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Due Diligence and Psychosocial Risk:
Examining the Construction of Compliance.

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ABSTRACT

New Zealand's Health and Safety at Work Act 2015 introduced two significant changes to the country's work health and safety regulatory landscape: (1) it placed a duty upon officers to ensure that the business of which they are an officer complies with its duties under the Act; (2) it broadened the definition of health to include mental health. The latter inclusion confirmed the scope of the Act to apply to psychosocial risks at work. Despite the officers' duties being lauded as a profound change to New Zealand's regulatory landscape, there has been little research investigating how officers respond to these legal duties. Further, internationally, there are significant gaps in knowledge regarding the role senior company managers play in psychosocial risk management, particularly relating to the intersect of legal responsibilities and psychosocial risks. This research adopted a Foucauldian analytical approach to examine how ideas about compliance and psychosocial risks are constructed and organised. Specifically, the research questions led to an investigation of the ways in which officers conceptualised and carried out their due diligence duties as they applied to the protection of workers' mental health and the implications thereof. Semistructured interviews were conducted with 24 officers of large companies operating in New Zealand. The findings indicate that officers tended to discursively construct risk in ways which frequently obfuscated causes of harm arising from work while also problematising the possibility of eliminating or minimising risks to workers. Further, through a process of "risk translation," psychosocial risks were often transformed into risks which were individualised, psychologised and managerialised. This translative effect functioned to displace psychosocial risks with risks which were more recognisable and amenable to management and posed less challenge to management prerogative. In this way, a dominant construction of risk came to represent worker mental health as a cause of risk to the organisation and the object of compliance, rather than a consequence of psychosocial risk exposure. The resultant compliance responses may therefore be considered symbolic in that they represented attention to legal ideals while marginalising the management of risks arising from work. Thus, the potential of work health and safety legislation to regulate psychosocial harm arising from work was largely curtailed, highlighting the limits of self-regulation in a legal context characterised by uncertainty and ambiguity.

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TABLE OF CONTENTS

Abstract.....	ii
Acknowledgements.....	iii
Table of Contents.....	iv
List of Figures.....	viii
List of Tables.....	viii
Abbreviations.....	ix
1. Introduction.....	1
1.1 The HSWA: A new era in NZ work health & safety regulation.....	2
1.2 Role and impact of officers in the regulation of psychosocial risk.....	5
1.3 Endogenous approach to compliance.....	7
1.4 Research aim and questions.....	8
1.4.1 Research aim.....	8
1.4.2 Research questions.....	9
1.5 Research design.....	9
1.6 Significance/Contribution.....	10
1.7 Structure of the document.....	11
2. Literature Review Part A: Risk, Regulation, and Compliance.....	12
2.1 The concept of risk.....	13
2.1.1 Ways of thinking about risk.....	15
2.1.2 The technico-scientific perspective.....	16
2.1.3 The cognitive psychological perspective.....	17
2.1.4 The social constructionist perspectives.....	18
2.1.4.1 The sociocultural perspective.....	19
2.1.4.2 The risk society perspective.....	20
2.1.4.3 The Foucauldian perspective.....	22
2.1.5 Summary.....	23
2.2 Regulation: Its definition and purpose.....	24
2.2.1 Self-regulation.....	27
2.2.2 Compliance.....	30
2.3 Risk and regulation.....	32
2.3.1 Regulatory risk.....	33
2.3.2 Risk-based regulation.....	33
2.3.3 Risk regulation.....	34
2.4 Risk and regulation in work health and safety.....	36
2.4.1 The development of New Zealand’s work health and safety regulation.....	38
2.4.2 Pike River Mine: A turning point in NZ’s work health and safety regulation.....	39
2.4.3 The HSWA and risk.....	41
2.5 The officers’ duties.....	42
2.5.1 The genesis of officers’ liabilities and duties.....	43
2.5.2 Who is an officer under the HSWA?.....	46
2.5.3 The nature of the officers’ duties.....	47
2.5.4 Prosecutions under the HSWA.....	50
2.6 Conclusion.....	51

3. Literature Review Part B: The regulation of psychosocial risk at work	53
3.1 Definitions and mechanisms	53
3.2 Individual and organisational impacts of psychosocial harm	55
3.3 Work-related stress theory	57
3.3.1 Psychological models of occupational stress	59
3.3.1.1 The Job Demand–Control and Job Demand–Control–Support models	60
3.3.1.2 Effort-Reward Imbalance Model	61
3.3.1.3 The Job Demands–Resources Model	62
3.3.1.4 Organisational Justice	63
3.3.1.5 Psychosocial Safety Climate	63
3.3.1.6 Summary	64
3.4 Taxonomy of psychosocial hazards	65
3.5 The application of general duties to psychosocial harm	67
3.5.1 Ambiguity in regulation	71
3.5.2 The lexicon of psychosocial risk	73
3.5.3 Complexity	74
3.5.4 Individualisation and responsabilisation	75
3.5.5 Lack of focus on primary prevention	77
3.5.6 Management prerogative	80
3.5.7 Inspection and audit	82
3.5.8 Summary	83
3.6 Guidance for officers	83
3.7 Officers’ duties and psychosocial risk: The gap in knowledge	85
3.8 Conclusion	87
4. Methodology	89
4.1 Research questions	89
4.2 Philosophical perspective	89
4.2.1 Ontology and epistemology	90
4.2.2 Analytical approach	91
4.2.3 Foucauldian discourse analysis	93
4.2.4 Foucauldian tools and concepts	94
4.3 Quality	96
4.4 Research strategy	98
4.4.1 Selection of texts	98
4.4.1.1 Interviews	99
4.4.1.2 Other sources of texts	100
4.4.2 Sample design	100
4.4.3 Research ethics	103
4.4.4 Interview considerations	104
4.4.4.1 Pilot interviews	104
4.4.4.2 Recruiting and interviewing “elites”	105
4.4.4.3 Interview media	108
4.4.4.4 Interview questions	109
4.4.4.5 Conducting the interviews	110
4.4.5 Further texts	110
4.4.6 Data analysis	111
4.4.6.1 Transcription	112

4.4.6.2	Coding.....	112
4.4.6.3	Memos.....	115
4.4.6.4	Data synthesis	116
4.5	Conclusion	117
5.	The Exercise of Due Diligence.....	118
5.1	Acquire knowledge	118
5.2	Gain understanding	121
5.3	Ensure resources and processes to eliminate or minimise risks.....	124
5.4	Ensure processes for receiving and responding to information	126
5.5	Ensure compliance processes.....	129
5.6	Verify provision of resources and processes.....	133
5.7	Discussion.....	134
5.7.1	Ambiguity and lack of guidance	134
5.7.2	Ensuring compliance.....	138
5.7.3	Receiving and considering information regarding incidents, hazards, and risks	141
5.7.4	Reframing of compliance.....	146
5.8	Conclusion	150
6.	Representations of Psychosocial Risks.....	152
6.1	Problematisations	153
6.1.1	New and unestablished.....	154
6.1.2	Uncertain and unknowable.....	156
6.1.3	Subjective experience	158
6.1.4	Outside the boundaries.....	160
6.1.5	Invisible.....	163
6.1.6	Unmanageable.....	164
6.2	Discussion	167
6.2.1	The obfuscation of causality	168
6.2.2	Psychosocial risk management as new, uncertain, and unevidenced.....	172
6.2.3	Implications of problematising for psychosocial risk management.....	175
6.3	Conclusion: The creation of a novel risk	176
7.	The Organisation, Construction and Translation of Risks	177
7.1	Risk construction and organisation	177
7.2	The identification and naming of risk objects.....	179
7.3	Novel risks and risk translation.....	182
7.3.1	Psychosocial risks as a threat to workers' health	186
7.3.1.1	Describing psychosocial risks	186
7.3.1.2	Managing psychosocial risks	188
7.3.2	Translation 1: Safety risk	190
7.3.2.1	Identifying safety risks.....	190
7.3.2.2	Managing safety risks	191
7.3.3	Translation 2: Individual risk.....	192
7.3.3.1	Identifying individual risks	192
7.3.3.2	Managing individual risks.....	195
7.3.4	Translation 3: Operational risk	197
7.3.4.1	Identifying operational risks	197

7.3.4.2	Managing operational risks	199
7.3.5	Translation 4: Reputational risk	202
7.3.5.1	Identifying reputational risks	202
7.3.5.2	Managing reputational risks	203
7.4	Discussion and conclusion	204
8.	The Displacement of Risk and the Managerialisation of Law	208
8.1	The individualisation and psychologisation of risk	209
8.1.1	The individualisation of risk	210
8.1.1.1	Interpersonal relationships at work	210
8.1.1.2	Organisational culture	214
8.1.2	Psychologisation of risk	220
8.1.3	Summary of the individualisation and psychologisation of risk	225
8.2	The managerialisation of the law	227
8.2.1	Symbolic power and managerialisation	231
8.3	Conclusion: The limitations to, and prospects for, the officers' duties and psychosocial risk management	236
9.	Conclusion	241
9.1	Overview	241
9.2	Contributions.....	245
9.2.1	Original contribution.....	247
9.2.2	Extension of extant knowledge	248
9.2.3	Practical or policy implications.....	249
9.3	Limitations and future research.....	250
9.3.1	Size of PCBUs	250
9.3.2	Focus on primary duty of care	250
9.3.3	Partial application of the theory of legal endogeneity.....	251
9.3.4	Methodological limitations	252
9.3.5	Other related legal fields	254
9.3.6	Research on wellbeing	255
9.4	Concluding comments	255
References	257
Appendix A	– Participant Information Sheet.....	296
Appendix B	– Participant Consent Form	298
Appendix C	– Ethics Approval	299
Appendix D	– Interview Questions.....	300
Appendix E	– Coding Prompts	302
Appendix F	– Excerpts from the HSWA	304

LIST OF FIGURES

Figure 1 Continuum of Regulatory Strategy Adapted from Bartle & Vass (2005).....	28
Figure 2 Risk Objects Linked to Workers' Mental Health – Work-related Risk Objects Only.....	180
Figure 3 Risk Objects Linked to Workers' Mental Health – All Risk Objects.....	181

LIST OF TABLES

Table 1 Scope of Literature Review.....	13
Table 2 Risk Perspectives	15
Table 3 Who is an Officer?	47
Table 4 Taxonomy of Psychosocial and Organisations Hazards.....	66
Table 5 Types of WHS Regulatory Standards.....	68
Table 6 Levels of Intervention for Workplace Stress and Psychosocial Risk Management	79
Table 7 Coding Rounds.....	113
Table 8 Symbolic Structures Mentioned by Participants	140
Table 9 Summary of Constructions of Psychosocial Risk	184
Table 10 Summary of Risk Translations of Psychosocial Risk	185
Table 11 Research Contributions	246

ABBREVIATIONS

ACoP	Approved Code of Practice
BPA	Bisphenol A
CEO	Chief Executive Officer
COVID/COVID-19	Corona Virus Disease
CSR	Corporate social responsibility
CVD	Cardiovascular disease
DCM	Demand-Control Model
EAP	Employee Assistance Programme
EEC	European Economic Community
EEO	Equal Employment Opportunity
ERI	Effort-Reward Imbalance
ESENER	European Survey of Enterprises on New and Emerging Risks
ESG	Environmental, social, and governance
EU	European Union
HSE	Health and Safety Executive
HSEA	Health and Safety in Employment Act 1992
HSWA	Health and Safety at Work Act 2015
ILO	International Labour Organisation
IOD	Institute of Directors
ISO	International Organization for Standardization
JDC	Job Demand-Control Model
JD-R	Job Demands-Resources Model
JDCS	Job Demand–Control–Support Model
MSD	Musculoskeletal disorders
NGO	Non-governmental organisation
NSW	New South Wales
NZ	New Zealand
NZDC	New Zealand District Court
NZHC	New Zealand High Court
OHS	Occupational health and safety
OSH	Occupational safety and health
PAS	Publicly available specification
PCBU	Person conducting a business or undertaking
PRIMA- EF	Psychosocial Risk Management Excellence Framework
PSC	Psychosocial Safety Climate
RBR	Risk based regulation
SME	Small and medium-sized enterprises
TRIFR	Total recorded injury frequency rate
UK	United Kingdom
WHO	World Health Organization
WHS	Work health and safety
WHSMS	Work health and safety management systems

1. INTRODUCTION

New Zealand’s central piece of work health and safety law, the Health and Safety at Work Act 2015 (“HSWA” or “the Act”) requires that workers and others are given the highest level of protection from health and safety hazards and risks arising from work. This protection is principally realised through the primary legal duty to “ensure, so far as is reasonably practicable, the health and safety of workers who work for the PCBU¹, while the workers are at work in the business or undertaking” (HSWA, s 36). Further to this primary duty are other general duties, including that of officers (company directors, chief executives, and others—see section 2.5.2, Table 3) of a PCBU to exercise due diligence to ensure that the PCBU is complying with its duties under the Act.

The duties of officers are important in two ways. First, in requiring officers to ensure that there are processes and systems to understand, monitor, respond to, and manage risks to workers arising from the work of the PCBU, the duties lend oversight to the health and safety risk management functions of the PCBU. Therefore, these duties can also be thought of as providing the function of a regulatory overseer: an internalised policing of the company’s compliance with the HSWA. Second, company officers, at the apex of company management, influence and control the imperatives of production and the distribution and deployment of company resources to achieve those imperatives. Therefore, the decisions, actions and inactions of officers themselves are a powerful determinant of the experience of work for workers and of the risks they face in carrying out their work. In requiring that officers ensure that the PCBU is compliant in its obligation to eliminate or minimise risks to workers, the due diligence duties require officers to consider the impact of their decisions in either causing risks to workers or eliminating or minimising them (Johnstone & Tooma, 2022).

Although New Zealand (NZ) officers are charged with these duties under the HSWA, there appears to be a dearth of regulatory guidance and enforcement in relation to them, coupled with a scarcity of research relating to their performance and impact. These gaps appear even more pronounced where

¹ Person Conducting a Business or Undertaking (“PCBU”)—generally, a business entity, government department or agency, nongovernmental organisation, or charity.

these duties relate to the protection of the mental health of workers from risks arising from the work carried out by the PCBU (see section 3.7). These gaps are concerning as it is currently unknown whether, how, or in what ways the potential of the duties to achieve better outcomes for worker health and safety is being realised.

The flexibility inherent in the regulatory design of the HSWA means that organisations have immense scope to determine the meaning of compliance. This research investigates the ways in which officers conceptualise and carry out their due diligence duties as they apply to the protection of workers' mental health. Given that the HSWA is rooted in the assessment and management of risk, I examine how the meaning of compliance is constructed through the lens of risk.

The remainder of this chapter is laid out as follows: In section 1.2 I provide a brief description of the contextual factors and key foundational points from the literature that underpin this research.² In section 1.3, I introduce the research problem by explaining what is missing in the current literature and why it is important to address this problem, and section 1.4 introduces the particular perspective I took to understanding the problem. In section 1.5 I will explicate the research aims, objectives, and questions, followed by the research design at 1.6. Then, at 1.7 I highlight the contribution that this study makes before providing an overall thesis structure at 1.8.

1.1 THE HSWA: A NEW ERA IN NZ WORK HEALTH AND SAFETY REGULATION

The enactment of the HSWA in 2015 introduced two profound changes to New Zealand's work health and safety ("WHS"³) regulatory landscape. First, the HSWA introduced specific duties for officers of PCBUs to exercise due diligence to ensure that the PCBU complies with its statutory duties or obligations (see s 44, Appendix F). When almost identical inclusions were introduced in Australia via

² I have written, where I considered appropriate, in the first person rather than in a passive voice so that attribution of authorship and responsibility for choices, practices, and interpretations made in this research is upon myself. See Section 4.3 for more on my approach to reflexivity.

³ In this research I use the phrase "work health and safety" rather than "occupational health and safety" to reflect the wording of the HSWA which is the focus of this study. However, the reader will encounter the terms "occupational health and safety" or "occupational safety and health" and their abbreviations, "OHS" and "OSH" as they are reproduced in quotes from other sources throughout. Similarly, I use the term "worker," rather than "employee," to reflect the wording of the HSWA.

the Model Work Health and Safety Act (Cth) 2011 (the “Model Act”), legal academics lauded this as the most significant change of the new legislation (Johnstone & Tooma, 2012). Second, the Act specifically included mental health within the definition of health. This inclusion cemented the scope of the HSWA to consider the risk of harm to workers arising from exposure to psychosocial hazards in the workplace, psychosocial hazards being “those aspects of work design and the organisation and management of work, and their social and environmental contexts, which have the potential for causing psychological, social or physical harm” (Cox et al., 2000, p. 14). There is a body of robust evidence demonstrating that such harm commonly manifests as mental illness, cardiovascular disease, and musculoskeletal disorders (for example, see Harvey et al. (2017), Niedhammer et al. (2021), and Nielsen & Einarsen (2018) for systematic and metareviews).

The regulation of corporations has been subject to the process and consequences of decentring—the dispersion of regulatory control, influence, and responsibility to diffuse actors beyond the state (Black, 2001). In the field of WHS, the Robens Report (Committee on Safety and Health at Work, 1972) is often considered to have been influential in triggering this process (Sirrs, 2016b). The report catalysed the reimagining of health and safety regulation, first in the United Kingdom (UK) and, later elsewhere, by advocating a shift in the style of WHS regulation from a state-centred approach characterised by prescriptive specification standards to a principles-based regulatory strategy based on self-regulation through the application of “general duties”—specific roles and responsibilities for various parties. The regulatory style of New Zealand’s HSWA is therefore characteristic of “Robens Philosophy” in that it relies, for the most part, on businesses to self-regulate to fulfil legislative intentions. In this way, regulatory objectives are achieved through “principles which duty holders must follow, such as ensuring health and safety as far as practicable, leaving it to the discretion of the duty holder how they achieve those principles or goals” (Gunningham, 2015b, p. 940).

There is much research evaluating the regulation of psychosocial risks at work, particularly in the UK and the European Union (EU) (For example, see Cousins et al., 2004; Hansen et al., 2015; Rasmussen et al., 2011, Jain et al., 2022, Leka et al., 2023) and, to a smaller degree, Canada and Australia (for example, see Johnstone et al., 2011, Lippel et al., 2011). While it is generally accepted that the

principles-based approach to WHS described in the preceding paragraph is an appropriate and effective strategy for regulating psychosocial risks, a number of authors have conversely highlighted the challenges of regulating psychosocial risks in terms of their complexity and uncertainty (Jespersen et al., 2016), difficulties with audit and inspection (Bruhn & Frick, 2011; Indregard et al., 2019; Johnstone et al., 2011; Rasmussen et al., 2011; Weissbrodt & Giauque, 2017), and challenges relating to the connection of psychosocial hazards with the prerogatives of management and the organisation of work (Bruhn & Frick, 2011; Jespersen et al., 2016; Walters, 2011). However, in their assessment of psychosocial risk management strategies, Metzler et al. (2019) observed that barriers, such as a lack of awareness, expertise, and guidance, stigma around mental health, and insufficient supervision and control by governments, were bigger influences in determining the effectiveness of psychosocial risk assessment and the prioritisation given to it in businesses than the inherent characteristics of the psychosocial risks and hazards in themselves. Similarly, Weissbrodt and Giauque (2017) suggested that inadequate resourcing and training of labour inspectorates proved a greater barrier to regulatory intervention than conceptual challenges presented by psychosocial hazards.

Others have asserted that applying general duties to psychosocial risks is problematic because the general duties entail too much ambiguity and uncertainty for duty holders. Many authors hold the view that the general duties on their own, especially where there is no explicit reference to psychosocial hazards in the legislation (as is the case of the HSWA) or accompanying guidance, hinder regulatory efforts toward the management of psychosocial hazards at work (Bruhn & Frick, 2011; Hansen et al., 2015; Jain et al., 2022). The lack of specificity also means that, ultimately, duty holders cannot be sure they are really complying with their duties until they have been tested and determined by the courts (Bluff & Gunningham, 2003).

1.2 ROLE AND IMPACT OF OFFICERS IN THE REGULATION OF PSYCHOSOCIAL RISK

A review conducted by Ebbevi et al. (2021) has demonstrated that there are significant gaps in knowledge regarding the role of senior company management and governance in psychosocial risk management, particularly relating to the specific intersect of legal responsibilities and psychosocial

risks. The international grey literature reveals a number of government reports that are relevant to understanding the role of officers in the broader context of work health and safety, many of which were produced in the UK with the purpose of informing reform on the matter of directors' liabilities and responsibilities (Bergman et al., 2007; Boardman & Lyon, 2006; Gunningham, 1999; James, 2006; Lekka & Healey, 2006; McMahon et al., 2006; Wright, 2006). While several of these consider the proactive duties for directors, the due diligence duties have only been passed into legislation in Australia and New Zealand. Thus, it is axiomatic that there is a jurisdiction-limited scope for research regarding their implementation. While other research has considered the role of company directors in terms of health and safety from the perspective of examining attitudes (Heathrose Research, 2013; Smallman & John, 2001), legal liabilities and penalties (Harpur, 2008; Klettner, 2014; Pavlovich & Watson, 2015), and mechanisms of influence (Ferguson, 2015; Lornudd et al., 2021; Lornudd et al., 2020), these examine neither the conduct of due diligence nor psychosocial risks. The most thorough consideration of the due diligence duties exists in the work of Australia-based legal and WHS experts Johnstone, Tooma, and Dekker (for example, see Dekker & Tooma, 2022; Johnstone & Tooma, 2012, 2022; Tooma, 2017). However, these pieces mainly provide legal interpretations and theoretical perspectives, are not empirical studies, and do not exclusively consider the application of the duties to psychosocial risk.

The consequences of poor psychosocial risk management are of increasing salience in New Zealand. For example, the most recent New Zealand Workplace Barometer reported that 39.5% of respondents believed that they worked in an environment where they are exposed to a high level of psychosocial risk, which places these workers at increased risk for negative health outcomes (Forsyth et al., 2021). Similarly, the New Zealand Psychosocial Survey (Khieu et al., 2022) showed that New Zealand workers reported exposure to various psychosocial risks at work. Although the management of psychosocial risk in the work environment is not a new concept, with requirements to manage such risk being regulated by way of legislation as early as the 1970s in Norway (Gustavsen, 1977), the issue of psychosocial risk only recently appears to have permeated the consciousness of the business community in New Zealand as something that may be addressed under the auspices of health and

safety regulation (see section 3.7). While the New Zealand government and its advisory agencies have published a number of research and guidance documents on aspects of stress and psychosocial harm at work since the late 1990s (for example, see Driscoll et al., 2004; Occupational Safety and Health Services, 2003; Pearce et al., 2005; WorkSafe, 2017, 2018, 2019b, 2020a) and a significant amount of academic research into various aspects of psychosocial harm in New Zealand workplaces has been undertaken (for example, see Catley et al., 2013; D'Souza et al., 2022, Forsyth et al., 2021), there has been relatively little research specifically or substantially considering regulatory strategy or compliance relating to psychosocial harm at work (for exceptions, see Scott-Howman and Wall, 2003; Walls and Darby, 2004, Lo and Lamm, 2005, Blackwood et al., 2013, and Duncan 2016, 2018).

Given that New Zealand and Australian work health and safety legislation share almost identically worded due diligence duties, it is reasonable to consider that research in Australia is generally relevant to New Zealand. However, even in Australia, there is an absence of research on the role or execution of due diligence as it is applied to psychosocial risks. Case law does not provide much insight either. In New Zealand, as of January 2024, there have only been a handful of cases before the courts regarding the officers' duties since the passing of the HSWA. These cases provide little opportunity for an in-depth analysis of the duties, and none of the cases related to psychosocial hazards at work. As such, the relatively small body of case law has not generated much regulatory influence or academic analysis. Similarly, there are no published data on enforcement practices used by the regulator relating to the officers' duties or to psychosocial harm, suggesting that the regulator has adopted a conservative approach to this issue. Accordingly, Peace et al. (2017) and Dabee (2020) have written of both the research and regulatory gap in the area of officers' duties in New Zealand.

This lack of both regulatory and academic attention to the officers' duties is concerning. The officers' duties have the potential to be a powerful regulatory lever in improving New Zealand's work health and safety outcomes. There is abundant research, including analysis of serious health and safety incidents, showing that the actions or omissions of senior managers and directors are key determinants of a healthy and safe working environment (Gunningham, 1999; Hopkins, 2001, 2010; Kletz, 2001). The importance of these duties can also be underscored in remembering that the inclusion of officers'

duties in New Zealand's HSWA was prompted by a regulatory failure, resulting in the deaths of 29 people in a methane explosion at the Pike River Mine in November 2010. While the precise causes of the 29 deaths remains unknown, one factor was established with certainty: lax oversight of health and safety by senior management and directors occurring within a broader state system of poorly enforced regulation was directly related to the tragic outcome (Gunningham, 2015a; Royal Commission on the Pike River Coal Mine Tragedy, 2012b, 2012c).

1.3 ENDOGENOUS APPROACH TO COMPLIANCE

Most research into regulatory compliance falls into either an objectivist, or an interpretivist or social constructionist framework (Parker & Nielsen, 2009, 2017; Talesh, 2021). The focus of objectivist research tends to focus on the variables that cause organisations to comply with the law or that correlate with compliance. Objectivist research takes the view that the law is “exogenous or outside of organizations and the role of organizations is limited to reacting to law by either complying or not complying with law” (Talesh, 2021, p. 63). In contrast, interpretivist and constructionist approaches seek to elucidate how various actors in a regulatory system conceptualise and socially construct the meaning of compliance and, thus, view compliance as a “complex, ambiguous process in which the meaning of regulation is transformed as it is interpreted, implemented and negotiated in everyday life by those to whom it is addressed” (Parker & Nielsen, 2017, p. 218).

Researchers taking the interpretivist or social constructionist approach to studying compliance may adopt an endogenous view of compliance whereby they are typically interested in how organisations themselves “influence and shape the content and meaning of law and compliance” (Talesh, 2021, p. 64). Specifically, interpretive approaches aim to “discover the plural meanings of compliance that exist among key actors in the regulatory field ... [and social constructionist approaches focus on] ... uncovering the network of social construction processes that create understandings of compliance and on the power relations between the actors involved [which] might result in one understanding being socially accepted as more legitimate than others” (Parker & Nielsen, 2009, p. 50). This research adopts a social constructionist approach that focuses on examining how laws are given meaning and

operationalised in ways that produce various effects (Edelman, 2016; Stryker, 2007). Such effects include: the avoidance of a substantive impact, symbolically or ceremonially attending to compliance, or the accomplishment of regulatory objectives.

The concept of “risk” also forms a focus of this research. The relationship between regulation and risk has been theorised extensively so that the relationship between modern forms of regulation and risk has been considered both “inextricably” (Hutter, 2001b) linked and “inherently about the control of risks” (Baldwin et al., 2012, p. 83). Given that the duties in the HSWA encompass a duty to manage risk, the idea of risk as a social construction constitutes a key theme that I explore throughout this research. In particular, I examine how company officers construct the meaning of compliance with health and safety legislation through social constructions of risk. I take a critical approach to examining risk, considering the various ways in which risk is constructed, discussed, deliberated, and deployed by participants as they talk about their legal duties.

1.4 RESEARCH AIM AND QUESTIONS

1.4.1 RESEARCH AIM

In this research, I aim to critically examine the way New Zealand officers of large companies fulfil their duties of due diligence as they apply to psychosocial risk. In order to achieve the research aim, I interviewed New Zealand company officers about the conduct of their duties and described—through discourse analysis—the ways in which officers conceptualised and practised their duties as they applied to psychosocial risk. Although psychosocial risk exposure is associated with a variety of psychological, social, and psychological harms, I focused this research on psychological or mental harms. I also examined how the meaning of compliance was constructed through the lens of risk and assessed the implications of these conceptualisations and constructions relative to the regulatory purpose of the HSWA and the specific duties of officers therein. Consequently, this research intersects several bodies of knowledge: work health and safety regulatory theory and law, risk theory, and psychosocial risk management.

1.4.2 RESEARCH QUESTIONS

This research is driven by three research questions:

1. How do officers conceptualise, express, and carry out their duties under the Health and Safety at Work Act with specific regard to psychosocial risk?
2. How do constructions of risk shape how officers respond to this duty?
3. How do the ways that officers construct compliance relate to the regulatory intentions of the officers' duties, and what are the implications for managing psychosocial risk?

1.5 RESEARCH DESIGN

This research adopts a relativist ontology and social constructionist epistemology with a poststructuralist perspective. I take a Foucauldian analytical perspective and use social constructionist theories of risk as they apply in management settings (Hardy & Maguire, 2020; Hilgartner, 1992), as well as constructionist theories and models of compliance. I also draw on the theory of legal endogeneity, which holds that because organisations both respond to and construct the law that regulates them, the meaning of the law is rendered endogenous. In other words, the legal endogeneity thesis holds that the meaning of law is significantly determined within the same social field that it is designed to regulate (Edelman, 2016; Edelman & Talesh, 2011; Edelman et al., 1999).

The research design takes a qualitative approach and is primarily based on my analysis of semistructured interviews I conducted with officers of large New Zealand companies who had a particular interest or expertise in the topic area. Interviews were transcribed and then uploaded to NVivo for coding and analysis. In addition to the interviews, I assembled a corpus of related and relevant texts consisting of various document types. These were, for the most part, gathered opportunistically and included texts where officers or experts wrote or spoke about the application of WHS law to psychosocial risks, or where company officers discussed perspectives relating to psychosocial risk management. These sources included case studies, opinions, and written sources of

guidance on how officers should, or do, conduct their legal duties with respect to mental health at work.

1.6 SIGNIFICANCE/CONTRIBUTION

Social constructionist research into compliance is important because it examines or highlights the often taken-for-granted ways that commonly accepted views of compliance can promote the substantive purpose of the law or serve to limit the possibilities of regulation to achieve its social goals. With this in mind, this research makes several contributions. Specifically, this research is the first empirical study that aims to address the research gap around how New Zealand company officers understand and carry out their duties of due diligence in relation to psychosocial risk.

More broadly, the findings of this research contribute to the existing body of knowledge of how organisations respond to decentred⁴ regulatory strategies and to existing knowledge regarding how organisations respond to legal duties to manage psychosocial risks. Relatedly, this research also contributes to an understanding of how discourse, particularly the discourse of risk, shapes compliance practices and, thus, ultimately, whether intended legislative or regulatory objectives and purposes are achieved.

There are also some practical implications of this research. It may help bring a greater critical awareness of the ways in which officers and the organisations they govern respond to psychosocial risk that may obscure harmful risks to workers. Thus, the findings may inform compliance responses within organisations or regulatory strategy and guidance. Finally, the findings may be of relevance to regulators or organisations taking, or considering, alternatives to shareholder primacy-based governance strategies. This may include those attending to environmental, social, and governance (ESG) initiatives and regulation, or those organisations aspiring to broader stakeholder perspectives to

⁴ Decentred regulation is explained at section 2.2.1 and entails a dispersion of regulatory power away from the state.

governance which attend relatively more to the management, internalisation, or avoidance of negative externalities (Awatere et al., 2017; Mika & O'Sullivan, 2014).

1.7 STRUCTURE OF THE DOCUMENT

This thesis is presented in nine chapters. The current chapter has briefly introduced the overall premise, background, research questions, contribution, and structure of the thesis. Chapters 2 and 3 present a review of the relevant literature. Two literature review chapters are included due to the multiple topics that intersect in this research, including risk, regulation, and psychosocial risk management. These chapters will conclude by highlighting the gaps in the literature around which the research design is built. Chapter 4 provides the methodological approach taken in the research, outlining the theoretical frameworks, research design, and conduct of the research process, and provides a discussion of, and justification for, the methods used.

In Chapters 5 to 8, I present the combined findings and discussion of the research. In Chapters 5 and 6, I address the first research question, “How do officers conceptualise, express, and carry out their duties under the Health and Safety at Work Act with specific regard to psychosocial risk?” Chapters 7 and 8 focus explicitly on risk as a central organising concept of WHS. These chapters will examine how officers talk about risks and will scrutinise the types of risks officers talk about and respond to as they fulfil their duties and will also consider the implications of these risk constructions. Chapter 7 aims to answer the second research question, “How do constructions of risk shape how officers respond to this duty?” and Chapter 8 addresses the third research question, “How do the ways that officers construct compliance relate to the regulatory intentions of the officers’ duties, and what are the implications for managing psychosocial risk?”

Chapter 9 will conclude the thesis and present an overview of the research and its contributions. This chapter will make the limitations of the research explicit, note findings that were not included or fully explored in the thesis, and identify opportunity and scope for future research and publication.

2. LITERATURE REVIEW PART A: RISK, REGULATION, AND COMPLIANCE

This chapter begins at 2.1 with an examination of the key perspectives of risk, focussing on the phenomena of risk as a central organising concept of modernity. Using that examination as the basis, in section 2.2 I then consider characteristics of modern forms of regulation as they relate to work health and safety. In that section, I also examine compliance as a related but separate concept to regulation. Section 2.3 synthesises the two preceding sections, detailing the entwined relationship between risk, regulation, and compliance. In section 2.4 I examine risk, regulation, and compliance as a backdrop to understanding the philosophies underpinning the HSWA, and in section 2.5 I review the specific duties of officers within this Act. The key findings of this part of the literature review are summarised in the conclusion in section 2.6.

The literature review was conducted by searching selected academic databases using various search terms. These databases and search terms are listed in Table 1. The date range was chosen to reflect the decade of emergence of a general duties approach to WHS law (see section 2.4), and the emergence of key theories of psychosocial risk in the context of work (see section 3.3). Articles with abstracts that I judged to be relevant to the study were downloaded into EndNote. In EndNote, I classified articles into topic groups, for example, “history WHS law,” “regulation psychosocial risk,” “due diligence,” and “general duties.” As articles were read and reviewed, I entered my own key words or comments in the relevant fields in EndNote and gave articles star ratings relating to how relevant I considered they were to my research questions. The conduct of the literature review reflects an iterative process where search terms were added over the full span on the research period, such as when literature searches were conducted as various themes became salient during the analysis phase. For example, when I identified the concept of risk as a key theme in the research, I then conducted a literature review on risk theory and perspectives. Further, once key authors in various subject areas—such as risk theory, health and safety law, and compliance theories—started to become apparent, I conducted searches of the literature by author names.

Table 1*Scope of Literature Review*

Literature review search terms	Date range	Sources
Regulation (NOT emotional regulation) OR Law OR Laws OR Legislation OR Policy OR Legal AND Compliance OR “Mental health” OR Psychosocial OR Work OR Stress OR “Health and safety” OR “Due diligence” OR Governance OR Directors OR Management OR Officers (NOT “police officers”) Terms added to search after analysis: Risk Governmentality Wellbeing OR well-being OR “well being”	1970–2023	Web of Science ⁵ Google Scholar Scopus Business Source Complete Discover Emerald Insight

2.1 THE CONCEPT OF RISK

There is no universally agreed definition of risk (Aven, 2012). Across various disciplines and ways of studying risk, a common problem is trying to determine what the concept entails. As Luhmann (2002, p. 6) points out, “When we seek definitions of the concept of risk, we immediately find ourselves befogged, with an impression of being unable to see beyond our own front bumper.” The issue,

⁵ Institutional access to this database ended in January 2023.

according to Rosa et al. (2014, p. 13), is not just one of defining risk but one that “goes to the core question of whether risk exists, and if they do, under what conditions. It raises the question of how do we come to recognize and give meaning to risk.” Despite the challenge of multiple approaches to, and definitions of, risk, there are some common themes: risk is about danger, probability, uncertainty, and time. However, the many ways of describing risk using various assemblages of these themes are dependent on the context in which they are used and the discipline that employs them (Aven, 2012, 2016).

Further to the lack of a universal definition, the common usage of risk differs in two fundamental ways. First, as Zinn (2008) explains, in some contexts, risk is framed as an unwanted event, meaning something similar to a hazard, loss, damage, or threat. Second, risk is used to describe a calculation of the likelihood that a loss or harm will occur (Lupton, 2013). Risk, therefore, can be defined in multiple ways as “either the possibility/uncertainty/chance that the activity will have some undesirable consequences, or the activity (person, gasworks) itself, that which is often also referred to as a risk source or a threat” (Aven, 2012, p. 36). In this thesis, while the term “risk” is used to capture both these meanings, Chapters 7 and 8 will pay attention to the latter definition of risk by examining the objects and subjects of risk⁶ that officers spoke about as well as the implications of different constructions of risk.

To add further complexity, risk is sometimes referred to in situations with the potential for positive outcomes. For example, a “risky investment” implies the possibility for a higher than standard return. However, it also necessarily implies a higher than standard potential for loss and therefore the negative feature is not eliminated from the equation. Hence, even in the circumstances where risk is conceptualised as the potential for a positive outcome, the underpinning premise is the avoidance of a negative outcome (Hardy & Maguire, 2016). Viewed in this way, risk is inherently about imagining a potentially negative outcome.

⁶ The objects risk are the things that are considered to pose a threat and subjects of risk are the things that are of value that are considered threatened.

2.1.1 WAYS OF THINKING ABOUT RISK

Many authors have examined the history of risk, tracing the changes in the way society has conceptualised thinking about harm, tragedy, and misfortune (Beck, 1992; Doron, 2016; Lupton, 2013; Rose & Miller, 2008). According to Rose and Miller (2008, pp. 98–99), risk emerged as “a particular style of thinking” in the 19th century when “risk thinking brought the future into the present and made it calculable.” However, according to Burgess (2016), studies of risk only really accelerated in the late 1960s when perceptions of risks relating to health, the environment, and nuclear issues brought about a “culture of public risk anxiety” (p. 4) and the “risk society” (p. 9), a world preoccupied with the future and, hence, the management and control of risk, unfolded. Since then, a focus on risk ideas has grown to dominate public and private governance thinking so much so that “within the business world, the satisfactory management of a portfolio of disparate risks ... has become the basis for sound corporate governance” (Horlick-Jones, 2005, p. 293).

Risk is theorised in the academic literature from several perspectives. Generally, most approaches to risk can be categorised along an epistemological continuum ranging from a realist position on one end to a constructionist position on the other (Lupton, 1993; Rasborg, 2020; Renn, 1992; Zinn, 2008). The range of the continuum refers primarily to whether risk is considered as an objective entity, a socially constructed one, or somewhere between (Zinn, 2008). While Table 2 implies a clear separation between perspectives, the boundaries are, in fact, not so demarcated, with many studies incorporating or overlapping elements of one or more into another.

Table 2

Risk Perspectives

Epistemological position	Theoretical perspective	Key questions
Naïve realist: Risk is objectively determined and can be measured independently of social and cultural processes.	Technico-scientific perspective	What risks exist? How can they be measured and managed? How should information about risks be communicated?

Epistemological position		Theoretical perspective	Key questions
Perceptions of real risks can be distorted through cultural frameworks of interpretation.		Cognitive psychology perspective	How do people respond to risks? What worldviews shape their responses? How do people subjectively experience real risks?
Social constructionist	“Weak” constructionist or critical realist	Risk society perspective Sociocultural perspective	What is the relationship of risk to modernity? How do social values determine or shape what risk is? How are threats transformed into risks?
	Constructionist, poststructuralist	Foucauldian perspective	How do discourses of risk operate? What subjects and objects are created by the discourse of risk? How do the technologies that ascribe risk function?

The following sections 2.1.2 to 2.1.4 will consider these theoretical perspectives in turn.

2.1.2 THE TECHNICO-SCIENTIFIC PERSPECTIVE

This perspective focuses on a generally positivist understanding of risk as “the product of the probability and consequences (magnitude and severity) of an adverse event (i.e., a hazard)” (Bradbury, 1989, p. 382). According to Lupton (2013), this perspective is characterised by the employment of scientific instruments and theories to monitor, measure, and calculate risks, which, in turn, are used to develop models that serve to predict the impact of risks on individuals, groups, businesses, markets, nations, and so on. This approach to risk characterises such domains as insurance, engineering, statistics, epidemiology, economics, and, relevant to this research, the field of workplace health and safety. More generally, it is a perspective typically employed by those undertaking risk analysis, risk management and risk communication, and is underpinned by

frameworks such as the ISO31000 risk management standards (International Organization for Standardization, 2018).

The technico-scientific approach to risk is immensely important in that it is designed to anticipate or reveal and, thus, prevent, avoid, or reduce harm to people and the environment, improve the reliability of systems, or to facilitate policy decision-making. However, this perspective is less likely than other approaches (to be detailed in sections 2.1.3 and 2.1.4) to take into account the value judgements and knowledge systems that render some risks intelligible or important and appropriate to manage, or indeed manageable at all. Accordingly, the key critique levelled at the technico-scientific approach is that in its adoption of a rationalistic, naïve realist viewpoint that assumes the authority of science as the basis on which risks may be understood and managed, there is a further assumption that decisions made in the name of risk management are value free (Lupton, 2013; Zinn, 2008).

2.1.3 THE COGNITIVE PSYCHOLOGICAL PERSPECTIVE

The cognitive psychological perspective⁷ examines how individuals rationally and subjectively understand risk. This perspective stands in contrast to the technico-scientific's purportedly objective, expert, or *real* view of risk. Research informed by the cognitive psychological perspective examines why individuals or groups may evaluate risks differently and how risks are "dealt with" cognitively, an examination that is often framed in terms of risk perception. The cognitive psychological perspective often considers intervening variables that impact on how people perceive risks, such as voluntarism, knowledge, perceived benefits, trust, fairness, values, and affective associations (Visschers & Siegrist, 2018).

Researchers investigating the concept of voluntarism, for example, report that people perceive risks higher when they are involuntarily exposed to them, when risks are forced upon them, or when they perceive few benefits from them (Starr, 1969). Overall, the more apparent benefits there are to individuals, the less risk they perceive (Visschers & Siegrist, 2018). Similarly, studies show that when

⁷ Sometimes also referred to as the psychometric approach (Bradbury, 1989).

people encounter risks that are unfamiliar, receive high media coverage, or relate to situations where people can imagine harm happening to themselves, they tend to overestimate them (Clarke et al., 2015; Visschers & Siegrist, 2018).

Lupton (2013, p. 31) observes that this cognitive psychological perspective exhibits an “epistemological uncertainty” in that some studies imply that risk assessments by experts are “real”, “correct”, and “value free” versus the subjective assessments of the public. This approach therefore most often assumes a naïve realist epistemology in the same way as the technico-scientific approach in that it frames risks constructed socially as “perceived” and risks constructed scientifically as “real”.

2.1.4 THE SOCIAL CONSTRUCTIONIST PERSPECTIVES

Constructionist perspectives on risk are often grouped into three subperspectives (Burgess, 2015; Lupton, 2013; Zinn, 2008): the sociocultural perspective, the risk society perspective, and the Foucauldian governmentality perspective. Lupton (2013) situates each of these three subperspectives in positions from the “weak” (p. 41) constructionist/critical realist position of the sociocultural perspective through to the “strong” (p. 43) constructionist or poststructuralist position of the Foucauldian governmentality perspective. Notwithstanding their differences, Lupton (2013) notes that all of them share common foci on the rise of risk as a dominant feature of modern—particularly Western—society, on subjectivity, on risk as managed by human intervention, and on the association of risk with responsibility, choice, and blame.

Overall, each of the constructionist approaches, whether “weak” or “strong”, emphasise the social context in which risks are constructed and deployed as facts. Accordingly, researchers taking a social constructionist perspective focus less on identifying to which risks people are exposed or the techniques of measuring and managing them. Rather, they consider how and why particular phenomena come to be known as risks in a certain time or place and not in others, who benefits or is disadvantaged by constructions of risk, how risk is experienced, and how it may be contested or resisted. As much as this perspective examines which risks come to be constructed as facts, it also examines why other risks are ignored, subverted, or de-escalated (Luhmann, 2002).

A key problem with the constructionist approach to risk is the implication that socially constructed risks are somehow false, bogus, or illegitimate. Such an implication

can be experienced as threatening in environments where identities become bound up with an insistence on causal relations to particular physical causes. More broadly, the idea that something is the product of social rather than only physical causes can be particularly problematic in the world of risk. (Burgess, 2015, p. 8)

The next three sections will examine the three constructionist approaches in more detail.

