging with PCBUs to address these psychosocial characteristics at the workplace. It may include proactive support and advice from WorkSafe NZ on working practices, resources or processes to eliminate or minimise psychosocial hazards, the immediate actions to take after receiving reports, and recognising the early warning signs of physical or mental ill-health, or the potential secondary effects of psychosocial hazards.

Furthermore, the framework analysis indicated how these characteristics could be grouped in relation to sections of the HSWA 2015. This may support WorkSafe NZ in delivering targeted interventions to address effective governance under the HSWA 2015.

5.2.2 PCBUs, Officers, and Workers Playing an Important Role in Managing Psychosocial Hazards at Work

It was observed that a certain pattern exists where companies, officers, and workers play an important role in managing psychosocial hazards at work. This is illustrated in figure 19.

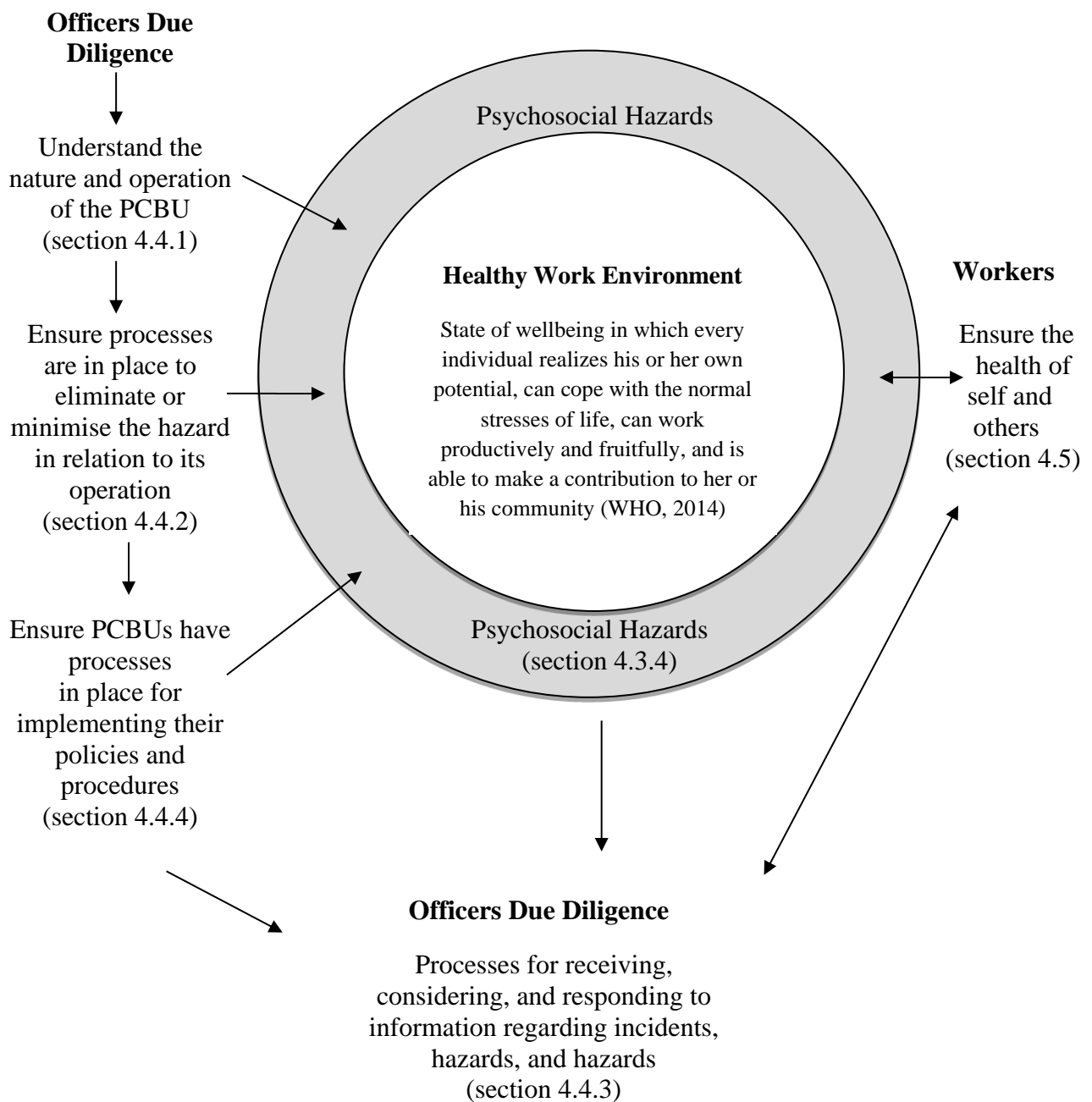


Figure 19. PCBUs, officers, and workers' influence to ensure a healthy workplace

An officer is a director, a partner, or a person occupying a position comparable to that of a director. The officer's duty is to exercise due diligence to ensure that the PCBU complies with their duty or obligation. The due diligence duties for officers include keeping up-to-date with work health and safety matters; gaining an understanding of the nature of the operations of the PCBU and the hazards and risks associated with them; ensuring that the PCBU has appropriate resources and processes in place to eliminate or minimise hazards to health and safety; ensuring appropriate processes for receiving, considering and responding to information regarding incidents, hazards and risks; and ensuring PCBUs have processes in place for implementing their policies and procedures.

On the other hand, workers must take reasonable care for their own health and safety and must ensure that their actions or inactions do not adversely affect others' health and safety. They must also cooperate with any reasonable workplace health and safety policy or procedure and comply with any reasonable instruction given by the PCBU so that the PCBU can itself comply with the HSWA 2015 and regulations.

The flowchart can be explained as a healthy workplace being the core of any PCBU. A healthy workplace is a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community (WHO, 2014).

During case analysis, unhealthy workplaces were associated with mental ill-health, warning signs, workers experiencing different types of mental or physical ill-health, and these conditions leading to secondary effects (section 4.3). Unhealthy workplaces were also associated with work environments where psychosocial hazards are likely to play a role in causing harm.

Psychosocial hazards are inevitable at any workplace and may contribute to workers' ill-health and wellbeing if not adequately managed. Companies have the duty to understand these hazards and how to manage them effectively. Psychosocial hazards will have an impact on workers, for example, workload. Still, it could also be that workers influence psychosocial hazards such as not reporting matters or creating interpersonal relationship issues with others (section 2.3).

As illustrated on the left, officers of companies must practice due diligence to ensure an understanding of psychosocial hazards specific to the PCBU's industry and the location (section 4.4.1). Officers must ensure processes are in place to eliminate or minimise these psychosocial hazards (section 4.4.2) and implement policies and procedures (section 4.4.4). Adherence, or lack of it, will impact the psychosocial hazard in the work environment. It is also essential for workers to be aware of these processes to ensure trust and confidence within the work environment.

Processes for reporting, considering, and responding to risks, hazards, and incidents must be in place and communicated to workers ensuring the system's continual improvement (section 4.4.3).