2.1.4.1 The sociocultural perspective

Mary Douglas is one of the foundational figures in the theorisation of the sociocultural perspective of risk. Adopting a cultural anthropological approach, Douglas postulated that within a particular society, certain things come to be perceived as risks (as opposed to being perceived as “natural” or “normal” happenings) in accordance with interpretations made through social or cultural frameworks. This perspective “is a way of thinking about culture that draws the social environment systematically into the picture of individual choices” (Douglas, 2003b, p. xi). In this view, risk is not a fixed, objective phenomenon but one with a shifting boundary determined by the social context in which the risk is created, understood, and managed.

Douglas’s work describes many issues that remain pertinent in contemporary studies of risk. Key elements of her work include the topics of “risk and blame” (Douglas, 2003b) and “risk and acceptability” (Douglas, 2003a). Her book, *Risk and Culture: An Essay on the Selection of Technological and Environmental Dangers* (Douglas & Wildavsky, 1983), written with political scientist Aaron Wildavsky, argues that those things that a society names as risks do not arise in a manner proportionate to their scale or threat but because of dominant values, moral behaviours, and social norms. In this sense, Douglas and Wildavsky (1983) observed that the perceived harms in society are generally associated with the transgression of social norms. As a result, the things that are constructed as risks serve the purpose of maintaining the status quo via the attribution of moral or political blame for the negative outcomes of risk to marginalised groups who digress from those

norms. Therefore, “our analytic task is to unwind the causal theories until they reveal who is being kept out and who is being kept in” (Douglas & Wildavsky, 1983, p. 37).

2.1.4.2 The risk society perspective

The risk society perspective stems from the work of the German social theorist, Ulrich Beck, and his book *Risk Society: Towards a New Modernity* (Beck, 1992). Beck’s work influenced sociologist Anthony Giddens (Giddens, 1991, 1999), who also wrote about risk society: a term that moved beyond the title of the book to encapsulate this overall approach to thinking about risk. Beck (1992) examined risk as a phenomenon resulting from the way society is organised, and, therefore, central to the thesis was that risk is inextricably tied to, or is a defining characteristic of, modernity. For Beck, modern society is characterised by its preoccupation with managing risks created by itself. This preoccupation arises from the purported end of two phenomena or discursive epochs: the end of nature, and the end of tradition. The end of nature presents a distinct turning point in the discourse of risk from preindustrial society. In preindustrial society, risk discourse revolved around matters that were *external* to those affected by them—weather, natural disasters, and so on. Modern risk discourse, however, centres upon risks caused by society itself – pollution, crime, illness, terrorism, and so on.

Based on observations of contemporary risks, Beck (1992) noted that risk was increasingly inequitably distributed. Moreover, where the responsibility for creating risk was unclear or diffuse, risks could be redistributed unequally through the responsabilisation of parties for risks for which they held less culpability for their manufacture. For example, Beck (1992) describes how the rise of nonstandard labour through flexible work arrangements has the effect of shifting and privatising the physical and mental health risks encountered by workers in the conduct of their work away from employers and on to workers.

The second turn, the “end of tradition”, means “essentially to be in a world where life is no longer lived as fate” (Giddens, 1999, p. 3). Where fate no longer determines outcomes, the focus of the risk society perspective becomes the ensuing question of responsibility—if fate, God, or some other deity is not responsible for the future, then who is? In this respect, Beck details a process of

individualisation in which the individual rises to the fore as the central unit of social life over the collective or the group. The end of tradition, and its inherent security in codes and rituals, results in overwhelming uncertainty, “out of which we are more prone to manufacture risk” (Burgess, 2018, p. 93). In terms of social problems stemming from inequalities, individualisation sees such matters redefined as individual problems framed in terms of what Beck (1992, p. 100) describes as “personal inadequacies, guilt feelings, anxieties, conflicts, and neuroses,” which, he suggests, may account in part for the modern interest in psychology. In this way, social crises are reframed as individual crises, “which are no longer (or only very indirectly) perceived in terms of their rootedness in the social realm” (Beck, 1992, p. 100).

Reflective of its popularity, Beck’s (1992) work has also been subject to extensive critique. Burgess et al. (2018) summarise the key criticisms as being both methodological and epistemological.

Methodologically, they note the theory’s lack of empirical evidence, its narrow focus on catastrophic or cataclysmic risks, and its totalising focus on risk at the expense of other social and material factors. Epistemologically, they point out that critique has been levelled at *Risk Society’s* metanarrative approach, and its ambiguous or confused epistemological position, which, on the one hand, takes a constructionist view of risk and, on the other hand, a realist approach to risks such as environmental degradation.

Nevertheless, Beck’s (1992) work remains central to contemporary academic work on risk for two main reasons. First, it provides a challenge or alternative to predominant ways of thinking about risk based on psychological, behavioural, and technical approaches. His thinking provides a device to “illuminate different paths of critical inquiry into the hidden and global dynamics and impacts of risks, both old and new” (Burgess et al., 2018, p. 4) through its focus on cultural, social, and political determinants of risk. Second, taking a holistic view of Beck’s work, the concept of risk society “indubitably tells us something about the world we live in today” (Mythen, 2016, p. 282), and, despite the aforementioned critiques, risk society presents an “attractive” theory because it appeals to and offers an explanation for “the widely held perception that we are living in a ‘runaway world’ in which threats can no longer be harnessed or controlled” (Mythen, 2016, p. 282).

2.1.4.3 The Foucauldian perspective

The third constructionist approach to risk is the Foucauldian perspective. This approach is shaped by many elements of Michel Foucault's work, but particularly dominant are his ideas on governmentality (Foucault, 2007). Notwithstanding the utility of Foucault's work to think about risk, Foucault did not write or speak about the concept of risk per se, and, thus, this perspective draws from his theories that would identify risk as a system of knowledge.

The concept of governmentality is rooted in Foucault's conceptualisation of power as a circulating, generative, and productive force. Thus, the governmentality perspective focuses on "the diverse ways in which we may govern the conduct of others *and ourselves*" (O'Malley, 2008, p. 54) through a range of apparatuses, experts, technologies, and techniques that bring various institutions, people, and organisations into alignment (Dean, 2010; Miller & Rose, 1990; Rose & Miller, 1992). Miller and Rose (1990) explain that "political power is exercised today through a multitude of agencies and techniques, some of which are only loosely associated with the executives and bureaucracies of the formal organs of state" (p. 1). The governmentality perspective, therefore, views economic, medical, legal, spiritual, educational, and other institutions as entities that do political work by virtue of the ways in which they "endeavour to administer the lives of others in the light of conceptions of what is good, healthy, normal, virtuous, efficient or profitable," (Rose & Miller, 1992, p. 175). Governing, as Foucault points out, is an activity distinctly different "from 'reigning or ruling,' and not the same as 'commanding' or 'laying down the law'" (Foucault, 2007, p. 116). The governmentality perspective therefore holds that power manifests through a plethora of institutions that produce knowledge, which shapes the behaviour of individuals such that, through the application of that knowledge, they govern themselves.

The concept of risk has been theorised extensively from a governmentality perspective as a way of making certain things visible through the practices and technologies that render risks into calculable and knowable forms. By naming something as a risk, it is presented in a way that presupposes its governability (Dean, 2010). This perspective therefore explores the ways in which various apparatuses may govern populations by way of discourses, strategies, technologies, and so on, and, in doing so,

attempts to uncover the contingency of the present by showing “that our taken-for-granted ways of doing things and how we think about and question them are not entirely self-evident or necessary” (Dean, 2010, p. 31).

Governmentality analytics are therefore concerned with how we constitute certain social issues as problems; the language we use to describe, understand, and react to them; how we characterise them in terms of their causes; how we attribute responsibility for them; and how we create or delimit the possibilities of what can be done about them. Collectively, these features construct what is considered governable in that “problems are construed in ways that make them subject to practicable solutions” (O'Malley, 2008, p. 56). Accordingly, in this view, risk can be thought of as a strategy for ordering reality or “a particular way in which problems are viewed or ‘imagined’ and dealt with” (O'Malley, 2008, p. 57). Similar to the risk society approach outlined at section 2.1.4.2, a common theme that emerges in governmental analysis of advanced liberal democracies is how problems, including those conceived within the discourse of risk, have become “desocialized, privatized and individualized” (Dean, 2010, p. 221). This occurs when social or political issues or problems are represented as either private or personal matters requiring individuals to act upon them or by “transforming them into technical, professional or administrative matters to be resolved by the application of rational knowledge and professional expertise in relation to objective and apparently neutral criteria” (Rose & Miller, 1992, p. 197).

2.1.5 SUMMARY

This section 2.1 has reviewed three core approaches to risk—technico-scientific, cognitive psychological, and social constructionist. Within the social constructionist approaches to risk, three further subcategories were explored—the sociocultural approach, the risk society approach, and the Foucauldian approach. Although Tullock (2008) suggests this subcategorisation may be too blunt and thus miss some nuances between different intradisciplinary approaches to risk, he nevertheless notes it is “extremely useful” (p. 140) in delineating the main approaches to risk. On the other hand, rather than seeing the various constructionist perspectives of risk as mutually exclusive or in opposition to

each other, Rasborg (2020) upholds the utility of viewing them as supplementary in various ways so that together they offer a coherent understanding of risk. Indeed, a *bricoleur* approach, drawing on multiple perspectives, is often used in the literature when examining how organisations construct, conceptualise, and respond to risk (see for example, Hardy & Maguire, 2016; Power, 2007; Rothstein et al., 2006).

2.2 REGULATION: ITS DEFINITION AND PURPOSE

Regulation has a range of meanings, extending from deliberate actions of the state to procure socially valuable behaviour by creating and enforcing legal rules through to broader definitions that conceptualise regulation as something encompassing all forms of social control, including those imposed by institutions other than the state. Morgan and Yeung (2007, p. 3) explain that “regulation is a phenomenon that is notoriously difficult to define with clarity and precision, as its meaning and the scope of its inquiry are unsettled and contested.” Van der Heijden (2019, p. 7) characterises the regulation of business as being in a constant “state of conflict”, which, according to Haines (2011), frequently presents itself as a binary between too much and too little, with the regulation of business activity often expressed “in the lull between disasters” as a manifestation of a “nanny state”, a threat to individual liberties, or an economic handbrake (pp. 1–2). Far from being seen as necessary for the effective functioning and sustainability of markets or the protection of people and the environment, regulation is often represented negatively and synonymously with “red tape” (Freiberg et al., 2022, p. 437). This representation generally prevails until dramatic instances of regulatory failure, such as the global financial crisis, the degradation of oceans, rivers, and drinking water, or accidents that kill large numbers of people at work, uncover a lack of effective regulation and spark a reversal in sentiment coupled with calls for reform and an effective and accountable regulatory system (Haines, 2011).

Despite strong antiregulation discourse since the 1970s, empirical research has shown that there has never been more regulation of business activity globally, although the nature of it has changed (Drahos, 2017; Levi-Faur, 2005, 2017). Beginning in Europe and North America then spreading internationally, a pattern has been described whereby, as a result of the liberalisation of the welfare

state and the privatisation of public assets, an upswing in regulation was necessitated to ensure that the public good as well as the efficient operation of markets were maintained during and after this devolution. In this way, modern forms of regulation are considered to have been deployed to cover the gaps formed by the “hollowing out of the state” (Morgan & Yeung, 2007, p. 2).

Theories asserting the need for regulation range from the economic to the social and principled (Baldwin et al., 2012; Posner, 1974; Prosser, 2006). When considering the regulation of businesses, much of the technical justifications are aligned to a market-centred model whereby regulation represents efforts to correct various manifestations of market imperfections and failures. Free market activity, for various reasons, may “fail to produce behaviour or results in accordance with the public interest” (Baldwin et al., 2012, p. 15) and therefore requires regulatory intervention to ensure efficiency and outcomes that align with the public interest. Common market-centred justifications for regulation therefore include: the avoidance or management of monopolies, windfall profits, and information inadequacies, to ensure continuity and availability of service, to avoid anticompetitive behaviour and predatory pricing, to maintain public good, to moderate the market during scarcity and rationing, to rationalise and coordinate industries for the purpose of future planning, and to address unequal bargaining power and market externalities (Baldwin et al., 2012).

Understanding the rationale or case for regulation is important as these describe the nature of the problem that a particular law or system of regulation aims to solve or correct. In examining the regulation of work, for example, there have been many and various cases and justifications for regulating the employment relationship and work environment through labour laws, some overt and some theorised retrospectively. Historically, these have included: to ensure growth and the stability of the economy (Marx, 1887/2001), to control disease outbreak and to uphold the morals of workers (Hutchins & Harrison, 1903/2013), to maintain the stability of the patriarchy and gender norms (Rose, 2003), and to ensure the long-term sustainability and reproduction of the labour force (Moos, 2021).

In the modern labour market, however, the most often cited case for regulating the employment relationship and the work environment is that attributed to the doyen of modern British labour law, Sir

Otto Kahn-Freund (Lewis, 1979). Famously, Sir Otto drew on an economic or market-centred rationality to describe the purpose of labour law as being to mediate the consequences of unequal power between the parties in an employment relationship. According to Kahn-Freund, the main purpose of labour law was

to be a countervailing force to counteract the inequality of bargaining power which is inherent and must be inherent in the employment relationship. Most of what we call protective legislation—legislation on the employment of women, children and young persons, on safety in mines, factories, and offices, on payment of wages in cash, on guarantee payments, on race or sex discrimination, on unfair dismissal, and indeed most labour legislation altogether—must be seen in this context. (Kahn-Freund, 1979, p. 18)

However, noting that the justification for regulation can draw on multiple rationales, Baldwin et al. (2012) suggest that several further justifications for health and safety regulation arguably also fall out of this inequality: externalities (workers bear the burden of costs of work-related accidents or illnesses) and information inadequacies (workers may not know to what risks they are exposed).

Further to the economic or market-centred justifications for labour law, the regulation of work may also be justified for reasons of protecting human rights and to further social solidarity (Prosser, 2006). In terms of human rights, rights to healthy and safe working conditions have been included peripherally in various core, universal human rights instruments over the past century. For example, the Universal Declaration of Human Rights (1948) recognises the right to just and favourable conditions of work, and the International Covenant on Economic, Social and Cultural Rights (1966) recognises the same, specifically including within this right the right to safe and healthy working conditions. Recently, in 2022, after years of marginalisation of work-related human rights (Hilgert, 2012; MacNaughton & Frey, 2011, 2018), the right of workers to a healthy and safe work environment became the fifth principle in the International Labour Organization's Declaration on Fundamental Principles and Rights at Work (International Labour Organization, 2022a). Overall, both the economic and human rights perspectives are aligned in their assertion that labour law, including

occupational health and safety law, is concerned with labour within the broad context of employment so as to protect workers (Arthurs, 2011, p. 18).

2.2.1 SELF-REGULATION

There are a number of different “hard” and “soft”⁸ (Abbott & Snidal, 2000; Iavicoli et al., 2014) legal strategies and instruments that can be used individually or in tandem to regulate work health and safety. Understanding the regulatory strategy underpinning a given piece of legislation suggests the mechanisms and levers by which law intends to stimulate or enable, or, conversely, restrict or deter the behaviours of individuals, organisations, markets, industries, and nations in order to achieve desired regulatory objectives. This section examines the regulatory strategy that informs the HSWA and the officers’ duties therein.

The conventional view of regulation, according to Coglianese and Mendelson (2010), describes two polar positions: on one hand, freedom, where the state gives business complete discretion to act according to their own interests in a laissez faire or free-market environment, and, on the other hand, control, where it imposes regulations that remove discretion and, by way of threat of sanctions, aims to direct businesses into aligning their interests with those of wider society (see Figure 1). Although this dichotomy is a caricature, macro level changes in the international economic environment throughout the 1970s and 1980s strengthened the impetus for an increase in self-regulatory and coregulatory strategies as a replacement to models based more on traditional command and control regulation centred on the state (Levi-Faur, 2005). Described by Power (2007, p. 37) as a “family of related concepts”, these self- and coregulatory strategies are related in their nuanced approaches to the same basic idea that “the key elements of regulation, namely the production and enforcement of norms may, and should, be dispersed across many different actors” (Power, 2007, p. 37); that is, these approaches all entail a dispersion of regulatory power away from the state.

⁸ While not a strict binary, “hard law” encompasses legally binding obligations that are precise (or where precision is attained through adjudication or detailed regulations) and which delegate authority for interpreting and implementing the law whereas “soft law” is law that is weakened along one or more of the dimensions of obligation, precision, and delegation (Abbott & Snidal, 2000).

Indeed, contemporary views, while recognising the importance of rules and standards, acknowledge that “a plurality of public and private actors and mechanisms influence firm and individual behaviour at global, national and local levels, and regulation by governments is only the more formal tip of the iceberg” (Bluff, 2018, p. 46). In terms of New Zealand’s health and safety regulatory model for example, this can be illustrated by the fact that most organisations will be rarely, if ever, visited by a health and safety inspector, nor penalised or prosecuted. The result is that for many organisations in similar legal contexts, health and safety regulators exist only in the form of “a remote disembodied agent” (Gray & Silbey, 2011, p. 128).

There is no consistent or widely accepted definition of self-regulation and coregulation in the literature on regulatory compliance (Gunningham, 2011). In general, however, at one end of a continuum, pure self-regulation relies wholly on industry to regulate themselves whereas coregulation is a form of self-regulation with varying degrees of state oversight or participation (see Figure 1).

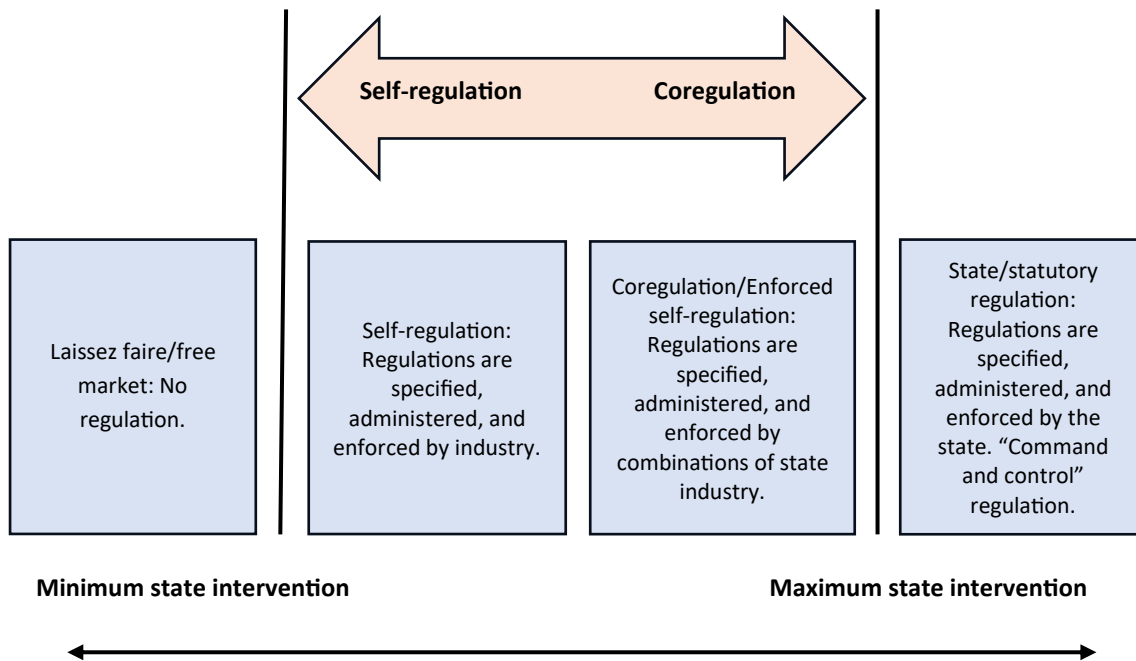


Figure 1

Continuum of Regulatory Strategy Adapted from Bartle and Vass (2005)

A related concept, metaregulation, also evades consensus in its definition (Coglianese & Mendelson, 2010) but generally describes the regulation of self-regulation achieved through the strategy of

allocating regulatory power or oversight to third parties, such as public agencies or private corporate self-regulators (Parker, 2002).

Self-regulatory (or coregulatory) initiatives, therefore, see the balance for various regulatory responsibilities, such as standard setting, monitoring, and enforcement, shift proportionately from the state to business (Levi-Faur, 2005; Talesh, 2016). This “decentred” approach entails

a move away from an understanding of regulation which assumes that governments have a monopoly on the exercise of power and control ... [and] a shift (and recognition of such a shift) in the locus of the activity of 'regulating' from the state to other, multiple, locations. (Black, 2001, p. 112)

The decentring of regulation sees governments taking a lighter touch in their role as regulator and an expansion of the role of government as an overseer of regulation with a corresponding emphasis on the “responsibilization” (Parker & Nielsen, 2009, p. 47) of capital for the societal goals of regulation, particularly as they pertain to environmental, health, and social outcomes. In such an environment, managing or ensuring compliance forms a substantial part of most senior managers’ (including company directors’ or officers’) roles. Accordingly, the New Zealand Institute of Directors holds “Effective Compliance” (Arcus, 2021) as one of its four pillars of good governance.

In theory, the merits of self-regulation exist in its ability to co-opt the capacity, knowledge, and expertise of business to design relevant, innovative, and resource-efficient responses to regulatory goals and to fulfil the regulatory role or actions previously occupied and undertaken by the state (Baldwin et al., 2012; Hutter, 2001a). Self-regulation is thus a strategy palatable to those concerned with regulatory burden or “red tape” (Ayres & Braithwaite, 1992, p. 106), and is considered the “least burdensome approach from the point of view of both taxpayers and the regulated industry” (Ayres & Braithwaite, 1992, p. 38). As a result, it is also an approach that sits comfortably with a liberal approach to the state’s involvement in the market.

However, without meaningful coregulatory strategies, such as incentives or disincentives imposed by external actors, business entities and industries are seldom motivated to comply and revert to

opportunistic action to maximise profits (Fleming-Milici & Harris, 2020; Hutter, 2001b; Noel & Babor, 2017; Seferidi et al., 2021; Zetterqvist & Mulinari, 2013). Others have demonstrated that in self-regulatory systems, particularly where laws are ambiguous or use vague language, “discretion pervades” (Black, 2002, p. 170), and there is greater scope for regulated entities to determine the meaning of compliance or embed self-interest. In doing so, regulated entities may engage in “symbolic” (Edelman, 1992; Edelman & Cabrera, 2020) or “creative” (McBarnet, 2016; McBarnet & Whelan, 1991) compliance where the law is interpreted, manipulated, or applied in ways to avoid its intended impact. A crucial factor, therefore, appears to be the underpinning of an external, third-party presence, influence, or intervention sufficient to ensure that the legislation intention achieves its goal toward the public interest (Ayres & Braithwaite, 1992; Gunningham & Johnstone, 1999; Hutter, 2001a; Kagan & Scholz, 1984). As such, more common expressions of self-regulation exist in systems of coregulation or enforced self-regulation (Ayres & Braithwaite, 1992; Baldwin et al., 2012; Gunningham & Rees, 1997), which have various roles for oversight, input, monitoring, and enforcement by other parties, including the state.

2.2.2 COMPLIANCE

As opposed to a focus on the policies, strategies, and tactics used by legislators and regulators, the study of compliance entails a shift toward a critical examination of the relationship between regulation and the actions of the regulated, in particular the responses *within* businesses to regulation and the conceptualisation and management of compliance activity. While compliance is defined by Parker (2002) as the “corporate accomplishment of regulatory objectives” (p. 67), researchers examining compliance within businesses argue that compliance cannot simply be thought of as a state whereby the regulated entity simply demonstrates compliance or noncompliance but rather as a complex social and political process of negotiation and interpretation (Black, 1997; Parker, 2002). Black (2001, p. 110) explains, “in the decentred understanding of regulation, [compliance] is the product of interactions, not of the exercise of the formal, constitutionally recognized authority of government.”

When it comes to research on compliance, Parker and Nielsen (2011) identify two main approaches: the objectivist and interpretivist. Objectivist research examines how, why, and in what circumstances firms come to comply with regulation and in which circumstances they do not. As such, the objectivist approach aims to identify and study variables and the interactions between them that may impact on compliance. These may include such things as the internal motives and capacities of businesses, or external factors, such as enforcement strategy or the involvement of third parties such as industry bodies or interest groups. Thus, much compliance research is based on the objectivist view where the aim is to understand the circumstances in which people and organisations respond to and adapt their behaviour to comply with ostensibly clear and unambiguous written law. This view is based on an understanding that legal norms and rules are exogenous to organisational responses, that is “they assume that law is formulated and defined outside of organizations and prior to reaching organizational domains” (Edelman & Tesh, 2011, p. 103).

In contrast, interpretivist approaches, including social constructionist approaches, “uncover the complexity, ambiguity and transformation of regulation as it is interpreted, implemented and negotiated by firms, their stakeholders and internal constituencies in everyday business life” (Parker & Nielsen, 2011, p. 2). Specifically, social constructionist approaches describe an interaction between rules and behaviour where compliance is created by regulated parties as they respond to it. The focus of interpretive and social constructionist research on compliance, therefore, is on “understanding the processes of negotiation and social construction of compliance that are masked by apparently unified, singular and unproblematic social practices and linguistic terms” (Parker & Nielsen, 2011, p. 7). For example, in her research on laws governing racial discrimination in employment, Edelman (1990, 1992, 2016) describes a processual theory of legal endogeneity where ideas about compliance are fashioned from law within the same businesses required to respond to it. According to Edelman (1992), businesses develop rules, policies, and procedures that indicate legal legitimacy, but which, by their filtering through managerial lenses, simultaneously mediate the impact of the law on managerial prerogative and power. Thus, “through the process of response to law, organizations construct the meaning of compliance and thus mediate the impact of law on society” (Edelman, 1992, p. 1532).

Ambiguous laws, such as laws that use vague or controversial language or broad and imprecise principles, are particularly susceptible to this mediation due to their scope for variable interpretation.

This research draws on these constructionist approaches to compliance, adopting the premise that for the law to be implemented successfully (that is, in accordance with the regulatory intention), the organisational and social contexts in which the law operates need to be understood. Regulations are created, interpreted, and operationalised in a socioeconomic, political, and cultural context with the very notion of compliance open to contestation. Exploring the ways in which regulations are interpreted and enacted by those same actors whose activities are regulated by them is fundamental to understanding how regulations may be effective or, conversely, their impact mediated as they are translated and interpreted through organisational discourses and practices.

2.3 RISK AND REGULATION

So far, this literature review has considered the concept of risk independently from the concepts of regulation and compliance. These ideas come together where risk conceptually guides regulation and compliance. There is a significant body of literature on risk and regulation and the relationship between the two concepts has been theorised extensively, so much so that regulation and risk have been considered “inextricably” related (Hutter, 2001b, p. 8). Others similarly describe modern business regulation as being “inherently about the control of risks” (Baldwin et al., 2012, p. 83).

Several related but distinct ideas feature in the academic and business discourse around risk and regulation. I will delineate three separate risk/regulation concepts: (1) the concept of regulatory risk as a category of risk; (2) risk-based regulation as a regulatory strategy; and (3) risk regulation as a structural characteristic of regulation. Each concept will be explained briefly below.

2.3.1 REGULATORY RISK

Regulatory risk is a category of operational risk which focuses on the potential for loss that businesses are exposed to because of regulation. In offering an explanation of regulatory risk, Ergas et al. (2001, p. 6) state that “regulatory risk arises when the interaction of uncertainty and regulation changes the

cost of financing the operations of a firm.” Health and safety legislation may produce a regulatory risk to an organisation where, for example, it requires an organisation to cease operations or make significant changes to a manufacturing system to reduce exposure to safety hazards, resulting in a financial loss.

2.3.2 RISK-BASED REGULATION

Risk-based regulation (RBR; Black, 2005; Black & Baldwin, 2010) is primarily conceived of as a strategy employed by regulatory agencies. Black and Baldwin (2010, p. 181) define RBR as “systematised decision-making frameworks and procedures to prioritise regulatory activities and deploy resources, principally relating to inspection and enforcement, based on an assessment of the risks that regulated firms pose to the regulator’s objectives.” Accordingly, for regulators using an RBR framework, priorities are set, and resources are deployed, to intervene in those factors that are most likely to provide a threat to the *regulatory organisation* achieving *its* strategic goals. This may occur through a focus on areas where noncompliance is highest or by targeting those areas where noncompliance presents the greatest risk of harm to a regulatory objective. This style of regulation is seen in a variety of contexts, such as financial, food hygiene, environmental, and health and safety regulation.

Risk-based frameworks to health and safety regulation were initially endorsed and gained traction in the UK through a series of government reports (Hampton, 2005; Löfstedt, 2011; Young, 2010) that were driven by an ideological conception of health and safety regulation as a burden to business. The RBR framework is also influential in New Zealand where the government explicitly promoted the adoption of a risk-based regulatory approach in its review of health and safety regulation in *Working Safer: A Blueprint for Health and Safety at Work* (New Zealand Government, 2013).

The fundamental limitation of risk-based regulation exists in its selectivity as to which risks demand regulatory attention. In this selectivity, the deficits of RBR are highlighted: “Risk-based regulatory frameworks have the potential both to expose and obscure key socio-political and socioeconomic choices ... as to the amount or types of regulatory failures that an agency will tolerate” (Black, 2006,

p. 3). Thus, where RBR delimits which regulatory failures a regulator or government will tolerate, it therefore requires that others (such as individuals, communities, or wider society) bear responsibility for those failures instead. In this way, RBR “can in effect be used in an attempt to define the parameters of blame” (Black, 2006, p. 3).

Risk is the guiding concept behind the New Zealand Health and Safety regulator’s *Strategic Plan for Work-Related Health 2016 to 2026* (WorkSafe, 2016). In that 60-page document, the term “risk” is mentioned 253 times, and different occupational health issues are prioritised in terms of risk as target areas for regulatory attention. Of relevance to this research, psychosocial risk, “including work-related stress” (WorkSafe, 2016, p. 42), is identified as a probable target area.

2.3.3 RISK REGULATION

Although sometimes described under the wider strategy of RBR (Black, 2006), risk regulation is a *structural* characteristic of laws or regulations, such as WHS law, which require regulated entities to manage risk in order to comply and is a concept underpinning the officers’ duties. Accordingly, risk regulation is the focus of this research. Risk regulation operates within the framework of self-regulation outlined in section 2.2.1. As explained by Bamberger (2010, p. 673), risk regulation “ultimately enlists the judgment of regulated firms themselves, delegating to them the tasks of interpreting the regulatory norm in local context and implementing the appropriate response. In these contexts, implementation by private institutions ultimately animates the law’s meaning.” Risk regulation therefore operates by requiring regulated businesses to either develop, or capitalise upon existing, internal systems, processes, and controls that are geared toward achieving the public good determined by the regulation with an emphasis on preventing harm through the management of risk. This preventative focus is also known as *ex ante* (as opposed to *ex post*)⁹ regulation. Bamberger (2010) continues his explanation of this strategy when he describes how risk regulation

⁹ *Ex ante* means before the event, as opposed to *ex post*, which means after the fact.

delegates, to regulated entities themselves, wide discretion in deciding how to interpret and achieve those goals in particular contexts. Such regulatory delegation thus enlists the judgment of firm decisionmakers to draw on the superior knowledge of internal firm workings that are inaccessible to regulators, and seeks to harness firm risk-management systems as regulatory assets by aligning public and private incentives. (p. 679)

Both Parker (2002) and Power (2007) draw on the Foucauldian governmentality perspective described in section 2.1.4.3 to describe how modern forms of regulation, such as risk regulation, operate. Power (2007, p. 41) describes risk regulation as one of multiple “neoliberal regulatory strategies [which] draw our attention to the many sources of control, discipline and normative order beyond the state”. In risk regulation, Power argues, the influence of the state, or government, is replaced by diffuse points of *governance*. This dispersion or diffusion of regulatory power from the state to business, from government to governance, is named by Parker (2002, p. 12) as “the new regulatory state” and summed up by Power (2007, p. 42) as the “‘managerial turn’ with an increased emphasis on systems of control, senior management responsibility and ‘naturally’ enforced systems of compliance.” This “responsibilisation” (Power, 2007; p. 39) of business for achieving the goals of their own regulation (which arguably might be epitomised by such legal duties such as the officers duties of due diligence in the HSWA), inherently results in managerial and regulatory processes and objectives becoming “blurred” (Power, 2007; 41). The impact of this blurring is that, as Edelman (2016) suggests, regulatory requirements and responses are interpreted through the logics of opportunity and enterprise, and, accordingly, the goals of regulation are reimagined in ways that are perfectly aligned with the goals of business – “control activities can be imagined both to be ‘compliant’ and to facilitate core business processes in an organization” (Power, 2007, p. 41). In this way, the “problem” of compliance disappears—an imagining of an ideal that Power (2007) notes is “not an empirical reality” (p. 41).

2.4 RISK AND REGULATION IN WORK HEALTH AND SAFETY

The regulation of health and safety at work has been subject to the process and consequences of decentring (see sections 2.2.1 and 2.2.3). The decentring of WHS law can arguably be traced back to the influential British “Robens Report” (Committee on Safety and Health at Work, 1972). The Robens Report provided the catalyst for the reimagining of health and safety regulation from a state-centred approach characterised by prescriptive specifications to one embodying principle- and performance-based regulatory strategy hinging upon self-regulation and the management of risk. This approach, which was eventually labelled the “Robens Philosophy”, was “intimately bound with the changing political discourse on risk in the 1960s, and wider concerns about the economy and industrial relations” (Sirrs, 2016b, p. 249). The Robens Report triggered significant reforms in both legislation and regulatory strategy, first in the UK and later in other jurisdictions, such as Canada, Australia, and New Zealand, where its principles and theories are strongly retained in modern health and safety regulation (Bennett, 2015; Ellen et al., 2016; Sirrs, 2016a).

The Robens Report asserted that the then approach to regulating health and safety at work was not effective and no longer tenable. The report identified three key “defects” (Committee on Safety and Health at Work, 1972, p. 6) of the law. First, the report asserted that because of its detailed, prescriptive nature, there existed simply too much law. Second, the law was ineffective and complicated, based on outdated modes of work, inflexible in its application, and limited by its focus on the physical hazards presented by traditional industrial processes. Third, the law’s application was administratively fragmented. The approach favoured by the report to overcome these defects was for general duties, backed up by codes of practice and official guidance documents, that would provide a more flexible way to give direction to businesses in their compliance efforts. In terms of enforcement, the report favoured enforced self-regulation and advocated “for ways of reducing the negative influence of an excessively regulatory approach” (Committee on Safety and Health at Work, 1972, p. 80). The report envisaged the regulator’s key role as providing advice, and, while it did see a role for prosecution, it was considered an option appropriate only in cases of flagrant abuses of the law. Drawing together all these threads, the Robens Report ultimately recommended one Act covering

WHS in the UK, based on general duties applying to all workplaces and industries. This single Act would be administered by one inspectorate overseeing a series of measures to promote a more preventative approach, greater awareness of health and safety issues, and improved risk management through the cooperation of workers and management.

Despite many of the changes outlined in the Robens Report being welcomed and widely adopted (Sirrs, 2016a) there was also criticism then and in the ensuing years. Such criticisms related to: (1) the report's position that "apathy" (Committee on Safety and Health at Work, 1972, p. 15) was the root causes of poor occupational health and safety; (2) its assumptions of mutual interest between capital and labour; (3) its position on the nature of enforcement; and (4) its partial implementation. First, contrary to the position taken in the Report, critics asserted that the cause of industrial accidents was not "apathy", but the inherent pressures generated by a capitalist mode of production and its asymmetrical employment relationship (Nichols & Armstrong, 1973). Further, there were causes emanating from the organisation and management of work, such as worker inexperience, poor training, comprehension, and information, and from production pressure, fatigue, stress, and monotony (Gunningham, 1984). Second, the Robens Report's contention that, when it came to health and safety, there was a "natural identity of interest between 'the two sides'" (that is, labour and capital; Committee on Safety and Health at Work, 1972, p. 21) was interrogated by Baldwin (1995) and considered possible in some circumstances but mainly "wishful thinking" (p. 133). Similarly, Kinnersly (1973) described the assumption of an identity of interest as "a dangerous myth which dovetails with the fiction that most accidents are caused by carelessness and therefore can be eliminated if 'everyone pulls together'" (p. 10). Third, the report advocated for the regulator to take a light-handed approach to enforcement and instead adopt a more advisory and educative role. This strategy was based on the supposition that strict enforcement of the law had not proven to be an effective regulatory strategy in the past. This position was critiqued by those who observed that the perceived failures of enforcement to improve WHS outcomes had not been for reasons of conceptual shortcoming, but simply because a policy of strictly enforcing legal standards in health and safety had never been tried (Gunningham, 1984; James et al., 2013; Tombs & Whyte, 2007, 2013). Finally, in the

longer term, selective or partial implementation of aspects of the Robens Philosophy has, in many cases, been associated with regulatory underperformance and failure in those states with Robens-style legislation, such as the UK (Baldwin, 1995; Hutter, 1993; Sirrs, 2016a) and New Zealand (Jager et al., 2013; Sissons, 2016; Lamm et al, 2017). Baldwin (1995, p. 301) sums up the critiques of the Robens Philosophy with his assertion that “the Robens legacy demonstrates quite graphically how distortions and mistaken assumptions can be built into a regulatory structure and how difficult it is, even decades later, to reform legislation so as to make it more effective and legitimate.”

2.4.1 THE DEVELOPMENT OF NEW ZEALAND’S WORK HEALTH AND SAFETY REGULATION

The genesis of the regulation of work health and safety in New Zealand can be traced back to the reforms made to protect workers’ health during England’s industrial revolution. Indeed, much of New Zealand’s legislation has been transposed from the UK and, latterly, Australia. In this sense, New Zealand’s health and safety laws prior to the 1990s were similar to the British laws problematised in the Robens Report in the sense that they were, according to Schmidt-McCleave and Shortall (2016, p. 7), “piecemeal and reactionary, dealing with issues as they arose in a prescriptive manner” and showed “no attempt to obtain consistency or overall coherence in the law or connecting policy” (Lamm, 1994, p. 59).

New Zealand was delayed in adopting the Robens Philosophy, distracted, according to Lamm (2010), by the establishment of its “no fault” (p. 172) worker accident compensation system that it let reform of its “scattered and often ineffectual” (p. 172) occupational health and safety laws slide by the wayside. The Walker Report (Walker, 1981) tentatively suggested that New Zealand follow the UK in adopting some elements of Robens-style regulation; however, this recommendation was not adopted at the time. In 1990, the Labour Government put forward the Occupational Health and Safety Bill, but, having lost the general election, it was subsequently withdrawn. The Occupational Health and Safety Bill was replaced by the National Government’s Health and Safety in Employment Bill, which was passed by parliament in 1992 as the first Robens-style legislation in New Zealand.

2.4.2 PIKE RIVER MINE: A TURNING POINT IN NZ'S WORK HEALTH AND SAFETY REGULATION

In November 2010, a methane explosion occurred in the Pike River Mine near Greymouth on the South Island's West Coast, killing 29 men—employees of and contractors to Pike River Coal Ltd. The Pike River Mine tragedy triggered multiple investigations and inquiries, from an examination into the events that occurred at the mine that day through to a review of New Zealand's entire WHS regulatory framework.

A Royal Commission of Inquiry ("the Commission"; Royal Commission on the Pike River Coal Mine Tragedy, 2012a, 2012b, 2012c) was formed to investigate the chain of events that unfolded on the day of, and in the preceding weeks, months, and years leading up to, the incident. The Commission made several findings of relevance to this literature review regarding the duties of officers, regulation, and legislation. At the regulatory level, it found that the regulator, then the Department of Labour, clearly prioritised economic development in its strategic intent and therefore did not see its role as a health and safety regulator as its primary purpose. As a result, inspectors were inadequately resourced and trained (Gunningham, 2015a). The Commission also identified that a preoccupation with production targets at the Pike River Mine Company board meetings set the tone for executive managers and their subordinates and led to "a culture of production before safety" (Royal Commission on the Pike River Coal Mine Tragedy, 2012a, p. 19). Because of this, the board did not give adequate attention to systems and processes that could have protected the safety of workers. The passive attitude of the board's chair toward safety at the mine was reflected in the assumption "that things were under control, unless told otherwise" (Royal Commission on the Pike River Coal Mine Tragedy, 2012a, p. 56). The Commission pointed out that under the then current health and safety legislation, the Health and Safety in Employment Act 1992 (HSEA), the directors of the company owed no specific duty to ensure the health and safety of the company's workers, and that in their opinion, the absence of such a duty contributed to a failure to pay appropriate attention and concern to health and safety at the board level.

Haines (2011) argues that disasters often provide a social and political mandate for regulatory reform, which certainly seems to be apparent in the case of law reform in the wake of Pike River. The Pike River Mine incident highlighted the failings of the health and safety regulatory system and this, coupled with the findings of the Commission's report regarding the lack of accountability for workers' health and safety, provided a mandate to consider legislative reform. Accordingly, the Commission recommended various legislative changes, among which included the introduction of proactive duties for company officers.

The Commission reasoned that director responsibilities for health and safety at work should align with other governance responsibilities, such as financial fiduciary duties. In this sense, it observed that "best practice recommended by the New Zealand Institute of Directors identifies the importance of 'holding to account'" (Royal Commission on the Pike River Coal Mine Tragedy, 2012c, p. 327). Accordingly, the Commission recommended that the board should hold management "strictly and continuously to account through informed, astute, effective and professional oversight" (Royal Commission on the Pike River Coal Mine Tragedy, 2012c, p. 327). In these statements, the intention of the Commission to co-opt company officers to perform the role of a risk "overseer" became evident, illustrating a situation where within an organisation, "risk management ideas fill the normative vacuum created by weaker state-centred authority" (Power, 2007, p. 194).

Concurrent to the Commission's investigation into Pike River Mine, an Independent Taskforce on Health and Safety ("the Taskforce"; Jager et al., 2013) found that New Zealand's current health and safety regulatory system and legislation was not fit for purpose. In particular, the Taskforce held a similar view to the Commission in identifying a lack of legal duties in the upper echelons of company structures and a weak regulator as key points for reform. In its focus on identifying and prioritising population groups and industries that respectively bore and caused most health and safety risks, the Taskforce's report adopted a clear risk-based regulatory approach.

The Taskforce also recommended that to support the establishment of a duty on those in governance roles, the New Zealand Institute of Directors should develop a code of practice. Further, they

recommended that other key actors, such as the New Zealand Stock Exchange, develop and incorporate guidance for reporting on health and safety matters. Both recommendations reflect a clear expression of a decentred regulatory approach in the dispersion of regulatory authority across a multiplicity of actors beyond the state. Shortly after the release of the Taskforce's report, a blueprint for occupational health and safety law reform was released that followed through on the report's recommendation for a positive duty on directors (New Zealand Government, 2013). New Zealand's Health and Safety at Work Bill underwent its third reading in August 2015 and came into force on April 4, 2016, replacing the HSEA.

2.4.3 THE HSWA AND RISK

New Zealand's HSWA is an example of risk regulation in that it requires PCBUs to manage the *risk* of harm to workers. The Act is an example of self-regulation in that the legislative intentions are achieved via "*principles* which duty holders must follow, such as ensuring health and safety as far as practicable, leaving it to the discretion of the duty holder how they achieve those principles or goals" (Gunningham, 2015b, p. 940). The primary duty of care is outlined in s 36, which requires that a PCBU ensure, so far as is reasonably practicable, the health and safety of workers and others. The principle of risk management is introduced at s 30(1), where the Act requires duty holders "a) to eliminate risks to health and safety, so far as is reasonably practicable; and b) if it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable."¹⁰ In this sense, the Act is forward looking in that offences relate to the failure to manage risk and the exposure of individuals to risk, and does not suggest that an offence has been committed simply when a worker has been harmed. The Act provides a meaning of "reasonably practicable" in s 22:

¹⁰ Although focused on the management of "hazards" as opposed to "risks", New Zealand's preceding work health and safety legislation, the HSEA s 2A(1), similarly required employers to take "all practicable steps," meaning that they must take "all steps to achieve the result that it is reasonably practicable to take in the circumstances" (s 2A(1)).

What is or was reasonably able to be done to ensure health and safety taking into account and weighing up relevant matters including:

- (a) the likelihood of the risk concerned occurring or workers being exposed to the hazard
- (b) the degree of harm that might result
- (c) what the person concerned knows, or ought reasonably to know, about:
 - (i) the hazard or risk
 - (ii) ways of eliminating or minimising the risk
- (d) the availability and suitability of ways to eliminate or minimise the risk
- (e) after assessing the extent of the risk and the available ways of eliminating or minimising the risk, the cost associated with available ways of eliminating or minimising the risk, including whether the cost is grossly disproportionate to the risk.