As illustrated on the right, workers are responsible for reporting harm to ensure a healthy workplace for themselves and others. Workers have the option to report non-work-related matters and medical conditions for PCBUs to act on (section 4.5) It is important to notice the interactions between both officers and workers on influencing the overall health of the PCBU.

The findings in figure 19 were two-fold where the legislative duties must be implemented by PCBUs, officers, and workers to improve a healthy workplace. It must also be enforced and regulated by WorkSafe NZ to verify whether necessary actions have been taken by all parties to ensure a healthy work environment.

5.2.3 Early Warning Signs

Early warning signs (section 4.3.1) such as feelings of emotional exhaustion (most prevalent), feeling unprotected or vulnerable at work, experiencing physical symptoms, feeling verbally, sexually or physically abused, or feeling sleep deprived (least prevalent) were present during all the cases. It could be argued that these signs were 'red flags' for PCBUs to manage psychosocial hazards proactively. Yet, based on the evidence from the 24 cases, it is concerning that these opportunities were not generally addressed and subsequently escalated to physical or mental ill-health requiring judicial attention. This may imply that companies could benefit from improved awareness by WorkSafe NZ targeted around early warning signs.

5.2.4 Secondary Effects

Section 4.3.3 supported Leka & Jain (2010) by providing sufficient evidence that mental or physical ill-health can cause secondary effects on workers impacting their physical, psychological, and social health. These secondary effects ranged from sick leave, resignation, counselling, major health concerns, or physical assault and vehicle accidents. A risk matrix explicitly created for the study's purpose assessed the consequences against the impact on worker's wellbeing. This illustrated that although a secondary effect caused by mental or physical ill-health may occur less frequently, such as fatigue causing vehicle accidents less often than anxiety causing counselling, the impact on the worker has the possibility to be more extreme with long-term or life-changing effects. This could imply that PCBU's failing to manage psychosocial hazards at the workplace is not only a breach under the HSWA 2015 but also has the potential to impact the worker with immediate, long-term, or life-changing effects. These effects could attract higher court penalties, and cause liability and reputational damage for the PCBU's.

5.2.5 Relationship Between Psychosocial Hazards and Mental or Physical Ill-health

A comparative analysis (section 4.3.5) discovered that specific psychosocial hazards are related to certain types of mental or physical ill-health. For example, workload and schedule, interpersonal relationship issues at work, and organisational culture and function are associated with anxiety, mental harm, depression, and (often) fatigue. This could imply that where workers (from the same PCBU) are experiencing similar types of mental or physical ill-health, there may be a pattern of psychosocial hazards at the workplace affecting workers' health. This provides WorkSafe NZ with an opportunity to engage with companies to explore potential trends further and, consequently, provide supportive tools.

5.2.6 Nature and Operation of the PCBU

The cases did not show any trends in relation to industry sectors, job positions, or geographical regions (section 4.4.1). While the number of cases is small, it can be inferred that psychosocial hazards at the workplace can potentially affect all industries, job positions, and geographical regions. Therefore, WorkSafe NZ should notice that psychosocial harm could occur in any job position, even if considered 'not too stressful' (section 4.6.1, CN 14).

5.2.7 Resources and Processes to Eliminate or Minimise Hazards

Companies with resources or processes, such as stress and fatigue or bullying policies; processes on how to resolve health and safety concerns; EAP including specialist counselling in the event of traumatic incidents; or contracting a health and safety professional, were evident in just over half of the cases (section 4.4.2). This supported the recommendation made by Duncan (2018), where additional supportive tools, provided by WorkSafe NZ, may be beneficial to address the problem of psychosocial harm at the workplace adequately.

5.2.8 Receiving, Considering and Responding to Information

Most cases had processes in place for workers to report psychosocial harm to the PCBU (section 4.4.3). Almost three-quarters of workers used these methods to report psychosocial harm to the PCBU (section 4.5.1). However, it is concerning that under one-third of the companies considered and responded to the information received (section 4.4.3). This could imply that officers had the ability to influence workers' health but failed to do so, indicating an opportunity for WorkSafe NZ to intervene.

5.2.9 Non-work-related Concerns

More than half of the workers experienced non-work-related concerns contributing to work-related psychosocial harm. Individual characteristics seemed to contribute to non-work-related matters where individuals responded to incidents differently (section 4.5.2). This section supported section 2.3.1 in that work-related stressors affects individuals in different ways. It has an individualistic nature, and what may be perceived as a stressor by one person may have no effect on another and may even lead to self-improvement. This could suggest that, during investigations, companies or WorkSafe NZ should be vigilant towards situational factors (section 4.5.2) likely to contribute to ill-health.

5.2.10 Medical Conditions Reported to PCBUs

Almost three-quarters of workers were diagnosed with medical conditions by a medical practitioner, which may or may not have been caused by psychosocial harm at the workplace (section 4.5.3). Their PCBUs offered less than half of these cases counselling after becoming aware of the workers' conditions. This could be due to the size of the PCBUs or the funds available. It could also be due to PCBU perceptions that the employer-funded counselling should only be used to address issues stemming from the worker's work life.

5.3 Limitations

There are several limitations that this study encountered, which will be explored during this section.

Firstly, secondary data as a research design method. The nature of using court case transcripts as secondary data is limited to the data being only available at the time of the court hearing. The information presented in the transcripts is deemed relevant to the prosecution at hand, which was the original purpose of the secondary data, and may omit information of relevance to the present study's objectives. Additionally, secondary data from court hearings represent the 'worst-case scenario.' The data may, therefore, not be a true reflection of a typical work environment. Consequently, it is expected to find high ratings during data analysis and performance assessments.

Secondly, the cases are selected where psychosocial hazards played a significant role in causing harm. It is acknowledged that work has the potential to harm a person's health, and a person's health can affect safety at work (WorkSafe, 2017c). Biological, chemical, ergonomic, physical, and psychosocial hazards can play a role in influencing a worker's health at work. However, this study focused on cases where there was reason to believe that only psychosocial hazards played a significant role in causing potential harm to the worker's mental health and wellbeing. Subsequently, cases where biological, chemical, ergonomic, or physical hazards may have played a role in causing psychosocial harm were eliminated.

Thirdly, most of the cases are prosecuted under the ERA 2000, as opposed to the HSE Amendment Act 2002 or HSWA 2015. Considering that most cases are not explicitly measured against the HSE Amendment Act 2002 or HSWA 2015 at the time of the court hearing, it is acknowledged that the data does not provide an in-depth scope of the health and safety environment, or hazard management, within the PCBU. The selected cases do not, for most cases, consider all hazards that had the potential to cause mental or physical ill-health to the worker. For example, it could not be assumed that particular cases failed to address certain topics. Instead, this was regarded as cases not providing information relevant to the specific research subject matter at that point in time.

Lastly, the frequency versus relevance of topics discussed during the cases could also be identified as a limitation to secondary data. Certain factors may not have been mentioned as frequently as others; however, this does not necessarily mean they are less important (Krippendorff, 2013). This issue may influence the percentage of subject matters identified during analysis. There could be potential problems with using frequency as a proxy indicator for relevance.

5.4 Future Research

With psychosocial hazards considered an emerging risk, future research within this field is essential in both workers' and employers' interest. Potential future research topics have been identified during the study and will be discussed in this section.

Firstly, the WorkSafe NZ prosecution policy (as mentioned in section 2.5), including the evidential test and public interest test, was published during August 2019. This policy describes how WorkSafe NZ decides to initiate a prosecution following an investigation, inspection, or assessment. The prosecution test is a two-part process, made up of the evidential test and the public interest test. Both parts of the test for prosecution must be met for a prosecution to be commenced. This policy has not been examined or applied during the study. It could become a topic for future research in relation to its relevance to psychosocial harm prosecutions (WorkSafe New Zealand, 2019b).

Secondly, jobs considered being 'not too stressful' as discussed in section 4.6 are an interesting issue. During the case, the judge concluded that

'Psychological pressures are inevitable in all jobs, although greater in some than in others. But it is rather more difficult to identify which jobs are intrinsically so stressful that physical or psychological harm is to be expected more often than in other jobs. - CN 14

The individual differences in psychosocial harm cases play a significant role in the court outcomes and could also be further examined.

Thirdly, during the study, the psychosocial harm was central to psychosocial hazards influencing worker's ill-health. However, it was evident that physical or other hazards, such as lack of ventilation may also contribute to, for example, emotional stress (section 3.4.5).

This may potentially become an opportunity for future research exploring how the impact of work-related hazards, other than psychosocial, can cause mental or physical ill-health.

Lastly, applying secondary data to the framework analysis as a new endeavour for qualitative research. During this study, secondary data provided sufficient evidence to answer the research objectives (section 4.7). Furthermore, analysing the secondary data utilising a framework analysis created a systematic and yet flexible approach. To the best of my knowledge, framework analysis has not been applied to secondary data during research. As it has worked in this instance and served the study's purpose, it could be considered a new endeavour for secondary data analysis in future research.

5.5 Conclusions

It can be concluded that by applying sections 36, 44, and 45 of the HSWA 2015 to the court case transcripts, sufficient evidence is available for WorkSafe NZ to investigate and assess psychosocial harm at the workplace.

The study successfully provides insight into the New Zealand legal response on work-related psychosocial harm. The secondary data provide sufficient evidence to support WorkSafe NZ regulators in addressing psychosocial harm at the workplace. The study further suggests that amendments to the HSWA 2015 may be beneficial but are not essential for work-related psychosocial harm court prosecutions.

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Appendices

Appendix A. Comparisons between New Zealand HSWA 2015 and the Safe Work Australia Model Work Health and Safety Laws

This table only highlights several comparisons. A full list is available from the Australian Industry Group (2016).

Australian Model WHS Laws	New Zealand HSW Act 2015; effective 4 April 2016	Comments
Part 1 – Application of the Act (other than Division 3 – definitions and important terms)	Part 1 – Application of the Act	Application provisions are different and need to be specifically addressed in individual jurisdictions.
Section 13 to 16 – Principles that apply to duties Duties are not transferrable A person can have more than one duty More than one person can concurrently have the same duty; each duty holder must comply with that duty to the standard required by this Act even if another duty holder has the same duty.	Sections 31 to 33	Provisions are identical.
Section 17 A duty to ensure health and safety requires the person to eliminate or minimise risks so far as is reasonably practicable.	Section 30	Provisions are identical.
Section 18 Reasonably practicable is outlined as taking into account and weighing up all relevant matters: Likelihood; Degree of harm; What is known about the hazard/risk and ways of eliminating or minimising it; Availability and suitability of ways to eliminate or minimise the risk; After assessing the above, the cost associated with eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk	Section 22	Provisions are identical.

Appendix A. Comparisons between New Zealand HSWA 2015 and the Safe Work Australia Model Work Health and Safety Laws

Australian Model WHS Laws	New Zealand HSW Act 2015; effective 4 April 2016	Comments
<p>Section 19 Primary duty of care (1) A person conducting a business or undertaking (PCBU) must ensure, so far as is reasonably practicable, the health and safety of: (a) Workers engaged, or caused to be engaged by the person; and (b) Workers whose activities in carrying out work are influenced or directed by the person, while the workers are at work in the business or undertaking (2) A PCBU must ensure, so far as is reasonably practicable that the health and safety of other persons is not put at risk from work carried out as part of the business or undertaking. Notes: A PCBU is defined in s.5 of the Act A worker is defined in s.7 of the Act A workplace is defined in s.8 of the Act</p>	<p>Section 36 Notes: A PCBU is defined in s. 17 of the Act A worker is defined in s.19 of the Act A workplace is defined in s.20 of the Act</p>	<p>Provisions are almost identical. There are some minor variations of definitions, but they are mostly the same.</p>
<p>Section 20 Duty of persons conducting a businesses or undertaking involving management or control of workplaces – that the workplace, the means of entering and exiting the workplace, and anything arising from the workplace, are so far as is reasonably practicable, without risk to the health and safety of any person. Duty holder is abbreviated to “person with management or control of a workplace”</p>	<p>Section 37 Duty holder is abbreviated to “a PCBU who manages or controls workplace”.</p>	<p>Almost identical; but with a few more specific inclusions and exclusions.</p>
<p>Section 27 Duty of officer An officer must exercise due diligence to ensure that the person conducting the business or undertaking complies with their duties under the Act. An officer has the same meaning as in the Corporations Act 2001, with some additional detail to clarify the application to governments, statutory bodies and partnerships (see s.4 of the Act for the specific definition).</p>	<p>There are some additional words in this Act that refer to the care, diligence, and skills that a reasonable officer would exercise in the same circumstances. An officer is defined in section 18 of the Act. Officer (a) means, if the PCBU is— (i) a company, any person occupying the position of a director of the company by whatever name</p>	<p>Principles are basically the same; some slight wording change; definition basis is obviously different as the Australian definition is reliant on the Australian Corporations Act. The due diligence “description” is identical.</p>

Appendix A. Comparisons between New Zealand HSWA 2015 and the Safe Work Australia Model Work Health and Safety Laws

Australian Model WHS Laws	New Zealand HSW Act 2015; effective 4 April 2016	Comments
<p>Due diligence includes, taking reasonable steps: to acquire and keep up-to-date knowledge of work health and safety matters; to gain an understanding of the hazards and risks; to ensure appropriate resources and processes to eliminate or minimise risk; to ensure appropriate processes for receiving and considering information; to ensure the PCBU has and implements processes for complying with duties; to verify the provision and use of the resources and processes referred to above.</p>	<p>called: (ii) a partnership (other than a limited partnership), any partner: (iii) a limited partnership, any general partner: (iv) a body corporate or an unincorporated body, other than a company, partnership, or limited partnership, any person occupying a position in the body that is comparable with that of a director of a company; and (b) includes any other person occupying a position in relation to the business or undertaking that allows the person to exercise significant influence over the management of the business or undertaking (for example, a chief executive); but (c) does not include a Minister of the Crown acting in that capacity; and (d) to avoid doubt, does not include a person who merely advises or makes recommendations to a person referred to in paragraph (a) or (b).</p>	
<p>Section 28 Duties of workers to take reasonable care for own health and safety; to take reasonable care that acts or omissions do not adversely affect the health and safety of and other persons; to comply so far as reasonably able with any reasonable instruction related to health and safety; to cooperate with any reasonably policy related to safety</p>	<p>Section 45</p>	<p>Provisions are identical.</p>