In simple terms, the determination of that which is reasonably practicable requires an assessment of the time, trouble, and money required to manage a risk and is therefore a qualifier to an otherwise absolute duty. Therefore, that which is reasonably practicable may be very different in different situations, and, accordingly, those responsible for managing health and safety risks are required to exercise judgement in each case to determine the scope of reasonable practicability. Although posed as an objective test requiring that PCBUs weigh up “cost” against “risk”, the goal of such an objective judgement is complicated by the inherent inequity of the calculation due to the cost being borne by the PCBU and the risk by workers (Gunningham, 1984). The concept of reasonable practicability is considered further in section 3.5.

2.5 THE OFFICERS’ DUTIES

For a long time, regulators have faced a significant challenge in applying criminal law to corporations. Criminal law was developed from the view of attributing fault to the individual, and applying this perspective to a corporation presents a challenge. However, in its consideration of the role of

company directors, the Robens Report examined and acknowledged the important role within health and safety held by senior management:

At the top, at board level, direct responsibility for the general oversight of health and safety matters within the firm should be included within the duties of one of the directors, in the same way a director may be allocated overall responsibility for production or marketing or exports. In our investigations we formed the impression that undivided line management responsibility for safety and health matters more often than not stops at some point in the middle management chain; further up the chain the responsibility tends to become diffused and uncertain. Safety and health should be treated like any other management function, with a clear line of responsibility and command running up to an accountable individual at the very top. (Committee on Safety and Health at Work, 1972, pp. 16-17)

The legal responsibilities and liabilities of company directors are defined and constructed differently in various jurisdictions. This review will not consider the full array of variations in all jurisdictions¹¹ but will focus on the duties as first enacted in Australia's Model Act on which the officers' duties in the HSWA are based.

2.5.1 THE GENESIS OF OFFICERS' LIABILITIES AND DUTIES

Despite the Robens Report identifying the need for clear responsibilities for directors, there were no specific *duties* placed on officers or company directors in the UK's Health and Safety at Work Act 1974. Instead, *liability* for health and safety offences was laid out in s 37 and remains the same today:

37 Offences by bodies corporate.

- (1) Where an offence under any of the relevant statutory provisions committed by a body corporate is proved to have been committed with the consent or connivance of, or to have been attributable to any neglect on the part of, any director, manager, secretary

¹¹ Bergman et al. (2007) provide a comparison of different regimes although this is now somewhat out of date since the due diligence duties were enacted in Australia and New Zealand.

or other similar officer of the body corporate or a person who was purporting to act in any such capacity, he as well as the body corporate shall be guilty of that offence and shall be liable to be proceeded against and punished accordingly.

It is important to note that these duties only exist in the context of a prosecution—they are reactive, not proactive, provisions. They are only tested when an offence has been found and provide for the attribution of liability for the conduct of the company (Bergman et al., 2007)¹².

Similar liabilities have existed in various Australian health and safety laws since the 1970s and in New Zealand's previous HSEA. As with the UK law, the HSEA provided for accessorial liability and an absence of specific duties; in other words, it told officers what *not* to do and did not give them any proactive duty to fulfil. Thus, criminal liability only existed where it could be proved that an officer, “directed, authorised, assented to, acquiesced in, or participated in” (HSEA, s 56(1)) an act that caused the body corporate to fail to comply with a provision of that Act. The fundamental problem with this accessorial model of liability was that company directors and senior management may not know what law breaking may be occurring in their company and, therefore, under this type of legislation, could not be liable for it (Braithwaite & Makkai, 1991).

There are significant regulatory and theoretical challenges in attempting to modify corporate behaviour through fines and penalties. For example, as Braithwaite and Makkai (1991) explain, financial penalties against a corporation, instead of a person, are often simply passed on to consumers, which makes them a less salient deterrent to the individuals who comprise, lead, and make decisions on behalf of a company. As Johnstone and Tooma (2012) point out, therefore, the ability of regulators to persuade corporates to abide by the rules hinges upon the influence that can be exerted onto the individuals who stand behind the corporation. Thus, penalties or sanctions that “pierce the corporate veil” (Johnstone & Tooma, 2012, p.100) are considered more likely to be effective than those which target the corporation as an entity. Indeed, these points about liability and impact were explored in

¹² UK Company officers have also been prosecuted under the Company Directors Disqualification Act 1986 and the Companies Act 1986 for work health and safety related offences (Dobson, 2013).

Australia prior to the introduction of the Australian Model Act where the inclusion of a specific duty for officers had been considered and recommended in the National Review into Model Occupational Health and Safety Laws (“the National Review”; Stewart-Crompton et al., 2008), several years prior to New Zealand’s Pike River Mine incident. The National Review explained the reasoning for the inclusions as:

A company is an artificial entity, which cannot make decisions or act other than through individuals. A company cannot comply with a duty of care placed upon it, unless those who manage the company make appropriate decisions and ensure necessary actions are taken [...] Decisions relating to the availability and allocation of resources that are important for health and safety are also made by those who manage the corporation. (Stewart-Crompton et al., 2008, p. 104)

The National Review went on to suggest the “due diligence” model. In this model, in a similar fashion to the South Australian WHS law at the time, officers assumed a proactive duty to ensure that the PCBU of which they were an officer was complying with its obligations under the Act. This recommendation went on to be included in the Model Act, which, at s 27 states:

- (1) If a person conducting a business or undertaking has a duty or obligation under this Act, an officer of the person conducting the business or undertaking must exercise due diligence to ensure that the person conducting the business or undertaking complies with that duty or obligation.

Due diligence is, of course, not a term solely related to this duty but is a concept used across many legal and business spheres. Whereas in the business context, due diligence commonly refers to the analysis of another company or entity done in advance of a transaction, in a legal sense, due diligence means to “act with a certain standard of care” (Spiller, 2023, section DU) or to take “the care that a reasonable person exercises to avoid harm to other persons or their property” (Merriam-Webster, n.d.). *Black’s Law Dictionary* (Garner, 2019) offers a definition of due diligence that highlights the dependence of the context in which the duty is owed:

Such a measure of prudence, activity, or assiduity, as is properly to be expected from, and ordinarily exercised by, a reasonable and prudent man under the particular circumstances; not measured by any absolute standard, but depending on the relative facts of the special case. (p. 573)

The introduction of officers' duties was therefore a significant departure from the accessorial model in that it removed the incentive for senior management to ignore undesirable information or situations, much less participate in them, and entailed a proactive duty.

2.5.2 WHO IS AN OFFICER UNDER THE HSWA?

The HSWA draws much of its content from the Australian Model Act. Under the HSWA, duties are imposed on various parties, including PCBUs, workers, and officers. However, there are subtle differences in the wording of the officers' duties in the Model Act compared to the duty in the HSWA, and it is useful to clearly delineate the differences so that application of the literature from the Australian context can be interpreted in relation to the limitations of the application of the definition of "officer" in the New Zealand HSWA. Whereas the Model Act draws on the definition of officer taken from the Australian Corporations Act 2001 (Cth), the HSWA does not draw on definitions provided in other New Zealand statutes and instead provides a definition of an officer in s 18 (see Appendix F). There has been some debate around the significance of the role and influence of middle managers in health and safety and their apparent exclusion in both country's definitions of officer. One issue that Johnstone and Tooma (2012, p.128) raise is that in the Australian law, whereas senior management may *make* key decisions affecting the company, "in practice ... middle managers will participate in making decisions affecting a substantial part of the business of the company, bringing them within the definition of officers". Indeed, in prosecutions in Australia, the level of participation in management decision-making appears to be a key factor in determining who is an officer (Wheelwright, 2016). The HSWA, however, as suggested by Klotz and Tooma (2015), appears to provide a narrower definition of an officer than the Model Act in that it suggests that an officer is a person in a position to exercise significant influence over the management of the business or

undertaking. Table 3 summarises these inclusions where those roles coloured green are specific roles mentioned in the HSWA, those coloured orange may be included depending on the degree by which they make decisions affecting the company, and those coloured yellow are less likely to be included because of the decreasing degree by which they exercise significant influence over the management of the business or undertaking.

Table 3

Who is an Officer?

Who is an officer in the HSWA?					
Inclusion in definition of officer	Director, partner, trustee	Chief Executive Officer	Senior executives, such as Chief Financial Officer, Chief Operational Officer	Other senior managers	Middle managers

Note: Information taken from the HSWA (2015), Johnstone and Tooma (2022) and Klotz and Tooma (2015).

2.5.3 THE NATURE OF THE OFFICERS' DUTIES

The HSWA places a duty on each officer to take reasonable steps to exercise due diligence to ensure that the PCBU of which they are an officer complies with its duties or obligations under the Act (see Appendix F). The duty cannot be delegated to another person or deferred to a committee; it is a nontransferable duty resting on each officer. The duty of officers is also a positive duty, meaning it places a requirement on officers to *do something* as opposed to a negative duty, which requires an *avoidance* of something or requires a person *not to do* something.

They are also proactive duties, meaning that officers are required to fulfil their duties *ex ante*¹³ to ensure the PCBU is complying with its duties. In this respect, the duties require officers to take action to proactively ensure that the company is fulfilling its legislative duties. The duties can be seen to

¹³ See footnote 9, p.34.

align with a self-regulatory strategy by requiring officers to take on the role of an overseer of compliance in ensuring that appropriate systems and processes are in place, are resourced, and are used to manage risk. Officers are required to fulfil their duties individually and independently of the PCBU, and, therefore, an officer can breach their duties even without the PCBU being found to have breached its duties.

In terms of what the exercise of duty diligence entails, s 44(4) of the HSWA states that due diligence includes taking reasonable steps:

- (a) to acquire, and keep up to date, knowledge of work health and safety matters; and
- (b) to gain an understanding of the nature of the operations of the business or undertaking of the PCBU and generally of the hazards and risks associated with those operations; and
- (c) to ensure that the PCBU has available for use, and uses, appropriate resources and processes to eliminate or minimise risks to health and safety from work carried out as part of the conduct of the business or undertaking; and
- (d) to ensure that the PCBU has appropriate processes for receiving and considering information regarding incidents, hazards, and risks and for responding in a timely way to that information; and
- (e) to ensure that the PCBU has, and implements, processes for complying with any duty or obligation of the PCBU under this Act; and
- (f) to verify the provision and use of the resources and processes referred to in paragraphs (c) to (e).

These duties can be clearly characterised as risk regulation. Officers are required to understand what risks to the health and safety of workers arise from the operations they govern or manage, to ensure that the organisation of which they are an officer has systems and processes for identifying, assessing, and reporting risks, and to ensure that there are resources available and used for responding to these

risks. In this way, the due diligence duties embody an expression of metaregulation (see section 2.2.1) of the self-regulatory system—a duty is assigned to officers, rather than the regulator, to ensure that the PCBU has substantive and appropriate risk assessment and risk management processes in place. In requiring officers to exercise this risk oversight (Zhivitskaya & Power, 2016), the due diligence duty somewhat paradoxically places a responsibility—that would otherwise be held by the regulator—upon officers of the PCBU, and therefore constitutes the “mobilization of management control as a regulatory resource” (Power, 2007, p. 40). Here, the governmentality perspective of risk (see section 2.1.4.3) and risk regulation (see section 2.3.3) emerge as meaningful ways to think about the positioning of regulatory power to diffuse actors beyond the state. In this sort of configuration, Power (2007, p. 41) writes:

The regulatory state is much more than a system of semi-autonomous agencies, it is a distinctive mode of self-observation and self-discipline for organizations, a reflexive mode of regulation mediated in part by dedicated officerships¹⁴. Internal control systems in their proudest sense play a critical role in neoliberal regulatory regimes which operate indirectly via the ‘control of control.’

As noted in section 2.3.3, in the regulatory context, self-regulation assumes, or is contingent upon, a “perfect alignment” of the goals and values of both regulation and business. However, as Power (2007, p. 41) notes, such an alignment is not an “empirical reality.” At the heart of corporate regulation is a divergence between corporate and statutory purposes, which distorts the goals of regulation when firms self-regulate (Black & Baldwin, 2010). Thus, to bring those goals and values into alignment, empirical studies have demonstrated that in carrying out “riskwork” (Power, 2016, p. 3)—the day-to-day organisational work undertaken to make sense of and manage risk—business interests and values tend to permeate the construction and operationalisation of risk concepts. For

¹⁴ By “officerships”, Power (2007) refers to a group of people who may or may not be included in the definition of officer outlined above. In this case, Power means those roles having a combined managerial and regulatory function, such as Chief Risk Officer, Compliance Officer, or Chief Operating Officer, which are both expressions of reflexive governance but also, Power notes, quoting Abbot (1988, p. 81), a producer of it: “To say a profession exists it to make it one.”

example, Horlick-Jones (2005, p. 303) observes that “risk assessment, far from being an objective scientific procedure, has been conducted in such a way as to avoid change, and associated expenditure and disruption.” Accordingly, in a risk-based self-regulatory framework, it becomes highly relevant to examine the “critical interface between regulatory and business values” (Power, 2007, p. 42).

2.5.4 PROSECUTIONS UNDER THE HSWA

There have been very few successful prosecutions relating the due diligence duties in New Zealand. The first was led by New Zealand’s Civil Aviation Authority at the end of 2019 (*Director of Civil Aviation v Sarginson*, [2019]), more than four years after the HSWA was passed. A second case was brought before in the courts, this time by Maritime New Zealand, in early 2020 (*Maritime New Zealand v Nino’s Ltd and Basile* [2020]) and the prosecution was unsuccessfully appealed by the defendant in June 2020 (*Nino’s Ltd and Basile v Maritime New Zealand* [2020]). The first charges brought against company officers by New Zealand’s core health and safety regulator, WorkSafe, relating to the due diligence duties were in regard to the incident at Whakaari/White Island in 2019 in which 24 workers and tourists were killed in a volcanic eruption and another 25 seriously injured (*WorkSafe New Zealand v Buttle* [2023]). However, these charges were dismissed by the court in 2023. Since laying those charges, WorkSafe has successfully prosecuted three officers under s 48 for failures related to the due diligence duties at s 44.

No New Zealand officer or PCBU has been charged with a health and safety offence relating to psychosocial risks (Dyhrberg, 2022), however, lower-level enforcement actions have been taken, such as the issuing of improvement notices (Blommerde, 2022). The ostensive lack of regulatory enforcement pertaining to both the officers’ duties and in regard to psychosocial risk more generally is noteworthy in a context where WorkSafe has recently suggested that it is under-resourced to be able to effectively carry out its role (Pennington, 2023).

Also of note is that each of the New Zealand prosecutions of officers for failing to fulfil their duties has occurred *post hoc*, after a worker (or another person) has been injured or after the PCBU has been found to be at fault. In this way, the regulators have deployed the law in the way it was framed in the

previous accessorial laws under the HSEA—as reactive provisions after an offence has been found or after harm has occurred. Although a legitimate use of the law, this application is incongruent with the casting of the officers’ duties as a proactive and positive duty conducted with a view to preventing harm. The officers’ duties are independent of the PCBU’s health and safety performance and therefore there is scope for assessing whether officers are fulfilling their duties in the absence of any assessment of breaches of the PCBU’s duties. As Johnstone and Tooma (2012) point out, “if such requirements are proactively enforced by inspectors, there is the potential to have far more lasting improvements in health and safety standards than the mere reactive enforcement of the law in the aftermath of an incident” (p 250). The apparent failure to capitalise on the preventive potential of the officers’ duties suggests that the power of the duty to improve WHS has not been realised. In this respect, Carson (1974) and Tombs and Whyte (2013) have both observed in other WHS contexts that legal reforms that hold potential to substantially curb harms are often found to be combined with weak enforcement in order to maintain legitimacy with, and avoid the political implications of, regulating elites.

2.6 CONCLUSION

This chapter has provided an overview of the key concepts, events, and theoretical developments relevant to the conceptualisation and development of specific risk-related duties in health and safety law for New Zealand company officers. The chapter began with a review of the key theoretical perspectives on the concept of risks, then tied this into the review of regulation, culminating in an understanding of regulation as a phenomenon inextricably entwined with risk. Compliance was examined and framed in terms of the response that regulated actors make and which, using a constructionist view of compliance, is determined by organisational and social contexts, including, in the context of risk regulation, actors’ understandings, conceptualisations, and deployment of dominant discourses about risk. In this way, several paradoxes of WHS regulation in New Zealand were noted, firstly that in a self-regulating system, regulated entities have wide discretion to determine the meaning of compliance themselves, and secondly, that officers of PCBUs are assigned a regulatory duty to oversee compliance of the same entities of which they are an officer.

The chapter also presented an overview of the legal duty that this research focuses on—the officers’ duties in the HSWA. In a significant departure from the British legislation on which most of the country’s occupational health and safety legislation was based, New Zealand introduced legislation (the HSWA) in 2015 that contained specific, proactive duties for officers. Based on the Australian Model Act, the introduction of this legislation was legitimised by the public and obtained political support following the Pike River Mine incident in 2011. The duty can be viewed as being a characteristic of risk regulation or, in fact, be considered the pinnacle of risk regulation in a self-regulatory system in that the duties co-opt those sitting at the apex of company structures to ensure compliance by way of overseeing the organisational responses to health and safety risks and ensuring organisational compliance with the Act.

The next chapter will look at psychosocial risks as a particular type of health and safety risk and will outline key models in the technico-scientific understanding of these types of risks. I will then review the literature relating to the application of health and safety legislation to these risks, culminating with an analysis of themes relating to often-cited difficulties in regulating these risks. Finally, I will place these specific risks in the context of the officers’ duties, leading to the research questions, which, in light of this two-chapter literature review, this piece of research will aim to answer.

3. LITERATURE REVIEW PART B: THE REGULATION OF PSYCHOSOCIAL RISK AT WORK

In this chapter I review the literature on psychosocial factors at work and how WHS legislation relates and responds to them. In sections 3.1–3.4, I review the key terms, concepts, and mechanisms relating to psychosocial risk and its management, the literature on work-related stress and its impact, and a taxonomy of psychosocial risks. In section 3.5, I consider the current literature on psychosocial risk management in relation to WHS legislation. Subsequently, in section 3.6, I consider guidance for the officers' duties in the HSWA as they apply to psychosocial risk, and, finally, in section 3.7, I detail the substantial gap in current knowledge that needs to be addressed from Chapters 2 and 3. A conclusion to this chapter is provided at section 3.8.

3.1 DEFINITIONS AND MECHANISMS

The related terms, “psychosocial factor”, “psychosocial hazard”, and “psychosocial risk”, are sometimes used interchangeably in both public and academic literature. However, they refer to different concepts. Although, typically, discussion about psychosocial factors at work relates to those with a negative impact on workers' health, the term “psychosocial factor” relates to aspects of work design, organisation, or management and their social and environmental contexts that hold neither a positive nor negative connotation (International Labour Organization, 1986).

An early definition of psychosocial factors, as they relate to the work environment, was provided by the International Labour Organization (ILO; 1986, p. 3) as “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.” According to Cox et al. (2000), however, this definition drew too strong an association between the impact of exposure to psychosocial hazards and workers' individual experiences of stress.

Whereas reference to psychosocial factors can refer to both their positive or negative potential, “psychosocial hazard” refers specifically to an intrinsic negative quality (Leka et al., 2017). In what has now become a commonly used definition, Cox et al. (2000, p.14) offer an alternative to the ILO conceptualisation, defining psychosocial hazards as:

those aspects of work design and the organisation and management of work, and their social and environmental contexts, which have the potential for causing psychological, social or physical harm.

Consistent with a social epidemiological approach, this definition de-emphasises individual-level perceptions and cognition to give greater focus to the conditions of work. This also aligns with the broader occupational health and safety literature, which conceptualises a hazard as the intrinsic property or potential capacity of an agent, process, or situation¹⁵ to cause harm or adverse health effects to a person at work (Stranks, 2002).

In the psychosocial risk management literature, and in alignment with the technico-scientific approach to risk used in WHS, “risk” is understood as the likelihood or probability that a person will be harmed or experience adverse health effects if exposed to a (psychosocial) hazard and is a calculation of the magnitude of the potential of the hazard to cause harm (Leka, Van Wassenhove et al., 2015). The relationship between hazard and risk is exposure, and potential harm may express immediately or be latent. Thus, risk assessment, when applied to psychosocial hazards, aims to “establish an *association* between hazards and health outcomes, and to evaluate the risk to health from exposure to a hazard” (Cox et al., 2000, p. 102). The harm arising from exposure to psychosocial hazards predominately occurs via a stress-mediated pathway, but it is important to note that psychological harm may also occur directly as a result of exposure to physical and chemical hazards (Brown, 2002; Cox et al., 2000; Levi, 1984).

¹⁵ In this context, a “situation” refers to a working environment, aspect of work organisation, or working practices, including a departure from the normal situation.

3.2 INDIVIDUAL AND ORGANISATIONAL IMPACTS OF PSYCHOSOCIAL HARM

In terms of individual harm, exposure to psychosocial hazards at work is associated with a variety of psychological, social, and physical health problems. In particular, research consistently demonstrates reliable evidence for an association between exposure to psychosocial hazards at work and adverse health outcomes, most notably in terms of mental illness and cardiovascular disease (Leka & Jain, 2010). There is also clear evidence of a relationship between psychosocial risk and musculoskeletal disorders (MSDs; Bongers et al., 2006; Sobeih et al., 2006), although Graveling et al.'s (2021) recent literature review suggests that the precise nature of the relationship is not as consistent or as clearly established as the evidence for cardiovascular disease and mental health-related harms.

One of the strongest associations between psychosocial risk and health-related harms is between psychosocial risk and stress-related mental illness (Stansfeld & Candy, 2006; Svane-Petersen et al., 2020; van der Molen et al., 2020). These associations display variable relationships with such harms being alternately additive, in that exposure to multiple hazards is related to proportionately more harms, or synergistic, in that psychosocial factors may interact and thus be related to disproportionately more or less harm (Levi, 1984). Further, different types of risks may be variously associated with different types of psychological harm, mental illnesses, or health-limiting behaviours (Harvey et al., 2017; Niedhammer et al., 2021, 2018).

The association between psychosocial risk at work and cardiovascular disease (CVD) is also well established in the literature, including by way of evidence from the well-known Whitehall I and II studies (Kuper et al., 2002; Marmot et al., 1997). A more recent review of systematic reviews (Fishta & Backé, 2015) confirmed that work-related stress is an important social determinant of CVD and mortality. Kivimäki and Kawachi's (2015) review of prospective cohort studies examined the evidence of an association between various psychosocial risks and CVD, and concluded that, "taken together, the excess cardiovascular disease risk for individuals exposed to work stressors—including job strain, long working hours or job insecurity—seems to be in the ballpark of around 10–40% compared with those free of such stress" (p. 73). Additionally, Rivera et al. (2020) examined

systematic reviews with meta-analyses of the epidemiologic evidence and reported moderate-grade evidence for an association between shift work, long hours, and increased risk of stroke. The review found similarly graded evidence associating these work scheduling factors with breast cancer.

International research indicates that psychosocial risks also impact organisations. For example, psychosocial risks are associated with lower rates of worker engagement, commitment, job satisfaction, and productivity, and higher rates of absenteeism, intention to quit, and staff turnover (Leka & Jain, 2010). A range of studies has been conducted estimating different cost impacts to organisations comparing different variables or using different methodologies for assessing costs. However, the review of a number of cost-of-illness studies by Hassard et al. (2018) concluded that the majority of measurable economic losses associated with work-related stress was in productivity (between 70 to 90%), with health care and medical costs constituting the remaining 10 to 30%. Using the construct of Psychosocial Safety Climate as an indicator of psychosocial risk, Becher and Dollard (2016) estimated the cost of a low Psychosocial Safety Climate to Australian employers to be approximately \$A6b per year. In the UK, the Health and Safety Executive (HSE; 2020) reported that 17.9 million working days were lost in the 2019/2020 year due to work-related stress, depression, or anxiety, and that stress, depression, or anxiety accounted for 51% of all work-related ill health cases and 55% of all working days lost due to work-related ill health.

Although there is less evidence to draw on, the New Zealand context seems consistent with the international research. The Southern Cross Health Society and BusinessNZ's (2019) industry-led survey reported that "mental wellbeing/stress" (p. 14) was the fifth most common reason why an employee took sick leave, accounting for 22.2% of all absences, and that "general workload," "change at work" and "relationships at work" (p. 21) were the main causes of stress in the workplace. The New Zealand Workplace Barometer takes an annual sample of New Zealand businesses and assesses leading workplace indicators of mental health, stress-related conditions, and some aspects of physical health. The most recent study reported that 39.5% of workers worked in an environment with a low Psychosocial Safety Climate (see section 3.3.1.5), placing these workers at high risk of negative

health outcomes (Forsyth et al., 2021). Similarly, the New Zealand Psychosocial Survey (Khieu et al., 2022) showed that New Zealand workers reported various psychosocial risks at work.

In quantifying the impact of psychosocial risk, many cost-of-illness studies, however, do not reflect the full costs of harm, with many such costs borne by the worker, their family, community, and wider society as they are intangible, indirect, or difficult to measure (Hassard et al., 2018). Worker illness and injury may be treated as an externality, with the majority of the costs of work-related illness and injury borne by the worker and society and not the organisation (Baldwin et al., 2012; Johnstone et al., 2012; Johnstone & Tooma, 2012; Löfstedt, 2011). Beyond the harm experienced by workers in terms of ill health and the associated medical costs, work-related stress has also been associated with a range of other health and social impacts on workers, including, but not limited to, suicide (Milner et al., 2016; Milner et al., 2018), work–family conflict (Hall et al., 2010; Leka & Jain, 2010), and alcohol dependence (Head et al., 2004).

3.3 WORK-RELATED STRESS THEORY

Psychosocial risks are closely linked with the notion of work-related stress (Leka & Jain, 2010). Stress is a complex phenomenon, and there have been numerous definitions and uses of the word over time (Cooper & Dewe, 2004; Cooper et al., 2001; Cox & Griffiths, 2005; Houdmont & Leka, 2010). These divergent meanings have resulted in a sometimes-confused application of the word in the academic literature where it has been used to describe—alternately—a stimulus, a response, and an interaction (Cooper & Dewe, 2004). Furthermore, in the grey literature, especially that relating to management, it is most often used in ways that do not align with the thinking and lexicon of contemporary domain researchers where there is relative consistency at the macro level (Cox & Griffiths, 2005; Cox et al., 2000). For example, in some governmental and industry materials, stress is referred to as a psychosocial hazard itself (Department of Mines, Industry Regulation and Safety, 2012.; WorkSafe, 2019b) rather than an outcome of exposure to psychosocial hazards. Another longstanding, common, and “pernicious misunderstanding” (Cox & Cox, 1996, p. 183) about stress arises from its conflation with arousal or stimulus, resulting in a belief that stress is a conduit to

optimal functioning as opposed to harm (Corbett, 2015; Dekker & Hollnagel, 2004).¹⁶ For example, stress is often described in New Zealand management grey literature as a driver of performance (Government Health and Safety Lead, 2018) or as something that is “beneficial” and which can “keep the mind active and stop people becoming bored” (Cooper, 2022, p. 2019). These ways of thinking about stress sit in contrast with the research literature in the field of occupational stress and psychosocial risk management, which differentiates it from other types of work pressures or challenges. Instead, within these research domains, stress is conceived as a negative experience relating to a perceived imbalance between the demands made of people and the resources available to meet those demands (Cox, 1993; Cox & Griffiths, 2005; Leka et al., 2003). On this basis, the belief that there are optimal levels of stress that can contribute to heightened performance is considered “misguided” (Cox & Griffiths, 2005, p.787) and “erroneous ...[and] has been used on occasions to justify poor management practices” (p. 786).

This multiplicity of meanings of stress extends to the broader scientific literature where there is no one accepted universal model. However, key occupational stress theorists like Cox (1993), Cox and Griffiths (2005), and Cox et al. (2000) consider that the broad theories of stress can be grouped into overlapping conceptual frameworks encapsulated by the stimulus-response approach, the physiological approach, and the psychological approaches. These frameworks place varying emphasis on the environment, the person, and the interaction between the person and environment, and draw differentially on the conceptualisation of stress as a stimulus, response, or interaction. In the context of this research, contemporary literature on psychosocial factors at work focuses predominantly on the psychological approaches and the interactions between people and their environments.

¹⁶ Corbett (2015) suggests misinterpretation of the Yerkes Dodson Law (YDL; or, according to Corbett, the Yerkes Dodson “folklaw”), where stimulus strength and arousal are commonly conflated with stress and thus incorrectly associated with performance, underpins this common misconception in managerial literature. He further suggests the simple and intuitively appealing logic entailed in the YDL’s ubiquitous “inverted-U” graph bolstered its uptake and popularity. Dekker and Hollnagel (2004) similarly refer to the YDL as a folk model.

3.3.1 PSYCHOLOGICAL MODELS OF OCCUPATIONAL STRESS

Psychological models of stress hold that stress is a dynamic response inferred from problematic person–environment interactions and, thus, these models attend to qualities of the cognitive processes and emotional reactions that underpin those interactions (Cox & Griffiths, 2005). Psychological theories can be grouped into two subcategories: interactional and transactional models. The main difference between the two models is in the relative emphasis placed on certain variables, in particular, the degree of emphasis that is placed on the individual in determining the overall outcomes of the situation. Whereas interactional models tend to place a greater emphasis on variables in the (work) environment, transactional models tend to give more agency to the role of the individual.

In this sense, transactional models attend more to the cognitive and emotional processes that occur when an individual interacts with their environment, and draw mainly on theoretical ideas from the fields of clinical and social psychology (Cox & Griffiths, 2005). In the work context, transactional models view stress as the result of a constantly changing, dynamic interaction between an individual and their work environment. This interaction hinges on the personal appraisal of a situation and a person’s perceived ability to cope with those situations.

The uptake of transactional models has produced several consequences in terms of the societal and business responses to work-related stress. When transactional models were coming to the fore, occupational health researchers expressed concern that the popularity of this way of thinking about stress was leading to an individualised perspective and a subsequent responsabilisation of work-related stress down to the individual level. For example, Baker (1985, p. 367) was concerned that the approach had led to a “domination by a clinical perspective of stress as a psycho-physiological phenomenon that arises from an individual’s perception of the balance between environmental demands and response capabilities.” Baker (1985) went on to note that the impact of this domination was that “most interventions have been directed toward individual coping strategies, ... [an approach that was] ... quite different from that of most other areas of occupational health” (p. 367). This observation has been similarly made by many other researchers (Ertel et al., 2010; Harvey et al.,

2017; Moncada et al., 2011; Page et al., 2013), noting a tendency for responses to work-related stress to focus on individual variabilities, resulting in a preponderance of interventions directed at the individual, often presenting in the form of stress management training, resilience training, or psychological counselling.

Where transactional models focus on the individual appraisal that people make of their work environment, interactional models focus on the *structure* of the interaction between a person and their work environment. The interactional models are based in social epidemiological theory (Cox & Griffiths, 2005), which focuses on the effects of social structures and social organisation on health (Diez Roux, 2022). As such, this approach places greater emphasis on the conditions of work that have the potential to impact workers' health rather than on individual appraisal and coping. As a result, these models are more relevant to the management of psychosocial risk in the context of WHS regulation with its focus on work and the harms that may arise from it. Examples of interactional models or frameworks include the Job Demand–Control Model (Karasek, 1979), the Job Demand–Control–Support Model (Karasek & Theorell, 1990), the Effort–Reward Imbalance Model (Siegrist, 2017), the Job Demands–Resources Model (Demerouti et al., 2001), and Organisational Justice (Elovainio et al., 2002). Each of these will be reviewed in sections 3.3.1.1 to 3.3.1.4. A further concept, Psychosocial Safety Climate (Dollard & Bakker, 2010), will be considered at 3.3.1.5.

3.3.1.1 The Job Demand–Control & Job Demand–Control–Support models

Karasek's (1979) Job Demand–Control Model (JDC) contends that job strain results from the interaction of job demands and job decision latitude. By job demands, Karasek (1979) refers to “psychological stressors involved in accomplishing the workload, stressors related to unexpected tasks, and stressors of job-related personal conflict” (p. 291). Decision latitude refers to “the working individual's potential control over his [*sic*] tasks and his [*sic*] conduct during the working day” (Karasek, 1979, pp. 289–290). According to the theory, when a worker experiences demands (for example, excessive workload, conflicting demands), they are compelled to take action to address those demands. In an ideal situation, the worker has high decision latitude, such as decision authority and intellectual discretion, in electing what actions to take. However, when the worker is unable to act

or is restrained in their discretion to act, they experience mental strain—where strain is the residual of demands offset by decision latitude—and this can lead to adverse health outcomes. A later iteration of the model called the Job Demand–Control–Support Model (JDCS; Karasek & Theorell, 1990) added a further dimension of social support, such as that which might be received by coworkers or supervisors. This support serves to moderate the effect of job demands (Johnson & Hall, 1988).

Critique has been levelled at both the JDC and JDCS for their lack of attention to individual-level factors (Kain & Jex, 2010; Van der Doef & Maes, 1999). However, Karasek (1979, p. 287) foresaw this critique, explaining that, consistent with a social epidemiological approach, “mixing both the environmental and the individual characteristics into a single measure, such as ‘overload,’ not only shifts attention away from environmental moderators but makes it difficult to derive unambiguous implications for either work environment or personnel policy.” Perhaps the most enduring critique of the JDC and JDCS relates to them being premised on the inclusion and interaction of limited variables: demands, control, and, in the latter model, support (Bakker & Demerouti, 2007; Johnson & Hall, 1988; Schaufeli & Enzmann, 1998; Siegrist, 1996). Even after the JDC model was revised to include the “support” variable, for some, it remained “unclear why autonomy is the most important resource for employees in the DCM¹⁷ and additionally social support in the extended demand-control-support model” (Bakker & Demerouti, 2007, p. 311).

3.3.1.2 Effort-Reward Imbalance Model

The Effort-Reward Imbalance Model (ERI; Siegrist, 1996, 2017; Siegrist & Li, 2016) is based on notions of social reciprocity and distributive justice and asserts that stress is experienced when the reward received by a worker does not adequately compensate for the energy expended. Reward can exist in three different forms: salary or wage (financial reward), career promotion or job security (status-related reward), and esteem or recognition (socioemotional reward). The experience of a lack of reciprocity elicits stress, leading to adverse health consequences. The imbalance is more likely to occur in certain situations, such as job dependency where workers have few choices in the labour

¹⁷ There is inconsistency in the literature regarding the form of the acronym used to describe the Job Demand-Control Model. Here, DCM refers to the JDC.

market. Thus, the model can account for external factors in the labour market, such as job instability or job loss due to mergers or job contracting arrangements, organisational downsizing, rapid technological change, and growing economic competition (Siegrist, 2017).

While the JDC and JDCS did not consider the personal or individual-level factors, in the ERI model personal factors are introduced in that the imbalance between energy expended and reward received is moderated by personal factors. The model has been shown to reliably predict stress–health outcomes such as mental illness and coronary heart disease, as well as health-diminishing behaviours, such as alcohol consumption (de Jonge et al., 2000; Kuper et al., 2002). More recently, the ERI model was shown to predict vulnerability to bullying (Notelaers et al., 2019).

The ERI model has been subject to similar critiques as the JDC/JDCS in that it reduces a plethora of determinants and variables to just two: effort and reward. In doing so, it excludes the factors deemed primary by the JDC/JDCS, those being control, autonomy, and support. Bakker and Demerouti (2007) sum up the critique of ERI in that it does not “leave room for the integration of other work-related factors that can (and have been found to) be related to well being” (p. 311).

3.3.1.3 The Job Demands–Resources Model

Purporting to address some of the weaknesses of the JDC, JDCS, and ERI models, the Job Demands-Resources Model (JD-R; Bakker & Demerouti, 2007; Demerouti et al., 2001) significantly expanded the factors included in the job demands variable. The revised notion of demands included “physical, psychological, social, or organizational aspects of the job that require sustained physical and/or psychological (cognitive and emotional) effort or skills and are therefore associated with certain physiological and/or psychological costs” (Bakker & Demerouti, 2007, p. 312). Further, the model subsumed job control into a broader category of job resources, which referred to the “physical, psychological, social, or organizational aspects of the job that are either/or: functional in achieving work goals, reduce job demands and the associated physiological and psychological costs, [and] stimulate personal growth, learning, and development” (Bakker & Demerouti, 2007, p. 312). The model allows for both the situation where high job demands lead to strain and health impairment as

well as a motivational process whereby high resources lead to increased motivation and productivity. A recent metareview of JD-R studies found that the overall findings from empirical research confirmed the core assumptions of the model (Lesener et al., 2019).

3.3.1.4 Organisational Justice

Organisational Justice (Greenberg, 1990) considers the extent to which employees are treated justly and whether organisational outcomes and the processes carried out at the workplace are fair. In this case, workers are affected not only by rewards but also by the procedures used to determine how those rewards will be distributed (Elovainio et al., 2006; Elovainio et al., 2002). Low levels of organisational justice are associated with negative health outcomes in workers (Elovainio et al., 2001; Elovainio et al., 2006). Different theories of organisational justice may focus on various aspects of justice; however, key domains of organisational justice include procedural justice (fairness of decision-making processes and rules), relational justice (fairness of treatment), and distributional justice (fairness of outcomes) (Colquitt et al., 2005; Elovainio et al., 2001).

3.3.1.5 Psychosocial Safety Climate

Psychosocial Safety Climate (PSC) is conceptually different than the models reviewed above in sections 3.3.1.1. to 3.3.1.4 in that, while still allowing for integration with the above models, it takes a different perspective on the root causes of psychosocial harm at work. While the above models of work-related stress examine features of the work environment, its management, and organisation, PSC focuses on the precipitating conditions of psychosocial safety at work as reflected in the extent to which workers perceive that management fundamentally values the psychological health of workers (Dollard et al., 2019). PSC therefore is the sum of shared perceptions regarding “policies, practices and procedures for the protection of worker psychological health and safety” (Dollard & Bakker, 2010, p. 579).

At the heart of the PSC is an acknowledgement of the social, economic, and market forces, especially the unequal nature of the employment relationship, which results in harms and negative externalities such as worker ill health (Dollard et al., 2019). The basic premise of PSC is that when management is

perceived to hold concern for the psychological welfare of staff in mind when making decisions about the company, a healthier PSC is reported. As Dollard et al. (2019, pp. 10–11) note,

since resources are finite any management decision requires the weighing up of competing interests such as the need for productivity and profit versus concern for worker health. In making decisions managers are guided by ethics and values, including decisions about creating healthy workplaces, and the design and quality of work.

In this respect, PSC integrates the various interactional models above because a “good” PSC will impact management decisions about the way that work is designed and carried out and, therefore, the nature of the psychosocial hazards to which workers are exposed. In this way, PSC can be seen as a predictive antecedent of the above models (Dollard & Bakker, 2010).

3.3.1.6 Summary

Five key models that have been developed by researchers to help explain and understand work-related stress and psychosocial risk have been briefly reviewed here. The key debates around each of the psychological models of stress relate to the inclusion of extrinsic and intrinsic variables, the primacy given to each, and the quantification, description, or tools of measuring the precise nature of the interaction between them. Despite these variations, some generalisations can be made, and, as Siegrist and Li (2016, p. 432) point out, “most experts agree that distinct demanding or threatening extrinsic features of job environments and employment conditions act as determinants of workers’ health, and many researchers claim that specific intrinsic characteristics (personality traits, coping behaviour) increase the working people’s vulnerability to stress.” Cox and Griffiths (2015, p. 567) sensibly sum up the various perspectives, assessing that

within this genre of theory, there are many different variants, developed by different researchers or for different work groups, situations and organisations. Many of these differences are either semantic or ones of perspective, and there is a reasonably strong consistency in thinking at the more macro level.

An understanding of those psychosocial factors that constitute risks to workers' health is clearly of relevance for health and safety regulation and compliance with the HSWA which requires businesses to "eliminate risks to health and safety, so far as is reasonably practicable; and if it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks as far as is reasonably practicable" (s 30). Noting that the Act defines "health" as both mental and physical health, the models of work stress examined above provide an evidential basis for the sorts of actions which can be taken by PCBU's in the workplace to address psychosocial risks. These models can therefore be seen to underpin most risk assessment methodologies, guidelines, or standards that have been developed internationally to support businesses and organisations to identify, assess and manage psychosocial risks at work. For example, the Copenhagen Psychosocial Questionnaire (Kristensen Tager et al., 2005), a risk assessment tool, includes the main dimensions of the JDCS and ERI models. The UK's Management Standards uses a specially developed "Indicator Tool" to assess psychosocial risk, which is based primarily on the JDC with modifications to include other models, such as the ERI (Cousins et al., 2004; Cox, 2016), the Danish Working Environment Authority's risk assessment tool is based on an extended JDC model (Rasmussen et al., 2011), and Schaufeli and Taris (Schaufeli & Taris, 2014; Schaufeli, 2017) have identified the practical implications of the JD-R model to meeting legal obligations under WHS regulations, such as the European Union Framework Directive 1989/391/EEC.

3.4 TAXONOMY OF PSYCHOSOCIAL HAZARDS

The taxonomy of psychosocial hazards details "work and organizational characteristics which, if they fail in some sense or are inadequate or lacking, have the potential to cause harm to employees' health" (Cox & Griffiths, 2015, p. 571). The taxonomy was developed as a starting point for the assessment of factors that could inform interventions and improvements to the work environment, and a thorough explanation of, and evidence for, each of these factors is presented in both Cox et al. (2000) and Leka and Jain (2010).

Table 4*Taxonomy of Psychosocial and Organisational Hazards*

Psychosocial hazard	Conditions
Content 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, etc.
Physical environment and equipment	Inadequate equipment availability, suitability, or maintenance; poor environmental conditions, such as lack of space, poor lighting, excessive noise.
Context of work	
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, bullying, harassment.
Role in organisation	Role ambiguity, role conflict, responsibility for people.
Career development	Career stagnation and uncertainty, under promotion or over promotion, poor pay, job insecurity, low social value to work.
Home-work interface	Conflicting demands of work and home, low support at home, dual career problems.

Note: The taxonomy is taken from Cox and Griffiths (2015).

Cox and Griffiths (2015) note that the information in Table 4 is not exhaustive, and, over time, several authors have suggested refinement. For example, since its inception, psychosocial factors relating specifically to modern forms of labour have been consistently noted in the literature, such as part-time, casual, and precarious employment, all of which have been linked to various physical and psychiatric morbidity (Benach et al., 2014; Chirico, 2017; Underhill & Quinlan, 2011).

The tables of hazards presented in the International Standard on Psychosocial Risks, ISO 45003 (International Organization for Standardization, 2021), shows considerable overlap with Table 4. However, ISO 45003 includes more categories of hazards. The nonexhaustive nature of psychosocial risk is summarised by one of the original authors of the taxonomy, who stated, “This hierarchical way of thinking about psychosocial hazards should be extended further to include those work-related challenges to health which originate in the wider community or which reflect the more general economic and political landscapes” (Cox, 2016, p. 2). These points highlight the inherent problems in the creation of taxonomies, which, while they aim to “tame the wild profusion of existing things” (Foucault, 1970/2002, p. xvi), also may serve to delineate what is “in” and what is “out” and therefore act as something of a boundary to what might be possible to be considered as a psychosocial risk, and thus what might be considered an appropriate subject of management or regulation.

3.5 THE APPLICATION OF GENERAL DUTIES TO PSYCHOSOCIAL HARM

Although this research focuses on the duties of officers in the HSWA, these duties are linked to the duties of the PCBU by way of the requirement of officers to ensure that the PCBU of which they are an officer is complying with *its* duties. It is therefore necessary to understand what the duties of the PCBU entail and what the nature of compliance with them suggests. This, in turn, will suggest the nature of the application of the officers’ duties. Consequently, I will begin with a brief description of the general duties, which is the standard relied on in many jurisdictions internationally, including New Zealand, to regulate psychosocial risks in the work environment.

WHS laws typically employ four main types of standards: (1) specification, (2) general duties, (3) performance-based, and (4) systematic process-based standards (Bluff & Gunningham, 2003).