Appendix B. Terminology Comparison to Describe Work-related Psychosocial Risk, Factor, Hazard, or Harm

Guidance/ Framework/ Law/Regulation	Year	Terminology	Definition/Meaning
Globally			
ILO & WHO (ILO & WHO, 1986)	1986	Psychosocial factors	Page 3: Psychosocial factors at work refer to interactions between and among work environment, job content, organisational conditions and workers' capacities, needs, culture, personal extra-job considerations that may, through perceptions and experience, influence health, work performance, and job satisfaction.
	1986	Psychosocial risks	Interactions among job content, work organisation and management, and other environmental and organisational conditions, on the one hand, and employees' competencies and needs on the other that prove to have a hazardous influence over employees' health through their perceptions and experience.
	1986	Health	A state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.
WHO, 2002 (WHO, 2002)	2002	Occupational or work-related diseases	Adverse health conditions in the human being, the occurrence or severity of which is related to exposure to factors on the job or in the work environment
		Psychosocial factors	These may include boring, repetitive tasks, production pressure, stress, low pay, and lack of recognition
		Common workplace stressors	Organisational (change, conflict, communication), career development, role, task, work environment, shift work
WHO, 2003 (Leka et al., 2003)	2003	Work-related stress	Psychosocial risks go hand in hand with the experience of work-related stress. Work-related stress is the response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope

Appendix B. Terminology Comparison to Describe Work-related Psychosocial Risk, Factor, Hazard, or Harm

Guidance/ Framework/ Law/Regulation	Year	Terminology	Definition/Meaning
WHO, 2008 PRIMA-EF (Leka & Cox, 2008)	2008	Psychosocial hazards	Job content, workload and work pace, work schedule, control, environment and equipment, organisational culture and function, interpersonal relationships at work, role in organisations, career development, home-work interface.
WHO, 2010 (Leka & Jain, 2010)	2010	Burnout	The issue of burnout has also gained prevalence as a result of exposure to a poor psychosocial environment and the resulting work-related stress experience. Burnout has been defined in the literature as a state of physical, emotional and mental exhaustion that results from long-term involvement in work situations that are emotionally demanding
		Stress reactions	Physiological, behavioural, emotional reactions, cognitive reactions
WHO, 2010 (Burton, 2010)	2010	Indirect influence of psychosocial hazards	Sleep badly, over-medication, drink excessively, depression, anxiety, anger
		Work-related symptoms of common mental disorders	Depression, anxiety, burnout
WHO, 2014 (WHO, 2014)	2014	Mental health and wellbeing	State of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community
ILO (ILO, 2016)	2016	Psychosocial reactions to stress	The impact of stress on health can vary according to individual response; however, high stress levels can contribute to developing health-related impairments, including mental and behavioural disorders such as exhaustion, burnout, anxiety and depression, as well as other physical impairments such as cardiovascular disease and musculoskeletal disorders.
ILO & WHO (ILO & WHO, 2018)	2018	Burnout	Burnout is a term commonly used to refer to long-term exhaustion and diminished interest in work as a result of long-term stress and work overload. It can occur particularly among individuals who are highly motivated, dedicated and involved

Appendix B. Terminology Comparison to Describe Work-related Psychosocial Risk, Factor, Hazard, or Harm

Guidance/ Framework/ Law/Regulation	Year	Terminology	Definition/Meaning
European Union			
Framework Directive, 1989 (EU-OSHA, 1989)	1989	Psychosocial risks	No specific rules on psychosocial risks. Including the words working environment and health and safety. Embracing all factors, physical or otherwise, capable of affecting the health and safety.
EU-OSHA, 2000 (Griffiths et al., 2000)	2000	Work stress	Psychosocial hazards may have negative effects on both physical and mental health directly or indirectly through work stress. A number of psychosocial hazards can be experienced as stressful or have the potential for harm
EU-OSHA, 2007 (Brunand & Milczare, 2007)	2007	Occupational health	Violence, harassment, bullying (or mobbing) are widely recognised and major challenges to occupational health and safety
		Psychosocial risks	Psychosocial risks at the workplace have been defined as those aspects in the design, organisation, and direction of work and its' social environment which may cause psychological, social or physical health damages in workers
EU-OSHA, 2012 ESENER-1 (Staetsky et al., 2012)	2012	Psychosocial hazards	Those aspects of work design and the organisation and management of work, and their social and environment contexts, which have the potential for causing psychological, social and physical harm
EU-OSHA, 2018 ESENER-2 (Vandenheuvvel et al., 2018)	2018	Psychosocial risk management	Describes the number of procedures and measures in place to deal with psychosocial risk
British Standards			
PAS 1010:2011 (BSI, 2011)	2011	Psychosocial factor	Interaction among job content, work organisation and management, and other environmental and organisational conditions, and the employees' competencies and needs
		Psychosocial risk	Likelihood that psychosocial factors have a hazardous influence on employees' health through their perceptions and experience

Appendix B. Terminology Comparison to Describe Work-related Psychosocial Risk, Factor, Hazard, or Harm

Guidance/ Framework/ Law/Regulation	Year	Terminology	Definition/Meaning
			and the severity of ill health that can be caused by exposure to them
		Work-related stress	Pattern of emotional, cognitive, behavioural and physiological reactions to adverse and noxious aspects of work content, work organisation and work environment
South America			
Regulations to prevent and address psychosocial risks in the workplace (Espada, 2019)	2019	Psychosocial risks	Psychological risks are those that may provoke anxiety disorders, sleep disorders, severe stress, and adaptation disorders. These risks stem from the employee's job activities, the type of work shift, or the exposure to severe traumatic events or work-related acts of violence
Canada			
National Standard of Canada for psychological health and safety in the workplace (Mental Health Commission of Canada, 2013)	2013	Hazard	A potential source of psychological harm to a worker
		Health	A state of complete physical, social, and mental wellbeing, and not merely the absence of disease or infirmity.
		Mental Health	A state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. Synonym: psychological health.
		Psychologically healthy and safe workplace	A workplace that promotes workers' psychological wellbeing and actively works to prevent harm to worker psychological health including in negligent, reckless, or intentional ways.
Australia			
Occupational Health and Safety Act 2004 (Occupational Health and Safety Act 2004)	2004	Health	Includes psychological health
	2019	Guidance on work-related psychological health	Psychosocial hazards or factors are anything in the design or management of work that increases the risk of work-related stress.
			A stress response is the physical, mental and emotional reactions that occur when a worker perceives the demands of their work exceed their ability or resources to cope.
			Work-related stress if prolonged and/or severe can cause both psychological and physical injury.

Appendix B. Terminology Comparison to Describe Work-related Psychosocial Risk, Factor, Hazard, or Harm

Guidance/ Framework/ Law/Regulation	Year	Terminology	Definition/Meaning
New Zealand			
HSE Amendment Act 2002 (HSE Amendment Act, 2002)	2002	Harm	Harm includes physical or mental harm caused by work-related stress
		Hazard	Work-related physical or mental fatigue being the actual or potential cause of (work-related) harm
HSWA 2015 (HSWA, 2015)	2015	Health	Physical and mental health
WorkSafe NZ (WorkSafe New Zealand, 2017e)	2017	Work-related disease	The impact work can have on people's health. In the past, this has been referred to as occupational health
		Psychosocial risks	Psychosocial work-related health risks such as bullying, excessive workload, and lack of autonomy.
		Impairment risks	Health-related safety risks as stress or mental distraction, and fatigue
WorkSafe NZ (WorkSafe New Zealand, 2019c)	2019	Psychosocial hazards	Psychosocial hazards for examples bullying, harassment, violence, deadlines. Health outcomes: stress, depression, anxiety, sleep disorders, suicidal ideation
		Psychosocial hazard	Work-related psychosocial hazard (or risk) is an adverse workplace interaction or condition of work that compromises a worker's health and wellbeing
		Psychosocial stressor	A workplace psychosocial hazard directly or indirectly inducing a stress response, that can result in low self-esteem, anxiety, fatigue, burnout, depression, sleep disruption, in extreme cases, post-traumatic stress disorder (PTSD).

Appendix C. The Definition of Work-related Psychosocial Harm Used in This Study

Definition	Meaning/Description	Act/Legislation/Reference
Mental or physical ill-health	Failing to adhere to the definition of health and wellbeing: 'Healthy work and it's social environment where individuals realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.	WHO, 2014
	Difficult experiences or feelings that go on for a long time and affect our ability to enjoy and live our lives in the way we want to.	Mental Health Foundation, 2020
	Physical and mental health	HSWA 2015
where there is reason to believe that work-related psychosocial hazards played a significant role	Work-related psychosocial risk factors include, but are not limited to, work-related job content, workload and work pace, work schedule, control, environment and equipment, organisational culture and function, interpersonal relationships at work, role in organisations, career development, and home-work interface. It may also include work shifts, or the exposure to severe traumatic events, or work-related acts of violence as potential psychosocial risks.	ILO & WHO, 1986 ILO, 2016 PRIMA-EF (Leka & Cox, 2008)
in causing potential psychological, social and physical harm to the individual	Psychosocial risks at the workplace have been defined as those aspects in the design, organisation and direction of work and its' social environment which may cause psychological, social or physical health damages in workers.	EU-OSHA, 2007 (Brunand & Milczare, 2007) PAS 1010:2011 (BSI, 2011)
	Psychosocial reactions to stress: Fatigue, anxiety, depression, aggression, mental disorders, psychosomatic disorders	WHO, 2002
	Harm: Includes mental harm caused by work-related stress	HSE Amendment Act 2002
	Hazard: Harm (including mental harm) resulting from mental fatigue	
	Those aspects of work design and the organisation and management of work, and their social and environment contexts, which have the potential for causing psychological, social and physical harm	EU-OSHA, 2012 (Staetsky et al., 2012)

Appendix C. The Definition of Work-related Psychosocial Harm Used in This Study

Definition	Meaning/Description	Act/Legislation/Reference
	Burnout: A state of physical, emotional and mental exhaustion that results from long-term involvement in work situations that are emotionally demanding	WHO, 2010 (Leka & Jain, 2010)
	Work-related symptoms of common mental disorders: Depression, anxiety, burnout	WHO, 2010 (Burton, 2010)
	The impact of work-stress on health can vary according to individual response; however, high stress levels can contribute to developing health-related impairments, including mental and behavioural disorders such as exhaustion, burnout, anxiety and depression, as well as other physical impairments such as cardiovascular disease and musculoskeletal disorders.	ILO, 2016
	Cardiovascular disease	(Dragano et al., 2017; Kivimäki & Kawachi, 2015; Kivimäki et al., 2012; Steptoe & Kivimäki, 2012)
	Musculoskeletal disorders	(Bongers et al., 2002; Wei et al., 2006).

Appendix D. Abandoned Searches

Search word 'wellbeing' entered onto the NZLII database on 19 August 2019:
Results (n=134) listed alphabetically
A v B (Wellington) [2009] NZERA 454 (6 July 2009)
A v B CA148/10 (Christchurch) [2010]
A v R limited (Auckland) [2018] NZERA 232; [2018] NZERA Auckland 232 (24 July 2018)
Air New Zealand Limited v Wulff [2010]
ANZ National Bank Limited v Svensson CC 13/08 [2008]
Arora v Restaurant Brands Limited (Auckland) [2018] NZERA 363; [2018]
Arras v Spotless Facility Services (NZ) Limited (Christchurch) [2016] NZERA 528; [2016]
Arthurs v Lyttelton Port Company Limited (Christchurch) [2017]
Asby v Wairiki Institute of Technology (Auckland) [2014] NZERA 373; [2014]
ASG v Hayne [2016]
ASG v Hayne, Vice-Chancellor of the University of Otago [2016]
Asure New Zealand Ltd v NZ Public Service Association Inc (Christchurch) [2007] ZERA 236 (26 January 2007)
Auckland District Health Board v Bierre [2011]
Barton v Dargaville High School Board of Trustees (Auckland) [2013]
Bay of Plenty Regional Council v Whitiakau Holdings Limited [2018]
Broughton v Plane Biz Ltd (Christchurch) [2008]
Burns v Chief Executive, Legal Services Agency WA 22/04(Wellington) [2004]
Burrows v The Commissioner of Rangiora High School (Christchurch) [2017]
Canterbury Regional Council v Shirtcliff [2018]
Chief Executive of the Department of Corrections v Imo AC 57/07 [2007]
Clarke v Air New Zealand Ltd (Wellington) [2011] NZERA 780; [2011]
Clunie v Prison Inmates' Loved ones Linked As one to Renew Strength Incorporated Society (Pillars) CA 40/04 (Christchurch) [2004]
Cronin-Lampe v Board of Trustees of Melville High School [2017]
Crutchley v Chief Executive of the Ministry of Social Development (MSD) (Auckland) [2008]
Dahren v General Distributors Ltd CA 125/04 (Christchurch) [2004]
Dave v The Board of Trustees, Sunnydene School AA357/10 (Auckland) [2010]
Department of Labour v Gibb Holdings (Nelson) Ltd (NZDC Nelson) [2008]
Department of Labour v Lincoln Bakery Limited CRI-2012-090-001980 [2012]
Department of Labour v Storm Logging Ltd (NZDC Whakatane) [2007]
Derbie v Tranzurban Hutt Valley Limited [2019]
Downer New Zealand Limited v Jones [2018]
Dr Julia Taylor & Ors v Canterbury District Health Board (Christchurch) [2010]
DSH v QME (Auckland) [2017] NZERA 192; [2017]
Esdale v Royal New Zealand Society for the Prevention of Cruelty to Animals Inc-Tauranga Branch (Auckland) [2011] NZERA 596; [2011]
FGH v RST [2018]
FGH v RST [2018]
Filbry v Department of Corrections (Auckland) [2014] NZERA 251; [2014]
Flynn v Fonterra Brands (New Zealand) Ltd (Auckland) [2014] NZERA 2; [2014]
Frahm v Fonterra Co-Operative Group Limited (Christchurch) [2018]
Franks v Alliance Group Ltd (Christchurch) [2016] NZERA 157; [2016]
Fredericks v VIP Frames and Trusses Limited [2015]
Gallagher v Presbyterian Support Services (Otago) Inc (Christchurch) [2013]
Graham v Bank of New Zealand (Christchurch) [2010]
Gray v Airways Corporation of New Zealand Ltd (Christchurch) [2008]
Hamilton v B&D Doors Ltd, previously known as Dominator International Ltd and ors (Christchurch) [2007]