Definitions for each of these types are presented in Table 5. At one end of a conceptual spectrum, specification standards detail what a regulated party is required to do in such detail that little or no interpretation is required. Performance standards, on the other hand, do not dictate what is to be done to achieve compliance but “define the duty holder’s obligation in terms of goals they must achieve, or problems they must solve, and leave it to the initiative of the duty holder to work out the best and

most efficient method of achieving the specified standard” (Bluff & Johnstone, 2005, p. 198).

Contemporary WHS legislation relies much less on technical and detailed specification standards and instead relies more on general duty requirements, performance standards, and requirements around process and documentation (Bluff & Johnstone, 2005).

Table 5
Types of WHS Regulatory Standards

Standard type	Definition
Specification	Tells a duty holder in detail what is required of them and how to do it. Little or no interpretation required.
General duties	<p>Also called “principle-based” and sometimes included in “performance-based” standards (Gunningham & Johnstone, 1999). They are broad in nature and do not specify a clear performance outcome.</p> <p>The principal “general duty” in the HSWA is that the PCBU must ensure, so far as reasonably practicable, the health, safety, and welfare of employees. Other duty holders include, for example, workers, manufacturers of machinery, suppliers of plant, and officers.</p>
Performance-based	Specifies the outcome or target but not how it should be achieved.
Systematic process-based	Requires a regulated party to undertake and/or document a process, such as a risk assessment.

Note: Information taken from Bluff and Gunningham (2003) and Gunningham and Johnstone (1999).

In New Zealand, WHS regulation is laid out in various types of instruments, including acts, regulations, codes of practice, and guidance documents. Acts are statutes passed by parliament, which can only be changed by further acts of parliament. Regulations are enabled by acts, and typically provide further detail about how the overarching requirements of the relevant act will apply, often in relation to specific hazards or industries. Codes of practice provide an evidentiary standard in that a party must show that they have met the standard described in the code. Finally, guidance provides further information, interpretation, and suggestions for duty holders on how to comply with their duties under the act or various regulations but does not constitute an evidentiary standard.

The general duties comprise the “pivotal provisions in contemporary OHS statutes” (Bluff & Johnstone, 2005, p. 197) and form the basis of WHS regulation in countries such as the UK, Canada, the European Union (EU), Australia, and New Zealand. They are of value in that they “establish the broad goals of OHS law, providing unifying themes that clarify the intentions of the law” (Bluff & Gunningham, 2003, p. 16). In New Zealand’s HSWA, the primary duty of care is found in s36 and requires a PCBU to ensure, so far as is reasonably practicable, the health and safety of workers and others. The primary duty of care is an absolute duty, meaning that a party can be found guilty even when there is no criminal intent, recklessness, or purpose and therefore is not amenable to a defence of absence of fault. The absolute duty, however, is qualified by the limiter of reasonable practicability (see section 2.4.3).

Reasonable practicability is very closely bound up with an assessment of risk. It does not mean that a duty holder is required to do everything possible to eliminate every hazard. It means that a duty holder must perform a calculation, balancing the risk of harm and known ways to manage that risk against their assessment of the difficulty, trouble, and cost necessary to avert that risk. Accordingly, if the risk of harm is low, reasonable practicability suggests that the PCBU will invest relatively less in managing that risk; however, in one where the risk of harm is high, a duty holder will be expected to invest more resource (that is, bear higher costs) to eliminate or minimise it. It is a well-accepted legal test that when weighing up the costs associated with eliminating or minimising risk, the limit of costs should transparently err toward protecting worker health and safety to the extent that to do so would be “grossly disproportionate” to the risk (Bluff & Johnstone, 2005; Johnstone & Tooma, 2012).

There are several advantages to regulating health and safety risks, including psychosocial risks, using the general duties approach. The general duties allow flexibility on behalf of regulated business to devise systems and responses that work best in the context of their work environment and, thus, may stimulate creative, innovative, and cost-effective solutions. The duties do not become out of date or redundant with new technology nor require constant revision in the same way detailed specifications do, and, by not naming or defining particular risks, they theoretically provide for comprehensive

coverage of all risks. Finally, they provide clear direction regarding who has duties and responsibilities (Bluff & Gunningham, 2003).

These same benefits also present challenges with the general duties entailing uncertainty for duty holders by not providing enough guidance for businesses. Further, the lack of specificity and prescription means that, ultimately, no business can be sure they are really complying until compliance has been tested and determined by a court (Bluff & Gunningham, 2003). The approach also presupposes that duty holders can, in assessing risk and reasonable practicability, undertake an objective assessment of risks—an assumption characteristic of the dominant discourse of risk, which assumes that risks can be assessed by way of value-free, objective, scientific means (Hardy & Maguire, 2019; Hardy et al., 2020; Jasanoff, 1998). In the face of the ambiguity inherent in the general duties therefore, codes of practice and guidance documents are considered a necessity to provide interpretative guidance and, in some cases, further standards that must be met (Bluff & Gunningham, 2003; Committee on Safety and Health at Work, 1972). Presently, in New Zealand, there are no specific regulations or codes of practice relating to psychosocial risks or the officers' duties.

When the purpose of the due diligence duties is to ensure compliance with the general duties of the HSWA, then it is necessary to understand what compliance with the Act is expected to look like. In this respect, New Zealand's regulatory response to psychosocial risk in a WHS context appears considerably underdeveloped compared to other jurisdictions. Accordingly, it is logical to look to more mature jurisdictions, to principles of WHS, and to research on psychosocial risk to examine how compliance with the general duties in regard to psychosocial risks might be defined.

In the EU, the EU Framework Directive 89/391/EEC on the Safety and Health of Workers adopts a general duties approach and has prompted policy change in a number of member countries by way of translation into "hard" policies, such as national health and safety legislation, or "soft"¹⁸ policies, such as guidelines and voluntary standards (Iavicoli et al., 2014; Leka, Jain, Cox, et al., 2011; Moncada et

¹⁸ See footnote 8, p.27.

al., 2011). The UK, Canada, and Australia also appear considerably more mature than New Zealand (see, for example, Bluff (2016) and Hansen et al. (2015) for overviews of legislative approaches), and there is a plethora of guidance material in these jurisdictions with whom New Zealand shares a similar legislative approach. It is particularly notable that psychosocial-risk-related WHS regulations exist in many Australian states, and both the Australian national WHS policy body, Safe Work Australia, as well as federal regulators in many states, have developed codes of practice on psychosocial risks (Department of Mines Industry Regulation and Safety, 2022; Safe Work Australia, 2022; SafeWork NSW, 2021; Workplace Health and Safety Queensland, 2022).

While there is strong consensus at an academic or expert level regarding the nature of psychosocial risks and their management under WHS legislation (Leka, Van Wassenhove et al., 2015), and despite being widely acknowledged as a worldwide occupational health issue (Chirico et al., 2019; Leka, 2016), there have been considerable challenges and difficulties internationally in applying WHS law to psychosocial risks. The following subsections outline seven key themes I have drawn from the review of literature relating to challenges to the regulation of psychosocial risks. These include: (1) ambiguity in regulation, (2) ambiguity in lexicon, (3) complexity, (4) individualisation and responsabilisation, (5) lack of focus on primary prevention, (6) management prerogative, and (7) inspection and audit. These will be discussed in the following sections 3.5.1 – 3.5.7.

3.5.1 AMBIGUITY IN REGULATION

The first theme relating to the challenge of regulating psychosocial risks lies in various aspects of ambiguity. The first part of section 3.5 commented on the nature of the general duties approach to health and safety regulation in that sometimes this type of regulation, especially when unaccompanied by clear guidance, codes of practice or further regulations, can entail too much ambiguity for businesses to enable them to respond effectively. Many authors, like Bruhn and Frick (2011), Hansen et al. (2015), Johnstone et al. (2011), and Lippel and Quinlan (2011), have expressed the view that the general duties on their own, especially with no explicit reference to psychosocial hazards or accompanying guidance, are neither conducive to effective compliance in the work environment nor

effective intervention by regulators. Terms relating to psychosocial risk, factors, or hazards are often implied or rarely defined in policy or legislation (Leka et al., 2017), leaving stakeholders to contest meanings or work with apparent univocality and ambiguity. Lippel et al. (2011) highlight the potential limiting effect of the absence of clear guidelines relating to psychosocial risk management and few legal precedents in pointing out that “in a litigious climate, ambiguity associated with broad legal language could have a serious dampening effect on initiatives of inspectors” (p. 588). Accordingly, there have been calls for better clarity in regulatory instruments, including ensuring that specific terminology is used harmoniously across key pieces of legislation and policy (Leka, Jain et al., 2015).

Conversely, too much specificity can be problematic in three ways. First, cognisant of the fact that psychosocial risks rarely present as isolated phenomena, Lerouge (2017a) has argued that in terms of better defining psychosocial risk in legislation, “it does not seem necessary to adopt highly specific mechanisms, since work-related risks, including psychosocial issues, need to be addressed in a general, holistic way” (p. 22). Second, when a particular matter, such as one type of harm, risk, or hazard, is deemed important enough to require the development of specific rules or laws, the process of debate, consultation, and negotiation around inclusions and exclusions often dilutes the regulatory purpose. In this way, resultant legislative definitions “are the product of political compromise; they are often intentionally convoluted, and should not be used by occupational health and safety or social psychology practitioners as guides to determine when prevention interventions are justified” (Lippel, 2011, p. 5). Third, in defining a particular type of harm, hazard, or risk in regulatory instruments or guidance, others are omitted, relegated, or demoted to positions of less importance or focus. The result of a narrow focus brought about by a proliferation of policy on particular types of psychosocial risks may either reflect or, alternately, construct the types of risks that organisations perceive most prevalently and, thus, are most likely to act upon. This effect can be seen in the international abundance of regulatory materials addressing bullying and violence, where many jurisdictions have produced regulations and interpretive materials on these topics, including Sweden (Hansen et al., 2015; Hoel & Einarsen, 2010), Norway and Finland (Hansen et al., 2015), France (Lerouge, 2017b),

Quebec (Cox, 2010; Lippel & Quinlan, 2011; Lippel et al., 2011), Australia (Hanley & O'Rourke, 2016), and New Zealand (WorkSafe, 2017, 2018, 2020a).

Overall, despite their potential for ambiguity, there generally appears to be consensus in the literature that the general duties form an appropriate and effective basis for the regulation of psychosocial risk at work. However, any potential ambiguity needs to be tempered with supporting detail in the form of, but not limited to, nonprescriptive guidance materials and codes of practice to support duty holders to effectively interpret the general duties requirements (Blackwood et al., 2013; Gunningham, 1984; Gunningham & Bluff, 2008; Johnstone & Tooma, 2012). This aligns to a fundamental recommendation of the Robens Report (Committee on Safety and Health at Work, 1972) on which New Zealand's WHS legislation is based, that in removing prescriptive details from legislation, interpretive guidance by way of codes of practice were deemed necessary.

3.5.2 THE LEXICON OF PSYCHOSOCIAL RISK

The second challenge in regulating psychosocial risks stems from the language used in psychosocial risk management and adjacent fields. Contributing to the regulatory ambiguity described in section 3.5.1 is the diverse and equivocal array of terms that are used to describe concepts associated with psychosocial risk management. Workplaces purporting to address psychosocial risk may commonly invoke “mental health”, “wellbeing”, “wellness”, “stress management”, “psychological safety”, or “psychological health and safety”, which, as well as referring to different constructs, are sometimes conflated or defined and deployed in inconsistent ways, leading to both a lack of clarity and a shift in focus. As Leka et al. (2017, p. 2) point out, “there is often confusion in relation to this terminology in scientific publications, policy documents and practical guides that complicates understanding, interpretation of the legal texts by courts, institutions and stakeholders, and as a result effective management of psychosocial risks in the workplace.”

In the Australian policy context, Potter et al. (2019, p. 126) found “scant specificity of terminology” relating to psychosocial risk management. Likewise, the Australian Institute of Health and Safety (2020) notes that various terms in the field of workplace mental health are often used interchangeably

or misapplied. Furthermore, the language of risk provides additional room for confusion where within organisations the language of risk management may be deployed across multiple fields of risks where terminology is variable (Bluff & Johnstone, 2005). All this suggests that psychosocial risk management in WHS is a field with much potential for variable interpretations due to the use of broad and imprecise concepts and terms invoked by those involved in the field.

3.5.3 COMPLEXITY

The third challenge to regulating psychosocial risks relates to their complexity and perceived complexity. Indeed, psychosocial risks are often described as complex and therefore difficult to regulate (Jespersen et al., 2016; Potter, O'Keeffe, Leka et al., 2019; Rick & Briner, 2000). Jespersen et al. (2016, p. 25) considered psychosocial risks to be “wicked problems’ ... [characterised by] ... high levels of social complexity, uncertainty, and divergence of value.” In terms of their regulation, Rasmussen et al. (2011, p. 570) observes that Danish regulators found it “necessary to give the workplaces more leeway because it is considered a more complex matter than other regulated working environment problems,” and researchers studying the audit of psychosocial risk management (Hohnen & Hasle, 2011, 2018; Hohnen et al., 2014) found similar complexities relating to psychosocial risks and their management resulted in a tendency among auditors to focus on objectively measurable or monocausal, noncomplex issues.

Notwithstanding these points, others have challenged the prevailing assumption that psychosocial risks are too complex for businesses to understand or act upon. In many countries, there is an abundance of accessible guidance, standards, and publications on the assessment and management of psychosocial risk, including guidance specifically interpreting the application of WHS law to psychosocial risks in the EU (Leka & Jain, 2014). Yet, as Leka et al. (2015) observe, stakeholders and businesses consistently claim to be unclear on them. Leka et al. (2015) suggest that some confusion may result from inconsistent use or conceptualisations of the terms “risk” and “risk management”, in particular by those working in occupational health who have traditionally come from a reactive perspective of mending harm; therefore, a lack of expertise in proactive risk management within this

professional group may be a barrier. Metzler et al. (2019) concur, identifying that a lack of awareness, expertise, and guidance, coupled with insufficient supervision and control by governments, were bigger influences in determining the effectiveness of psychosocial risk assessment and the prioritisation given to it in businesses than the inherent character of psychosocial factors per se. Similarly, Moncada et al. (2011) assert that failures in psychosocial risk management initiatives in Spain were related to particular ways of thinking about psychosocial risk that undermined their potential management.

Some authors (Cox, 1993; Cox & Cox, 1993; Cox et al., 2003) have suggested that techniques and frameworks related to the management of other health and safety risks can simply be transposed on to the management of psychosocial risk, and there has been some empirical backing for this approach. For example, when considering whether Danish WHS management systems (WHSMSs) used to meet EU Framework Directive 89/391 could be responsive to the complexity of psychosocial risks, Dahler-Larsen et al. (2020) found support for a systematic organisational approach to the management of psychosocial risk factors. Having observed that “the ontological difficulties with psychosocial risks can be used as an argument to justify lack of commitment to building and improving WHSMSs, ... [they concluded that] ... exactly *because* psychosocial factors are difficult to address, a systematic approach such as the one known from WHSMSs could in fact be particularly needed” (Dahler-Larsen et al., 2020, p. 1).

3.5.4 INDIVIDUALISATION AND RESPONSIBILISATION

The fourth challenge to the regulation of psychosocial risk relates to the tendency in WHS generally to focus on individual-level behaviours, decisions, errors, and failings as opposed to systemic and structural factors (Dekker et al., 2013; Johnstone et al., 2012). This tendency presents an even more significant barrier to psychosocial risk management with matters relating to mental health in the workplace being commonly “perceived as an individual-based personality issue rather than an occupational health topic” (Moncada et al., 2011, p. 592). Reasons that have been suggested to explain this include that it is simply easier to focus on individuals, that it absolves employers from

having to substantively change systems of work from which they benefit while the health impacts are externalised onto workers and broader society, and that it precludes employers from having to confront work-related problems stemming from an imbalance of power (Jespersen et al., 2016).

The tendency to focus on individual-level factors undermines the very purpose of WHS law, which, as pointed out in section 2.2, is premised on acting as a countervailing force to the inherent inequity of the employment relationship. Lerouge (2017b, p. 389) explains:

The execution of the employment contract is accompanied by occupational risks that can jeopardize the health of workers making as such the employer responsible for their health.

Health law at work intends to regulate the occurrence of violations of worker integrity during their working time and in the workplace, under the subordination of the employer. These rules implement health and safety measures, in order to avoid accidents and occupational diseases.

The right to health at work, he continues, is premised on the protection of the health of workers in a specific context—that context being one of subordination that links the employer and the employee. Accordingly, WHS law aims to “prevent abuses that can result from this relationship” (Lerouge, 2017b, p. 391). This clearly implies that the core focus of WHS law should be on risks arising from systems, places, and contexts of work.

Various schematics can be used to think about the appropriate focus for WHS law. Extraorganisational (macro) primary prevention may occur at a sector, supply chain, or national level. Within a workplace, interventions can be universal, directed toward different groups, intervene at the task/job level or at the individual level. Interventions at the organisational level are concerned with designing or modifying work from an organisational perspective to eliminate sources of risk. Task- or job-level interventions may focus action down to particular groups who perform certain jobs or tasks or groups who are exposed to particular variables that present differential risks. At the individual level, workers may have their jobs or workplaces adapted or training providing to meet individual needs. In terms of prevention, strategies may focus on a primary, secondary, or tertiary levels (see section 3.5.5). The literature suggests that “organizations employing predominantly organization-directed, primary

prevention strategies will show greater levels of worker well-being and morale relative to organizations employing predominantly individual-directed interventions alone” (Bailey et al., 2014, p. 105).

Despite this, empirical studies have found that most stress management, mental health, or psychosocial risk management actions at work focus on interventions at the individual level rather than at the task, group, or organisational level—even when purportedly motivated by WHS obligations (Lamontagne et al., 2007; Oakman et al., 2018; Walden, 2017). Almond et al. (2022) observe that, in the UK, remedy to psychosocial risk exposure and resultant harms is predominately expected to be resolved through individual rights mobilisation as opposed to being addressed through the collective rights that health and safety law provides. According to these authors, the distinct lack of regulatory action in the criminal law (the authors note that the UK’s Health and Safety Executive has never made a prosecution relating to failures to manage psychosocial risks) has resulted in a shift of the responsibility for preventing harm in the workplace on to the worker which renders those unable to take steps to exercise their voice through employment contract disputes as complicit in their own situation.

The systemic individualisation of psychosocial risk to workers and ensuing de-responsibilisation of employers is also observable in the New Zealand regulatory context. Perhaps most telling of all, as with the UK, in New Zealand, there have been no prosecutions relating to psychosocial risks made by any regulator under the HSWA¹⁹ (Dyhrberg, 2022). The deference to laws characterised by individual rights mobilisation was evidenced in Oosthuizen’s (2020) analysis of a sample of cases heard by the New Zealand Employment Relations Authority and Employment Court (that is, where individual workers have made a claim against their employer). In that research, she reported that 88% of cases prosecuted under the Employment Relations Act 2000 contained evidence, sometimes quite explicitly

¹⁹ There has been at least one prosecution related to fatigue in NZ, however in the work-related psychosocial risk literature fatigue is generally considered an outcome of psychosocial risk exposure rather than a psychosocial risk itself (Cox & Griffiths, 2015; Schulte et al. 2024). An exception is the US’s National Institute for Occupational Safety and Health (2024) which lists fatigue as an example of a psychosocial hazard.

so, that workers had been subject to unsafe systems of work and systematically exposed to psychosocial hazards arising from the work environment, thus evidencing grounds for criminal prosecution under WHS law.

3.5.5 LACK OF FOCUS ON PRIMARY PREVENTION

The focus of psychosocial risk management, including in terms of compliance with health and safety legislation, can be characterised in terms of an organisational-level emphasis on primary prevention to address hazards arising from the content or context of work (Jain et al., 2022; Leka & Cox, 2009; Leka, Jain, Cox et al., 2011; Rasmussen et al., 2011). This focus aligns to the broader mandate of WHS law to prevent harm, and which holds that:

In OSH crime the actual injury is a consequence of a work process that has not been organised, structured and monitored so as to ensure that is safe and without risks to health. At a deeper level, the issue is the control of the work process by the employer to the detriment of the employee, the prevalence of other organisational objectives (such as short term or long term profitability, increased market share, productivity, increased utilisation of capital, longer production runs, and so on) over OSH objectives, and the failure to practise systematic OSH management. (Johnstone, 2003, p. 119)

However, a consistent finding in the literature, (Lamontagne et al., 2007; Oakman et al., 2018; Walden, 2017), and the fifth challenge to the regulation of psychosocial risk, is the tendency for duty holders to not focus on primary prevention when addressing psychosocial risks. The avoidance of primary prevention is therefore related to the topic of individualisation outlined in section 3.5.4.

Primary interventions are usually proactive and concerned with addressing potential causes of harm through the design of good work and by eliminating or minimising risks arising from aspects of work design and the organisation and management of work, and their social and environmental contexts. Beyond primary prevention, secondary interventions aim to intervene early, and reduce, reverse, or slow down the development of ill health by acting on workers themselves, and may include strategies

such as bolstering workers’ capacities to cope with stress arising from primary-level hazards. Depending on the nature of the risk in organisations and its impact on workers, these interventions may also play an important role in risk management (Leka & Cox, 2009). WHS law is also relevant to this stage in that where primary-level mitigations have been exhausted or may only partially address risks, secondary-level interventions may have a supplementary role (Lamontagne et al., 2014), but, accordingly, secondary-level preventative controls can therefore be considered lower-order controls. Finally, tertiary-level interventions provide for treatment, rehabilitation, and return to work of workers who have been harmed or are unwell. In this way, tertiary prevention interventions “prevent” workers from becoming *more* unwell and such interventions may include access to counselling or other types of therapy. New Zealand’s accident compensation system provides for workers harmed by psychosocial hazards only in very limited circumstances (Duncan, 2018, 2019). These three levels of intervention are presented in Table 6.

Table 6
Levels of Intervention for Workplace Stress and Psychosocial Risk Management

Intervention level		Intervention target	Examples
Definition and description	Effectiveness		
1° - Primary (focus of WHS law) <ul style="list-style-type: none"> • Preventative, proactive • Goal – to minimise or eliminate hazards before workers experience stress-related symptoms and disease. 	+++	<ul style="list-style-type: none"> • Hazards at the source; arising from work design and the organisation and management of work and their social and environmental contexts. 	<ul style="list-style-type: none"> • Job redesign, improved communication, workload reduction, role clarity, change management structure, fair reward for work.
2° - Secondary <ul style="list-style-type: none"> • Ameliorative • Goal – to help equip workers with knowledge, skills, and resources to cope with stressful conditions which are not amenable to elimination by way of primary interventions. 	++	<ul style="list-style-type: none"> • Individual workers. 	<ul style="list-style-type: none"> • Resilience education, cognitive behavioural techniques, time management skills, relaxation and meditation, biofeedback.

<p>3^o - Tertiary</p> <ul style="list-style-type: none"> • Reactive <p>Goal – to treat, compensate, and rehabilitate workers with stress-related symptoms or disease. Minimise the effect or impact of disease.</p>	+	<ul style="list-style-type: none"> • Individual workers who have been harmed. 	<ul style="list-style-type: none"> • Return to work programmes, counselling, medical care, sick leave.
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Note: Based on information taken from Cooper et al. (2001) and table provided in LaMontagne et al. (2007).

The emphasis on primary prevention is expressed in well-established health and safety conceptual frameworks, such as the hierarchy of controls (also called the general risk management hierarchy). This is a heuristic that frames the appropriate implementation order of risk management interventions from the most effective—being elimination of the hazard or risk—through to controls that are lower in the hierarchy and that should only be invoked in a lower order of precedence, in conjunction with higher-level controls, or where higher-level controls are not reasonably practicable. The hierarchy of controls has been invoked in various grey literature, such as official guidance materials and codes of practice for managing psychosocial risk, as well as in the academic literature, in particular through its emphasis on addressing psychosocial risk mainly from a primary prevention perspective (Dollard et al., 2012; Lamontagne et al., 2007; Oakman et al., 2018; Potter, O’Keeffe, Dollard et al., 2019; Safe Work Australia, 2019; Workplace Health and Safety Queensland, 2022).

3.5.6 MANAGEMENT PREROGATIVE

The sixth challenge for the regulation of psychosocial risks lies in their relationship to the management and organisation of work. Because of this relationship, psychosocial risk management holds high potential to encroach upon management functions which are traditionally considered to reside strictly within the management prerogative. Management prerogative refers to the rights and functions of management as, or as trustees for, the owner of property, business, plant, etc. to control and direct the work process, as limited by the bounds of laws, policies, and other regulations (Heery & Noon, 2017). Psychosocial risks are often borne out of decisions made by management related to staffing, job security, intensification, production, market demands, and so on, and are often decisions

that are made at locations remote and removed from where the risk is realised (such as the boardroom). Such “performance” and “operational” decisions are therefore not typically considered to sit within the traditional remit of work health and safety (Benach et al., 2014; Walters, 2011). The regulation of psychosocial risks and their embeddedness in the wholesale organisation of systems of work may seem “at a considerable distance from the debates around the proper boundaries of the criminal law” (Haines & Almond, 2014, p. 845), highlighting the fact that both bounds of psychosocial risk management and the bounds of “what is and is not criminal behaviour, is politically fraught and likely to engender strong opposition from those benefit from current ways of working” (p. 845).

Ostensibly to make the regulation of psychosocial risk more palatable to business, some jurisdictions have placed limits on the types of risks that may be considered under WHS laws by excluding those that may be considered relating too directly to management prerogative. For example, in 1994, a Danish tripartite committee comprising of government, union, and employer representatives set limitations on the types of psychosocial factors in which the state inspectors could intervene under Danish WHS laws. This agreement narrowed the remit to the more “common ... [or] ... simple” (Rasmussen et al., 2011, p. 566) risks of work-related violence, traumatic experiences, emotional demands, workload and pace, working alone, and night and shift work. Those psychosocial risks that were considered to be based more in management prerogative, such as those that were a “direct result of managerial decisions or the relations between either management–workforce or between members of the workforce...” (Rasmussen et al., 2011, p. 567), were excluded.

Another strategy adopted by regulators that may temper the abutment of psychosocial risk management with management prerogative is to regulate by way of voluntary standards. For example, the UK Health and Safety Executive’s Management Standards is a voluntary tool that identifies six areas of work design as its foci: demands, control, support, relationships, role, and change (Health and Safety Executive, 2019). Brunsson and Jacobsson (2002) note that as a regulatory tool, standards occupy a particular niche as voluntary programmes containing explicit rules. However, as a voluntary obligation, the degree by which standards are adhered to is not contingent on a legal obligation or

requirement – but rather on their acceptability to their followers.²⁰ A standard that is considered acceptable and reasonable to regulated entities invokes less political risk and arouses less resistance. Consequently, such a standard is likely to be less disruptive of status quo conditions, and therefore will have fewer consequences within organisations than if it were considered by regulated entities to be challenging or problematic in its requirement for significant or system-wide change.

The exclusion of particular risks in both standards and other regulations may create a totalising narrative of the risks that might exist in a work environment and theoretically serve to undermine the capacity of the general duties to be responsive to a broad range of risks, including new, emerging, and future ones. In this way, standards or regulations that specify particular risks may become constitutive of the very conditions that they aim to regulate. Omitting risks that impact on management prerogative may be viewed as undermining health and safety regulation, precisely because the main purpose of health and safety regulation is the mediation or limiting of management prerogative as an expression of the unequal relationship between employers and workers.

3.5.7 INSPECTION AND AUDIT

The seventh challenge to the regulation of psychosocial risks relates to difficulties with audit and inspection. Challenges to audit and inspection may arise where hazards are complex and uncertain, and studies have identified the unsuitability of traditional inspection audit tools and skills when addressing psychosocial risks (Bruhn & Frick, 2011; Hoel & Einarsen, 2010; Johnstone et al., 2011; Rasmussen et al., 2011). Notwithstanding these challenges, a number of inspectorial methods, tools, and strategies have been developed or adapted to specifically address psychosocial risk with varying degrees of success, such as those in Australia, Norway, Finland, Denmark, Sweden, Germany, and Spain (Bruhn & Frick, 2011; Hansen et al., 2015; Indregard et al., 2019; Johnstone et al., 2011; Moncada et al., 2011; Rasmussen et al., 2011). Weissbrodt and Giauque (2017) conducted a systematic review of studies reporting findings regarding inspection strategies for psychosocial risks

²⁰ This observation might be expanded to binding legislation too, as all regulators must seek to maintain legitimacy in the eyes of regulatees whilst simultaneously regulating in accordance with values that may conflict with those of regulated entities (Almond & Esbester, 2018; Prosser, 2010).

and found notable successes in the development of specific training for inspectors and in the development of tools and strategies for inspection. Rather than conceptual issues, such as complexity, limiting the effectiveness of inspectorial work, they found that the development of such initiatives was relatively more limited by a lack of inspectorial resources triggered by reform under New Public Management initiatives. Overall, the authors contended that positive outcomes from inspectors' interventions on psychosocial risks are possible in supportive contexts and with appropriate training and resources. More recently, in 2022, the ILO added two modules relating to psychosocial risk to the ILO Curriculum on Building Modern and Effective Labour Inspection Systems (ILO, 2022b, 2022c) with view to enhancing labour inspection systems worldwide.

3.5.8 SUMMARY

In section 3.5 I have reviewed seven challenges relating to the regulation of psychosocial risks under WHS law. A consistent thread across all these factors is the problematisation of these types of risks as complex, unmanageable, and therefore unregulatable. In this sense, more seems to have been written in the academic literature on the challenges of regulating psychosocial risks and the *incorrect* ways that businesses respond to legal obligations for psychosocial risk management. Consequently, it is almost necessary to utilise a reverse logic to establish a consensus on what might be considered acceptable practice. Consistent with this point, several prominent researchers have suggested that the biggest challenge in regulating psychosocial risk at work may not be the inherent challenges or nature of psychosocial risk in themselves, but in addressing the gap between research and science around psychosocial risk management and policy and/or implementation (Leka & Jain, 2016; Leka & Kortum, 2008; Leka, Van Wassenhove et al., 2015).

3.6 GUIDANCE FOR OFFICERS

The nature of the officers' duties was examined in detail in section 2.5. To recap, they are a duty upon officers of a PCBU to exercise due diligence to ensure that the PCBU complies with its duties and obligations under the HSWA. There is, therefore, a relationship between the officers' duty of due

diligence and the duties of the PCBU in that officers are required to provide a degree of oversight of the PCBU's compliance response.

Internationally, there is very little guidance available specifically for senior managers, executives, or directors relating to legal duties as they apply to psychosocial risk management. Although von Thiele et al. (2022) have suggested how corporate boards can influence employee health and wellbeing, overall, there is a lesser understanding of the board's role in health as opposed to safety, and an even poorer comprehension of the board's role in protecting workers from psychosocial harm (Ebbevi et al., 2021; Lornudd et al., 2021), particularly through the lens of legal obligations. This deficit may in part be because in most jurisdictions, there are no proactive duties for officers relating to health and safety, and the due diligence duty of officers is only found in Australia's and New Zealand's WHS laws.

Johnstone and Tooma (2012) characterised the adoption of general duties (in this case with respect to Australia's Model Act on which the New Zealand legislation is based) as a "welcome development" (p. 264), albeit one that is "incomplete" (p. 264). They argue that accompanying regulations and codes of practice are essential when general duties are being relied upon in a self-regulating system. Whilst the first code of practice for managing psychosocial risks in Australia was published by SafeWork NSW in May 2021 (SafeWork NSW, 2021), there is currently no similar code in New Zealand.²¹ Further, while there is some general guidance available for New Zealand officers regarding the execution of their specific duties (Business Leaders' Health and Safety Forum, 2015; WorkSafe, 2019a), there remains a lack of detailed information to support the practical application of the duties and provide an evidentiary standard, such as that which would be found in a code of practice.

The value of a code of practice cannot be understated and has been emphasised as a critical factor assisting in the practical application of the duties (Johnstone & Tooma, 2022). The Independent

²¹ Draft regulatory guidance (which does not provide the evidentiary standard that would be provided by a code of practice) entitled *Mentally healthy work – good practice guidelines for managing psychosocial risks at work* was released for public consultation by WorkSafe in November 2023. See <https://www.worksafe.govt.nz/dmsdocument/62713-draft-for-consultation-mentally-healthy-work-good-practice-guidelines-for-managing-psychosocial-risks-at-work/latest>

Taskforce on Health and Safety, which informed the legislative reform leading to the HSWA, considered that codes of practice were a key lever in improving accountability through “empowering state agencies by providing them with the mandate and functions to ensure compliance with legal requirements, and empowering individuals” (Jager et al., 2013, p.43). Accordingly, the Taskforce placed considerable emphasis on developing and maintaining new codes of practice. The Taskforce specifically recommended that, “the new agency [WorkSafe] and IoD [Institute of Directors] develop an ACoP [Approved Code of Practice] and guidance to support directors’ new legal duties” (Jager et al., 2013, p. 53). As indicated above, however, this code of practice has never been developed. Dabee (2020, p. 379) sums up the situation, which arguably still stands, noting that there are “no formalised regulatory structures to help officers ‘self-regulate’ effectively in order to comply with their due diligence duties. Instead, it appears that officers have been left mostly to regulate their own behaviour with some guidance from WorkSafe.”

3.7 OFFICERS’ DUTIES AND PSYCHOSOCIAL RISK: THE GAP IN KNOWLEDGE

Searches of the international literature identify a number of government reports that are relevant to understanding the role of officers in health and safety, many of which appear to have been produced with the purpose of informing legislative reform on the matter of directors’ liability and responsibilities. For example, Gunningham’s (1999) report to Australia’s National Occupational Health and Safety Commission summarises, among other issues, the literature about how senior management could be motivated to place a much higher premium on, and commitment to, improved WHS outcomes by way of various regulatory strategies. In the UK in 2006–2007, there was a series of reports commissioned by the Health and Safety Executive on the role and responsibilities of company directors (Bergman et al., 2007; Boardman & Lyon, 2006; James, 2006; Lekka & Healey, 2006; McMahon et al., 2006; Wright, 2006), and several of these considered proactive duties of due diligence. However, as these duties were not passed into British legislation, it is axiomatic that there is no empirical evidence from that jurisdiction regarding their implementation. Along with these reports, there is a significant body of research considering the role of those who control companies at the highest levels in terms of health and safety from a number of perspectives, including examining

boards' and senior executives' influence on health and safety (Dahl et al., 2022; Ebbevi et al., 2021; Hopkins, 2016a; Lornudd et al., 2021), attitudes and motivations (Heathrose Research, 2013; Lornudd et al., 2020; Smallman & John, 2001), and legal liabilities and penalties (Harpur, 2008; Klettner, 2014; Pavlovich & Watson, 2015). However, that body of research examines neither due diligence nor psychosocial hazards specifically, though some (Ebbevi et al., 2021; Lornudd et al., 2021) include psychosocial factors as one type of risk in their broader consideration of health and safety.

In New Zealand, the government and its advisory agencies have published a number of research and guidance documents on stress and psychosocial harm at work since the late 1990s (see, for example, Driscoll et al., 2004; Occupational Safety and Health Services, 2003; Pearce et al., 2005; WorkSafe, 2017, 2018, 2019b, 2020a), and a significant amount of academic research into various aspects of psychosocial harm in New Zealand workplaces has been undertaken (see, for example, Catley et al., 2013; D'Souza et al., 2022, Forsyth et al., 2021). However, there has been relatively little research published that specifically or substantially considers regulatory strategy or compliance behaviours relating to psychosocial harm at work, with the exceptions of Scott-Howman and Walls (2003), Walls and Darby (2004), Lo and Lamm (2005), Blackwood et al. (2013), Oosthuizen (2020), and Duncan (2016, 2018). While Peace (2017) and Dabee (2020) both consider the due diligence duties, they do so without specific regard to psychosocial risk. Psychosocial risk has only just started to reach the consciousness of businesses in New Zealand as something that may be addressed through the health and safety regulatory system and a matter on which the regulator may be taking more action signalled by the employment of the agency's first "Mentally Healthy Work" lead in 2020. The dearth of academic consideration of regulation and compliance as they apply to psychosocial harm at work in New Zealand mirrors the long-term shortfall in regulatory attention.

Given that New Zealand and Australia share very similar health and safety legislation, including the due diligence requirements, it is reasonable to consider that research in the Australian jurisdiction would hold relevance to the New Zealand context. In this respect, Australia-based legal experts Johnstone, Tooma, and Dekker (see, for example, Dekker & Tooma, 2022; Johnstone & Tooma, 2012, 2022; Tooma, 2017) provide legal interpretation, commentary, and theoretical perspectives relating to

the officers' duties, and Wheelwright (2016) reviewed six prosecutions for failing to exercise due diligence that had made their way to the Australian courts by that time. However, none of these authors consider in any detail how the due diligence requirements can be framed or carried out in regard to psychosocial risk or present empirical consideration of how officers conceptualise or respond to these duties.

Back in New Zealand, as of January 2024, there have been very few prosecutions of officers in the courts (see section 2.5.4), and none of those cases related to psychosocial factors. As such, this relatively small body of jurisprudence has not generated much in the way of academic analysis. Similarly, there are no published data on enforcement practices used by the regulator relating to the officers' duties or to psychosocial harm, suggesting that the regulator has adopted a conservative approach to this issue.

3.8 CONCLUSION

The HSWA not only introduced the new duty of due diligence for officers as a part of an overall self-regulatory strategy but also, in making explicit the inclusion of mental health in the definition of health, required them to apply that duty to psychosocial risk. Worker mental health is undoubtedly a matter of concern for New Zealand companies. However, to date, no research has examined company officers' perspectives or responses to legal duties to manage psychosocial risk, and very little is known about how officers conceptualise or exercise their duties. This research attempts to address that deficit.

The literature on compliance highlights that where there are elements of uncertainty on a regulated issue because it is vague, new, or not clearly defined through legislation, judicial judgements, or guidance, actors have greater scope to construct and shape the meaning of compliance, often in a way that serves their interests. The strategy of self-regulation with light-handed oversight by the regulator, combined with the flexibility permitted by the general duties approach, together create a space in which businesses have considerable discretion to determine the meaning of compliance. No research has been conducted to examine how officers are filling this space in their construction of due

diligence duties as it applies to the management of psychosocial risk at work. The next chapter, Chapter 4, will lay out the research methodology, beginning with a statement of the research aim and objectives.

4. METHODOLOGY

In this chapter, I outline the methodological approach that I have taken in this research. In section 4.1 I will explain the research purpose and present three research questions that the study addresses. Section 4.2 outlines the philosophical perspective taken in the research, and section 4.3 explains matters relating to research quality and rigour. Section 4.4 presents the research strategy and details the methods and steps taken in the conduct of the research. Section 4.5 concludes this chapter.

4.1 RESEARCH QUESTIONS

In this research, I critically examine the way New Zealand officers of large companies fulfil their duties of due diligence as they apply to psychosocial risk. In doing so, I consider how psychosocial risks are socially constructed and organised and examine the implications of these conceptualisations and constructions relative to the regulatory purpose of the HSWA and the specific duties of officers therein. Although psychosocial risk exposure is associated with a variety of psychological, social, and psychological harms, I focus this research on psychological or mental harms. Consequently, this research sits at the intersect of several bodies of knowledge: work health and safety regulatory theory and law, risk theory, and psychosocial risk management.

In undertaking this critical examination, the research addresses three questions:

1. How do officers conceptualise, express, and carry out their duties under the Health and Safety at Work Act with specific regard to psychosocial risk?
2. How do constructions of risk shape how officers respond to this duty?
3. How do the ways that officers construct compliance relate to the regulatory intentions of the officers' duties, and what are the implications for managing psychosocial risk?

4.2 PHILOSOPHICAL PERSPECTIVE

This research was conducted using a qualitative approach. Qualitative research may be based on various epistemological and ontological assumptions. However, in deciding upon which assumptions

to base research, the literature suggests it is of most importance that: researchers identify which perspective they are adopting, there is logical alignment and coherence between the fundamental philosophical perspectives that are chosen through to the methods and techniques used to gather and analyse information, and the decisions made in the design of the research are relevant and meaningful to the specific inquiry situation or interest—that is, that the research design decisions are methodologically appropriate (Braun et al., 2017; Flick, 2007; Patton, 2015; Spencer et al., 2020). Accordingly, sections 4.2.1 to 4.2.4 further explain the philosophical perspectives underpinning this research with later sections detailing the methods and techniques that were used to gather and analyse the data.

4.2.1 ONTOLOGY AND EPISTEMOLOGY

An ontological position establishes a researcher’s approach to reality. The ontological position I take in this research is one of ontological relativity. O’Grady (2002) asserts that, at its most general premise, the idea of relativity implies that whatever is being described arises relative to something else. Patton (2015, p. 122) sums up the ontological relativist thesis in that “all tenable statements about existence depend on a worldview and no worldview is uniquely determined by empirical or sense data about the world.” The relativist position therefore allows for multiple, divergent, or alternate truths or realities to be tenable according to the variable contexts in which those truths and realities are realised. In the context of this research, the relativist position allows for the coexistence of multiple interpretations of social phenomena, such as compliance and risk.

Epistemology is the theory of knowing and, in the context of research, an epistemological position describes how we may gain knowledge and the relationship between the researcher and the world (Spencer et al., 2020). Because relativism holds that knowledge is constituted by cognition and the object of knowledge cannot be known independent of cognition, relativism views reality as a social construction and is, hence, concomitant with a social constructionist epistemology. As an epistemological approach, social constructionism considers that people make meaning in the context of interactions, relationships, and experiences, and through historical and cultural norms that operate

in their lives (Berger & Luckmann, 1967). Because of these influences, meaning is not considered fixed, but, rather, individuals are constantly negotiating meaning (Gergen, 1997). Burr (2015) has provided four premises or fundamental ideas that define social constructionist approaches:

1. A critical stance towards taken-for-granted knowledge and understanding;
2. The historical and cultural specificity of knowledge and understanding;
3. That knowledge is sustained by social processes; and
4. That knowledge and social actions are intertwined.

In this view, knowledge and meaning do not simply reflect some underlying truth but are created, sustained, and changed through social processes. Research into business compliance with health and safety legislation taking a social constructionist approach examines how individuals and institutions shape the meaning and functioning of rules, and how popular and common-sense ideas and ideals about health and safety compliance are formed (Almond, 2009, 2015; Gray, 2009; Lamm, 2002).

Within this epistemological approach, I draw upon poststructuralist perspectives that place discourse at the centre of analysis and, in doing so, give explicit focus to the role of language and the historical and social situatedness of knowledge claims (Hardy et al., 2004). This perspective thus destabilises purportedly fixed meaning by highlighting the contingency of accepted or supposed truths. I will outline this approach further in 4.2.2.

4.2.2 ANALYTICAL APPROACH

In this research, I take a discursive approach to the analysis. Willig (2014) confirms the coherency of this approach with the social constructionist epistemology and relativist ontology explained at 4.2.1. Discourses are not simply systems for referring to or describing things but are both socially shaped, and socially shaping or constitutive (Fairclough, 1992). Discourse analysis may, in the first instance, describe or identify an object or phenomenon, such as a “risk” or a WHS “problem”, but also describes how the phenomenon came to be conceptualised as an object, how it is maintained or reproduced, and how it is shared and spoken about in social (including organisational or institutional) settings. Therefore, a discursive approach provides many ways to approach the analysis of a text. As

Hardy (2022, p. 3) points out, discourse analysis rejects the conception of meaning as “unequivocal, singular, and inherent – regardless of how matter of fact it may appear... [and, therefore] ...a discursive approach is thus founded on a profound interrogation of the precarious status of *meaning*.”

Amongst those who undertake discourse analysis, many have noted that it is problematic to decisively name discourse analysis as a method, framework, methodology, or analytical approach. For example, Reynolds (2019) observes that various authors using discourse analysis may name their approach by any one of these terms or, alternately, fail to name how they conceptualise it at all. However, overall, there appear to be two points of consistency: that discourse analysis is fluid, ununified, multidisciplinary, and diverse in nature, and, relatedly, that there is no correct way to “do” it. For example, Hart and Cap (2014) call discourse analysis a “difficult discipline to pin down” (p. 2), and Grant et al. (2004) characterise the many approaches to discourse analysis as “disparate and fragmented” (p. 2). Despite this, or perhaps because of it, discourse analysis provides a flexible interdisciplinary analytical framework for examining a broad range of topics (Hardy, 2022).

There are many approaches to, and traditions within, discourse analysis with none being superior to others; the key appears to be taking an approach that best fits the issues or questions the researcher wants to address. Wetherell (2001) notes that some academic disciplines lean toward one style of discourse analysis more than others, either out of habit or routine, or due to an underlying epistemological perspective. Others highlight that discourse analysis entails flexibility in approach as, for example, in their assertion that there is no singular or right way of doing discourse analysis. Gee (2011), for example, describes his style of discourse analysis as one that has been “begged, borrowed and patched together ... adapted and mixed together ... [into a kind of] soup” (p. 10).

Notwithstanding this flexibility, Gee (2011) explains that the broader family of discourse analysis can be roughly cleaved into two parts: one that examines the structure of language and how it functions in terms of syntax, semantics, grammar, and rhetoric, that is based in the discipline of linguistics, and includes forms such as conversation analysis, and the other that typically examines macrolevel social and cultural phenomena and structures that are represented in texts, such as critical discourse analysis

and Foucauldian discourse analysis. Rather than conceptualising these as mutually exclusive approaches, Hart and Cap (2014) refer to the different approaches as a spectrum where a researcher's position is determined by preferences and analytical emphases. In highlighting the multiplicity of disciplinary perspectives that fall within the family of discourse analysis, Grant et al. (2004) reject any attempt to catalogue or classify "types" of discourse analysis, noting that methodologies utilising a discursive approach are often complex and overlapping. Additionally, studies will often take up, or at least draw on, multiple methodologies at the same time. Despite the seeming intangibility of the various approaches to discourse analysis, for the purposes of some sort of methodological alignment or underpinning, the type of discourse analysis from which my approach most closely draws is Foucauldian discourse analysis.

4.2.3 FOUCAULDIAN DISCOURSE ANALYSIS

Michel Foucault never produced or endorsed a particular method of "doing" discourse analysis, and the diverse and evolutionary nature of his work, coupled with its "elliptical style" (Arribas-Ayllon & Walkerdine, 2017, p. 110), eludes the extraction of a consistent, coherent, or systematic way of conducting research. In terms of the methods of research he used, he primarily relied on an extensive examination of archives and historical documents. According to Hardy (2013), Foucault's methodologies were his defining characteristic; in this sense, it was "the particular theoretical frameworks he used to order and interrogate his collected data – that was so innovative and particular to him" (p. 96). By way of these methodologies, "he aided the development of what would now be termed discourse analysis: the interrogation of a series of related statements in order to discern the overt or covert assumptions, generalisations or prescriptions that they contain" (Hardy, 2013, p. 96).

A Foucauldian approach to discourse analysis can therefore be classified as any that works in congruence with Foucault's philosophical and methodological aims, and is deemed appropriate to the research area, topic, and questions at hand (Fadyl et al., 2013). In line with this, Foucault himself conceived of his vast works not as a comprehensive approach but, rather, as a set of tools that can be wielded in a way that the craftsman themselves determines:

I would like my books to be a kind of tool box which others can rummage through to find a tool which they can use however they wish in their own area ... I would like [my work] to be useful to an educator, a warden, a magistrate, a conscientious objector. I don't write for an audience, I write for users, not readers. (Foucault, 1974, pp. 523–524, cited in O'Farrell, 2005, p. 50)

Section 4.2.4 presents several aspects or “tools” of Foucauldian discourse analysis that underpin my analysis.

4.2.4 FOUCAULDIAN TOOLS AND CONCEPTS

Foucault explained in *The Archaeology of Knowledge* that discourses are not simply, or only, signs or representations of reality but “practices that systematically form the objects of which they speak” (Foucault, 1972/2002, p. 54). Whilst discourses are composed of signs, they do more than simply represent, describe, or designate meaning and, accordingly, the aim of discourse analysis is to “reveal and describe” (Foucault, 1972/2002, p. 54) that which is represented by “more”: discourse analysis uncovers what language *does*.

Foucault’s work emphasises the production of knowledge and meaning through discourse, and that discourse is historically contingent in that the sense and coherence of a discourse arises in relation to a particular and broader episteme, or system of knowledge of a historical era. Hall (1992) offers a clear statement about the nature of discourse from a Foucauldian perspective when he describes discourse as “a group of statements which provide a language for talking about—a way of representing the knowledge about—a particular topic at a particular historical moment” (p. 291). Hall (1992) continues: “When statements about a topic are made within a particular discourse, the discourse makes it possible to construct the topic in a certain way. It also limits the other ways in which the topic can be constructed” (p. 291). Knowledge, therefore, exists within the possibilities offered by discourse.

The notion of institutions is important in discourse analysis because institutional practices are bound up with “ways of organizing, regulating and administering social life that reflect and support the discourses” (Gibbs & Flick, 2018, p. 97). In the fields of regulation and compliance, discourse analysis is an appropriate framework by which to examine regulatory compliance. Indeed, Black (2002) has contended that “discourse forms the basis of regulation” (p. 165) in that it is discourse that creates regulatory problems, solutions, and subject positions (for example, offender, officer, victim, worker, duty-holder, etc.). Black (2002, p. 165) also highlights that discourse “produces shared meanings as to regulatory norms and social practices which then form the basis for action (for example, the formation of regulatory interpretive communities).”

Foucault’s genealogical studies brought attention to the role of power in discourse. Most common-sense conceptions of power envisage it as a unidirectional force, such as sovereign power, which is directed in a hierarchical, downward, or oppressive manner. This view is taken, for example, in the Marxist conceptualisation of power where power is equated with class status and the related ownership of the means of production in an economic system. In Marxist analysis, power is explored through examination of the legitimate and illegitimate uses of power—that is, the use of power by the *powerful*, such as elites, management, the patriarchy, or the ruling class. Marxist analyses of power pay attention to the ways in which power may be disguised or wielded through ideology or normalised and framed as common sense through hegemony. However, Foucault does not view power in this way, instead conceiving it as a circulating, generative, and productive phenomena dispersed across multiple agencies and actors. He thus suggests that we need not search for the “headquarters” (Foucault, 1978, p. 95) of power but, rather, that we can think of power existing in a network of capillaries that permeate through all levels of society and in all different directions. These capillaries are conceived less in terms of domination or control than in production and creation. The discourse of mental health, for example, creates and sustains disorders, hospitals, doctors, patients, clinics, charities, self-help books, podcasts, smart phone applications, magazines, counsellors, a speaking circuit, entrepreneurs, academic institutions, regulation, legislation, and more.

Genealogical analysis, then, looks at the conditions under which truth is formed and how particular forms of knowledge become known as the truth. In this way, Foucault uses the concept of knowledge/power to speak of the generative effect of power to not just limit but to allow for and create norms, social practices, and institutions. Resultantly, dominant discourses arise and may serve to legitimise types of power and control, particularly when they become viewed as natural, normal, or common sense, and, accordingly, truth exists in a relationship with political, economic, and social power.

In the context of this research, I place particular focus on the discourse of risk, and examine how the discourse of risk relating to worker mental health limits, defines, and produces what compliance with WHS regulation means. By utilising the discourse of risk in different situations—at the board table, in reports, in directives to management, in emails, in the allocation and use of company resources, and, in this case, in interviews, officers' language and practices construct and form the meaning of compliance. The way in which I conducted the discourse analysis will be discussed further in section 4.4.6.

4.3 QUALITY

To demonstrate aspects of methodological rigour, I have endeavoured to record significant details of how I carried out this research. This aim to make explicit where I made certain choices and decisions relating to how the data were produced, handled, used, transformed, reduced, synthesised, analysed and ordered. In this way, I intend to demonstrate through this chapter and the remaining sections, various actions and aspects that may indicate the quality and credibility of the research process. In this respect, I aim to show or demonstrate: transparency in my role as the researcher (Morrow, 2005), adequacy of texts (Lincoln & Guba, 1985), repeated and deep engagements with the texts (Morrow, 2005), authenticity (Seale, 1999), and reflexivity (Hardy, 2022).

According to Hardy (2022), a discursive approach lends itself to two forms of reflexivity. The first approach to reflexivity characterises, or is “part and parcel” of, the discursive approach—reflexivity here means “problematizing the phenomenon under investigation, often with the aim of unsettling

more established versions of reality and generating alternative ways of thinking” (Hardy, 2022, p. 143). The other form of reflexivity is self or radical reflexivity. In this research, I used a qualitative, inductive approach, meaning that this research was conducted by way of the human research instrument (Lincoln & Guba, 1985). Positivist approaches see knowledge as something to be objectively found if correct or standardised research procedures are followed, and even many qualitative researchers suggest that pre-existing themes “emerge” (Patton, 2015, p. 542) from the data, implying that it is just a matter of discovering them. However, the constructionist approach taken in this research explicitly acknowledges and takes into account that it is the researcher, who, through repeated and deep interactions with the data in a process of analysis and interpretation, generates these themes, patterns, and knowledge. In this context, reflexivity entails shedding doubt “on the idea of an objective, expert researcher who is somehow able to step outside of discourse in order to comment upon it” (Hardy, 2022, p. 143). Self-reflexivity acknowledges that because researchers are participants in the social phenomena being investigated, “that all data and findings involve presuppositions that reflect the ways in which researchers are themselves involved in the social world” (Hammersley & Atkinson, 2019, p. 16).

There is an extensive literature of strategies that researchers can adopt to develop self-reflexivity (Hammersley & Atkinson, 2019; Morrow, 2005). Olmos-Vega et al. (2023) provide both a critical and practical overview of reflexive practice and suggest that, in terms of incorporating reflexive practice into research, “rather than reporting reflexivity via a discreet paragraph or as an apology for the researcher’s influence on the data, we suggest that effective reporting should embrace researcher subjectivity and address the nuances of decisions throughout the research process” (p. 247).

Therefore, to bring attention and awareness to my presence in the research, I have written, where I considered appropriate, in the first person rather than in a passive voice so that attribution of authorship and responsibility for choices, practices, and interpretations made in this research are upon myself. Further, noting that the methods section “will likely offer the most detail about authors’ reflexive practices” (Olmos-Vega et al., 2023, p. 247), I have also provided considerable detail in the research strategy section (section 4.4) to make those choices made and practices undertaken explicit.

Further, in section 4.2 I have aimed to be transparent in the theoretical perspectives and conceptual frameworks that I have adopted so that the reader can evaluate the findings and discussions of the research in light of those.

4.4 RESEARCH STRATEGY

4.4.1 SELECTION OF TEXTS

Texts are manifestations of discourse (Hardy, 2022) and places where discourse is realised (Parker, 1992). Accordingly, texts can be analysed for “pieces” (Parker, 1992, p. 6) of discourse or “clues” (Hardy, 2022, p. 6) to a particular discourse. In terms of selecting which texts to analyse, Given (2008) observes that Foucauldian discourse analysis uses conventional data collection techniques to generate texts—interview transcripts, media items, web pages, and documents—although texts can exist in anything where meaning exists, from a bus ticket to a stained-glass window (Parker, 1992).

The groupings of texts analysed from a Foucauldian perspective is referred to as a corpus, that being, “a selection of discourse samples about an *object* relevant to one’s inquiry” (Arribas-Ayllon & Walkerdine, 2017, p. 115). Acknowledging that a detailed analysis of an entire corpus is impossible, Fairclough (1992) suggests researchers focus on selected items from the corpus that are representative or characterise discursive practice and that “yield as much insight as possible into the contribution of discourse to the social practice under scrutiny” (p. 230). Similarly, Arribas-Ayllons and Walkerdine (2017) note that in Foucauldian discourse analysis, inclusion criteria for insightful samples of text in a corpus may include those which problematise an object, speak of how those objects are constructed, acted upon, or regulated, or change over time. Reynolds (2019) reiterates this point, noting that discourse analysis does not aim to collate representative samples but, rather, to focus on salient examples that exemplify the research problem.

In terms of selecting which texts to analyse, ultimately, the suitability of a text is relative to the research question. In this case, I wished to understand how officers conceptualised their duties under the HSWA as they applied to mental health; thus, I considered that an appropriate way to generate an

insightful text about this was to interview officers and ask them about their duties. However, noting that the officers duties in the HSWA require that officers acquire, and keep up to date, knowledge of work health and safety matters (s 44(4)a), I also wanted to consider various sources of information about the duties, including public information, training, guidance, and case studies, that officers may draw upon. Accordingly, while texts were produced and assembled mainly from interviews, I also collected relevant publicly available guidance or information. I discuss and detail these two types of text further in the next sections 4.4.1.1 and 4.4.1.2.

4.4.1.1 Interviews

The majority of texts analysed in this research comprised transcripts from interviews I conducted with company officers. Several theorists have identified the limitations or the methodological challenges of using research interviews as text for discourse analysis (Meyer & Wodak, 2016; Potter & Hepburn, 2005). For example, Wodak and Meyer (2016) note that critical discourse analyses “mainly rely on existing texts, such as mass media communication or organizational documents” (p. 28). The assumption underlying such an assertion is that research interviews are not naturally occurring examples of discourse and are therefore tainted by the researcher’s involvement (Cruickshank, 2012). However, this argument adopts a positivist reasoning which assumes that the selection and analysis of existing or naturalistic texts is not influenced by a researcher’s involvement in data selection, gathering, and analysis. Despite these limitations and debates, Willig (2008) notes—with relevance to this research—that if “we want to find out how ordinary people construct meaning in relation to a particular topic ... we can work with the transcripts of semi-structured interviews” (p. 114).

The use of research interviews, in this case, was also a pragmatic decision in that I considered it unlikely that the population I was researching would have the time available or indeed the motivation to engage in research strategies that required a great(er) commitment on their behalf, such as keeping diaries of the actions taken to fulfil their duties. Further, this research commenced in late 2020 during the first year of the Corona Virus Disease (COVID-19) pandemic in New Zealand and was impacted by subsequent restrictions on travel and closure of workplaces; therefore, fieldwork or in-person observations were not a feasible option. Finally, “naturalistic” observations of officers conducting

their duties would also be very difficult because the duties are not carried out in a circumscribed or easily defined time or place.

4.4.1.2 Other sources of texts

Gibbs (2018) describes a corpus as consisting of “a wide range of documents alongside any interview or observational data you have collected” (p. 98) from which the researcher selects key examples, “either because they are typical, or because they constitute key cases and types of discourse within the topic you are investigating” (p. 98). Consistent with this perspective, as an addition to the interviews conducted with company officers, I also gathered other texts that related to the object of study and which I considered provided insights into the discursive construction of the officers’ duties as they relate to psychosocial risks at work. In this way, these texts were not core units of analysis but are provided to illustrate typical examples of themes or issues from the wider, but related, legal field. The collection of other texts was, in many cases, opportunistic, and not the result of a systematic search or formal process such as the interviews. They included various publicly available texts (N=13) where New Zealand officers or experts wrote or spoke about psychosocial risks or the due diligence duties, including relevant case studies, opinions, and written sources of guidance relevant to officers, and relating to legal duties with respect to mental health at work. These texts are directly referenced throughout the findings where they provide typical examples of the discursive features being discussed.

4.4.2 SAMPLE DESIGN

The inclusion criteria for participants for interviews and other texts was in the first instance based on the inclusion criteria for those holding responsibilities as officers in the HSWA. Participants had to be considered officers in terms of the HSWA, as did the intended audience of other texts included in the corpus. The definition of an “officer” was considered in the literature review in section 2.5.2.

Therefore, to ensure that the sample of interview participants was comprised of those for whom there was no doubt that the officers’ duties applied, the sample focused on the roles of company directors

and CEOs; however, it also included several other participants who fell outside of these roles but who identified themselves as fitting within the scope of the definition of an officer provided in the Act.

The sample was further refined by narrowing the focus to people holding these roles within large companies. The reason for this was that smaller businesses often have less capacity and capabilities when it comes to health and safety compliance (Bluff, 2017b, 2019; Lamm & Walters, 2004). Thus, amongst that population of officers of smaller businesses, I considered that there might not be the “threshold level of awareness of regulations” (Winter & May, 2001, p. 680) required to have formed a view of what might constitute compliance. Therefore, to obtain a purposive sample, I limited the focus to officers of companies with more than 50 employees. The focus on officers of large companies is also justified noting that larger companies have bearing on smaller companies’ WHS responses, whether through the supply chain and subcontracting (Lamm, 2000; Walters et al. 2024), or through various forms of isomorphic influence (DiMaggio & Powell, 1991; Alvesson, 2022). Companies fitting these parameters are significant employers of New Zealand workers, with 58% of New Zealand employees working in organisations of 50 employees or more (Stats NZ, 2020).

At the outset of the research, I identified that it was possible that the legal duty focused on in this research may not have a high degree of saliency with many officers of New Zealand companies. I suspected that, as a result of my literature review, knowledge of the field, and pilot interview, many company directors may not consciously, specifically, or intentionally exercise due diligence on psychosocial risks and, therefore, would not have much experience from which to reflect upon or discuss at an interview. Thus, in order to obtain an “information-rich” (Patton, 2015, p. 264) sample, I sought a purposive, criterion-based self-selected sample, also known as a purposeful (Lincoln & Guba, 1985) or theoretical (Glaser & Strauss, 1967) sample. That is, participants were (self-) “selected by virtue of their capacity to provide richly-textured information, relevant to the phenomenon under investigation” (Vasileiou et al., 2018, p. 2). This decision is also relevant to Fairclough’s (1992) suggestion that when establishing a collection of texts on which to perform analysis, that the sample should “yield as much insight as possible into the contribution of discourse to the social practice under scrutiny” (p. 230). Accordingly, the participants in this research are not considered, nor

intended, to be in any way a representative sample of officers in large New Zealand companies. Rather, the participants' interviews are considered in the way they may offer perspectives and experiences of a highly selected group of influential people involved in the exercise of the legal duties in question, which provide insights into the discourse(s) used in complying with these duties.

In order to recruit participants who met the aforementioned criteria, I created participant recruitment information, calling for company directors who considered that they had a special interest or expertise in governance responsibilities concerning workers' mental health as they related to legislative compliance with the HSWA. In terms of my positionality, although I have held previous roles as a company officer in both large and small organisations, I considered myself an outsider to this community (Agar, 1996) in that I do not hold a current role as an officer of a company employing or directing workers. Additionally, I am not a member of any group, institute, or organisation whose membership predominately comprises the intended research group. As a consequence of my outsidership, I was unsure how officers, even those holding a degree of interest or expertise in psychosocial risk management, spoke about this topic and what terminology they used, and this presented a challenge in both recruitment and interviews.

As noted in the literature review at sections 3.5.1 and 3.5.2, there is considerable ambiguity, inconsistent terminology, and lack of specificity in the language relating to psychosocial risk management. This provided a challenge in the wording of participant recruitment information. In New Zealand, while the HSWA uses the term "mental health" (in defining health at s 16 as "both physical and mental"), it does not use the term "psychosocial risk management" to refer to the process by which risks to mental health may be managed under a health and safety framework. Similarly, the Act does not mention "wellbeing", yet this term is prevalent across the grey literature in New Zealand relating to the management of psychosocial risk at work. Careful crafting of participant information ultimately emphasised that I was interested in the management of risks to mental health at work as required by the Health and Safety at Work Act, with particular interest in the officers' duties of due diligence. The Participant Information Sheet is included in Appendix A.

I considered whether taking an industry-specific approach would provide any benefit for this research. In particular, I wondered whether I might obtain a more informed sample if I focused on industries where health, specifically mental health, was likely to be the most salient work health and safety risk and therefore not overlooked or surpassed by safety risks. However, I decided against this based on several factors. First, industries where there are critical risks to worker safety also face psychosocial risks—often very significant ones. Second, officers, particularly independent directors, often sit on multiple boards spanning multiple industries, so it would be difficult to isolate their conceptualisations of the legislation to companies sitting within a specific industry. Further, the HSWA applies to all New Zealand workplaces, with the only differences in regulation being in the administering regulatory agency, with WorkSafe holding the mandate for land-based PCBUs, Maritime New Zealand for sea-based ones, and the Civil Aviation Authority for the air-based PCBUs.

With regard to a predetermination of an appropriate sample size, there are many different perspectives of the matter of ‘how many is enough’ in qualitative research, and the question remains a topic of debate (Braun & Clark, 2017, 2021; Tight, 2023). However, the volume of qualitative interviews in research taking a purposive sample should not be judged by quantitative criteria, as such data does not claim to establish credibility based on probability (Braun & Clark, 2021). Braun and Clark (2021) highlight that in qualitative thematic analysis, because meaning is generated from data, not “excavated” from it, judgements of “how much is enough” can never be made based on numbers alone, and thus such research instead prioritises reflexivity and theoretical sensitivity. The determination of adequacy is discussed later in this chapter at 4.4.6.4.

4.4.3 RESEARCH ETHICS

Having discussed the proposed research project and questions with my supervisors, I made a full ethics application prior to undertaking interviews. The key ethical consideration of the research was privacy and anonymity of the participants, particularly as they related to:

- The potential disclosure of commercially sensitive company information;
- The potential disclosure of illegalities; and

- The handling of personal information.

Full ethical approval was obtained (reference NOR 21/86). Participants were provided with information prior to gaining their consent to be interviewed. The Participant Consent Form is included in Appendix B and Ethics Approval in Appendix C.

4.4.4 INTERVIEW CONSIDERATIONS

4.4.4.1 Pilot interviews

A pilot interview was conducted with the aim to check the type of language and terminology used by officers, the salience of the topic amongst officers, and to inform what level of expertise I might expect from participants. These considerations influenced the composition of the research interview questions and format of the interviews. For this purpose, I identified an experienced company officer with whom I could discuss these matters. This person was identified through professional contacts and was a professional company director of more than ten years, sitting on boards of both listed (on the New Zealand Stock Exchange) and non-listed companies, and who held several chair positions.

At the pilot interview I outlined my general approach to the topic and what I hoped to explore with the research. Specifically, I asked questions relating to the terminology that was used at the board level to conceptualise and discuss psychosocial risks, the degree of salience that these topics had at the board level, the types of conversations in which they were discussed, and where this topic fitted in with other matters or risks that the board may be considering. I also asked questions from a draft interview schedule to test and check the logic and pitch of the interview and for possible redundancies in questioning (Seidman, 2019).

Following the pilot interview, it was clear that I had too many questions; therefore, I made significant edits to the interview questions. Further findings from this interview suggested that the term “psychosocial” may not be meaningful for many participants, and that “psychosocial risk management” was not a salient phrase at the board level. However, the issue of worker mental health was a nascent issue but often one that presented in contexts other than health and safety, for example,

as it related to other organisational risks, such as retention, recruitment, and in presenting the company as a good place to work. I also met with three further field experts who were not officers but whose roles involved working with company officers in a health and safety context. These discussions contributed to the formation and refinement of research questions.

4.4.4.2 Recruiting and interviewing “elites”

Having observed the challenges of peers and colleagues in recruiting research participants for their PhD research, I had concerns that I might struggle to recruit officers to participate in this research. The reasons for this included that, first, business elites²² are known as a hard-to-reach population (Goldman & Swayze, 2012; Harvey, 2010; Ma et al., 2021), and second, I considered that there would be a very limited number of people meeting the inclusion criteria in terms of both job role as well as knowledge and experience on the topic.

McDowell (1998) attributes the successful recruitment of participants to serendipity, social networks, and particular circumstances. Although it was not easy to recruit research participants, three strategies and fortuitous circumstances enabled me to connect with interview participants. First, I believe that the likelihood of participants agreeing to be researched was improved by the fact that mental health at work is currently somewhat of a “trending” topic in New Zealand. Accordingly, many senior businesspeople wish to be seen as active and informed in this area, and this went in my favour with many agreeing to be interviewed on what was described by several as being an “important topic”. Indeed, as Ma et al. (2021) note, this population of research participants are “involved in impression management” (p. 2), and, in this sense, I may have been favoured by a social desirability bias to participate in research on this topic. Second, Harvey (2010) observes that “the academic discipline of researchers will also affect their experiences of gaining access to elite members” (p. 200). In this sense, I believe it was fortuitous that I am a PhD candidate in management within a business school as

²² Business elites are somewhat ill-defined in the articles on research methods mentioned in this paragraph, however (Harvey, 2010) suggests that “business elites” include those who occupy “senior management positions and were influential decision makers for their companies” (p. 196) and Ma et al. (2021) note that “the so-called business elite ... typically includes CEOs, top managers, and boards of directors” (p. 1). The roles of officer participants in this research, as defined at section 2.5.2, align with these inclusions.

this may have been seen as more relevant to the world in which participants operate than other disciplines in which this topic could potentially sit, such as public or occupational health, regulatory studies, or psychology.

Finally, I used three concurrent strategies for participant recruitment to improve my chances of connecting with participants. First, the research participant in the pilot interview provided, at my request, a list of names and personal email addresses of fellow directors whom they considered would offer an informed perspective, of which many resulted in an interview. Second, I worked with two membership-based organisations that I considered would be best able to identify and help recruit participants with interest and experience in the research topic, and, through their contacts, I recruited further participants. Later in the interviewing phase, a further three participants were recruited via personal contacts and a snowballing effect. The third and final participant recruitment strategy that I used a public call for participants to self-select and contact me if they wished to participate. This was carried out by way of an article in an online newsletter of one the aforementioned membership organisations. I drafted an article regarding the topic of the research and outlined the call for participants. The article was amended by the organisation and published online in their monthly newsletter. Unfortunately, this placement did not result in any contact from potential participants. Ultimately, the 24 research participants can be collectively described as officers of mostly well-known, large New Zealand companies, government agencies, or nongovernment and not-for-profit organisations. The protection of participants' confidentiality precludes further elaboration of the sample.

Siedman (2019) considers the situations where it is appropriate or necessary to seek permission from a research participant's employer prior to approaching them for recruitment. He suggests that it is likely required where the focus of the research is the operations within a particular organisation or when participation is sought on behalf of an organisation. For this research, I did not consider it necessary to seek the permission of the organisation for which the participant worked, given the high degree of autonomy and agency of the intended research participants in their positions as directors and senior-

most executives of companies. Further, I was not seeking interviews with participants based on their alignment to any particular company but because of their positions as officers per se.

Another challenge at interview related to the navigation of the labile power differential between me as the interviewer and the “elite” research participants because of the inversion of traditional roles. A researcher, by way of being the one asking the questions, exercises considerable authority, but, in this case, the participants, as business elites, are used to being the ones exercising authority over others (Harvey, 2010; Ma et al., 2021). This inversion was particularly salient in this case, given that I was asking essentially about how the person complies with a legal duty where the interviewee may fear reputational or legal risks if perceived as being noncompliant or having performed an illegality (van Rooij & Rorie, 2022). With this topic, in New Zealand at least, and as noted in the literature review, there is no established jurisprudence, code of practice, or widely recognised best practice. As a result, participants were usually careful not to overclaim expertise, often explaining that this was a “new” and “unknown” area, or one characterised by a sense of ambiguity and greyness, and even deferred to my assumed expertise. I found that many interviewees, while able to talk about what they did to comply with their legal duties, sometimes pointed to uncertainty about their knowledge of the topic. In this respect, for some interviews, where it became apparent that the interviewee did not have good knowledge of this topic, I found myself having to reformulate the question or adopt a slightly encouraging and naïve role to preserve the traditional power dynamic of the company officer as the wielder of authority and knowledge.

Once I had established contact with a potential participant, I always assumed that research participants would be time poor with many competing priorities. Therefore, I tried to make the process of recruitment, consent, and interviewing as convenient as possible. For example, I digitised consent forms so they did not need printing and could accept electronic signatures, liaised with personal or executive assistants where available and appropriate (for example, to follow up consent forms and schedule interview times) instead of directly with participants, and avoided sending extraneous emails. Time management was very explicit in interactions with participants: interviews were offered at times suggested by the participant, and, for the most part, were conducted via a videoconference

scheduled by me. This characteristic of online interviews, with greater determination by the interviewee for participating at a time and in a space of their choosing, has been observed as a clear benefit of the medium (Pocock et al., 2021). Most interviewees participated in online interviews from their home office (as did I), a situation which may not have been as likely had interviews been conducted face to face. Interview slots were very often booked weeks, even months, in advance to fit in with participants' schedules. The interviews were scheduled for one hour, and, throughout the interview, the meeting timer was visible to both the interviewer and interviewee.

4.4.4.3 Interview media

Although research has been conducted via online or virtual means for some time, the COVID-19 pandemic forced many researchers to turn to this method of interview out of necessity (Lobe et al., 2022; Oates et al., 2022). Several authors have suggested potential limitations of online qualitative research techniques (Oates et al., 2022; Pocock et al., 2021), including that the quality of the interview may be negatively impacted through a lack of rapport, and because online methods devoid the researcher of the opportunity to reflect on the context and setting of the interview. Online methods may also limit participation from those without access to appropriate technology or low digital literacy, and online methods may limit the capture of nonverbal communication, such as body language. However, empirical research has challenged, if not rejected, many of these critiques (Lobe et al., 2022; Oates et al., 2022). Others have emphasised that the decision to use online interviewing techniques should be considered in terms of the methodological consistency and coherence with other design decisions, including the acceptability and accessibility of the medium for research participants (Braun et al., 2017).

In terms of the research participants for this study, I considered online interviews an appropriate way by which to conduct interviews. Conducting interviews via videoconference contributed to a business-like meeting environment, with generally only minimal small talk engaged in at the outset of the interview. In this sense, it might be presumed that this impacted on the establishment of rapport with participants; however, some considerations warrant mentioning. In terms of the participant feeling comfortable in the interview, this cohort of participants were mainly senior business executives in

large organisations employing, in some cases, thousands of people, or were directors of multiple large companies. I therefore considered it reasonable to expect that all these people had a high degree of computer literacy, access to sound videoconferencing technology, experience in communicating using video conferencing software and hardware, and enough involvement in participating in dyadic interactions online to be able to participate in an interview confidently and competently. Indeed, throughout the interviews, many participants mentioned that this way of working having become embedded in the organisations they work for or with, and I did not perceive any technical or social difficulties for participants in using the online medium. I designed the interview specifically so that the first few questions were general, easy-to-answer questions that were interesting for the participant to answer and that contributed to building rapport and compensated for the limited small talk at the outset of the interview.

Several other factors impacted my decision to use, where possible, online interviews. First, the period of time during which I conducted interviews coincided with varying degrees of restrictions to movement under New Zealand's COVID-19 response framework. In this context, working from home, communicating by videoconference, and corresponding by electronic means had become commonplace. Even where movement was not restricted, for some organisations working from home and not interacting on a face-to-face basis was current policy. Second, I live in a rural area, and it was not feasible, cost- or timewise, for me to conduct all interviews in person. Face-to-face interviews were offered where participants resided in the same region as I live, but, in all but one instance, participants elected an online interview.

4.4.4.4 Interview questions

The structure of the interview was based around 13 questions reproduced in Appendix D. Questions one to four queried participants' general views, experiences, and opinions of the due diligence duties and the officers' role. Questions five to twelve explored the participants' experiences of performing due diligence and was based on the steps outlined at s 44(4)a-e of the HSWA (see section 2.5.3). A final question explored officers views of the role of New Zealand WHS regulator.. Following the first interview, I made minor amendments to the ordering of questions, and the interview question schedule

remained unchanged after that. However, given that the interviews were conducted in a semistructured style, impromptu questions were often added to clarify or explore matters raised at interview, or to pursue matters which the participants wished to discuss in more depth. The interview questions are reproduced in Appendix D.

4.4.4.5 Conducting the interviews

The 24 interviews were conducted during the period from March to November 2022. All but two interviews were conducted via videoconference, with one interview conducted in person and one participant providing a written response. Online interviews were conducted on either Zoom or Microsoft Teams, and participant consent forms were obtained and stored electronically prior to each interview. All interview participants provided consent for the interview to be recorded, and 13 participants requested and received a transcript of the interview for approval.

I began each interview with an introduction, brief summary of the research, participant rights, and confirmation of the preferences indicated by the participant in their Participant Consent Forms regarding the recording of the interview and provision of an interview transcript to review and approve. Interviews commenced with an assurance that I was not interested in finding out *whether* officers were compliant in their duties or not, but, rather, that I was interested in exploring the ideas that officers had around what compliance with these duties entailed. This introductory point was important to assure participants that I was not judging the legality or illegality of their responses.

4.4.5 FURTHER TEXTS

As mentioned at section 4.4.1.2, I also collected texts from a variety of other sources through the course of the research. The inclusion criteria for these texts were that I could reasonably judge that the intended audience was company officers or that the author was speaking from their position as a company officer, that they referenced mental health at work, and that they referred or suggested attention to legal obligations relating to work health and safety. Some of these texts were identified by research participants themselves as sources of information that they referenced to guide their exercise of due diligence, and others were found opportunistically during this research. This collection of texts

did not aim to constitute an effort to establish a complete archive of all public texts relating to the topic of research, and, indeed, as described in section 4.4.1, that is not the aim of discourse analysis. Nevertheless, I believe it may be a reasonably comprehensive sample of discourse in this area for the following reasons:

1. The time span in which texts about the role of company officers and mental health and work, and the relationship to these issues as they pertain to New Zealand's HSWA, has a limited time span. The Act was enacted in 2015, meaning there was only a period of seven years, at time of interviewing, in which this topic may specifically be spoken of.
2. As the literature review pointed out, there is not a lot of grey material that has been produced on company officers' roles, influence, and responsibilities as they pertain to mental health at work. Most government or industry materials focus on mental health at work in a general context or do not consider a regulatory perspective.
3. New Zealand is a small country with one main health and safety regulator, and only several other key organisations that are active in the fields of governance and health and safety. This meant that there were limited avenues to explore.

4.4.6 DATA ANALYSIS

As noted at section 4.2.3 the idea of “doing” Foucauldian discourse analysis can be misleading as Foucault never outlined a particular methodological framework for conducting analysis. Indeed, many researchers who take a Foucauldian perspective are careful to avoid claims to a particular method, instead referring to an approach informed by Foucauldian principles that underpin the way in which their research is framed and conducted, and by which data is thought about and analysed (Arribas-Ayllon & Walkerdine, 2017; Nicholls, 2009; Willig, 2008). Accordingly, I used Foucauldian methodological principles identified by a number of discourse analysts, primarily Willig (2008, 2015), Parker (1992), and Arribas-Ayllon and Walkerdine (2017). These will be outlined further in the following sections.

4.4.6.1 Transcription

Gibbs and Flick (2018) describe the act of transcription as a transformation of the data, and the relationship of the transformed product to the original diverges depending on the purpose of the study and methodological choices of the researcher. These choices reconstruct the data in a way that cannot claim to represent the reality of the original but instead aim to “produce an accurate record of what was said ‘in the words that were used’” (Hammersley, 2020 p. 376). Transcription techniques, or the choices made by transcribers, range on a continuum from naturalism to denaturalism (Oliver et al., 2005). In this case, and on the basis of Gibbs and Flick’s (2018), Oliver et al.’s (2005), and Hammersley’s (2020) suggestions, the transcriptions were denaturalised so the focus could be placed on content and meaning rather than on the details and intricacies of the mechanics of conversation.

Where interviews were conducted via videoconference, full transcripts were initially generated by Zoom or Microsoft Teams transcription features. However, due to the poor quality of these transcriptions, I went through each recording and transcripts line by line, making corrections where needed. For the final three interviews, I transcribed each one manually and, being a reasonably quick touch-typist, I found it took approximately as much time producing the whole transcript as it did to correct the automated versions. To preserve the anonymity of participants and their organisations, I removed any material which might reasonably identify an individual or a company. Examples of such identifying material included any personal and company names, particular situations (such as situations that had received media coverage), and any other information that a participant specifically asked to be excluded from the transcript—this happened on several occasions where a participant mentioned specific incidents that had occurred within their organisation. Participant names were replaced with an alpha-numeric code. Transcriptions were uploaded into NVivo and linked to the audio/audiovisual file to enable me to come back to the original interview in order to check text against the recording, if required.

4.4.6.2 Coding

I started the process of coding after I had completed 16 interviews. With qualitative approaches, unlike quantitative ones, analysis need not be delayed until all the data is gathered. Prior to beginning

coding, I created a list of prompts, ideas, and reminders to “prime” or “frame” my thinking when coding the transcripts because, as a novice discourse analyst, the major challenge was to keep my thinking in terms of principles of discourse analysis. By this, I mean keeping focused not only on what is being described through discourse but also being focused on what the discourse was *doing*. As Willig (2014) points out,

It is important to bear in mind that discourse analysis is not so much a recipe as a perspective from which to approach a text. It is a perspective on language which allows the researcher to produce a particular kind of reading of a text, a reading which foregrounds the constructive and performative properties of language. (p. 344)

Thus, to keep my coding focussed on “a particular kind of reading of a text”, I kept a list of prompts beside my laptop. This list included my research questions and Willig’s (2008) Procedural Guidelines for the Analysis of Discourse, with my contextualised notes beside them. These “prompts” formed the basis of many analytic memos (see 4.4.6.3) as I worked through the coding process. The list is reproduced in a table in Appendix E.

Alongside these prompts, I developed a specific coding strategy to give structure and focus to the process. Bringing together the coding strategies that Saldaña (2021) identified as appropriate for discourse analysis and drawing on Reynold’s (2019) coding strategy for critical discourse analysis, which, incidentally, also draws on Saldaña’s work, I assembled a framework for multiple coding rounds (see Table 7).

Table 7

Coding Rounds

Coding round	Coding type	Description (Saldaña, 2021), with examples taken from interviews.
First	Attribute coding	Coding for job role, organisation type, size, etc.
Second	Holistic coding, descriptive coding	Holistic: Assigns a code to a large section of text, e.g., “resourcing” or “compliance”

Coding round	Coding type	Description (Saldaña, 2021), with examples taken from interviews.
		Description: Assigns a code to a smaller unit of a text or a particular topic e.g., “stress”, “risk”, “wellbeing”, “engagement”
Third	Values coding and versus coding.	<p>Values (which included values, attitudes, and beliefs): <i>Values</i> being the importance placed on something (e.g., a critical risk); <i>attitudes</i> being the way in which person, organisation, thing, or idea was spoken about (e.g., sceptical, critical); <i>beliefs</i> included a system of assumptions, biases, morals, and other interpretative perceptions (e.g., “bullying easy to manage”). Metaphors and stories were also included in here.</p> <p>Versus: A code to designate where something is spoken about in terms of its relationship or comparison to another thing (e.g., home vs work, legal vs illegal, our organisation vs other organisations).</p>

The first cycle was very brief—there, I coded for attributes such as company type (e.g., not for profit, government, private, listed, etc.), company size, and officer role(s) (e.g., chief executive, director, trustee, etc.). With regard to the second cycle of holistic and descriptive coding, Saldaña (2021) recommends that holistic codes (also called macrolevel coding) should be generated from the texts/data themselves. As a variation to this recommendation, I had already generated a small list of holistic codes as a result of memos and notes made during and after interviews as it was here that I had already started noticing themes, commonalities, and patterns. In this way, these codes were based solely on the transcripts, not *a priori* concepts, and could still therefore be considered characteristic of an inductive coding process. The third coding cycle involved values and versus coding, which included coding the values, attitudes, and beliefs that participants explicitly stated or implied in their statements as well as literary formations used to express these values/beliefs/attitudes, such as metaphors or stories, and, finally, versus coding, which identified dichotomies or binary statements.

The way this coding framework is described implies a linear, consecutive process, which did not represent the reality of the coding process. As I generated codes in latter interviews, I returned to

earlier interviews to check if there was similar text in those interviews that I should include within the text captured by the latterly generated code. This was often done using the multiple key word searches and rereading to check that those key words were used in a similar way. This sometimes meant recoding earlier phrases to a different code, or renaming, splitting, or merging codes. In this way, the process is better described as iterative rather than linear. Similarly, codes were renamed, split, merged, and redefined throughout the entire coding and analysis process. As further interviews were completed, the coding process was repeated.

4.4.6.3 Memos

Throughout all these research steps, I recorded analytical memos as a practical project management tool to keep track of thoughts, actions, and ideas. For example, I wrote memos to remind me which interviews I needed to revisit or recode and as a tool for reflexive analysis of academic, personal, and ethical observations, thoughts, and dilemmas. Memos were initially recorded both on paper and in word documents, which I later transcribed into NVivo, and, during coding, I recorded memos directly into NVivo. Memos ranged from a single sentence through to many pages of notes and diagrams. Using Saldaña's (2021) observations regarding potential opportunities for memo writing as a prompt, I recorded most analytical memos at the following times:

1. Following interviews: A memo was written following nearly every interview. In these memos, I transcribed and added to notes I had taken during the interview. They included immediate observations, thoughts, and reflections—both professional/academic and personal (e.g. what was intriguing, surprising, confusing, or disturbing), ideas, patterns, similarities and differences with other interviews, tropes, and commonly used words, ideas, or concepts.
2. During transcription: Transcribing the interviews provided an opportunity to revisit what was said in detail, and I added to the interview memos I had already made as well as creating further memos, including memos about possible codes.
3. During coding: Coding enabled an even closer reading of the interviews and, thus, led to memos regarding the generation of codes (though codes were defined and refined within the coding properties fields in NVivo), possible analytical themes, categories and patterns,

memos relating to theories, personal and ethical considerations, and so on. In this sense, the content of the memos highlights that coding, rather than simply a practical task, was very much an analytical stage.

4. During analysis: I created new memos and added to extant ones through the process of analysis and essentially used memos as the mechanism by which, over time, I generated findings, themes, and discussion points.

4.4.6.4 Data synthesis

Qualitative data has been described as “voluminous, messy, unwieldy and discursive” (Spencer et al., 2003, p. 202) and managing and analysing it, “overwhelming” (Miles, 1979, p. 590). This certainly reflected my feeling toward the mass of information I assembled in NVivo. Data reduction is a key element of qualitative analysis and “refers to the process of selecting, focusing, simplifying, abstracting and transforming the data that appear in written up field notes or transcriptions” (Miles & Huberman, 1994, p. 10) and “is a form of preliminary analysis, which refines, iterates, and revises frameworks, suggests new leads for further data collection, and makes data more available for final assembly” (Miles, 1979, p. 594). Miles and Huberman (1994) note, as was my experience, that data reduction, in reality, occurs continuously throughout the research process as in even the design phases of research, the researcher makes analytic choices that will exclude and limit the data, not to mention similar decisions applied in transcription, coding, development of themes, and so on.

Using the conceptualisation of an analytic hierarchy (Spencer et al., 2003), the data synthesis stage of this research involved a nonlinear, iterative process of further code development and refinement, summarising, synthesising, identifying patterns, and considering theory and literature. To assist with this process, I employed Framework Analysis (also known simply as “Framework”), a technique within the broader family of the qualitative methods of thematic analysis or qualitative content analysis (Gale et al., 2013). Developed as a tool to help with evidence-based policy making (Ritchie & Spencer, 1994), it is more accurately a data management technique than an analytical approach. The relatively prescriptive, step-by-step technique uses a matrix format, which enables a researcher to systematically organise and, thus, analyse data by research participant and theme. NVivo, the

software that I used for data coding, has an in-built functionality that performed some of the practical steps in framework analysis by way of populating matrices based on those codes and cases (interviews) that I selected.

In congruence with the epistemological position outlined at 4.2.1 and in accordance with the discussion on research quality at 4.3, the analytical process outlined above, including further interviews, was conducted until I judged that adequate, rich information had been gathered from which I could produce coherent, evidenced, interpretive insights (Braun & Clark, 2021).

4.5 CONCLUSION

This chapter outlined the methodological framework that I took in this research to address the three research questions. The research was primarily based on discourse analysis of transcripts of participant interviews, but also drew from various pertinent texts relating to the officers' duties and psychosocial risk, such as case studies and expert advice. The inductive approach of this research allowed for the possibility of novel insights and interpretations. For example, at the outset of this research, it was not my intention to focus explicitly on constructions of risk. However, as the study progressed, it became evident to me that the analysis of the discourse of risk relating to the officers' duties was an insightful interpretive concept to explore in greater depth. The following Chapters 5 to 8 present the findings of the research that I have outlined in this Chapter 4, with discussion incorporated into each chapter.

5. THE EXERCISE OF DUE DILIGENCE

This Chapter 5 is the first of four chapters that present and discuss the findings of this research. In this chapter and the next, I focus on answering the first research question:

How do officers conceptualise, express, and carry out their duties under the Health and Safety at Work Act with specific regard to psychosocial risk?