Appendix D. Abandoned Searches

Search word 'wellbeing' entered onto the NZLII database on 19 August 2019:
Handy v New Zealand Fire Service Commission (Wellington) [2017]
Harbord v Waste Management Ltd WA 30/05 (Wellington) [2005]
Hayne v ASG [2014]
Heriot v Asteron Life Limited (Wellington) [2007]
Hilford v The Order of St John Northern Region Trust Board (Auckland) [2018] NZERA 190; [2018]
Hira v Barfoote Holdings Ltd (Auckland) [2013] NZERA 304; [2013]
Hong v Auckland Transport [2019]
Hunter v Te Ao Marama Kohanga Reo (Wellington) [2014] NZERA 413; [2014]
Huntley v Maataa Waka Waka Ki Te Tau Ihu Trust (Christchurch) [2008]
Idea Services Limited v Crozier [2017]
Idea Services Limited v Dickson WC17/09 [2009]
Isaac v Chief Executive of the Ministry of Social Development (Auckland) [2008]
Johnstone v Morrisson Bar Ltd AA 358A/05 (Auckland) [2005]
Ka v National Pacific Radio Trust Incorporated (Auckland) [2010]
Kerr v Sharna Ltd (Christchurch) [2013] NZERA 634; [2013]
Kilpatrick v Air New Zealand Limited [2016]
Kostic v Dodd and anor ta Allan Milligan Cars and/or Motoworld Systems Ltd ta Allan Milligan Cars CA 12/06 (Christchurch) [2006]
Kupa v Silver Fern Farms Beef Limited [2016]
Lambert v New Zealand Post Limited (Christchurch) [2018] NZERA 1198; [2018]
Landon-Lane v Annies Marlborough Ltd (Christchurch) [2013] NZERA 389; [2013]
Langdon v Pink t/a Junction Hotel [2019] NZERA 438 (23 July 2019)
Langdon v Pink t/a Junction Hotel [2019] NZERA 438 (23 July 2019)
Lata v Oceania Care Company Ltd (Christchurch) [2015] NZERA 243; [2015]
Law v Board of Trustees of Woodford House [2014]
Lealaogata v Timata Hou Ltd (Wellington) [2013] NZERA 178; [2013]
Lean Meats Oamaru Limited v New Zealand Meat Workers and Related Trades Union Incorporated [2015]
Lewis v Howick College Board of Trustees [2010]
Lloyd v New Zealand Fire Service Commission (Auckland) [2009]
McCann v Waste Management NZ Limited [2019] NZERA 107 (27 February 2019)
McConnell v Board of Trustees of Mt Roskill Grammar School (Auckland) [2013]
McCullough v Otago Sheetmetal and Engineering Ltd (Christchurch) [2008]
McHugh v Chief Executive of the New Zealand Fire Service (Auckland) [2014]
McIntyre v Pernod Ricard New Zealand Ltd (Christchurch) [2013]
McKenna v New Zealand Automobile Association [2019] NZERA 41 (30 January 2019)
Mealing v DB Breweries Ltd (Christchurch) [2016] NZERA 69; [2016]
Muthu v Chief Executive of The Department of Corrections (Auckland) [2014]
Neil v New Zealand Nurses Organisation [2019] NZERA 160 (20 March 2019)
Neil v New Zealand Nurses Organisation [2019] NZERA 160 (20 March 2019)
New Zealand Police v Freightlines Limited CRI-2015-009-004205 [2016]
Newman v Taxi Lease Ltd ta The Plant Place (Auckland) [2014] NZERA 783; [2014]
O'Flaherty v Landseer Investments Auckland Ltd t/a Andrew Simms Newmarket (Auckland) [2018]
Ovation New Zealand Limited v New Zealand Meat Workers and Related Trades Union Incorporated [2018]
Owen v Chief Executive of the Department of Corrections [2015]
Owen v The Chief Executive of the Department of Corrections (Auckland) [2016]
Police v Freightlines Limited [2016]
Rainford v Cooper Family Investments Ltd (Auckland) [2015] NZERA 21; [2015]
Ramkissoo v Commissioner of Police [2017]
Rangitakatu v Cloudy Bay Seafood Ltd (Christchurch) [2014] NZERA 859; [2014]
Rosenberg v Air New Zealand Ltd (Auckland) [2009]

Appendix D. Abandoned Searches

Search word 'wellbeing' entered onto the NZLII database on 19 August 2019:
Rowe v Toll NZ Consolidated Limited (Auckland) [2007]
Roy v Board of Trustees of Tamaki College [2016]
S v Attorney-General [2003]
Sanderson v South Canterbury District Health Board (Christchurch) [2017]
Sanger v New Zealand Post Limited CA223/10 (Christchurch) [2010] (
Sanger v New Zealand Post Limited CA223/10 (Christchurch) [2010]
Selliman v Te Runanga o Kirikiriroa Trust AA452/10 (Auckland) [2010]
Sergant v Western Mailing Ltd (Auckland) [2014] NZERA 108; [2014]
Service v Young Men's Christian Association of Christchurch Incorporated [2011]
Shaw v Bay of Plenty District Health Board (Auckland) [2018] NZERA 390; [2018]
Sidal v Aspire Incorporated (Wellington) [2013] NZERA 847; [2013]
Sigglekow v Waikato Health Board (Auckland) [2011]
Simpson v Tasman Glass Ltd (Christchurch) [2009]
Slabbert v Idea Services Limited [2019] NZERA 52 (4 February 2019)
Smith v Air2there.com (2008) Limited [2011] NZERA 235; [2011]
Smith v Director General for Ministry of Primary Industries (Wellington) [2017]
South Canterbury District Health Board v Sanderson [2017]
South Canterbury District Health Board v Sanderson [2017]
Spencer v Te Anua Nua Trust (Auckland) [2016] NZERA 173; [2016]
Steadman v Canterbury Employers' Chamber of Commerce Incorporated (Christchurch) [2013]
Tailor v BOF Limited t/as Moretons Restaurant and Bar AA468/10 (Auckland) [2010]
Taufua v Fonterra Brands (New Zealand) Ltd (Auckland) [2014] NZERA 4; [2014]
Tauhore v Farmers Trading Company Limited WC 3/08 [2008]
Taylor v Waikato District Health Board (Auckland) [2018] NZERA 10; [2018]
Thow v Canterbury District Health Board (Christchurch) [2016] NZERA 418; [2016]
Toatoa v City Line NZ Limited t/as Valley Flyer WA195/10 (Wellington) [2010]
Trustees Executors Ltd v Official Assignee [2015]
Walker v Firth Industries - A division of Fletcher Concrete and Infrastructure Ltd (Christchurch) [2013]
Watt v Canterbury District Health Board CA 122/06 (Christchurch) [2006]
Weston v Advkit Para Legal Services Ltd [2010]
Wikaira v Transpacific Industries Group (NZ) Ltd (Wellington) [2013]
WorkSafe New Zealand v BR & SL Porter Limited CRI-2014-070-001606 [2014]
Worksafe New Zealand v Northpower Limited [2017]
WorkSafe New Zealand v Northpower Limited CRI-2014-085-013982 [2017]
X v Auckland District Health Board AC 10/07 [2007]
X v Bay of Plenty District Health Board (Auckland) [2009]
X v Chief Executive of the Department of Corrections [2018]
X v New Zealand Fire Service Commission aka Fire and Emergency New Zealand (Wellington) [2017]
Yoo v Jesse and Associates Barristers and Solicitors [2019] NZERA 236 (18 April 2019)
Young v Bay of Plenty District Health Board (Auckland) [2010]