The first part of the chapter in sections 5.1 to 5.6 provides an overall summary of the findings relating to the ways in which officers described the performance of their duties, with particular attention to the systems, processes, tools, or frameworks that they used. In doing so, this first part of the chapter is structured around the six inclusions of due diligence in the HSWA in section 44(4), which were described at Section 2.5.3 of the literature review. Following this summary of findings, in section 5.7 I will discuss several key themes, followed by a conclusion in section 5.8.

5.1 ACQUIRE KNOWLEDGE

The first inclusion of due diligence in s 44(4)(a) (see section 2.5.3) requires officers to take reasonable steps to acquire, and keep up to date, knowledge of work health and safety matters. The purpose of this inclusion is to set the context for the fulfilment of the due diligence duties by ensuring that, fundamentally, officers have a working knowledge of “the tools and principles” (Tooma, 2017, p. 31) of WHS required to fulfil their duty. The need for officers to be competent, to have “a clear understanding” (Boardman & Lyon, 2006, p. 26) of key work-related health and safety issues, and to be “continually developing their skills and knowledge” (p. 26) in WHS has been highlighted as best practice. In much the same way that a company director would be expected to be financially literate to an extent that they are able to interpret and critique financial information, so should they have enough knowledge and understanding of WHS to be able to provide oversight and critical evaluation of the organisation’s health and safety situation (Johnstone & Tooma, 2012, 2022). The importance of having such knowledge and understanding was highlighted in a recent large-scale study, which found a higher standard of WHS systems in those organisations where the senior management had undertaken specific WHS training (Dahl et al., 2022).

The duty to gain knowledge therefore provides a foundation for officers to successfully fulfil the subsequent elements of their duties; if officers lack an understanding of WHS matters, then they will also lack the ability to critically evaluate systems of work and to ask the right questions when fulfilling the remainder of their duties. Thus, while the Act does not suggest how much knowledge should be gained, officers “should obtain enough health and safety knowledge to ask the right questions of the right people and to obtain credible information” (Institute of Directors & WorkSafe, 2016, p. 11). Noting that WHS and the law regulating it is rooted in the practice of risk management, Tooma (2017) asserts that this inclusion to the duties of officers should also entail that they gain an understanding of the principles of risk management. Despite the importance of this knowledge in underpinning their duties, participant P17 observed that “Most directors, unless you have a director that’s got direct experience from, ah, an executive role, come into director roles around this obligation quite naive and very reliant and trusting of the chief executive or the chair.”

Additionally, the Act does not suggest from which sources officers should seek or obtain information and knowledge about WHS matters. Consequently, participants reported seeking knowledge and information from a very wide range of places. More commonly mentioned sources included: other officers, the Institute of Directors, the Business Leaders’ Health and Safety Forum, management consultancy firms, law firms, nongovernmental organisations (NGOs), and, to a lesser extent, private mental health, health and safety, or wellbeing service providers and consultants. Participants who were members of particular governance groups tended to cite information produced by those groups, however, these sources were generally not referenced by those participants who were not connected to those specific groups, suggesting that, overall, there was a distinct lack of consistency in terms of where participants obtained knowledge. Further, although Tooma (2017) suggests that this duty should entail a systematic process where officers’ particular training needs are assessed, fulfilled, and updated on an ongoing basis, particularly as new information (that is, laws, guidance, authoritative publications) become available, no officer in this study described such a process.

Many participants cited other company officers as a source of information with whom they would “typically compare notes on because it’s relatively new and people are doing things differently” (P04),

highlighting the socially constructed nature of knowledge around compliance. This “comparing of notes” occurred informally as well as formally through events and networks of senior executives:

I'm good at networking, I meet with a lot of other business leaders all the time. We talk about the issues, we are talking about what they're doing, what I'm doing, how we're responding and reacting to these things, and I find that really helpful as well. You get some great ideas around what other people are doing. (P07)

However, others expressed that the idea of mental health as a topic within the scope of their duties under the HSWA was new and was one with which they and other officers had not yet fully engaged. Accordingly, P16 felt that they approached their duty to acquire knowledge on this topic with “a bit of a light touch.”

A number of participants (P02, P05, P17, P18, P19) cited management consulting firms, such as Deloitte, Boston Consulting Group, Ernst and Young (EY), PwC, McKinsey, and KPMG, and magazine publications, such as the *Harvard Business Review*, as sources of health and safety information. However, some participants noted that these sources were better thought of as a general source of governance information within which, “from time to time, you get health and safety topics” (P02). Having referenced several North American management consulting firms as a source of information, I asked P19 if they felt there were adequate sources of information specifically for New Zealand officers to fulfil their duties as they applied to mental health. They responded: “Well, I'm not aware of any [New Zealand-specific] information. That's either because I haven't looked for it, or it doesn't exist, or, if it exists, it's not well publicised.”

Another participant expressed a lack of awareness of specific guidance:

But I don't ... Yeah, I look, I don't recall seeing. And it might well be out there, but I haven't seen it. You know, some quite definitive sort of type discussion or written material or whatever around, you know, where does mental health start? What are our duties and responsibilities? How do we measure this thing? You know, what are the outcomes? [...] I

don't know. I don't know. Maybe that's because I haven't done enough work, I'm not sure.

(P20)

One participant felt that in terms of information, “there’s plenty of support out there” (P24), however, another felt that while “there’s quite a lot [of information] out there ... it’s a bit random” (P16).

Conspicuously absent as a source from which participants drew information, guidance, or gained knowledge was the regulator, WorkSafe. Only two participants mentioned the regulator as a source of WHS knowledge to which they turned to for information to fulfil this duty.

5.2 GAIN UNDERSTANDING

The second inclusion of due diligence in s 44(4)(b) (see section 2.5.3) requires officers to take reasonable steps to gain an understanding of the nature of operations of the PCBU and generally of the hazards and risks associated with those operations. This element of the duties has been interpreted by some to mean that officers should gain first-hand knowledge, which “allows an officer to discern and interpret the data presented to them through health and safety reports such as incident statistics or audit reports” (Johnstone & Tooma, 2012, p. 113).

In the small amount of guidance and literature available on the officers’ duty of due diligence, emphasis is often placed on developing and acquiring such knowledge through visiting workplaces, undertaking safety observations, or gathering insights directly from workers (Institute of Directors & WorkSafe, 2016; Johnstone & Tooma, 2012, 2022; Tooma, 2017). Consistent with this emphasis, these were also the common actions described by participants in their execution of this element. For example, some participants described spending time with workers whilst those workers undertook their usual work: “I’m going to be going along with him to shoot the breeze, see what he does, understand a bit more about that kind of work” (P03). Similarly, for P24, their focus was on understanding the content and context of the work that workers carried out:

They [officers] go to their offices and have a morning tea and go out [redacted] and go and engage at the front line where the mahi [work] is being done. [...] And then they go and say,

“How's it going? Have you got the right car? What's the equipment? How's your workload and what's the atmosphere like in the office? What do you think of [redacted, name of CE]”?
What do you think of ... whatever. So that's how we do it.

Similarly, P19 described how they

do a lot of walking around, talking to individuals to understand. I'll look. So, I'll sit [redacted] and I'll watch the staff there [redacted] and what they're doing, and I'll look again to see patterns. Have they changed their whole way of being from the last time I was [redacted] there? I'll go to the local [redacted] store and my [redacted] gets annoyed with me because I spend most of my time out in the yard watching the forklifts driving and having a look.

Likewise, P10 explained that in terms of this element of due diligence, “my responsibility as a director was, before I joined the company, was to go and see those sites to have a look at what we did and familiarise myself with what I thought the key risks in the business were.” One participant described a systematic process where the information and insights that each officer gleaned from their regular site visits was collated and shared with other officers.

Notwithstanding the popularity of the safety observation or “walkabout”, some participants expressed ambiguity regarding its value. While some felt that walkabouts did give them an understanding of operations, they were limited in providing a means by which officers could understand risks and, in particular, psychosocial risks. For example, P23 felt that

the health and safety stuff has got a little bit check box, so all, you know, so the Institute of Directors says you know, there's a checklist, and the Institute of Directors says you should do a walkaround so we should make sure we do some walkarounds. But is it fundamentally helping me to assess risk? Urgh, I would have reservations about whether it is. So then when I think about mental health, I think, oh I don't know, I mean, it probably doesn't take much to put out an all-points bulletin and say, the board are doing a walkaround this afternoon so smile and wave!

Similarly, P11 suggested that sometimes talking to workers during walkabouts did not give a full understanding of risks arising from operations, and multiple sources of information were required to gain a more comprehensive understanding:

People will always say you know, “No, no it's all good, we're fine,” so there you've got to look for other indicators like, are things not being delivered on time, are the, when you get presentations does it look like it's been put together in a bit of a hurry, is there data missing, you know?

While in the above examples the focus of this element of due diligence was on gaining an understanding of the nature of work and the risks arising from that, for others, the exercise of this duty entailed a subtle shift to a focus on understanding various facets of workers' behaviours or their personal mental health status. For example, when asked what sources of information they used to gain an understanding of the risks arising from work, P06 described how they observed individual workers' behaviours for symptoms of poor mental health:

Well, look, they're their own behaviours. I mean, they're the chatty ones that go quiet, all of a sudden an irregular attendance pattern, whether they are gaining weight, losing weight, whether they're losing their love for running at lunchtime, whatever else there might well be for that person.

Similarly, P18 implied that the safety observation may (albeit problematically) serve the role of identifying the symptoms of a mental health problem in workers:

Mind you, I'm guessing about with mental health, it's going to be..., issues are probably going to be displayed over a period of time. And of course, directors only have a snapshot, you know, once a month when they're on site, and it may well be better for an organisation to be ensuring that frontline staff, both the official frontline staff and the unofficial leaders in every workplace, are equipped to be able to recognise some of the emerging symptoms of a mental health issue.

Further, when asked how they gained an understanding of risks arising from the work of the PCBU, P15 felt that the biggest challenge in undertaking this duty was “actually identifying that there is that risk there, because each individual has a different tolerance level for what triggers them for stress or what creates challenges for them in their day-to-day activity.”

5.3 ENSURE RESOURCES AND PROCESSES TO ELIMINATE OR MINIMISE RISKS

The third inclusion of due diligence at s 44(4)(c) (see section 2.5.3) requires officers to take reasonable steps to ensure that the PCBU has available for use, and uses, appropriate resources and processes to eliminate or minimise risks to health and safety from work carried out as part of the conduct of the business or undertaking. As Tooma (2017) points out, the wording of this inclusion suggests a series of obligations, and requires that officers ensure that the PCBU or undertaking:

- (a) has available for use appropriate resources,
- (b) has available for use appropriate processes,
- (c) uses appropriate resources, and
- (d) uses appropriate processes,

to eliminate or minimise risks to health and safety from work carried out as part of the conduct of the business or undertaking (p. 59).

This series of obligations is closely linked to the general duties in that the provision of adequate processes and resources to eliminate or minimise risks is encompassed in the general duties.

Therefore, this duty of officers “merely requires the officer to take reasonable steps to ensure that the PCBU complies with that obligation” (Johnstone & Tooma, 2012, p. 117).

In a similar fashion to the previous findings, the descriptions of actions taken by participants to fulfil this duty showed wide variance when it came to applying this requirement to risks to workers’ mental health. However, generally, these differences in approach to resources and processes were presented in two ways, either as the resourcing of health and safety-related work or the resourcing of work such that risks to health and safety were eliminated or minimised. In the first approach, many participants

spoke about resourcing and processes in terms of the initiatives, programmes, job roles, and activities related to specific work undertaken in the name of workers' mental health. For example, P02 talked about bringing in people to the organisation to talk to workers on the topic of mental health:

That's where I feel more responsible sitting in the boardroom asking the question, what training programs are we running or what guest speakers are we bringing in at lunch time to talk to our staff about their own mental wellbeing and the mental wellbeing of their staff? [...]
So when you ask the question about resourcing, I'm much more about, at the right time bringing, you know, um, inspirational guest speakers in or people that can come in and share their stories or their tragedies or whatever.

In further alignment with this first approach, almost every officer talked about ensuring resources were available for employees experiencing distress or mental health problems or that resourcing was available for health and well-being initiatives, programmes, or projects. This conceptualisation of the meaning of resources also focused on ensuring that there were appropriately resourced staff to conduct the activities of the health and safety and human resources teams of the PCBU. For example, P07 spoke about how they had recently allocated more resource to health and safety by doubling the size of their health and safety team. Another participant (P09) talked about the various roles and initiatives relating to health and safety functions in the organisation, such as the human resources team and a Mental Health Network. P13 also described resourcing in relation to the capacity of the health and safety function of the PCBU but in a more cynical manner:

And so as far as resource allocation, we don't have a mental wellbeing manager. We have a health and safety manager, which is now the health, safety, and wellbeing manager. And so we expanded their title, right? We didn't add any capability to that other than if they need money to go and kind of do some work or look at some things, they've got resource, but really, in terms of commitment, what have we done? We've just expanded someone's title. We haven't thrown extra people at it.

The second way that resources were spoken of entailed resourcing the operations of the PCBU with the aim that risks to the health and safety of workers were eliminated or minimised. In terms of this way of thinking about resourcing, participants predominantly conceived of resourcing as “Manpower; if you haven't got enough resources to do what the board is asking you, you've got people being overworked and that results in mental wellbeing issues, health and wellbeing issues” (P19). However, other views included P18's, who spoke about how labour resources were deployed within the company to ensure that workers were not undertaking repetitive tasks for a long period of time or being assigned shift work unnecessarily. Similarly, P15 emphasised that for them, resourcing was considered in a strategic process whereby they and other officers attended to “how do we plan the work that we do, how do we make sure that our guys are trained well to do the things they're doing and have the resources they need to do that activity?”

This way of thinking about resources is emphasised in the literature, which states that, in accordance with this duty, “officers must consider the health and safety impact of every resource decision” (Johnstone & Tooma, 2012, p. 119). This duty requires that a process must be in place for making this consideration—that is, that an assessment of resources is made in the face of operational requirements, such as, for example, cost cutting or changes to shift patterns. In this respect, while a few participants did appear to consider this, most provided little or no evidence of a systematic process by which they did.

5.4 ENSURE PROCESSES FOR RECEIVING AND RESPONDING TO INFORMATION

The fourth inclusion of due diligence at s 44(4)(d) (see section 2.5.3) requires officers to take reasonable steps to ensure that the PCBU has appropriate processes for receiving and considering information regarding incidents, hazards, and risks, and for responding in a timely way to that information. This element draws on general strategic governance responsibilities of officers to monitor and manage the performance of the company, including health and safety performance. Here, many participants expressed a strong focus on measuring and monitoring the mental health status of workers, particularly monitoring for evidence of mental harms. For example, P06 spoke about having

the "tools to track and measure the mental wellbeing of our employees," and P02 described how "we're tracking their state of mind. Like, you know, they're like they've got a beeper on every day." In this respect, over half of the participants emphasised the importance of employees disclosing their mental health status or any mental health problems they faced to others in the workplace.

A variety of surveys and questionnaires were described by participants as ways by which they received information about incidents, hazards, and risks. Several participants described surveys that suggested a focus on identifying risk in individuals who are, or are becoming, unwell:

If you're only getting the data once a quarter or once every six months then that's not fast enough for somebody who's got a worsening level of mental health. And so for those, in those cases you are, the fact that there isn't data doesn't necessarily mean that the risk is not considered, but you are reliant on culture and management people and the risk being picked up that way. (P11)

Common sources of information that officers cited were sick leave rates and Employee Assistance Programme (EAP) data. Whilst some referred to monitoring the uptake of EAP services, several (e.g., P06) spoke of using cumulative insights from EAP data:

Yeah, look, the challenge, I suppose, is how do you measure success? And how do you determine whether in fact, it's meaningful, you know, you can look at sort of raw stats about the EAP scheme, the nature of the people that are referring self-referral versus being referred. What are the categories, the causes of why they find themselves in the EAP in the first instance?

A particularly common way of receiving and considering information that participants spoke about was engagement surveys, with 63% referring to these. However, these surveys were described in broad and varying terms and did not appear to be supported by a uniform conceptualisation or standard methodology across organisations. For example, some participants spoke of conducting these surveys once a year or less, and others monthly or more. Other participants explained that the content

of these surveys changed regularly and that their senior executives chose different questions to include in each survey, suggesting that a standardised or validated survey was not being used. Many participants equated engagement scores with a measure of employee wellbeing. For example, P23 explained that “often there's a direct correlation between employee engagement and mental wellbeing. So, if you've got a high employee engagement score, the mental wellbeing is likely to be in a good space. If it's low, somebody's stressed.” In addition, in terms of receiving and responding to information about hazards and risks, P07 explained: “I know they say hazard reporting is a lead indicator, but particularly in the, in the wellbeing space, for me, it's about um, engagement surveys, it's about the pulse surveys we've done...”

Despite putting forward several ways in which they were aware of systems that the organisation used to receive information about incidents, hazards, and risks, many participants expressed feeling somewhat unconfident in these systems. For example, P05 felt that, overall, the exercise of due diligence relating to mental health at work was “poor,” specifically due to the absence of appropriate “indicators,” “tools,” “resources,” and “surveys.” Some were particularly vague and unsure when describing the systems and indicators used to receive information about incidents, hazards, and risks, such as P22 when they suggested, “It's the engagement, the EAP, the walk arounds. Then I'm struggling to find a better answer for measuring that other than departures—involuntary departures—why they leave?”

When questioned about how they monitor risks and the organisational responses to risk, P10 explained that, in relation to a measure or tool for understanding psychosocial risks, “the fact is, they don't exist, because the best we have at the moment are proxy measures for essentially symptoms of good or bad mental health.” P19 concurred:

We do get measures there. Are there any specific mental ...? No. They haven't really been developed to what I would determine ..., I mean, you can get, we've got, ‘this many people have been to the EAP’ guys, we get some of that. But not specific.

Overall, many felt that their organisations did not have good systems for understanding, monitoring, and reporting psychosocial risks. P22 admitted that their organisation's approach to psychosocial risk assessment was "not very sophisticated at all."

Several participants did describe using multiple sources of information about incidents, hazards, and risks. P24 described using these multiple sources to form a "three-sixty of the organisation" (P24) where a sort of "triangulation" (P23, P24) was performed using various data points. The importance of considering multiple sources of data was also emphasised by P03, who noted the limitation of some indicators, such as sick leave rates, in providing "weak data," which needed to be combined with other sources of information to provide "a strong indication of the health of that organisation in so far as being a great place for workers." Similarly, P05 described that their aim was to understand where "we're systemically creating risk," although they then explained that they did not have a methodology in place to do that. Some participants were critical of those taking a sole focus on measuring mental harms, such as when P13 suggested that "I think our fascination with lagging indicators and the reporting that we structure around that is to convince ourselves that we're doing a good job because incident rates are tracking down over time actually is really one dimensional."

Perhaps surprisingly, few participants mentioned elected health and safety representatives as sources of information about incidents, hazards, and risks. Additionally, while several participants described various types of employee committees relating to mental health or wellbeing, they were seldom described as serving a function in providing information about incidents, hazards, or risks to officers. Also, no participant described current or ongoing use of a standardised or validated psychosocial risk assessment tool, survey, or methodology, although one suggested that such an assessment had been completed in one of the organisations that they governed at some stage in the past.

5.5 ENSURE COMPLIANCE PROCESSES

The fifth inclusion of due diligence at s 44(4)(e) (see section 2.5.3) requires officers to take reasonable steps to ensure that the PCBU has, and implements, processes for complying with any duty or obligation of the PCBU under the HSWA. These duties may include the primary duty of care as well

as other duties, such as the duty to consult with workers, to notify serious incidents, and so on. Interpretations of this duty suggest that this entails attention to an audit process (Johnstone & Tooma, 2012; Tooma, 2017), and, in line with this, many participants described general audits of health and safety systems that were undertaken periodically. Some participants, particularly those involved in very large companies, talked about specific compliance systems and roles within the organisation, such as compliance officers or legal teams whose purpose was to ensure compliance. For example, P22 explained how they relied on others within their organisation to ensure that the PCBU was compliant with WHS laws:

So, in my businesses, for example, I ask most of them, I ask the CEO to sign an attestation at every board meeting that to the best of their knowledge, they comply with the Act. So how they interpret that is up to them.

For some, the value of audits was to provide a “fresh set of eyes to an issue” (P11) or to bring awareness to “blind spots” (P24). However, total reliance on audits was cautioned by some because “The problem with audits is they tend to be paper based [...] the problem is it ticks the box to say whether you've got a policy or whether you've got a procedure” (P24).

Several participants expressed ambivalence as to whether they felt they were able to ensure compliance. For example, in talking about their organisational process for ensuring compliance, P22 felt that “the mental health component of that is relatively weak.” When asked about the process by which they ensured compliance, P13 admitted, “I'm not sure that I do,” and continued to express their discomfort that some actions taken in the name of compliance within the PCBU, of which they were an officer, were perhaps indicative of just “using words, talking the talk.” Similarly, when asked how they ensured that the resourcing allocated to manage risks was effective in causing the outcome desired of that allocation, P14 stated that they were “not sure [that] this is achieved all that well. It does not pay to kid yourself or others about outcomes.”

Conversely, P16 felt that it was difficult to ensure compliance because, presently, the constitution of compliance was not established: “There's an element of uncertainty in that space because there's an

element of uncertainty about the status of the law at the moment.” This paradox of ensuring compliance with little definition of what that meant was also noted by P15, who considered that “I don't think we're at a stage that we know what compliance is,” and P09 felt that, generally, the application of WHS law to mental health was “not properly understood at the moment.” Similarly, P05 felt that, in general, officers did not have a good understanding of what compliance with the HSWA looked like because of the absence of information signalling the nature of compliance by way of case law:

You learn it from legal cases and things like that, particularly anything which relates to safety. You know, the legal cases, or you know, which law firms will talk about this, that's why I talk about the precedent factor not being there with mentally healthy work. And that is not helping because it's not focusing governance directors' and CEOs' mind in the right space. They're focused on it abstractly because of the pressure on retaining and growing people and doing the right thing.

For P23, compliance was difficult due to the regulator not being clear about what their view of compliance was: “I tend to say well, it possibly doesn't matter where you think it sits or finishes, because the real question is where does the regulator think it starts and finishes?” Similarly, P16 explained that the notion of compliance was not clear when they explained that,

Officers are now looking at the legislation thinking, what do I think would be a reasonable interpretation of this? And then what might WorkSafe think would be a reasonable interpretation of this? And then, you know, there's still—because the jurisprudence under the new legislation is still relatively new—what might the courts think?

Noting the lack of New Zealand jurisprudence on the topic, P05 felt that without compliance being better defined in law, those in the governance community would not “get” their legal responsibilities:

Ok, so, if I was to talk to most directors around who, ah, obviously encourage and direct me, around mentally healthy work, and their responsibilities well they'd go, well, that's not, that's

not covered by the Act. They wouldn't see that that's their responsibility... that might start to see a bit of bullying. They might say, we've got a somewhat of a responsibility there because that's our staff behaving badly, but they generally wouldn't get it.

A further paradox emerged over the meaning of compliance. Some participants (e.g., P24) suggested that no one knew what compliance in this context really meant and scoffed at those who professed that they did. However, others (e.g., P07) purported to go beyond compliance, suggesting that the PCBU of which they were an officer not only met the standard that would suggest compliance but exceeded it. Interestingly, several participants (e.g., P07 and P24) suggested both: that compliance was unsettled but that they nevertheless went beyond it. For P07, their organisational responses to psychosocial risk were framed with an implication that the standards required of WHS were merely symbolic or bureaucratic, and were beneath those that an alternate approach, such as that taken by their organisation, would provide:

Well, it's not about, obviously compliance is important, but it's beyond compliance. It's actually about the principles, um, and aligned with our culture, um, as an organisation. So that's where we ..., that's where we've landed with the [wellbeing] strategy, it's what matters to us is a culture, ah, what ... what feels right for the messages that we, we are sending. And then obviously it has to be compliant. But that's all been tick boxed and done a long time ago. We've moved beyond that now.

Accordingly, many referred to compliance as nothing more than a symbolic activity encapsulated in the idea of it as a series of “tick box” (P02, P04, P07, P10, P13, P17, P19, P23, P22) exercises that protected the company and its officers from legal risks. This view of compliance was also expressed by P17 in the idea that compliance entailed managing “basic” risks and excluded innovative practices or the inclusion of workers’ perspectives:

I'm not trying to be negative about compliance. It's really important that basic health and safety risks are managed. But the opportunity of actually, um, particularly using workers to

drive actually drive innovation, design, and culture is a huge opportunity that most businesses haven't sort of taken advantage of yet.

Similarly, P07 spoke of compliance as being related to “the barest minimum”:

So, I think anyone, anyone managing teams today needs to have left all of that compliance ... um, what do I actually have to do? What's the barest minimum I can do? If you're, if you're operating in that world, you're gonna lose that connection of, of actually being part of the system around people's lives. And I, and I, I just don't think you're going to win. I really don't.

P22 also felt that compliance with WHS regulation as essentially an afterthought to actions that companies were already taking: “So, a lot of regulation doesn't ... it comes at the end of for most companies, maybe ... it comes at the end of the process where firms are already trying to look after their staff.”

Finally, some participants observed that various health and safety structures only served to fulfil notions of “compliance” as a symbolic function, such as when P17 noted that “... so you might have staff health and safety meetings and just become compliance meetings because staff feel like they have to do it ...”

5.6 VERIFY PROVISION OF RESOURCES AND PROCESSES

The final inclusion of due diligence at s 44(4)(f) (see section 2.5.3) requires officers to take reasonable steps to verify the provision and use of the resources and processes referred to in Section 44(4)(c) to (e). Whilst some participants also drew on the conduct of audits to provide verification, others described verification as an ongoing, multilayered process of critical consideration and analysis using both qualitative and quantitative methods, conducted both formally and informally. In this way, verification was not a separate “step” undertaken on top of the other inclusions in the duty but, fundamentally, incorporated continuously into the very act of conducting their duties of due diligence and in ensuring that the PCBU was compliant with its duties under the HSWA. This agrees with the approach suggested by legal scholars, which emphasises that officers should not rely only on the

assurances from other parties as a substitute for verification undertaken themselves (Johnstone & Tooma, 2012).

The idea of verification was similarly spoken about by P16, who spoke about not relying solely on audit, but instead,

... making sure that we are consistently, regularly, and quite systematically talking about it, that it's a genuine conversation that we are interrogating our systems and what we know about the wellbeing of staff and the like.

Similarly, P11 explained the verification was not a one-off activity but a “constant area of investigation and assurance ... So it's sort of, day to day, or BAU [business as usual] conversation.” Others described a full circle approach in describing that site visits, put forward as means by which officers could exercise their duty to understand the risks and hazards arising from work, were also a way by which verification could be carried out.

5.7 DISCUSSION

This discussion will focus on several pertinent themes that I identified relating to the ways that participants constructed compliance with their duties as they pertain to mental health. I consider these constructions in light of the purposes and principles of WHS laws, including both the general duties and officers' duties as well as the literature on the regulation of psychosocial risks as outlined in the literature review in section 3.5.

5.7.1 AMBIGUITY AND LACK OF GUIDANCE

The literature review discussed how ambiguity is an inherent quality of New Zealand's WHS law. Ambiguous laws are more likely to “set forth broad and ambiguous principles that give organizations wide latitude to construct the meaning of compliance” (Edelman, 1992, p. 1532). Edelman (1992, p. 1532) describes this in more detail, noting:

Laws that contain vague or controversial language, laws that regulate organisational procedures more than the substantive results of those procedures and laws that provide weak enforcement mechanisms leave more room for organisational mediation than laws that are more specific, substantive, and backed by strong enforcement.

Ambiguity not only characterises the general duties of the HSWA but also the officers' duties. For example, the Act does not suggest to officers what information and knowledge they should gain and maintain nor from where it should be obtained. Additionally, the Act does not suggest particular risk assessment tools or define the methodologies that officers should use to ensure that PCBUs have appropriate processes and systems in place. Rather, as outlined in the literature review in section 3.5, the law provides overarching principles and standards. This ambiguity has important and purposeful implications in that it means that by regulating by way of principles, the Act is flexible enough to apply to a broad range of risks, industries, company structures, and sizes. Further, the lack of specificity also allows organisations to respond to their duties in innovative, creative, and cost-effective ways. Conversely, ambiguity introduces uncertainty where duty-holders may not know how to respond to their duties (Black et al., 2007; Bluff & Gunningham, 2003).

In the face of this ambiguity, guidance for officers in undertaking their duties becomes an important requirement. Thus, guidance materials, such as codes of practice, are considered to be “quite central” (Committee on Safety and Health at Work, 1972, p. 46) to the thesis underpinning a general duties' approach to WHS regulation. Psychosocial risk management is no exception where, internationally, many have pointed out the need for clear interpretations of legal provisions as well as their promotion (Bluff, 2016; Leka et al., 2017; Oakman et al., 2019), especially in jurisdictions where the ideas and principles of psychosocial risk management as a legal duty are in low stages of maturity (Şahan et al., 2021). The need for officers to have specific guidance and information to best enable them to fulfil their duties has been identified as essential, and, while generalised information is useful, “tailored publications are far more beneficial” (Johnstone & Tooma, 2012, p. 113).

Whilst this sample of officers comprised very experienced senior or chief executives and company directors, many expressed distinct uncertainty as they described both their specific duties as officers as well as the duties of the PCBU. As outlined in the findings above at section 5.1, they associated this uncertainty with a lack of available guidance and interpretive information. Given the perceived absence of specific guidance, participants recounted fulfilling their duty to acquire, and keep up to date, knowledge of work health and safety matters by consulting a broad range of sources of information, many of which were not necessarily or specifically purposed for providing interpretation or regulatory guidance about officers' legal duties and responsibilities nor those of the PCBU. For example, P02, P05, P17, P18, and P19 relied, to varying degrees, on literature produced by international management consultancy firms. Many participants felt that there was no authoritative source of specific, relevant, and accurate information or regulatory guidance and, conversely, while others felt that while there was lots of information available about mental health and wellbeing at work, it was a "bit random." This resulted in, as described in section 5.5, participants such as P09, P15, P16, P23 and P24 expressing a belief that the very nature of compliance with the HSWA was unknown.

Conspicuously minimal as a source of information was the regulator. WorkSafe was mentioned by only two participants, and where participants did identify a specific source of regulatory guidance, it came from several private organisations with no regulatory function. Most concerning is that some participants said there were *no* sources of information about psychosocial risk management or legal approaches because it was simply, "not known" or "new," an issue that will be further examined in Chapter 6.

Sociolegal scholars have suggested that ambiguity, particularly in the absence of clear or authoritative guidance, provides scope for organisations to mediate, obscure, or avoid the intended impact of the law regulating them (Parker, 2002; Talesh, 2021). In the case where a regulatory issue is considered new or undefined, those operationalising the legislation may construct their own independent view of compliance prior to democratic debate or explication of a wider informed regulatory or legislative view. In this way, the construction of compliance can be effectively "gazumped" (Parker, 2002, p.

146) by regulated entities, with these ways of thinking becoming embedded and hard to change. For example, in examining the actions undertaken by a board to fulfil human rights due diligence, Landau (2019, p. 236) observes that:

Scope for interpretation would not seem problematic so long as the standard is subject to subsequent clarification and there are regulatory processes or a regulatory architecture through which competing interpretations of the concept can be contested and ultimately resolved. Without such refinement or dispute resolution mechanisms, however, there remains extensive scope for business to interpret the concept as it sees fit and for inconsistent interpretations and applications of the concept to thrive.

Ultimately, because there is no perceived authoritative voice guiding or directing officers in the conduct of their duty, an already ambiguous field of law is thus opened to even greater scope for interpretation or incorporation of constructs that are marginal or peripheral to the intent and purpose of the law. This has been seen in other regulatory areas where, in response to a vacuum of clear interpretation, multiple, prolific, or conflicting sources of guidance have emerged (Black et al., 2007; Landau, 2019; Parker, 2002), including in the regulation of psychosocial risks at work (Bluff, 2016).

In line with this perspective, the theory of legal endogeneity (see section 2.2.2) indicates that ambiguity in law provides scope for organisations to determine the meaning of compliance in a way that least disrupts the conditions the law aims to mediate. For example, Edelman (1992, 2016) showed in relation to Equal Employment Opportunity laws that organisations rarely demonstrate overt resistance to the law. Rather, they “are motivated by the weaknesses of EEO/AA [Equal Opportunity/Affirmative Action] law and the mechanics of the legal process to construct law in a manner that is minimally disruptive to the status quo” (Edelman, 1992, p. 1535). The primary mechanism by which the potential impact of compliance was mediated occurred via the creation of structures within the organisation which symbolised, but did not substantively achieve the goals of, compliance. As a result, legal endogeneity suggests that organisations create structures that signal attention to the law and its goals while allowing companies “the flexibility to adjust those structures to

accommodate managerial and business interest” (Edelman, 2016, p. 106). Therefore, the process of operationalising symbolic structures steers organisational responses made in the name of the law away from that law’s original purpose and intent.

5.7.2 ENSURING COMPLIANCE

The officers’ duties do not require officers to simply take reasonable steps to ensure that the PCBU has in place and uses resources, systems, and processes—the duties demand more than that. The Act requires that officers take reasonable steps to ensure that the systems and processes are *appropriate* and to ensure that the PCBU complies with any obligation or duty under the Act. For clarity and emphasis, at section 44(1) the duty requires that where the PCBU has a duty or obligation under the Act, an officer of the PCBU must exercise due diligence to ensure that the PCBU complies with that duty or obligation. Administratively, the due diligence duties place officers in the position of an overseer, fulfilling a regulatory function in a self-regulatory system where their role is to provide oversight and ensure the organisation’s effective compliance responses.

The duties are therefore characteristic of metaregulation when metaregulation is thought of as the regulation of the organisation’s self-regulatory system. Metaregulatory strategies ask “organizations to not only identify risks and devise internal control systems, but also to continuously evaluate the efficacy of their internal systems and incrementally improve them in light of this evaluation (i.e. double-loop learning)” (Gilad, 2010, p. 488). Thus, the exercise of due diligence is twofold: it asks that officers ensure that the organisation has appropriate systems and processes in place, and, importantly, it also requires that they ensure that they are appropriate in meeting the purposes and goals of the legislation.

However, a majority of the participants merely described or recounted the operational responses of their PCBU(s) rather than explain how they systematically performed their own duties. For example, while participants tended to describe systems or processes or interventions that were *present*, they rarely indicated the system, process, or method by which these were determined to be appropriate or, ultimately, how these responses were determined to be effective in eliminating or minimising hazards

and risks. Simply referring to the presence of a structure itself appeared to act as a heuristic to represent compliance. Accordingly, participants then deferred to the presence of these structures as indicia of compliance without examining their appropriateness or indeed their effectiveness in eliminating or minimising risk. In the WHS literature, this heuristic has been observed by Bluff (2017b) when she noted that many organisations give the impression of “‘doing risk management’ but that activity may not advance the regulatory goal of eliminating or minimising risks, so far as is reasonably practicable” (p. 11).

Empirical evidence of organisational compliance has shown that the organisational structures developed in response to regulation can become ubiquitous and institutionalised over time, as does the assumption that those responses fulfil the goals and intentions of the law (Edelman, 2016; Edelman & Cabrera, 2020; Krieger et al., 2015). There is some evidence from this study of such structures. For example, almost every participant gave the example of using EAP data, described some sort of wellbeing committee, or cited engagement surveys as a measure of psychosocial risk without describing the process by which these were ensured to be appropriate or effective. However, a small number of participants did question the substantive value of these widely used systems. This is not to say, of course, that any particular structure did not contribute to meeting the goals of compliance but that their substantive purpose in doing that was, for the most part, uncritically accepted.

In her research on Civil Rights laws, Edelman (2016) observed that the uncritical acceptance of particular structures as indicia of compliance creates “rationalised myths ... [which serve to] ... mask” (p. 155) the underlying organisational factors that the law intends to mediate. In other words, the implementation of various policies, committees, programmes, and initiatives has been found to serve the purpose of representing compliance with the law without substantively achieving its purpose or goals. These structures can become institutionalised over time, so much so that they evade empirical scrutiny and are uncritically accepted and deferred to by organisations—but also, sometimes, by regulators and the judiciary—as substantive compliance (Edelman, 2016; Edelman & Cabrera, 2020; Talesh, 2015). In this way, such structures can be referred to as “symbolic.”

Symbolic structures are, therefore, “an organizational office, officer position, program, policy, rule, or practice that exists independently of particular individuals” (Edelman, 2016, p. 101), which serve to evoke notions of legality and compliance. However, “being symbolic” “does not mean, nor does it necessarily imply, ineffective, and it is not the opposite of substantive” (Edelman, 2016, p. 101).

Indeed, these structures may be *merely* symbolic and thus ineffective at achieving the goal or purpose of the law, or symbolic and substantive in that they do achieve the substantive goals of the law.

At interview, participants described a plethora of symbolic structures to evoke notions of legality and compliance. Examples ranged from job roles, such as a “Health Safety and Wellbeing Manager”; to committees, such as a “Flourish Committee”; to policies and strategies, such as a “Wellbeing Strategy”; and to services, such as EAPs. These examples and more are presented in Table 8.

Table 8

Symbolic Structures Mentioned by Participants

Type of structure	Examples given ²³	
Committee/Group/Team	<ul style="list-style-type: none"> • Health, Safety and Wellbeing Committee • People and Culture Committee • People and Performance Committee • Health and Safety Committee • Environment Committee 	<ul style="list-style-type: none"> • Social Governance Committee • Wellbeing Group • Flourish Committee • Safety Group • Transformation Team • Mental Health Network
Role	<ul style="list-style-type: none"> • Wellbeing Manager • Mental Wellbeing Manager • Health and Safety “Person” • Health, Safety, and Wellbeing Manager 	<ul style="list-style-type: none"> • Health and Safety Officer • Health and Safety Representative • Compliance Manager • Wellness Manager
Assessment/Risk identification tool	<ul style="list-style-type: none"> • Peakon Survey • Pulse Survey • Ask Your Team Survey • Engagement Survey 	<ul style="list-style-type: none"> • EcoPortal • Bow-tie Assessment • EAP data • Sick leave/Absences data

²³ Where necessary, proper names of structures have been changed to ensure that information suggesting a particular PCBU have been kept confidential.

Type of structure	Examples given ²³	
	<ul style="list-style-type: none"> • Wellbeing Survey • Sharepoint Site • Wellbeing Portal • Whistleblower Hotline • Site visit 	<ul style="list-style-type: none"> • Walkaround/Walkabout • Gemba Walk • Leadership visit • Safety observation
Report	<ul style="list-style-type: none"> • Health and Safety Report • Health, Safety, and Wellbeing Report 	<ul style="list-style-type: none"> • EAP report • Traffic Light Report • Wellbeing update
Policy	<ul style="list-style-type: none"> • Drug and Alcohol Policy • Health and Safety Policy 	<ul style="list-style-type: none"> • Diversity and Inclusion Policy • Flexible Working Policy
Risk management programmes/actions	<ul style="list-style-type: none"> • Employee Assistance Programme • Dispute Resolution Scheme • Mental Wellness Programme • Wellbeing Programme • Wellbeing Strategy • Mental Wellbeing Programme • Leaders' Programme 	<ul style="list-style-type: none"> • Expert Speaker • Smartphone Application • Peer Support Programme • Guardian Programme • Critical Risk Programme • Programme of Events • Verification Programme

It can be seen from Table 8 that participants were able to list and describe many symbolic structures within the PCBU of which they were an officer. However, in the absence of systems to ensure their appropriateness, many of these structures are questionable as to their substantive purpose and impact in achieving the goals and objectives of the HSWA. The next section 5.7.3 will examine one subset of these symbolic structures—those that participants described when describing how they ensured that the PCBU had the appropriate processes for receiving and considering information regarding incidents, hazards, and risks arising from work carried out as part of the conduct of the PCBU.

5.7.3 RECEIVING AND CONSIDERING INFORMATION REGARDING INCIDENTS, HAZARDS, AND RISKS

Participants were asked at interview about how they sought and received information about incidents, hazards, and risks. Commonly cited sources of information included engagement surveys, satisfaction

surveys, or surveys measuring various constructs relating to subjective wellbeing. Other sources of information included data describing staff absences, rates of sick leave, and staff turnover. Each of these measures are problematic in that, for the most part, it is very difficult to make hazard–harm links between these types of measurements and the work environment (Rick & Briner, 2000).

Although I did not analyse the content of the surveys that various participants mentioned, in general, it can be observed that participants often relied on these instruments as the sole means by which employee experiences were surveyed as a workforce. While the types of surveys mentioned by participants can complement the assessment of the psychosocial work environment (Bergh et al., 2016; Bergh et al., 2018), as a sole measure, they are unlikely to reveal insight into psychosocial risks within the work environment due to their lack of construct validity as a psychosocial risk assessment tool. They are thus limited in their specificity and ability to offer explicit insights into the presence or nature of psychosocial hazards or links between those hazards and the likelihood of harms.

Nevertheless, such metrics were a near ubiquitous way that participants gained information about incidents, hazards, and risks. In addition, they also appear to have become taken for granted without their background assumptions or utility in understanding psychosocial risk brought into question. Similarly, many measures mentioned by participants, such as employee absence and sick leave rates, intention to leave, turnover, and EAP use, are better thought of as the *outcomes* of psychosocial risk exposure rather than ways of understanding and assessing risks themselves (Dollard et al., 2007; Metzler et al., 2019). The emphasis or reliance on such indicators over those identifying and assessing hazards and risks may also indicate a strategy of reaction as opposed to prevention (Zwetsloot et al., 2020).

The propensity of organisations to believe that measures of harms tell them something about risk has been well documented as well as technically critiqued and debunked (Dekker & Tooma, 2022; Hallowell et al., 2021; Lofquist, 2010). Further, the focus on measuring and reacting to harms has been noted as fundamentally inconsistent with the primary duty of care, which is inchoate and premised on the prevention of harm by controlling risks at their source (Bluff, 2017a; Johnstone, 2023; Johnstone et al., 2012). The technical critique of relying on harm as a measure of risk hinges on

two key factors. First, as mentioned earlier in this section, data regarding harms suffered by workers demonstrates poor construct validity in that while those using it believe it is telling them something about the future chance of harms, it has poor predictive power of future injuries and is thus not the same thing as hazard identification and risk assessment (Dekker & Tooma, 2022). Second, data relating to harm or injury is characterised by statistical weakness because such data points, generally being low in number, lack statistical power and thus fluctuations in rates are more accurately attributable to random variation than attributable to actions taken within the organisation to manage risk. Notwithstanding this myth-busting, these measures remain persistent and institutionalised ways that organisations assure themselves that they have a safe system of work.

The same critique might be applied here to the commonly cited use of EAP uptake data. First, employees may attend EAP for any number of reasons, work-related harms being only one (Bouzikos et al., 2022), thus there is limited use in making work-related inferences from service uptake data. Second, because of the low rates of usage of EAP services by employees and the fact that many workers do not avail themselves of EAP services, any thematic observations provided back to organisations are extremely limited as a source of information about systemic hazards and risks facing the workers across the organisation. Similarly, fluctuations in staff turnover, sick leave, engagement, and so on can be attributed to a wide variety of determinants and thus reveal little specific insight into the nature of hazards and risks arising from work. A similar observation has been made with respect to performing due diligence regarding safety, where Dekker and Tooma (2022, p. 376) note that:

Data in relation to total recordable incidents as a proportion of work performed provides little if any insight for that purpose since it masks the consideration and understanding of the actual incidents, hazards and risks that sits behind that number which is the essence of the due diligence exercise. By its very nature, TRIFR²⁴ is ill suited for that insight in that its purpose is to show a trend in lost production time and not the safety conditions that led to the injury or the potential from the incident that led to that injury. Furthermore, TRIFR is a record of

²⁴ Total recorded injury frequency rate.

injuries and not incidents. An incident may have significant potential but result in no injury. In that respect, TRIFR would fail to facilitate due diligence.

Here, the authors describe how the very tools or systems that are chosen to measure, monitor, or understand something can steer those using them away from the intended object of legal focus and reconstruct that object as something else. This phenomenon has been noted elsewhere in the literature on risk, where Jasanoff (1998) explains how “formal analytic techniques construct power relationships at the same time as they validate knowledge” (p. 96) and, therefore, in this way, particular methods for assessing risks “*frames* the world, so that users of the discourse are systematically alerted to certain features but desensitized to others. Such frames in turn delimit the universe of possible scientific inquiry, political debate and policy options” (p. 96). In this way, the choice of data, metrics, statistics, and surveys may “highlight certain domains as problems requiring attention, paradoxically simultaneously depoliticizing it, making it appear as simply a recognition of an objective reality, not the subjectivity of a political choice” (Rose, 2018, p. 39).

In the safety literature, researchers have identified that a tendency to focus on particular ways of measuring “safety,” when accepted uncritically and widely as indicators of how “safe” work is, can “function as a decoy, taking organizational attention away from the build-up of risks and a possible drift into failure in other areas. Underlying risks can then be left to grow misconstrued or unnoticed” (Dekker & Tooma, 2022, p. 377). In the same way, in relying on measures, such as engagement surveys, sick leave, EAP referrals, and turnover, or focusing on measuring “levels” of wellbeing, the identification and assessment of psychosocial risks arising from work is systematically marginalised by the very tools and systems of measurement that users of those tools purport to identify and understand them.

The findings of this research align with the international literature which finds that even in jurisdictions where psychosocial risks are regulated under WHS law, they are rarely systematically assessed (Beck & Lenhardt, 2019; Iavicoli et al., 2011; Kyaw-Myint et al., 2017; Metzler et al., 2019; van den Heuvel et al., 2018). For example, Oakman et al. (2019) found that key stakeholders holding

responsibilities for psychosocial risk management “were evidently unaware of available risk assessment and control procedures for psychosocial hazards” (p. 190). While some have associated this with a lack of guidance, information, and skills amongst stakeholders (Beck & Lenhardt, 2019; Langenhan et al., 2013; Mellor et al., 2011), others have observed that this shortfall occurs even with good guidance available (Leka, Van Wassenhove et al., 2015; Metzler et al., 2019).

The utility of symbolic structures to achieve the substantive purpose of the law was unquestionably upheld by many participants. In accepting and relying on these systems and processes as legitimate, it appears that many participants simply deferred to symbolic structures as indicia of the achievement of legal obligations. However, whilst no officer mentioned any specific or validated psychosocial risk assessment or survey methodology, some participants did suggest a critical awareness that the responses that their organisation made in the name of compliance were problematic in their predictive power. Within this group, a minority of participants therefore highlighted the need to garner information about whether the organisation was eliminating or minimising risks to workers’ mental health from various qualitative and quantitative sources and indicated their hesitancy to simply rely on singular sources of information or information that was passively presented to them. In this way, they signalled attention to the substantive purpose of compliance with the due diligence duties. These participants emphasised strategies, such as triangulation of data, and spoke of the need to comparatively evaluate various sources of information, consistently being sceptical and questioning of information regarding the organisation’s WHS systems and processes for risk assessment and management. This type of risk oversight highlights, to use Haines’ (2001) phrase, the “regulatory paradox” inherent in regulations such as the due diligence duties, which requires those in senior management or governance positions to balance being the “ultimate policeman” (Zhivitskaya & Power, 2016, p. 97) while, at the same time, being a collaborator of the executive function of the organisation.

5.7.4 REFRAMING OF COMPLIANCE

Whilst I have outlined the many and diverse ways that participants recounted their duty to ensure that the PCBU complied with its obligations and duties under the Act, for many, the very idea of compliance was unsettled, undetermined, and presented in contradictory ways. As outlined in section 5.7.1, many participants felt that in the absence of clear regulatory guidance, case law, or jurisprudence, the meaning of compliance was undetermined. Others felt that the notion of compliance itself was a minimal standard, or mere a bureaucratic or administrative activity, and, accordingly, several participants professed that the PCBUs with which they were associated went “beyond compliance.”

The idea of going “beyond compliance” is discussed in the literature mainly from the perspective of understanding what motivates companies or the individuals within them to either “take measures that provide a wider margin of safety against accidental regulatory violations ... [or, alternatively, to respond] ... directly to popular concerns that have not yet been embodied in specific regulatory mandates” (Kagan et al., 2011, p. 43). In either case, in going beyond compliance, companies are thought to demonstrate a “willingness to undertake socially positive behaviour even when not required to do so by law” (Borck & Coglianese, 2011, p. 140). This is done by implementing additional measures in response to peer pressure, reputational risks, public concerns, or other social forces.

As discussed in section 2.4.3, the standard of regulatory compliance with New Zealand WHS laws requires that organisations ensure, so far as reasonably practicable, the health and safety of workers. Within this duty, the term “reasonably practicable” is well established and suggests both a process by which a calculation is undertaken to determine the extent of action that a PCBU should take to eliminate or mitigate risk, and a standard of protection (Bluff & Johnstone, 2005; Johnstone & Tooma, 2012). However, for many participants, compliance was not conceptualised in terms of the extent to which risks to the health and safety of workers arising from the work conducted by the PCBU were eliminated or minimised. Rather, compliance was spoken of in terms of completing

mandated, bureaucratic tasks that stifled innovation, or as a basic and simplistic standard that did not substantively achieve beneficial outcomes for workers or the company and reflected in the significant number of participants describing compliance as a “tick box” activity. While “pointing to the burden of compliance can be part of a strategy by business to reduce their overall obligations to society” (Haines, 2021, p. 96), the framing of compliance as simply a bureaucratic or administrative task also highlights a contestation in the meaning of compliance itself – a contestation based on whether compliance refers to the presence of an auditable system of risk management—that is, a procedural interpretation—or a substantive interpretation (Edelman et al., 1991; Stryker, 2019; Parker, 2002) that accomplishes the regulatory objectives by substantively eliminating or minimising risks to workers (Bluff, 2017a).

In this context, those participants who framed compliance as entailing a minimum standard or professed to going “beyond compliance” did not appear to mean that the PCBUs of which they were an officer eliminated or minimised risks to workers *beyond* that which was reasonably practicable. Rather, most of those who framed compliance as a minimum or spoke of going beyond compliance described a range of policies, projects, or initiatives that appeared to focus instead on individual aspects of worker mental health. These initiatives were often framed as “wellbeing” initiatives or initiatives focusing on encouraging and enabling workers to talk about, disclose, and seek help for mental health problems that they faced. Therefore, most participants when describing how their PCBU went beyond compliance were in fact indicating an inattention to the social, structural, or organisational factors that are considered to be at the root of many work-related health risks.

This change of scope and shift in the meaning and value of compliance from an organisational concern to a worker-focused strategy is exemplified in this excerpt from a publicly available case study of a New Zealand organisation:

Health, safety, and wellbeing had become more of a compliance exercise at DIA. The organisation, while still ensuring the importance of health and safety, has taken a heart and

mind approach to engage with staff, and has shifted the spotlight to the wellbeing of their people. (Te Tari Taiwhenua/Department of Internal Affairs, n.d, p. 1)

Here, describing compliance as an “exercise” conflates it with a ritualistic or administrative endeavour characterised as inferior to the approach focusing on “wellbeing,” which is framed in opposition to compliance. Further, the phrase “heart and mind approach” suggests a more compassionate, advanced, and humanistic approach than that which compliance with the law would provide. In other words, a focus on wellbeing was framed as not only being *better* but, also arguably, more ethical than a focus on achieving the goals of health and safety law. This is essentially a reversal of the proposition that holds that an ethical approach lies in first addressing the structural determinants of poor mental health and distress at work (Lamontagne et al., 2014), and positioning, understanding, and, ultimately, preventing societal problems such as mental illness in their social contexts and not just in their individual, medicalised forms (Rose, 2018). This sentiment was also reflected in this research by the many participants who described a focus on individualised notions of wellbeing rather than on the protection afforded by the HSWA by way of risk management. Such a sentiment was exemplified in this comment by P18: “We probably don't, as directors, think specifically about mental health. We probably think more broadly in terms of overall wellbeing.”

A shift in the meaning of compliance made by focusing on alternative constructs to suggest an exceedance of compliance but which, in fact, serves to reframe the intent and purpose of the law has been evidenced by regulated entities in other fields of law. For example, a recent study (Monciardini et al., 2021) of organisations’ compliance responses to the UK’s Modern Slavery Act 2005 found that organisational structures put in place by those professing to go beyond compliance did not advance beyond the standard required of the law but, rather, were often ineffective structures by which to substantively achieve the goals of the law and were, thus, merely symbolic. Therefore, Monciardini et al. (2021, p. 329) suggest that “a more careful and critical approach to corporate proactive responses to regulation” is needed.

Similarly, in the United States, the popularised and managerialised rhetoric and practices of “diversity”, commonly used by organisations responding to Civil Rights Law, have been found to supplant the legal rights provided by the law (Edelman et al., 2001). Diversity rhetoric, according to Edelman (2001, 2016) operationalised through the proliferation of diversity structures such as diversity training and diversity officers, acts to recast and reframe the ideas inherent in Civil Rights Law by obscuring structural factors underpinning unequal employment opportunity. Such reframing also redirects the focus of the law to managerial ideals, such as that a mix of attitudes, styles, and knowledge is an asset to corporations operating in a changing world. Thus, the managerialised reframing of the law forges links between diversity and an organisation’s profitability, and this reinvented view of the meaning of the law brings organisational and legal imperatives into alignment. This idea can also be seen in the work of critical race theorist and legal academic, Derrick Bell (2003), who similarly observed that the deployment of organisational strategies and policies enacted in the name of “diversity” often serve as both a distraction from and a shield behind which the structures that uphold inequity can be hidden.

In the same way that compliance with the HSWA was often negatively represented by participants but wellbeing positively, Edelman (2016) found that in the academic and grey literature on civil rights, the law was most often portrayed as “external, imposed, and a negative force on organizations ... [whereas diversity was portrayed as] ... good for employee morale and for harmonious employment relations, as well as for profit” (p. 144). The deference to symbolic structures and the focus on individualised notions of wellbeing suggest that in a similar way as diversity rhetoric has usurped the legal construct of civil rights, so does the concept of worker-directed initiatives undertaken in the name of mental health and particularly wellbeing, coupled with the framing of WHS law as bureaucratic and administrative, suggest a usurping and undermining of the protection of workers’ mental health afforded by WHS laws. In this respect, a number of authors (for example, McLeod & Wright, 2015; Taylor, 2011; Wallace, 2022; Wyn et al., 2015) have traced the transformation of wellbeing from an idea referring to the collective or social to one that is individualised and focused on self-responsibility and therefore less attendant to the structural or social determinants underpinning

poor health. For example, in the context of examining the rates of mental illness amongst lawyers and the responses from the legal industry made in the name of wellbeing, Parker (2014) observes that “there is, however, a danger that the wellbeing discourse will be co-opted by powerful interests that seek to confine change to the individual and not the collective social, economic and political levels” (p. 1105). This highlights a wider concern that the discourse of wellbeing may be increasingly “uncritically substituted for structural action regarding health inequalities ... particularly because an emphasis on well-being allows them to promote broad and vague notions of positive health instead of discussing specific details, causes, and solutions for ill-health” (Ganesh & McAllum, 2010, p. 495). Others observe that “calls to address wellbeing are now so commonplace and widespread that they can mean both everything and nothing” (McLeod & Wright, 2015, p. 2). Academic attention is increasingly attending to the use of the term wellbeing and associated initiatives in the context of work (Jackson et al., 2022; Jarden & Roache, 2023; Wallace, 2022) where Jarden and Roache (2023, p. 3) have noted that “there is a growing dilution of the term through corporate initiatives which appear only superficial in their commitment to employee wellbeing.”

In this research, compliance with the HSWA is, for many participants, not viewed in terms of the goals articulated by WHS law whereby the risks to workers arising out of the employment relationship are eliminated or minimised so that workers enjoy good health and are not burdened by disease or ill health as a result of their employment. Rather, the dominant discourse represents compliance as being bureaucratic and ineffective. Further, the preponderance of reactive and/or worker-directed wellbeing interventions, which are considered synonymous with going “beyond compliance”, appears to be creating a legal consciousness that legitimises organisational symbolic responses which may ultimately preserve the working conditions which give rise to harm.

5.8 CONCLUSION

This first findings and discussion chapter presented an overview of findings regarding how participants conceptualised and carried out their duties as they apply to mentally healthy work.

Overall, the findings showed wide variation in the ways that participants conceptualised and carried

out their duties. This heterogeneity likely stems from the ambiguous nature of WHS law, coupled with the absence of an authoritative voice providing interpretive guidance for officers around the application of WHS laws to workers' mental health as well as little guidance on the meaning of the officers' duties as overseers of the organisation's regulatory response. In response to this ambiguity and perceived lack of guidance and knowledge of psychosocial risk management, participants tended to defer to symbolic structures within the PCBU as indicia of compliance. While many participants could describe the responses that PCBUs made in terms of their responses to the HSWA, very few could outline the process, system, or reasonable steps they took to ensure that these structures were appropriate or, ultimately, how they ensured that these structures, in fact, eliminated or minimised risks to the mental health of workers arising from work, as required by their duties of due diligence. This was elaborated on and explored by focusing on the ways in which participants measured and sought to understand incidents, risks, and hazards within the PCBU(s) of which they were an officer.

The vacuum produced by the perceived absence of specific regulatory guidance, coupled with the inherent ambiguity in the law, appears to have resulted in heterogeneous and unstable conceptualisations over the status and meaning of compliance. Further, a particular discourse of compliance was observed that delegitimised legal compliance with the HSWA by framing it in terms of being administrative, bureaucratic, and ineffective. However, in this research, a paradox emerged in that for some of those professing to go beyond compliance, this did not mean doing more than just the paper work, nor it did mean that they exceeded the regulatory standard implicit in the reasonably practicable qualification, but, rather, that they implemented a range of worker-directed "wellbeing" or "mental health" policies, strategies, and initiatives that, notwithstanding any value they may hold, appear to sit outside the frame of that which the literature suggests is the core focus on WHS legal approaches to psychosocial risk management.

The next chapter, Chapter 6, builds on this Chapter 5, considering the same research question from another perspective. It will examine the ways in which psychosocial risk management and compliance with the HSWA were represented as problematic and will discuss the impact of these representations on the possibilities for compliance with the HSWA.

6. REPRESENTATIONS OF PSYCHOSOCIAL RISKS

This chapter is the second of four chapters in which I present and discuss the findings of this research. Building on the findings detailed in the previous chapter, Chapter 5, Chapter 6 continues the focus on answering the first research question:

How do officers conceptualise, express, and carry out their duties under the Health and Safety at Work Act with specific regard to psychosocial risk?

However, this chapter examines the way participants represented psychosocial risks. In this respect, I present findings relating to the various ways that psychosocial risks were represented as problems in section 6.1. In section 6.2, I discuss these findings in three subsections: In section 6.2.1, I discuss how the representations lead to the obfuscation of causality, in 6.2.2 I discuss the representation of psychosocial risks as new, uncertain, and unevidenced, and in section 6.2.3, I discuss the overall implications of these representations. In section 6.3 I conclude the chapter by introducing the idea of “novel risks”.

Prior to beginning this chapter, it is important to note again that in talking about their duties within the HSWA, participants rarely used the term “psychosocial risk”. Instead, they would use various terms relating to wellbeing, mental health, or mentally healthy work, a use of language that contributes to ambiguity and a shift in focus relating to these duties.²⁵ Despite this variability of lexicon, it must be remembered that the discussions occurred in the explicit context of an exploration into how participants conceptualised their duties under the HSWA and not a general discussion of organisational responses to worker mental health or mental illness at work.

²⁵ In this chapter, while I use the term “psychosocial risks” as defined in the literature review, I also refer to mentally healthy work, mental health, wellbeing, or other terms as they were used by the participants and in this sense, I clearly state where a participant was talking about “mental health,” “mental health at work,” or “mentally healthy work”. I also use the phrase “psychosocial risk management” to describe the management of psychosocial risks arising from work.

6.1 PROBLEMATISATIONS

Problematization has two related meanings in a Foucauldian context. As a verb, problematization is a core methodology in Foucault-informed poststructural analysis, signalling a critical intent on behalf of the researcher (Bacchi, 2015). Problematization describes what an analyst does by scrutinising the apparently stable and conventional assumptions that make up knowledge in order to gain new insights. In the second meaning, problematisations are a noun and are often the topic of critical analysis because they are the things that our prevailing knowledge and sense making systems consider to be problematic (Lawlor & Nale, 2014). In this sense, the analysis of problematisations, as in this chapter, looks at what is named as a problem and how it is constructed as such through discourse. Analysing problematisations in this way can be insightful because it uncovers the way that “problems”, such as worker mental health or psychosocial risks, come into existence through the very practices that aim to understand or solve them. In this way, researchers analysing problematisations “share a conviction that ‘problems’ are more interesting than ‘solutions’” (Bacchi, 2015, pp. 4–5) in that because problems can be considered social constructions, they are thus reflective of deeply ingrained ways of thinking.

This section 6.1 therefore considers the way that participants represented psychosocial risks as problems in two ways: that psychosocial risks are a problem in themselves that need to be solved, and that psychosocial risks are problematic to solve due to their various qualities. These representations were expressed at interview in terms of the difficulties and dilemmas that participants described that they, and the organisations they managed or governed, experienced in responding to WHS law. Through analysing the ways that participants described these problems, I identified characterisations made of psychosocial risks that contributed to the representation of them as “a problem”. These conditions are grouped under the themes of “newness”, “uncertainty and unknowability”, “subjectivity”, “position outside the boundaries of managerial authority and responsibility”, “invisibility”, and, finally, “unmanageability”. These will be considered in turn below.

6.1.1 NEW AND UNESTABLISHED

Managing risks to the mental health of workers was spoken about in terms of it being in its “early days” (P17) or as “new ground” (P02) for company officers. This newness was expressed in three ways. First, some participants explained that worker mental health or wellbeing had only lately emerged as a salient issue for companies because mental ill-health was becoming more prevalent. Second, some participants described psychosocial risk management as new in that only in the HSWA did there arise a legal obligation to manage it at work. Third, psychosocial risk management was cast as new because the science associated with it was not established or it was considered an emerging field of research and, being new, not much was known about it.

Some participants felt that mental health was emerging as an important issue for businesses because rates of mental illness were increasing. Consistent with this view, some participants explained that mental health (or mental wellbeing) had in recent times been labelled a “critical risk” in their organisations. P03 describes this increasing salience:

And so the mental wellbeing risk is presently a high velocity risk. So it's... it's increasing. And for that reason, we have determined as a board that it's a strategic risk and a strategic critical risk. So, we want to have it on the list of things that we're monitoring with greater scrutiny than our other ah, high-risk areas.

P11 also described the increasing prominence of the issue at a governance level:

...we recognised that it was an area where the risk was increasing across the country, as in for businesses generally, we recognised that mental wellbeing was increasingly an issue that needed to be thought about.

For many participants, the issues of worker mental health and the legal obligations relating to it were of lesser importance prior to the COVID-19 pandemic. For these participants, the pandemic represented a turning point that brought a new focus on the mental health of workers, given the impacts of the lockdown restrictions. In particular, the rearrangement of work as a result of lockdowns

often highlighted issues arising from the blurring of the traditional separation of “home” and “work”. For example, P04 explained that in managing risks to worker mental health, “I had the benefit of inheriting things that were already in play, but clearly with COVID, it's kind of really lifted the visibility of it and our awareness of it.” Likewise, P18 explained that “Mental health has, obviously, in the COVID environment, um, it's something that boards across, across the full spectrum are much more aware of.” P10 suggested that “COVID has presented us with an opportunity to think more deeply about [mental health] and to find more solutions.”

For others, however, the pandemic represented a milestone on the organisational “journey” that was already underway:

And of course, COVID has just added another lens to it. But it's not because of COVID. We, we've had ah, the wellbeing of our team in our sights for several years. We're well on the journey with that ... But the COVID has definitely—probably unfairly—monopolised the conversation around health and anxiety. But actually, all that other foundational work that we have had in place has been a great foundation to launch from, with just different messages that feel like they have monopolised things, possibly. (P07)

Conversely, many participants expressed the idea that addressing mental health in a WHS context was of increased salience *because* it was new as, for example, was suggested by P09:

Everyone, everyone in those circles is pretty interested in this, partly because I think it's an extension of a traditional health and safety focus—a belief that health and safety's important. And as pretty much as soon as this whole thing came, it's ... whoa, this is the next area.

Associated with the newness of concern for worker mental health in a health and safety framework, many participants felt that there was not a good general understanding or consensus of what organisations should do to respond. Six participants described the consideration of mental health at work in terms of it being an emerging area, risk, issue, or discipline and, according to P09, was an area in which “we don't know exactly what to do.” Similarly, the disorientation inherent in newness

was expressed by many participants who described uncertainty about the scope of the issue:

Yeah, I think a lot of organisations are still getting their head around mental wellbeing as an issue that they have to manage. I think that would be the first thing. (P11)

I would have argued that because we are still ... and I would use the word 'we' advisedly, but we are still uncertain as to where our roles and responsibilities and learning, how do we learn in this space? And what good outcomes look like? (P20)

Others reinforced this idea of newness by expressing a belief that there was a distinct lack of understanding about how to respond to psychosocial risks and, as a result, any response was potentially relevant:

You could do just about anything you want in the space at the moment. It's so new that you almost couldn't go wrong. The important thing is to start, and that's sort of the view that we've taken. (P13)

And that's why I think that notion, so I guess it's, well, you... you've got to try some of these things without knowing what the answer's going to be and see how it goes, right? (P03)

6.1.2 UNCERTAIN AND UNKNOWABLE

The idea that psychosocial risks are both uncertain and unknowable was expressed by participants in three ways. The first was that mental health is generally a difficult matter to understand; second, that there is a lack of professional, regulatory, or expert consensus in the field of WHS regulation; and third, that there is a lack of academic research and knowledge on the topic.

P12, for example, expressed that, in general, matters relating to mental health were hard to understand:

The first one is just understanding what mental health is. I, you know, I, I have always struggled to understand this whole aspect of what is mental health. Is someone being upset at

work a mental health issue? They may claim that, but if it is? (raises both hands) I don't know.

Participant P09 concluded that, as a result of having received divergent advice from several WHS consultants, no one was sure about what compliance with the HSWA meant in relation to mental health:

I thought, you know, I think the stuff that the [consultant organisation name 1] are doing, [individual's name], and the stuff we are getting from [consultant organisation name 2], so they kind of like our two places, they, they're not the same.... I think it's confusing, and we certainly stumbled around for a while saying, well, what... what construct do we use, you know, what advice do we take? Because it's so new and no one's quite sure.

As a consequence of having received divergent advice from WHS professionals, the same participant felt that psychosocial risks and, therefore, their regulation, lacked conceptual consensus:

Um, and we, we feel that it's not properly understood at the moment, and we're not, we're not doing our job adequately in terms of understanding and addressing it. So we... we're trying to put enough structure in, in terms of the design we're using, the tools we have, the information gathering to start to get our heads around, at least understanding the problem. When we understand the problem we can dial in the solution, so... but I haven't spoken to anyone who really knows at the moment.

Relatedly, participant P24 explained that psychosocial risks are different to other risks that directors must deal with because with other areas of risk there were established ways of dealing with it. With psychosocial risk, that certainty was considered absent. In this respect, relative to other types of risks that officers faced, they felt that psychosocial risks were:

... not different in terms of the ambiguity and that it's in scope and the fact that they should be doing it, it's different in as much as it's newer because there's less research and it's ... and it's not perceived as equal to finance and traditional risk management and, you know, other things that directors do.

Others, like P24, expressed a perception that there was a lack of expert knowledge and research pertaining to mentally healthy work:

Changes in technology, think about the industrial revolution. So, actually, those, those ambiguities that directors deal with are not new and because they're not new, there's endless research about them There is, there is n ... there is very limited science and research around mentally healthy work.

For P05, the difficulties in understanding “mental wellness” was akin to a game riddled with uncertainty:

You know, it's a bit like, a game where you're trying to match different cards. You pick up one and look under and find another one over here you're looking for. But it's not systematic. There's no systematic process in comparison to physical safety risks, to mental wellness, there's just not.

6.1.3 SUBJECTIVE EXPERIENCE

The individual subjectivity and variability of workers' experience was consistently raised as a problem for those tasked with identifying, understanding, and managing psychosocial risks. These problems were highlighted when participants dwelt on the variance amongst workers' individual experiences of work, or when they compared their own, ostensibly objective, views of work to those made by workers. In highlighting these points, participants problematised the possibility of establishing etiological links between work and workers' mental health.

For example, many participants questioned the validity of using accounts of worker experience to guide hazard identification and risk assessment, believing that this could be problematic due to workers' individualised and subjective experience and their (presumably inaccurate) perceptions:

How we perceive the world... and so the mental health one is often, is a particularly difficult one because a lot of it, certainly for me, I can't get to the, um... Why do you see it that way,

point, because to me things are quite simple and logical and straightforward and we're living in a pretty easy part of the world to live in, and we don't have any real issues with our basic needs. So, where's the stress? (P15)

Because everybody experiences work differently, so it's not a one-size-fits-all machine guard that you can put on mentally healthy work because everybody's expectations and what they bring into the workplace is different. (P24)

Even in the case where participants accepted that the conditions of work could impact negatively upon a worker's mental health, the matter of implicating a causal link between mental harms and work was downplayed by either emphasising the subjective experience of individuals or pointing out that workers' personal mental health status could affect their assessment of the conditions of work:

... what is psychosocial mental health safety for one person is never that for another person. Because your levels, individual levels of resilience, of mental health, of history of mental health issues, of wellbeing, are all so different. So how do you know that you're doing the right thing? Because the right thing for one individual or one circumstance is so different for another. (P21)

The problematisation of workers' individual subjective experience of both work and the experience of harm was often expressed as doubt regarding possible links between conditions of work and a risk of harm:

And whilst we, we sort of aspire to have something that's reasonably lined up at a principles level, it'll always be variable because people are always involved and it's hard to see through that. It's hard to see if people are feeling uncomfortable whether that's relationship, whether that's a leadership issue, personal issue, um... where it's coming from. (P22)

You are asking people their opinions and their opinions can be affected by things like the Ukraine conflict. So, it is subjective. (P03)

Some participants questioned whether it was possible at all to get valid or reliable data about psychosocial risk. For example, P03 doubted whether they could get “hard data” on psychosocial risks at work given the unreliability of workers’ perceptions and opinions of the workplace because “peoples’ opinions on things do tend to be swayed by what's going on today, and also what's going on at home.”

6.1.4 OUTSIDE THE BOUNDARIES

Whereas the subjective experience of work problematised the attribution of a causal link between the work environment and mental harms, the attribution of a causal link to mental harms arising from the workers’ home life was represented as being considerably less problematic. Many participants described how workers’ home lives negatively affected their mental health, an issue considered further in Chapter 7. Notwithstanding the general acceptance of a causal link between workers’ home lives and harm, however, almost every participant also expressed uncertainty about the boundaries or limits to their due diligence to apply to risks arising from workers’ home lives or from other personal matters.

For example, P20 spoke of the difficulty in assessing which harms that workers may be experiencing could be attributed to life outside of work and which could be attributed to work itself:

If someone turns up and goes back home, how do we measure what state they turned up and what state that went home and whatever happens over the weekend, how much of it was a function of what happened during the week, how much was a function, what happened on Friday night?

The common expression of concern about “overreaching” into workers’ private lives highlights the strength of the idea that risks arose primarily from the private, personal, or home lives of workers. This was expressed by P10 to be a challenge for organisations in seeking to comply with the Act:

You know, so I think the challenges that most businesses really struggle to understand is their part in someone's mental health. And what I mean by that is, you know, they can't help the

fact that they go home to a disruptive family environment ... And so, for businesses, I think in a number of cases, they struggle with, what does that mean for us, and how do we be part of that effectively with overreaching? Because overreaching under the Act is also not a flash case to be, where you assume more responsibility and therefore liability than you actually have or want to.

Relatedly, P12 questioned whether it was the role of a company or a company officer to impact a worker's mental health:

There's another piece with ... whilst the legislation is passed to set up an environment safe and [indiscernible], the question I struggle with is, is it my role or company's role to be actually helping someone's mental health?

Aligned with this questioning, P23 described that, on the board on which they sat, there were "some who see, who think, that we have all gone too far in expecting employers to be responsible for everything that's happening in a person's life." Similarly, P08 explained that their fellow officers expressed concerns about "the line" of responsibility in the workplace:

And I know one of the things that causes many management teams and particularly the teams I'm involved in, and whether that's from a governance perspective or a management perspective, is what's the line that you actually don't want to cross? And where is that line and in many people's case, we crossed it a long time ago. And what I mean by that is where do we, where are we overreaching into peoples' private lives in terms of the type of due diligence that we're doing around what's going on and that sort of thing?

In accordance with this dilemma, P02 observed that "...it is a fine line, and it is not the responsibility of the employer to protect the individual twenty-four by seven, right? That is not the responsibility of the employer to impose on people's home lifestyles or, um, do you know what I mean?" Further, P06 identified, "the challenge ... [as] ... at what point does that [workers' personal lives] become an employer's issue or concern?" Similarly, P18 asked, "...how far beyond that factory gate, when our

employee has gone home, do we have a legitimate right to get involved? And should we get involved?”

P20 noted that many people in senior leadership roles were not only unsure as to the boundary and scope of their role as officers but shied away from understanding it:

I suspect we probably need clarity around what the boundaries of this mental health wellness thing is, you know, how wide is it? Is it beyond the workplace or not? So, I mean, I'm asking the questions. I know some of the answers. And then, secondly, once you sort of established that, then what are our, what are our legal responsibilities, firstly? And then secondly, what are our moral and ethical responsibilities, secondly? And then I guess thirdly, how do we measure that? And how do we set the tone and so on and so forth. And my experience with senior leadership teams is that there is usually about half of them who really just don't wanna have this debate.

For others, a difficult boundary arose regarding how far a workplace should enquire into or question its workers' mental health status:

Well, you can ask the question, right? But you actually know that when you ask the question, people aren't gonna be able to tell you an accurate answer because unless you've collected the data, um, in a way, and you know, if I gave people a checkbox to say, right, you filled out your sick leave, but can you please tell me, was it for mental health? Was it because you've got COVID? Was it like..., you can't do that right? And even if you could, people won't tell you. Yeah, we've got the hypochondriacs in the world that you know, every day is a mental sick day ... (P02)

For this same participant, their duty to “understand” these risks was difficult because it entailed the problematic action of talking to workers about their personal psychological status:

And I look at some of my colleagues around the table, and even if they wanted to discharge their responsibilities, I'd be a bit nervous um, having them sit down and have conversations

with staff. It's hard enough to get them to have a decent sort of safety conversation or safety behaviour conversation or whatever. God forbid, if they tried to engage on the topic of mental wellbeing.

These examples suggest that under the duties of the HSWA, participants feel that a main cause of risk is the poor mental health that workers bring with them into the workplace as a result of their lives outside of work.

6.1.5 INVISIBLE

When compared to physical risks and harms, many participants represented psychosocial risks as being relatively more difficult to see, measure, or understand. For example, P07 felt that working in this area was akin to “working a little bit in the dark.” Many others expressed the idea that both psychosocial risks and psychological harm were problematic in their obscurity and invisibility, and risks could not be known until a worker was not just harmed but revealed that harm to others in the workplace:

I suppose it's, I think, you know, from a physical health point of view, you tend to see a hazard or an incident. And then see physical consequence of that, and it's sort of ... simple. I think the moment you stray into, you know, mental health and wellbeing matters, it becomes less definitive and sort of invisible until it presents. (P06)

How do you detect (mental ill health) or how do you see it at the workplace? If you see it, what ... what is your responsibility? (P10)

Well, I don't want to use the word illness because it's, it's, it doesn't necessarily manifest itself very easily. I mean, you can see physical harm. You can see safety issues that you can quite easily identify by a walk around. You can see the physical issues on a site, like a construction site. Walking around an office of financial services people, when you're not part of relationships between those people that are dealing with a financial service, it is much harder to detect. (P22)

And so that's ... it's less, it's more nebulous, it's less tangible, it's so ... it's hard to It comes back to this, you know, if you can't measure it, you can't manage it sort of type conversation. (P20)

For P10, the use of engagement surveys to understand psychosocial risk was problematic because they did not provide enough insight into the state of mind of individual workers who were experiencing poor mental health:

The others (PCBUs) do have systems and do monitor things like engagement, but they are less mature and less, the data is less current or less regular and so the data is less timely You know, if you're only getting the data once a quarter or once every six months, then that's not fast enough for somebody who's got a worsening level of mental health.

P10 suggested that for WorkSafe, the invisibility of “mental health issues” made regulatory intervention impossible:

So, then you've got this issue, which is actually not visible, which is the mental health issues. And we're basically saying to WorkSafe, can you have a look at that? And I think the challenge for WorkSafe is that's almost impossible.

6.1.6 UNMANAGEABLE

Participants spoke about the unmanageability of psychosocial risks in several ways, including that there is a lack of appropriate skill in the New Zealand health and safety workforce to deal with them, the risks are difficult and complex, and they have a potentially limitless scope.

For many participants, the absence of capability and capacity to support organisations to manage psychosocial risks was a central issue. Many participants felt that there was simply not the skill or capacity available in the New Zealand workforce to effectively support organisations to understand and respond to psychosocial risks:

My group health and safety manager has started a catalyst, but he's quite unusual in the health

and safety profession—he quite likes the abstract, the big ideas. And it has come from me, but I would say his team is completely ill-equipped to deal with much of it because it's actually the people skill. Some safety people can do it, but there will be a tiny subset of the current safety professionals we have in New Zealand. (P05)

... for an area that is legislatively driven and morally needed for all organisations, the ability to attract people with skills in the area of health and safety generally, let alone the maturity of having a psychological wellbeing inclusive component, is pretty scarce. There's some real challenges around that. (P06)

This lack of capacity and competency in the workforce was seen to extend to other company officers. In this sense, competency was sometimes equated with being qualified as a psychologist:

And what, you know, first up on that really is, you don't know what you don't know. And in the area of psychological wellbeing, few of us have trained to be clinical psychologists or assessors of pure stress and those sorts of things. And so, you know, you're hesitant about your own competency and capabilities around that. (P06)

But we're not psychologists, and so you start to run into these issues of I'm not dealing with the physical system anymore, I'm not dealing with ... clean risks I can debate as an engineer and say, yes, do this, do this, do this. (P09)

Accordingly, in relation to the HSWA, participants also expressed difficulties in translating “mental health” into a topic of regulation and, therefore, problematised the notion of compliance with WHS legislation. P22, for example, expressed difficulty explaining how their responsibilities under the HSWA translated to mental health:

Um, but I'm rambling on here because I really am struggling in this space in terms of how we do this and how we apply some of the ... you know, if you can't measure it, you can't manage it, sort of type approach. Sorry it's not a clear answer, yeah.

Similarly, P15 expressed that they found it difficult to comprehend how mental health “fits into that health and safety framework.” This meant that for many, the very idea or possibility of complying with the HSWA was not only raised as a challenge but something that might not even be possible:

So the Act as it sits, I think, envisages largely two things. One is acute injury and two is chronic disease, which actually kills more people than acute injury. And I think it doesn't accommodate mentally healthy work at all. OK? (P10)

Interestingly, many of the adjectives used by participants to describe psychosocial risk management can be characterised as consistent with ambiguity, fear, and difficulty. The choice of such adjectives largely presupposed their unmanageability. For example, risks to workers' mental health - in this case, those arising from workers' personal lives - were conceptualised by P11 as “scary”:

I think it's a scary risk for directors to take on because it opens up that whole, you know, am I now taking on, for the business, a whole lot of risk which is actually to do with someone's home life and you know, how am I going to manage that? And am I then, by acknowledging that as a risk for the business, I'm then kind of putting more, giving the task of managing that risk, and it's a hard risk to manage.

Both P06 and P08 spoke about managing issues relating to mental health at work as being like opening “Pandora's Box.” Such a metaphor expresses the fear that once an issue is spoken about, a limitless torrent of difficulties will ensue. Similarly, the issue of mental health in the context of work was described by P09 as “a huge thing that none of us have come to terms with yet.” These fears can be summed up in P03's description of the problem of managing workers with multiple risk factors arising from behaviours, mental illness, and problematic home lives:

And I think what is really important is we need to understand both sides here. I have got a lot of sympathy for employers in this situation around issues of bullying and mental harm work where, given my own experience, both as a director and as a leader, where there are often significant exacerbating circumstances. And for big employers, they just have to be the good

guy and write the cheque and take the blame because they're too decent to say, 'You've had a string of situations like this, you know, we're the third employer you've pinged for bullying. We know you're going through a divorce, and we know you have a history of serious mental illness and somehow, we're the ones...' So, you know, I have sympathy that that really does happen. Is it the majority? Definitely not. But it's not a tiny minority.

Complexity was expressed in metaphors that described the issue as “a constant moving feast” (P06), while P15 felt like their efforts over the last 12 months to put together an approach to psychosocial risk management were akin to “spinning.” For P09, psychosocial risks were not “clean” like other types of risks. P13 felt that the organisation of which they were an officer was currently looking for “the roadmap” or the “Da Vinci code” but, in finding that “there isn't one,” was then forced to navigate its way with little direction. The result was a strategy that looked like “a pile of spaghetti” (P13). In this sort of language, psychosocial risks and harms are catastrophised due to their potential to be an overwhelming issue in terms of magnitude and complexity. P24 summed up a common sentiment around the unmanageability of psychosocial risks in stating that

There's no, there's no boundaries, there's no playbook, there's no formula they can follow, it's hard and it's complex and it's different for each person, and there's nobody who can point to and go, 'They've absolutely nailed it.'

6.2 DISCUSSION

These findings indicate a strong tendency amongst participants to represent psychosocial risks, their assessment, and management in ways that create or amplify complexity and uncertainty. Overall, the representations of psychosocial risk management can be characterised according to two themes. First, the focus on psychosocial risks as arising outside of work, or as a result of the subjective experience of workers, highlights an uncertainty and decoupling of a link between mental harm and the work environment. Second, the representation of the science and knowledge of psychosocial risk management as new and unestablished, and with little consensus in approach, brings into question the validity of psychosocial risk assessment and management. These two themes will be discussed in

detail in sections 6.2.1 and 6.2.2 along with a discussion of their implications at 6.2.3. Section 6.3 concludes the chapter while laying the ground for Chapter 7.

6.2.1 THE OBFUSCATION OF CAUSALITY

As detailed in sections 6.1.3 and 6.1.4, many participants expressed difficulty conceptualising or validating a causal link between characteristics or conditions of work and the potential for workers to be harmed. This was expressed in two ways. First, many participants emphasised that psychosocial harm was mainly caused by factors other than those that arose from the work conducted as part of the PCBU. For instance, participants tended to highlight problematic aspects of workers' private relationships, family, or community obligations, and, generally, workers' personal lives outside of work. As a result of these personal or nonwork matters, participants believed that workers were less likely to cope with work or that workers may, mistakenly or incorrectly, perceive work as more harmful or difficult than an otherwise objective assessment would suggest. Psychosocial harm was thus represented as being either caused by factors outside of work or caused by a multitude of factors, and therefore it was problematic to directly implicate work as a cause of harm. An overwhelming expression of this representation was in the dilemma expressed by many participants regarding concern over the limits or boundaries to the organisation's responsibility for workers' mental health where factors influencing the mental health of a worker may be rooted in nonwork causes.

Second, the possibility of there being a causal link between work and workers' mental health was consistently problematised by way of highlighting that the very conception of psychosocial risk is subjective because psychosocial risks are brought into being through the personal perception, experience, and assessment of workers. The implication of this being that workers may incorrectly or unfairly perceive work as hazardous due their perceptions being "swayed" by different individual factors, experiences, and capacities. Consequently, the attribution of a relationship between mental harm with aspects of work was undermined or invalidated. Participants therefore questioned the possibility of being able to manage psychosocial risk in a situation where the very conception risks arose from individual, subjective perceptions.

Importantly, the observation by participants that psychosocial risks are “only” or “just” subjective and may be influenced by a number of factors, including those outside of work, is not technically inaccurate. Psychosocial risks are indeed multicausal (Hohnen et al., 2014; Johnstone et al., 2011) and “are to a large extent determined by the way in which people perceive them” (Jespersen et al., 2016, p. 25), these factors holding implications for their objective measurement and management as well as for their audit and regulation (Jespersen et al., 2016). Notwithstanding these points, various authors (see, for example, Fujimura & Chou, 1994; Pausé et al., 2021) have shown that discourse regarding the cause(s) of disease entails a process of legitimising and delegitimising various theses of causality, a process in which particular or selected elements of causality are brought to the fore while others are problematised and discredited. This process is not one where facts are alternately found or refuted but where ideas regarding causality are constructed within a set of rules by which they are built and sustained. Relatedly, interests are embedded in, and represented by, particular ideas about causality in that various “proposals about disease causality implies a different locus of responsibility for disease prevention” (Tesh, 1981, p. 369). Due to the differential authority of various claim makers, certain proposals regarding causality may serve to maintain and reproduce the social or political conditions that sustain causes of disease whilst simultaneously diverting disease prevention activity away from more effective, but socially disruptive, activities. In the findings of this research, the discourse that, on one hand, highlights non-work-related causes of mental harm and, on the other, the subjective experience of risk, can be seen in this light. Arguably, psychosocial risk and its assessment differs from other risks because it very explicitly calls into question the management and organisation of work. This questioning can be confronting and difficult for those tasked with managing or governing organisations, not necessary because of the technical or scientific challenges but because “it entails challenges to management practices and the managers’ exercise of power” (Jespersen et al., 2016, p. 26).

The multicausal etiology of psychosocial risk and harms is not a complexity relating to those phenomena alone and can, in fact, describe most WHS risks and occupational injuries and illnesses. The belief that safety-related harms can be pinned back to a single root cause that triggers a chain of

events, or the belief that causation is linear and deterministic, has been critiqued in the broader WHS literature (Dekker, 2011a; Leveson, 2011). Within this critique, such “essentialist” views have been noted as a persistent style of thinking (Dekker et al., 2013) amongst those tasked with managing WHS who “demand simplification” (Hudson, 2014, p. 760) in understanding the causes of work-related harm. In the regulation of WHS, this type of thinking is also implicated in the isolation or splintering (Johnstone, 2003; Mathiesen, 2004) of WHS incidents, understood as the severing of a causal relationship between work-related harms and the broader systems and contexts of work surrounding or contributing to them. Splintering serves to decouple incidents of harm from the underlying systems of work and entails a redirection of focus to the immediate or proximate causes of harm, typically implicating worker behaviours, actions, or inactions. The result of splintering harm-causing events from their position in a wider system is that instances of harm become depoliticised, decontextualised, individualised, and sanitised (Johnstone, 2013).

The tendency to focus on or emphasise the characteristics of workers that gives rise to health and safety risks as opposed to those arising from systems of work has been observed in the literature (Dekker, 2011b; Hart, 2010; MacEachen, 2000; Rasmussen, 2013). In terms of psychosocial risk specifically, the multicausal nature of risk, coupled with a tendency to focus on workers’ personal lives as the loci of risk, has been observed in other studies. For example, Schuller (2019) found that a commonly held belief amongst central actors in the psychosocial risk management processes within organisations was that “well-being and health have their roots in the private sphere of employees, rather than in work design” (Schuller, 2019, p. 66). Page et al. (2013) found that many stakeholders perceived that stress at home influenced work while “others went so far as to say that stress at home was the primary cause of work stress, and often linked to mental health problems” (p. 453). The authors of both studies note how these conceptions downplayed and delegitimised work-related factors as risks to employees’ health.

Drawing on Foucauldian notions of truth and power, Rose (1999b) describes various political rationalities (such as liberalism, welfarism, and neoliberalism) as discursive fields, each having an organising vocabulary. These vocabularies provide the platforms from which “disputes can be

organized, by ethical principles that can communicate with one another, by mutually intelligible explanatory logics, by commonly accepted facts, by significant agreement on key political problems, ... [and provide a zone of] ... intelligible contestation” (Rose, 1999b, p. 28). These zones of intelligibility demarcate the availability of particular “conclusions ... [about] ... what should be done, by whom and how” (Rose, 1999b, p. 28). Applying Rose’s observations to the analysis here, it can be argued that because occupational health and safety laws are premised on a welfarist political rationality, underpinned by the idea that risks to worker health stem from the unequal exercise of power within the employment relationship, this understanding focuses responsibility on those that control the means of production to manage the risks to worker ill health. However, this rationality is in tension with a broader neoliberal rationality, which emphasises individual responsibility for health and the role of the responsabilised individual. Indeed, this uneasy coexistence of welfarist rationalities with dominant neoliberalist ones has been identified in a number of studies as an explanatory framework for the dominance of individual, behavioural, or generally worker-focused—as opposed to ecosocial, biopsychosocial systems or environment-oriented—health and safety management strategies and technologies (Gray, 2009; MacEachen, 2000; Rasmussen, 2011, 2013).