Appendix E. Secondary Court Cases

Search words entered onto the NZLII database during September 2019 including ' <i>fatigue, burnout, stress and depression, stress and anxiety, mental harm, and psychological harm.</i> '	
Results (n=24) listed in no specific order:	
Case No	Court Case Reference Number
1	[2016] NZERA 528
2	[2007] NZERA 448
3	[2008] NZERA 196
4	[2018] NZEmpC 145
5	[2018] NZERA 1130
6	[2014] NZERA 505
7	[2016] NZERA 322
8	[2010] NZERA 855
9	[2007] NZEmpC 167
10	[2017] NZEmpC 132
11	[2018] NZHSE 7
12	[2011] NZEmpC 117
13	[2018] NZERA 291
14	[2006] NZERA 181
15	[2008] NZEmpC 122
16	[2011] NZERA 320
17	[2010] NZERA 551
18	[2016] NZERA 533
19	[2019] NZERA 109
20	[2019] NZERA 191
21	[2014] NZERA 828
22	[2018] NZERA 190
23	[2007] NZERA 270
24	[2019] NZERA 210
25 -Case not used	[2001] NZHC 643

Appendix F. Analytical Framework Matrix

Charting data into the framework matrix: Court cases by rows and categories by columns - Court Cases 1, 2, and 3 only

Case Number	a) Working practices	b) Psychosocial hazards	c) Reporting method	d) Warning Signs: Applicants/ Respondents feelings and emotions	e) Harm: Type of mental or physical ill-health	f) Resources or processes to eliminate or minimise the hazards	g) PCBU's response to incidents received	h) Non -work related issues	i) Secondary effects of psychosocial hazards	j) Implementing PCBU policies and, or procedures	k) Medical concerns	l) Court conclusions
1. [2016] NZERA 528	Cleaner and kitchen worker	Exposed to bullying for quite some time	Verbally to manager	Applicant felt threatened, scared and trapped	Shouldered her, Rolled their eyes at her, Spoken to in an inappropriate manner	Applicant lack of control over negative culture	No actions taken by management during initial complaints	Manager had sick friend, felt upset	Applicant walked out and reported to senior management - did not resign	Senior management requested letter to explain what happened	Submitted by applicant one day after reporting to senior management	Unjustifiably dismissed
	35 hours per week	Organisational culture and function	Couple of times	Humiliation, loss of dignity and injury to her feelings.	Manager felt ambushed during meeting with all the complaints		After several complaints, the Manager issued a 'Process to resolve issues in the workplace'		Sick leave	Applicant too distressed to write letter		\$10,000
	Company Hospital	Relationship issues contribute to negative culture	Also discussed during staff meeting		Confirmed applicant feeling stressed and unwell		Manager backed Supervisor		Lack of sick leave payment 7 days following 'conflict' event	Did not investigate		Breaches of it duties
		Confirmed potential negative culture and bullying behaviour from manager and supervisor towards applicant	Applicant confronted by Manager and Supervisor				Manager picked Supervisor side		Intimidating behaviour from Supervisor and Manager towards employee			

Appendix F. Analytical Framework Matrix

Case Number	a) Working practices	b) Psychosocial hazards	c) Reporting method	d) Warning Signs: Applicants/ Respondents feelings and emotions	e) Harm: Type of mental or physical ill-health	f) Resources or processes to eliminate or minimise the hazards	g) PCBU's response to incidents received	h) Non -work related issues	i) Secondary effects of psychosocial hazards	j) Implementing PCBU policies and, or procedures	k) Medical concerns	l) Court conclusions
					Burst into tears when trying to put her complaints into writing.		Manager did not investigate complaint		Name calling by management towards applicant	After resignation, senior management investigated		
					Sleep, appetite, and mood were affected for a long time.		Manager did not report to senior management		Resigned following lack of sick leave paying out, 7 days after submitting medical letter			
							Talebearing, gossip, stirring staff					
2. [2007] NZERA 448	Truck driver	Work schedule	Dispatcher advised of truck break down	Fatigue/Tired		Apex dispatcher offered to put Mr Barnes and his partner up in a motel in Rotorua	Meeting following the incident	For personal reasons he and his partner wished to return to Hamilton. Mr Barnes completed his run and returned to his home in Hamilton just after 6.50 pm.	Suffered a lapse in concentration			Unjustifiably dismissed

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Case Number	a) Working practices	b) Psychosocial hazards	c) Reporting method	d) Warning Signs: Applicants/ Respondents feelings and emotions	e) Harm: Type of mental or physical ill-health	f) Resources or processes to eliminate or minimise the hazards	g) PCBU's response to incidents received	h) Non -work related issues	i) Secondary effects of psychosocial hazards	j) Implementing PCBU policies and, or procedures	k) Medical concerns	l) Court conclusions
	Delivery run from 11pm	Long work hours	No report re long hours		Implications for Mr Barnes' driving hours and duty time		Manager confirms no reason to 'sack' applicant, but recommended to resign	He said further that he worked the hours he did for economic reasons.	The trailer on his truck tipped over.			Compensation for injury to feelings.
		Physical environment and equipment issues - truck broke down	He did not request time off		Shocked and angry after being asked to resign		Applicant did not resign		One day stress leave			Reduce by two thirds the amount for contributing fault
		Decision to work despite fatigue					No further follow ups		Careless driving caused by fatigue			\$7,482 less the gross equivalent of \$2,334.99
							No investigation		Guilty to a charge of careless driving			\$2,000 as compensation for injury to feelings
							Manager phoned to request return of uniform		No, got told he is 'sacked'			Mr Barnes has statutory obligations in respect of his own health and safety
							Disagreement between applicant and manager whether applicant resigned					Applicant has significant degree of contributory fault

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Case Number	a) Working practices	b) Psychosocial hazards	c) Reporting method	d) Warning Signs: Applicants/ Respondents feelings and emotions	e) Harm: Type of mental or physical ill-health	f) Resources or processes to eliminate or minimise the hazards	g) PCBU's response to incidents received	h) Non -work related issues	i) Secondary effects of psychosocial hazards	j) Implementing PCBU policies and, or procedures	k) Medical concerns	l) Court conclusions
3. [2008] NZERA 196	MSD. Work broker role is to assist customers to access job vacancies or community work and to achieve placement.	Job control - management decision to abandon the vacant management team model and for workers to revert to working in service centres	Concern was not reported to manager	Not reported	Stress and anxiety likely caused by workplace issues"	2 weeks induction training; No penalties for failing to meet targets although	Mr Watene wrote to Mr Crutchley whilst he was on sick leave, offered EAP, requesting a meeting, return to work plan, telephoned Mr Crutchley.	Immigrated to NZ	Five weeks annual leave 25 Oct 2003 to Nov 2003		Sick leave letter due to stress and anxiety	No comparison between Crutchley and Gilbert re level of stress

Appendix F. Analytical Framework Matrix

Case Number	a) Working practices	b) Psychosocial hazards	c) Reporting method	d) Warning Signs: Applicants/ Respondents feelings and emotions	e) Harm: Type of mental or physical ill-health	f) Resources or processes to eliminate or minimise the hazards	g) PCBU's response to incidents received	h) Non -work related issues	i) Secondary effects of psychosocial hazards	j) Implementing PCBU policies and, or procedures	k) Medical concerns	l) Court conclusions
	Starting 10 Feb 2002	Job control - Placed at Dinsdale far from home	Self-reported sick leave letter - that should have triggered management to ask questions re employee stress	Felt under pressure to meet targets. Feeling unwell	Headaches Migraines	HS commitment to employee to create healthy and safe place of work	Mr Watene did not go far enough and effectively much of his response to the advice that Mr Crutchley had suffered ill health as a result of stress and anxiety (possibly as a result of workplace issues) was just empty words	Become increasingly involved with work organisation issues and to attempt procedural change leading to self-imposed additional pressure/stress, with unfortunate results when this was not successful.	9 days stress leave Feb 2004		Medical certificate stating Mr Crutchley was unfit for work for 9 days from 5 February 2004 “due to stress and anxiety likely caused by workplace issues”	Respondent breached its duty to the applicant; directed to a new service centre without developing a plan to facilitate his return to the workplace.
	Hamilton Central office of Work and Income (WINZ)	Job control: He set about to effect change and became intensely invested in his proposals for change.	Court may reject specialist evidence based on the self-reporting		Suffered ill health because of stress and anxiety (possibly as a result of workplace issues) was just empty words	Rehabilitation back to work programme	Did not develop an appropriate plan to facilitate his return to the workplace	Doctor 2007: “that factors in his former employment were the predominant cause of his depression” and	He felt he had been issued with an ultimatum – there was no discussion about his workload or what had caused his stress.		May 13 in 2004 Dr Fourie confirmed that Mr Crutchley has improved. He is fit to go back to work, as long as his work environment is safe from an OSH perspective.	\$3,750

Appendix F. Analytical Framework Matrix

Case Number	a) Working practices	b) Psychosocial hazards	c) Reporting method	d) Warning Signs: Applicants/ Respondents feelings and emotions	e) Harm: Type of mental or physical ill-health	f) Resources or processes to eliminate or minimise the hazards	g) PCBU's response to incidents received	h) Non -work related issues	i) Secondary effects of psychosocial hazards	j) Implementing PCBU policies and, or procedures	k) Medical concerns	l) Court conclusions
	Entry level job that is not inherently stressful.	Role conflict: He became frustrated, angry and unhappy when his proposals failed to gain traction (albeit that over time many of the recommendations have been adopted).		Increased pressure		Performance assessment process	After complaints MSD took all practicable steps commensurate with its obligations under the HSE Act .				Psychiatrist Feb 2005: Major Depressive Disorder from workplace stress	
	7.5-hour day with regular breaks	The difficulties experienced with management and the consequent disintegration in the relationship would continue to make working at WINZ a stressful environment.			Fatigue	Access to EAP						

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Case Number	a) Working practices	b) Psychosocial hazards	c) Reporting method	d) Warning Signs: Applicants/ Respondents feelings and emotions	e) Harm: Type of mental or physical ill-health	f) Resources or processes to eliminate or minimise the hazards	g) PCBU's response to incidents received	h) Non -work related issues	i) Secondary effects of psychosocial hazards	j) Implementing PCBU policies and, or procedures	k) Medical concerns	l) Court conclusions
	Staffing levels were adequate.				Likelihood of his depression/burn out/anxiety continuing	Ongoing training					Doctor 2008: major depressive disorder, but 'it is not evident that these factors arose directly from breaches of external (workplace) health and safety systems'	
	Flexibility, no overtime					Harassment definition part of policy						
						Workload is not excessive; work brokers have control over their day to day activities and how they manage their work load.						

Appendix G. Court Cases Measured Against Work-related Psychosocial Hazards

Case No	Work-related job content	Workload and schedule	Physical environment and equipment issues	Organisational culture and function	Interpersonal relationships at work	Role in organisations
1				anxiety, depression	Anxiety, depression	
2	fatigue	fatigue	fatigue			
3		anxiety, depression, fatigue, burnout, mental harm			anxiety, depression, fatigue, burnout, mental harm	anxiety, depression, fatigue, burnout, mental harm
4				anxiety	anxiety	
5	psych harm, mental harm		psych harm, mental harm			
6					anxiety, burnout	anxiety, burnout
7				anxiety, mental harm	anxiety, mental harm	
8				anxiety	anxiety	
9		depression, fatigue, mental harm	depression, fatigue, mental harm			
10		anxiety, psych harm				
11	fatigue	fatigue				
12				depression, mental harm	depression, mental harm	
13		mental harm		mental harm	mental harm	
14		anxiety, depression, fatigue, psych harm, mental harm			anxiety, depression, fatigue, psych harm, mental harm	
15	depression, psych harm	depression, psych harm				
16				depression, psych harm, mental harm	depression, psych harm, mental harm	
17	depression, psych harm,					

Appendix G. Court Cases Measured Against Work-related Psychosocial Hazards Appendix F.
Analytical Framework Matrix

Case No	Work-related job content	Workload and schedule	Physical environment and equipment issues	Organisational culture and function	Interpersonal relationships at work	Role in organisations
	mental harm					
18		anxiety		anxiety	anxiety	
19	fatigue	fatigue				
20		anxiety, depression mental harm				
21				anxiety	anxiety	
22		anxiety, depression mental harm				anxiety, depression, mental harm
23					Anxiety, mental harm	anxiety, mental harm
24				anxiety		