Regulations, including work health and safety laws, are a key constraint to the otherwise unencumbered prerogative of employers and management to organise work as they deem fit. In this way, psychosocial risk management cuts to the very heart of management prerogative by entailing critical scrutiny of the core rights, tasks, and goals of management. Thus, psychosocial risks are strongly implicated in the power disparities in workplaces and are therefore “highly political” (Jespersen et al., 2016, p. 25). As Jespersen et al. (2016, p. 26) note, “managers tend to avoid confronting issues of power and management style; however, it is precisely these practices that is critical to an understanding of how psychosocial risks and related occupational illnesses evolve.”

Despite the orthodoxy in the research literature that points to the diffuse factors that explain accidents, the political expediency of attributing cause to “human error” and to “focus on who is operating the system at the sharp end” (Dekker et al., 2013, p. 278) is persistent and can be seen reflected in the findings of this research. For example, although participants noted that psychosocial harm is

multicausal, they tended to emphasise those causes of harm that sat outside the realm of managerial control, notably the personal lives or characteristics of workers. The representation of psychosocial risk as having multifactorial causality but only emphasising those causes arising from the workers themselves systematically limited organisational responsibility for harms and obscured agency to act on those risks to worker health that did fall within the ambit of managerial responsibility.

6.2.2 PSYCHOSOCIAL RISK MANAGEMENT AS NEW, UNCERTAIN, AND UNEVIDENCED

The findings also indicated that many participants represented psychosocial risk management and the consideration of workers' mental health under WHS law as a new and unsettled field. In expressing this view, participants declared that there was very little research or consensus about what psychosocial risk was and what could be done about it. In terms of being new, it is important to note that "mental health" has only been included in the definition of health in New Zealand's WHS laws since 2015—seven years prior to these interviews being conducted. Before that time, "stress" had been included as a hazard in a 2002 amendment to the Health and Safety in Employment Act 1992, reflecting the thinking about work-related stress at the time. However, the study and management of the relationship between workers' mental health, wellbeing, or welfare, and the conditions of work has been around for decades, if not centuries: "The issue of the working environment is as old as industrialization itself" (Gustavsen, 1977, p. 266).

Arguably, the earliest English workplace health and safety legislation considered what are now known as psychosocial risks. The Health and Morals of Apprentices Act (1802) was focused on children working in English cotton mills and placed duties on employers around certain conditions of work, such as hours worked, as well as making various provisions for welfare, education, and spiritual practice. This, and later WHS Acts, conceivably held a more broader welfare objective than a safety one (Nardinelli, 1980). For example, the Factory Acts enacted from 1833 were introduced in the textile industry where 75% of workers were children, teenagers, or women and paid particular attention to these workers' welfare, health, and the general working conditions. It was not until the

Factory Regulation Act (1844) that specific safety provisions were included, primarily dictating a requirement to guard or fence machinery.

The issue of the specific relationship between workers' psychological selves and work has been a topic, if not a fundamental underpinning, of management interest over the past century. Although the language of psychosocial risk management, wellbeing, or even mental health may not have been used by industry over that time (Wallace, 2022), the centrality of understanding humans at work in terms of the relationship between work and workers' psychological selves is well established (see, for example, Miller & Rose, 1988, 1990; Mumby, 2019; Rose, 1996, 1999a). Management philosophies, such as the Mental Hygiene Movement, Industrial Psychology, Taylorism, the Human Relations Movement, the Quality of Working Life Movement, through to the management philosophies from the 1980s that drew on theories of the likes of Maslow, can all be considered technologies of management that place psychological aspects of the worker at their core. Central to these philosophies is that organisational problems can be overcome by "activating and engaging the self-fulfilling aspirations of the individuals who make up the workforce" (Miller & Rose, 1995, p. 454).

The direct and purposeful application of WHS law to psychosocial risks has occurred since at least the introduction of legislation in Norway in 1972—more than 50 years ago (Gustavsen, 1977). Policy references are made elsewhere in Europe to psychosocial risks and their control at work in the late 1970s (Peruzzi, 2017). Thirty years ago, in 1984, the International Labour Organization (ILO) released its well-known paper, "Psychosocial Factors at Work" (International Labour Organization, 1986), and, in Europe, by 2008, a best practice framework for psychosocial risk management (PRIMA-EF) had been designed from a basis of well-established evidence and released by the World Health Organization (Leka & Cox, 2009). In the PRIMA-EF, the authors observed that psychosocial risks were "widely recognized" (Leka & Cox, 2009, Preface). Standards for psychosocial risk management (Management Standards) were developed and introduced in the UK in 2004 (Cousins et al., 2004; Leka, Jain, Widerszal-Bazyl, et al., 2011; Mackay et al., 2004), and a plethora of other standards, policies, and regulations have been enacted around the world in the ensuing years (Leka & Jain, 2016; Potter et al., 2022).

Researchers consider that there is “strong” (Schuller, 2019, p. 61) evidence and consensus in the understanding of psychosocial risk as “the likelihood of aspects of work organization, design, and management potentially causing physical or mental harm” (Langenhan et al., 2013, p. 88). Further, the body of evidence describing and evidencing the relationship between psychosocial risk exposure and harms to workers has been characterised as “extensive” (Moncada et al., 2011, p. 591).

Internationally, “guidance on psychosocial risks and their management exists in abundance” (Leka, Van Wassenhove et al., 2015, p. 61), although others note a relative lack of studies regarding psychosocial risk management interventions (Oakman et al., 2016) and practical guidance (Oakman et al., 2022). Given this body of work and the background and approaches underpinning psychosocial risk management outlined in section 3.3.1, one of the more surprising findings of this research was the representation of psychosocial risk management as a new field of practice that was not underpinned by a coherent body of research.

Also as noted in section 3.5.8, however, the research into organisational perspectives on psychosocial risk management finds a persistent policy–practice gap. A number of researchers have observed that stakeholders often claim to be unclear about the meaning and scope of psychosocial risk management (Leka, Van Wassenhove et al., 2015), hold divergent views and perspectives (Iavicoli et al., 2011; Jespersen et al., 2016; Langenhan et al., 2013), and lack awareness (Leka et al., 2017). In a similar vein, Moncada et al. (2011, p. 592), contended that in Europe several years after the development of the PRIMA-EF, that a major obstacle to effective psychosocial risk management remained the “strong presence of false beliefs.” Example of such beliefs included that “psychosocial risk theory is too complex subject [sic] with no scientific paradigm and that no valid and reliable risk assessment method either exists or could be developed” (Moncada et al., 2011, p. 592). The belief held by participants that psychosocial risk management is new and uncertain, therefore, concurs with research from other jurisdictions suggestive of a stubborn policy–practice gap, underpinned by claims of uncertainty from stakeholders.

6.2.3 IMPLICATIONS OF PROBLEMATISING FOR PSYCHOSOCIAL RISK MANAGEMENT

A common representation of compliance, particularly relating to WHS, that is made by business is that it is a burden (Gunningham, 2015b; Hampton, 2005). Furthermore, pointing to this burden “can be part of a strategy by business to reduce their overall obligations to society” (Haines, 2021, p. 96). In this research, participants did not commonly refer to the burden of compliance alone as a reason to presuppose deregulation or inattention to compliance but, rather, to a suite of other problems that cumulatively represented psychosocial risks as problematic to understand or eliminate, or outside of the scope and possibilities of managerial control. These problematisations appear to have become a common and axiomatic way of thinking about psychosocial risk at work.

The way that participants represented psychosocial risks amplified particular aspects about them, such as their complexity and multicausality, which imply their unmanageability. This unmanageability was highlighted by posing psychosocial risks as beyond the reasonable control or influence of the organisation, and, thus, these representations limit the ability of those same participants to act upon them. Additionally, the representation of knowledge about psychosocial risk management as undefined and unknown also presupposes that even if risks were to be understood, there is no acceptable, known, or effective ways of managing them. In emphasising psychosocial risks as subjective and multicausal, with a related focus on non-work-related factors as the most salient causes of harm, responsibility for harm is redirected from the organisation to the worker. Consequently, this discourse works to dissociate managerial decisions and systems under the control and influence of management from the risk of harm to workers, thus absolving management of blame for causing them, and limiting, or releasing, officers and the organisations they govern, of their legal obligations. At the same time, by also focusing on workers’ personal lives, subjectivity, or mental characteristics, the discourse redistributes that responsibility to workers themselves. This finding aligns with research in other countries, which similarly found that managers and other influential actors consider psychosocial risks to be an individual responsibility (Sivris & Leka, 2015) and “largely or entirely beyond their own control” (Oakman et al., 2019).

6.3 CONCLUSION: THE CREATION OF A NOVEL RISK

Studies of discourses of risk examine how the deployment of (often expert or authoritative) knowledge construct and legitimate particular truths about risks. In the case of these research findings, the discourse used by participants reproduces uncertainties about the possibility of risk management and the presupposition of unmanageability. The preponderance of problematisations and dilemmas raised by participants in describing how they fulfill their duties further suggests instability in the meaning of the law as it relates to psychosocial risk. This instability is best represented in the characterisation of psychosocial risks as novel risks, those being risks that “are associated with uncertainty or unfamiliarity concerning the harm that an object may cause, the likelihood the harm will occur, or the causal processes connecting the object and the harm” (Hardy & Maguire, 2020, p. 688). Hardy and Maguire (2020) emphasise that attributes such as uncertainty, unfamiliarity, complexity, and so on are “themselves socially constructed” (p. 688), and, therefore, the novelty aspect of certain risks is a discursive construction too.

Hardy and Maguire (2020) go on to explore the construction and organisation of novel risks and the responses that organisations make to them. In particular, they pay close attention to how individuals and organisations “translate” (p. 688) novel risks into those that are more familiar and, ultimately, more manageable. The next chapter, Chapter 7, will explore this process, using Hardy and Maguire’s idea of risk translation as a guiding concept.

7. THE ORGANISATION, CONSTRUCTION AND TRANSLATION OF RISKS

This chapter is the third of four chapters that present and discuss the findings of this research. Having previously addressed the first research question, this chapter focuses on the second research question:

How do constructions of risk shape how officers respond to this duty?

Section 7.1 begins the chapter with a brief discussion on the construction and organisation of risk, followed by the presentation of findings regarding those risks that were spoken about or named by participants at interview (section 7.2). Section 7.3 explains how risks may be constructed in ways which translate their meaning, and I then apply this thinking on translations to the risks spoken about by participants as they described their duties. Further discussion and a conclusion to this chapter is provided in section 7.4.

7.1 RISK CONSTRUCTION AND ORGANISATION

As explained in the literature review in section 2.1.4, a social constructionist view of risk envisages risk as socially produced rather than reflective of a naturally given reality. In this sense, the significance of risk is not what it is itself but “what it gets attached to” (Dean, 2010, p. 206).

Hilgartner (1992) suggests that the construction of something as a risk is performed through texts, and formulated on two levels: first, the construction of an object and, second, the definition of that object as risky. In the first level, the very division of the world into differentiated objects can be considered a “conceptual achievement” (Hilgartner, 1992, p. 42). Here, that which is defined as an object is a source of insight because the selectivity inherent in drawing an object out of its background and making it discrete from its surrounding milieu can be considered dependent on, and created by, the knowledge systems that surround it.

The second level involves defining the object as “risky”. This occurs through the attachment of a link or linkages between the object and a harm or threat—a further conceptual achievement when risk can potentially be attributed to multiple objects and indefinite causal chains. Thus, where risk objects are “the things that pose hazards, the sources of danger, the entities to which harmful consequences are

conceptually attached” (Hilgartner, 1992, p. 41), the attribution of causal linkages between the object and a harm constitutes a further source of analytical insight. In this way, out of the potentially limitless objects, harms, and casual linkages that might be made, “those risks that will receive their attention will be the ones they identify as significant problems” (O'Malley, 1996, p. 204).

By way of example, Hilgartner (1992) suggests that if road accidents are the harm or threat, causal links may be made to unsafe roads, unsafe cars, or unsafe drivers (or indeed other causes). Of these, a dominant causal link may emerge that, for example, highlights unsafe drivers as the risk object, and subsequent causality might be attributed to age, inexperience, fatigue, or drug use. Of these, inexperience might be attributed to poor education, which, in turn, could then be attributed to funding shortages, and so on. The causal links that are made are important to note because the construction and dominance of particular objects, causal chains, and networks have implications in terms of what becomes the focus of risk management. The construction of risk is also characterised by concern for one or more ‘risk subjects,’ being the entities, actors, or phenomena that, having been “endowed with value” (Boholm & Corvellec, 2016, p. 111) are considered threatened by the risk object. Thus, constructions of risk are established by the cognition of a risk object, a risk subject, and a relationship of threat or harm between them.

The selectivity of that which is the risk object and the causal links that are made to risk subjects is imbued with power because particular risk objects become defined as such by “claim makers” (Burgess, 2015, p. 4). A “claim maker”, explains Burgess (2015), includes those individuals or groups who not only advance particular ways of thinking about problems such as risk objects but also the subsequent policy solutions to those very problems. Through this process, certain problems, and certain causes, rise in prominence while others are invisibilised. As a result, Hilgartner (1992) explains, risk objects are “emplaced” (p. 49) when people successfully define them as objects and successfully link them to harm or “displaced” (p. 49) when their existence as objects is challenged or the linkage between the object and harm is severed. In the following sections 7.2 and 7.3, a closer examination of the types of risk objects named by participants indicates those risks that have become emplaced.

7.2 THE IDENTIFICATION AND NAMING OF RISK OBJECTS

A social constructionist view of risk understands that there are material things in the world that constitute risks. This perspective, however, also understands and pays attention to the way that risks are given meaning and constructed through discourse, practices, and techniques—that they come into existence and are maintained, reproduced, and challenged through social acts of language. Bearing this in mind, the interviews that I conducted with officers focused on understanding how they carried out their duties, but I did not question participants specifically on the topic of risk at interview. Nor did I ask participants what risks they knew of, what they thought about certain risks, or about what risks existed in their organisations. Rather, unprompted, they named various risks as they described how they went about exercising their duties. The naming of risks by participants, therefore, suggests which risks participants were concerned about, those objects that exemplified risk, or those risks that otherwise held particular salience.

Figure 2 (below) represents the risk objects linked to workers' mental health (the risk subject) that were mentioned by participants. In this figure, I have only included those risk objects that participants noted arose from the work undertaken as part of the operation of the PCBU. The categories of risk objects are based on those described in the taxonomy of psychosocial risks provided in the literature review in section 3.4. In the category of "Interpersonal relationships at work", the types of things mentioned by participants included worker behaviours, such as bullying, harassment, stand-over tactics or intimidation, sexual harassment, dysfunctional team dynamics, personality conflicts, workplace rumours, personal disputes, and clashes. This category did not include these behaviours when directed at workers from customers, clients, patients, or other external parties, which were included in the category of "Job content". The second most mentioned risk category was "Organisational culture", which included all-encompassing designations, such as workplace culture, operational culture, the general work environment, or the cultural setting, as well as specific types of culture, such as a competitive culture. Together, "Interpersonal relationships at work" and "Organisational culture" comprised 71% of the occasions on which risks arising from work were mentioned by participants.

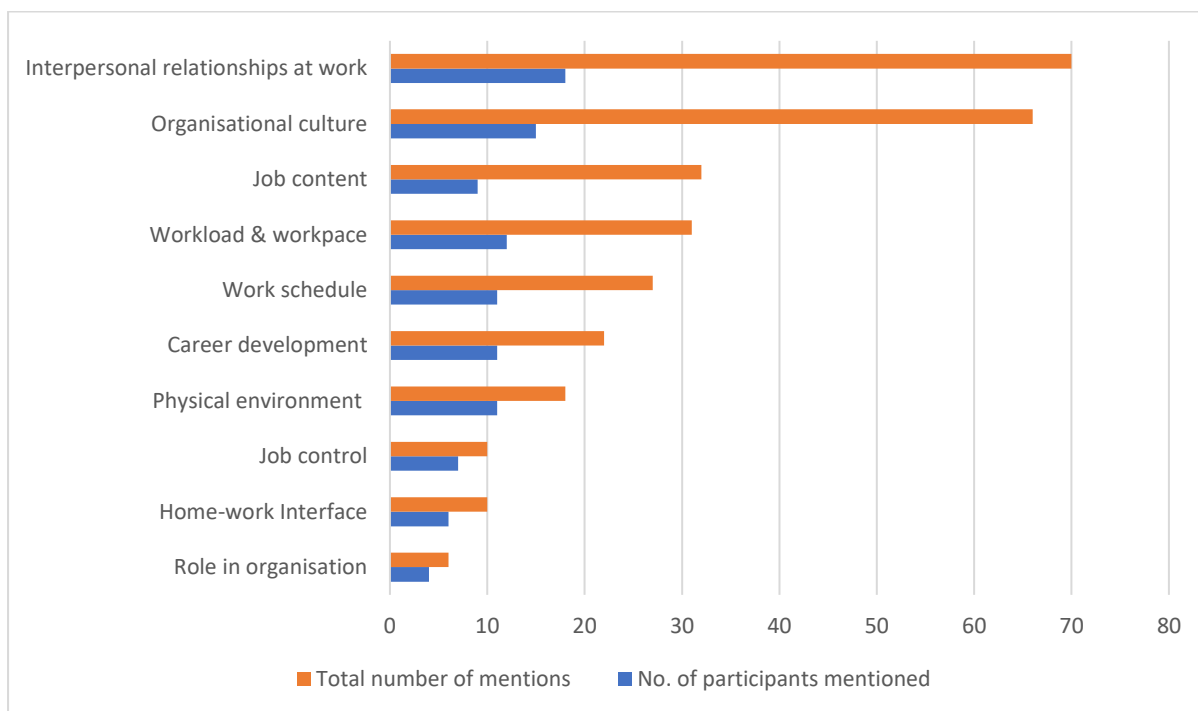


Figure 2

Risk Objects Linked to Workers' Mental Health—Work-related Risk Objects Only

However, because many of the risk objects named by participants were risks *not* arising from work, in Figure 3, I have included all the risks to workers' mental health named by participants when they described carrying out their duties of due diligence, illustrating the broad types of risk objects that participants mentioned in relation to the conduct of their duties. To incorporate these risks, I have added the additional categories of "Home or personal problems", "Individual psychological characteristics", and "External political, socioeconomic, climate". "Home or personal problems" included references by the participants to the difficulties and complexities of workers' personal or home lives, such as those that may stem from raising children, or from intimate personal relationships. The category also included references to workers experiencing loneliness outside of work or having financial problems. Finally, this category also included health-limiting behaviours that workers engaged in such as alcohol consumption, gambling, or drug use. Thus, this category was qualitatively different from the "Home-work interface" category, which considered the relationship between work and home and included such things as working from home and working during personal time. The category "Individual psychological characteristics" included risks to workers' mental health that arose

from intrinsic factors within the individual, such as having a history of mental illness or a lack of resilience. The third additional category, “External political, socioeconomic, climate”, included risks to workers’ mental health arising from general political, social, socioeconomic, or climate issues, such as war, climate change, or high interest rates.

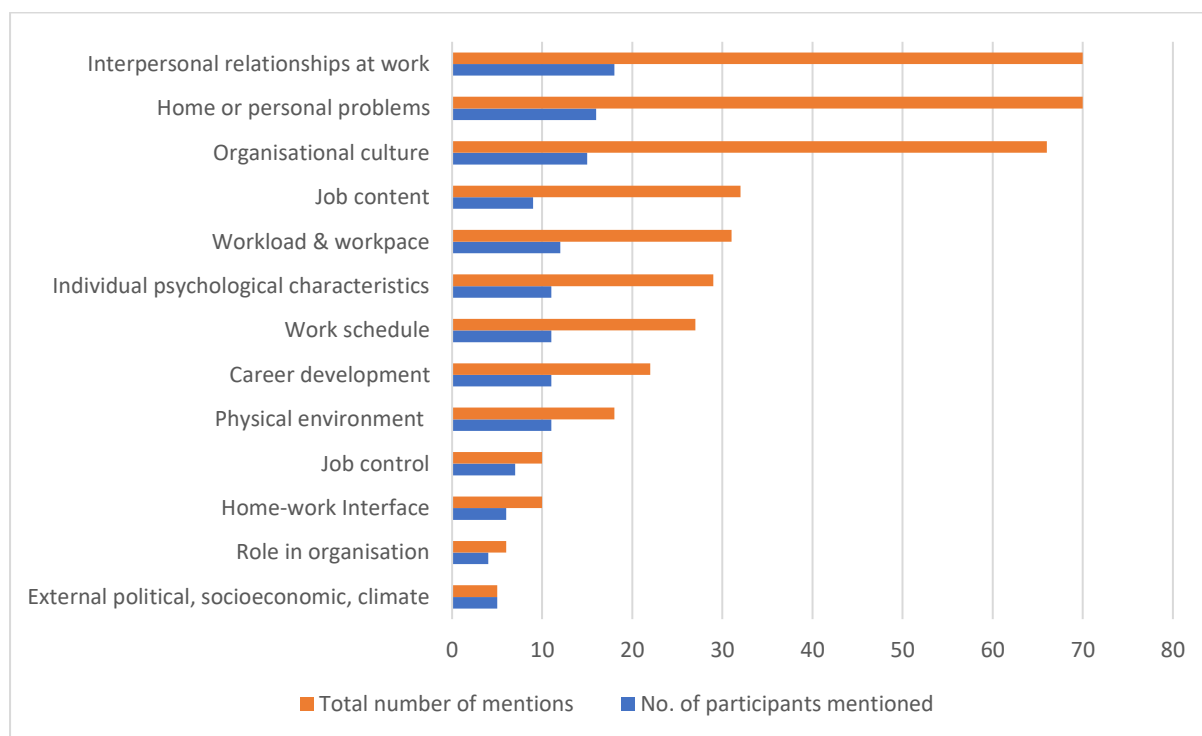


Figure 3

Risk Objects Linked to Workers' Mental Health—All Risk Objects

In Figure 3, once the “non-work” categories of risk objects were included, “Home or personal problems” became the first equally most mentioned risk object. The top three categories of risk objects, now being “Interpersonal relationships at work”, “Home or personal problems”, and “Organisational culture” were together mentioned 209 times by 21 out of 24 participants (or by 19, 17, and 17 out of 24 participants, respectively) and comprised 51% of the occasions in which participants spoke about risks whilst they described the conduct of their due diligence duties.

Therefore, in more than half the times in which participants identified a risk object, they identified the personal lives, circumstances, or relationships of workers, or the culture of the organisation. These findings and their implications inform the following section under 7.3, as well as Chapter 8.

7.3 NOVEL RISKS AND RISK TRANSLATION

As explained in the conclusion to Chapter 6, novel risks “are associated with uncertainty or unfamiliarity concerning the harm that an object may cause, the likelihood the harm will occur, or the causal processes connecting the object and the harm” (Hardy & Maguire, 2020, p. 688) and are otherwise described as new, emerging, or uncertain risks. Given this definition and the findings described in chapter 6, psychosocial risks can be considered novel risks in accordance with the problematising representations made of them by officers.

Hardy and Maguire’s (2020) study of novel risks examined the way that key actors wrote and spoke about BPA (bisphenol A), a plastic used in a wide variety of products that had “come to be constructed as posing novel risks to human health and the environment” (p. 686). In their findings, they found that in talking about BPA, actors described various risk objects that were not necessarily BPA itself. Accounts of the risk object—that deemed to pose the risk—varied between different groups of stakeholders. Through an analysis of the way that these risk objects were spoken about, Hardy and Maguire (2020) identified that different groups of stakeholders “translated BPA’s equivocality into other risks with which they were more familiar” (p. 690), thereby changing the focus of risk management from the health and environmental threats posed by BPA to risks such as professional, regulatory, reputational, and operational risks. These risk translations, although reflecting different constructions of risk than the original risk, provided stakeholders with a clearer basis for risk management actions. Over time, these translations stabilised to slowly replace equivocality, contestation, and novelty with familiarity. Hardy et al. (2020) note that while risk translation increases the number of risks an organisation has to deal with, it also increases the power of the organisation to deal with these now more “familiar” risks:

Organizations may struggle to understand risks to individuals associated with, for example, climate change, pollution, or infectious diseases since these risks are complex and organizational responsibilities are unclear. However, organizations usually do know what to do when they face specific legal, financial, regulatory, reputational, operational, or strategic

risks to themselves. Policies, routines and techniques are often already in place. (Hardy et al., 2020, p. 41)

Risks are therefore “translated” (Hardy & Maguire, 2020, p. 688) when an object’s meaning in relation to risk is changed. This translation has several implications. First, remembering that the emplacement of risk attributes danger to particular objects and, relatively, diminishes the danger posed by others, changing whether and how a risk object is defined is not a politically neutral process but one that can “reconfigure power relations among actors” (Hardy et al., 2020, p. 41). Changing the meaning of the risk object through risk translation does this because of the way that it “can redistribute responsibility for risks, change the locus of decision making, and determine who has the right—and who has the obligation—to ‘do something’ about hazards” (Hilgartner, 1992, p. 47). Therefore, not surprisingly, “efforts to construct new risk objects, or redefine old ones, thus often take the form of intense struggles” (Hilgartner, 1992, p. 47).

Second, risk translation may also have the effect of changing the risk subject—that which is considered to be affected by risk or the decisions made to manage them. The risk of *what* occurring and to *whom* are variables that are often disguised in an all-purpose or “rudimentary” (Zinn, 2010, p. 110) risk assessment. However, being explicit about all the relevant dimensions in the assessment of risk, including identifying that which is deemed to cause the risk and that to which the risk of harm is posed, and the nature of the anticipated harm, is essential in uncovering the relationships between who defines risk and who is affected negatively by risk, or who stands to gain from particular constructions of risk. This detailed investigation of the language of risk aligns with the aim of an “analytics of government” (Dean, 2010, p. 47), which aims to make explicit the largely tacit way in which we govern and are governed. These dimensions of risk will be explored further in the examination of risk translations from section 7.3.1 to 7.3.5.

In Chapter 6, I concluded that the participants’ representations of the risks emerging at the intersection of WHS laws and worker mental health suggest that these risks can be thought of as “novel risks”. In this section, I will show how this novelty was dealt with through the translation of risks from

psychosocial risks to those that company officers were more familiar with, but which also, through this translation, shifted attributions of cause and responsibility for these risks.

Drawing on Hardy and Maguire’s (2020) methodology for identifying risk translations, I identified the risk object—that which was considered to pose a threat of harm, and I also identified the risk subject - the entities, actors, or phenomena that, having been “endowed with value” (Boholm & Corvellec, 2016, p. 111), were considered threatened or potentially harmed by the risk object.²⁶ The findings of this examination are laid out in the two tables below. First, Table 9 summarises the way in which risks were constructed in ways that are most consistent with the definition of psychosocial risk and its application to the HSWA, that is, where the risk object is aspects of work, and the risk subject is workers. The next table, Table 10, then summarises the various translations of this risk construction into other constructions of risk and their variations to the subject and object of risk. These tables are followed by a more detailed description of each construction and translation.

Table 9

Summary of Constructions of Psychosocial Risk

Participants’ account of the negative impact associated with workers’ mental health	Risk subject (that which is harmed)	Risk object (that which poses the risk)	Risk type	Example(s) from this research
Psychosocial risks as risks to workers’ health (see section 7.3.1)				
a. Officers link workers’ mental health to aspects of the design and management of work and its social and organisational contexts that may cause harm.	Workers	Work – aspects of work design and the organisation and management of work, and their social and environmental contexts.	Health risk: Threat to the health of workers.	Workers’ mental health is put at risk by bullying and harassment at work, or by contracting arrangements which create job precarity.

Table 10 below illustrates the translations of psychosocial risks made by participants. In these examples, the translated construction of risk shifts the meaning of risk. This is indicated in the “Original risk object > Risk object translation” column where it is shown how the risk object has been “translated” from those risks arising from “work” to a different object that is considered to pose a risk.

²⁶ Bohholm and Corvellec (2016) refer to the risk subject as the object *at* risk.

Table 10*Summary of Risk Translations of Psychosocial Risk*

Participants' account of the negative impact associated with workers' mental health	Risk subject (that which is harmed)	Original risk object > Risk object translation (that which poses the risk)	Risk type	Example(s) from this research
Translation: Safety risk (Section 7.3.2)				
a. Officers link workers' behaviour to mental illness/poor mental health, which may cause those workers to harm themselves or others.	Workers	Work > Workers' behaviours that arise from mental illness, poor mental health, or poor wellbeing.	Safety risk: Threat to the safety of self or other workers.	Workers place their own and other workers' safety at risk because they have a mental health problem which impacts on their ability to work safely.
Translation: Individual risk (see section 7.3.3)				
b. Officers link workers' mental health to workers' home or personal life, which may cause these workers harm.	Workers	Work > Workers' home or personal life.	Individual risk: Threat to the health of workers who have risky home or personal lives.	Workers with problematic relationships at home are stressed and fatigued, which impacts on their mental health at work.
c. Officers link workers' mental health to workers' personal characteristics and capacities, which result in an inability to cope with work.	Workers	Work > Workers' psychological characteristics.	Individual risk: Threat to a worker's capacity or ability to cope with work.	Workers with low levels of resilience are less equipped to cope with the regular demands of work and, thus, experience poor mental health.
Translation: Operational risk (Section 7.3.4)				
d. Officers link workers' mental health to their compromised ability to work productively, which may cause harm to the organisation	Organisation	Work > Workers' mental health.	Operational risk: Threat to the effective operation of the organisation.	Workers with poor mental health do not function at optimal levels required to work productively and efficiently.
e. Officers link workers' mental health to workers' home or personal life, which may cause harm to the organisation.	Organisation	Work > Workers' home or personal life.	Operational risk: Threat to the effective operation of the organisation.	Workers who engage in health-limiting behaviours outside of work, such as drinking alcohol, are less able to work productively.
Translation: Reputational risk (see section 7.3.5)				
f. Officers link workers' mental health to organisational responses to mental ill-health, which, if are not seen to be in place, may cause reputational harms.	Organisation	Work > Organisational responses to mental health and wellbeing.	Reputational risk: Threat to the reputation of the organisation.	Organisations that do not have a well-regarded wellbeing programme are not seen as desirable places to work.

7.3.1 PSYCHOSOCIAL RISKS AS A THREAT TO WORKERS' HEALTH

In this first construction of risk shown in Table 9, participants described psychosocial risks arising from the work carried out as part of the conduct of the PCBU as the risk object that threatened the mental health of workers (the risk subject). This category of risk is that most aligned with the intent and purposes of WHS law because it considers the impact that work carried out as part of the conduct of the PCBU may have on the health of workers. It is also consistent with the definition of psychosocial risk in that it focuses on “those aspects of work design and the organisation and management of work, and their social and environmental contexts, which have the potential for causing psychological, social or physical harm” (Cox et al., 2000, p. 14). The causal link made here is shown in Table 9, where participants linked workers' mental health to aspects of the design and management of work and its social and organisational contexts that may cause harm.

7.3.1.1 Describing psychosocial risks

In the first construction of risk in Table 9, the various aspects of work design and the organisation and management of work and their social and environmental contexts were emphasised as risky in their potential to cause harm to workers' mental health. This construction aligns with those risks shown in Figure 2 in section 7.2. In this construction of psychosocial risk, the most mentioned type of risk was that associated with interpersonal relationships between workers, followed closely by organisational culture.

Interpersonal relationships between workers were most commonly represented in terms of behaviours between workers, such as bullying, harassment, abuse, violence, and conflict. For example, P06 reflected on their focus on eliminating “bad behaviours” in their organisation:

And now we've seen some pretty high behavioural standards across the organisation that applies to all staff ... and it's a zero tolerance to bad behaviour, a zero tolerance to a whole lot of other stuff, and I will hold them accountable for that. And certainly, it hadn't happened before, but I've been here [redacted] years um, and I have [instigated specific disciplinary action] for the failure to change or modify their behaviours.

The issue of interpersonal conflict also often extended to that existing between workers and middle managers, supervisors, or team leaders:

How do I diagnose the issue to start with? So, is it the team members, is it the team leader?

Most of the time, it's usually the team leader. So, then what do you do with that person? You know, is that um excuse me, don't come Monday? (P10)

On only one occasion was interpersonal issues amongst and between workers linked to other risks arising from work. For example, in discussing bullying, P02 noted that bullying behaviours may occur in the context of a work environment where such behaviours are enabled:

They don't go to work to harass people; they don't go to work to upset people. So, so, when that behaviour permeates, what's caused that? You know, is it, is it because they're role modelling leaders of the past because that's how they learnt? Um, is it that they've had no coaching and development? They don't know right from wrong? Or is it that, you know, they're just stressed and maxed out? Is it a cry for help?

The next most mentioned risk named in this category related to organisational culture. At the broadest level, culture was described with all-encompassing designations, such as workplace or organisational culture, operational culture, the general work environment, or the cultural setting. For example, P11 suggested that culture was a fundamental cause of risk:

I think, again, with wellbeing, I could ask for that and I could get a bow tie analysis of that risk; it would be harder for me to actually go and see that way in which that risk is being managed. It strikes me that it relies a lot more on culture and everyday conversations than it does on specific operational risk controls that you can see in practice.

Other descriptions of cultures that caused risk were organisational cultures where there was a lack of a “sense of togetherness, a real sense of purpose and a real sense of achievement” (P10). For others, culture referred to an environment in which workers were encouraged, and felt safe, to talk about

mental health, as suggested by P21: “I think having a safe culture that mental health issues and matters can be raised in an area, you know, in a culture and within the culture of your organisation.”

Beyond risks arising from interpersonal conflict and workplace culture, the next three most commonly mentioned risks were job demands, workload and work pace, and work schedule. For example, demands from clients, poor treatment by customers, and attending traumatic incidents were all described as job demands that could impact on workers’ mental health. In terms of job content, boring work was identified by P10 as something that might pose a risk to workers, and by P18, who observed that the repetitive nature of a manufacturing job may present a risk: “And a number of us were standing there looking at this machine thinking, excuse my French, *fuck* this would be boring.”

In terms of workload, P03 identified that high workload was a “key driver” of risk to workers. Workload was expressed in terms of workers being “under pressure” (P19), having too many “demands” (P07), or being “overloaded” (P09). Work pace was expressed in terms such as workplaces being “frenetic” (P18) and in descriptions of the high “cadence of work” (P08). Risks to worker health relating to work scheduling, such as long hours, work unexpectedly going over time, early starts, and shift work, were also mentioned as risks to workers’ mental health.

Other, lesser mentioned types of risk arising from work included those relating to career development and the physical work environment. Examples included risks such as unfair remuneration and the harms relating to restructures or redundancies, and job uncertainty and precariousness such as that faced by subcontractors (P05) or workers on maternity leave (P17). Risks relating to the physical work environment predominately focused on COVID-19 and contracting it through workplace exposure. Other risks arising from the physical work environment included cramped or uncomfortable workplaces, exposure to safety hazards, discomfort experienced in wearing physical protective equipment, and physical isolation.

7.3.1.2 Managing psychosocial risks

Where the risks identified by participants focused on interpersonal issues between staff, techniques for managing risks relied on having systems in place to avoid, minimise, report, resolve, or mend

interpersonal conflicts. For example, P10 described having a “two-up” system to ensure managers would not unfairly judge workers’ performance, and P10 and P24 both described dispute reporting and resolution systems as risk management strategies relating to bullying. Several participants (P06, P08, P12, P15) described organisational policies that declared intolerance for bullying or harassment, or which detailed processes for responding to them. Similarly, two participants (P07, P24) reported having a whistle-blowing line to report instances of bullying or harassment.

Strategies for managing risks regarding organisational culture related to efforts to develop particular types of cultures that, presumed, were without risk, or minimised or eliminated risk. These types of cultures were described using a wide range of terms, such as a “phenomenal culture” (P09), a “culture of openness” or an “aspirational culture” (P22), a “caring culture” (P02), “a safe culture” (P21, P17), “a strong culture of doing the right things” (P11), or a “supportive culture” (P02, P22). Related to most of these ideas, participants felt that a culture where people cared about and looked after one another was important. In this way, the risk management strategy inherent in these types of organisational cultures hinged on the way that individuals related to, and behaved toward, each other:

They're there to ensure that we have a, an operational culture whereby people can come to work, do their job, and get home safely, and that during the day when they're at work, they have a concept of looking after their mates, firmly, looking after themselves and looking after their mates firmly embedded in the way they approach their tasks. (P18)

Well, in my experience, the best thing that any senior leadership team can do is to build and grow a culture. And the culture is one of openness. One of support, recognising that some people are gonna be busier than others at times. Can I lend a hand? ... So, it comes down to how the business develops its culture, and it's, it has to recognise that there will be stress in the workplace and that people need support. (P22)

In the end, I set the culture of the organisation. If I'm seen to be caring and compassionate, then others will see that ... (P12)

For other participants, however, “support” had a somewhat more instrumental meaning. Here, support meant that which would be provided by managers or workers to others to support them in navigating challenging work situations. For example, in describing the challenging public-facing work situations that workers faced, P17 explained, “So part of it is making sure that um, when people are put in those situations, they’re supported and that every effort is made to ensure that they’re protected.” Similarly, P21 described an opportunistic observation of support between two workers: “So it was probably, it was their first day, so just being able to see that interaction and how supportive was that person ... was the senior person to the new person, what was going on, were they hung out to dry or not?”

In terms of managing other types of risks, several participants described organisational responses to risks related to job demands and scheduling. For example, P03 described a system to ensure that workers who were on leave were not contacted or emailed. For P21, managing the risks arising from workers spending long periods of time away from home meant reorganising shifts and rosters to ensure that time away from home or family was minimised. P17 also described how the need to ensure that workers were appropriately trained so they were competent to meet job demands was a way to manage risk.

7.3.2 TRANSLATION 1: SAFETY RISK

In this first translation, participants carrying out their duties of due diligence translated the equivocality of psychosocial risks into a *safety* risk. Here, participants described workers as the risk subject whose safety was threatened by their own mental health problems or poor wellbeing, or by other workers with poor mental health problems, as shown in Table 10, row (a). Thus, the focal risk object was changed from work to workers with poor mental health or wellbeing. The new causal link made was that participants linked workers’ behaviour to mental illness/poor mental health/poor wellbeing, which may cause workers to harm themselves or others. The risk to workers’ mental health was then translated into a risk to workers’ safety.

7.3.2.1 Identifying safety risks

Workers’ “wellbeing” was identified as a risk object when P11 observed that the behaviours of a

worker with poor mental wellbeing might be a contributing factor to safety incidents in the workplace:

The other thing is looking at things like near misses, or incident reports, particularly reports where you can see there's been an incident reported but it's effectively also a significant near miss. And really trying to get the organisation to acknowledge that and look at whether mental wellbeing was actually one of the things that contributed to that issue. So, I guess I'd always be looking for any evidence of that.

In the same way, P02 felt that it was a duty of leaders to have insight into workers' psychological status in order to be aware if it posed a risk:

... as a good leader you should know when something's not right with your staff without prying... you should know enough to know, are they presenting at work in a way that puts themselves and others at risk? (P02)

Similarly, the general idea that the mental health of workers might present a safety risk was expressed by P12, although dismissed as inconsequential:

Is it, a train driver is thinking, is feeling depressed because of a certain circumstance? I absolutely agree with you that that would be something that would directly impact their effectiveness and efficiency in the workplace, and they could put themselves or someone else at danger as a result, be it a self-harm incident or it's just not concentrating in a role that's technical and demanding. But I don't, I can't even recall an investigation that I've read in my life that's ever said mental health was a contributing factor to the incident.

7.3.2.2 Managing safety risks

In this risk translation where the mental health of workers was considered the risk object, techniques for measuring and understanding risk focused on making workers' mental health knowable and visible. This meant that an emphasis was placed on identifying workers who were mentally unwell in order to intervene before they presented a risk to safety.

For example, P09 described a system to manage the risks of workers approaching or experiencing a mental crisis:

P09 ...when you look at the theoretical work we've done, and when you look at the bow ties we've done and the controls we've put in place, they're all about that identification and support and intervention at that critical tipping point. Prior to that critical tipping point.

LD Ok, by, um ... are you talking about like, critical sort of mental health incidents, like a crisis or something like that?

P09 Yup, so that's a, that's a responsibility, I believe under, under and the Health and Safety Act, under our interpretation of the Health and Safety Act. That's where we're putting our focus.

7.3.3 TRANSLATION 2: INDIVIDUAL RISK

In this translation, participants carrying out the duties of due diligence translated the equivocality of psychosocial risks into a subjective, *individualised* risk. Here, participants described workers as both the risk subject and the risk object, whose own health was threatened by their problematic home and personal lives (see Table 10, row (b)) or personal psychological characteristics (see Table 10, row (c)). Thus, the focal risk object was changed from work to workers' individual personal circumstances or characteristics. The new causal link made here was that participants linked individual workers' home or personal life and personal psychological characteristics to an inability to cope with work, which, in turn, caused harm to those same workers. The risks arising from work were then translated into risks arising from workers.

7.3.3.1 Identifying individual risks

For P15, risk arose where an individual, because of their own tolerance level of stress, produced a risk of harm. As P15 explained, "... each individual has a different tolerance level for what triggers them for stress or what creates challenges for them in their day-to-day activity."

Similarly, P12 observed that people with a hidden or unrecognised mental health condition might cause risk, and this frustrated efforts to be compliant with WHS legislation:

I mean, let's be honest, a situation that you and I might deal with very happily can induce a critical event for someone with a mental health condition that you don't even, you don't understand. And that's my real challenge with this whole legislation.

P06 observed that risks arise disproportionately from workers who lacked “resilience”:

You know, someone's resilience is a key component to wellbeing, mental health, wellbeing aspects ... But the resilience factor from a mental health point of view, if COVID's done nothing, it's brought a whole lot of stuff our and you sit there and wonder. Um, look from right across our staff, we had some really robust people that you knew were going to do the hard yards and get the job done. And then you had others that you'd expected that from, and they flaked. You know, they just ... and you say, how did that happen? And you had others that weren't on your radar, and you wouldn't necessarily have rated them, stood up and showed leadership, and I suppose it is about the resilience factor.

Further, for P10, a worker's psychological “baggage” was a cause of risk:

They can't help the fact that they have a predisposition to, you know, delusional thinking or, you know, most of that you cannot help because that essentially is baggage that comes with all of us. We all have mental health, just you're somewhere on the spectrum at any point in time.

Workers were also seen as less able to cope with the demands of their jobs when they were already compromised by experiencing the challenges of life outside of work as, for example, in dealing with family and personal relationships, or by engaging in health-limiting behaviors, such as drinking alcohol, or gambling. In this way, any risks arising from the work itself (such as those relating to job demands, job content, etc.) were contingent on a worker's individual circumstances and framed in terms of a “but for” situation—that is, “but for” the risks arising in workers' home lives, which

compromised their mental health, workers would cope with the challenges and demands of their work lives.

In the following excerpt, P03 identifies workers' home or personal lives as risky by noting that most problems with workers' mental health arose outside of work:

I've never come across a serious mental collapse that did not have significant other contributors to it outside of the working environment. Now that's not to say they don't happen and of course they happen, but certainly that does not happen to be my experience. I'm right into this, so I think there is cynicism about what causes mental wellbeing crises or injuries. I think it is very hard to prove, which makes it easy to blow off to some extent. And I think in many cases, it hasn't genuinely happened at work. Um, so it has been caused by factors at home or by previous health issues.

Similarly, P06 talked about how most workers seeking help from an employee assistance programme (EAP) did so for factors relating to their home life:

Yeah, yeah, look, the disproportionate majority is non-work-related factors that are causing people to feel the need to actually get it [EAP]. A lot of it's about children, you know, teenagers hitting their straps can take the most stable parent to the extremes. And it's ah, a lot of it's about that, a lot of it's about um, aged parents and the, and strains about that, it's about the grandkids you know that's [indiscernible] in there. It's about the neighbour, you know, that they sort of feel obliged to do lots of things with—less about work.

Risks outside of work could also arise from health-limiting behaviours:

You know, watch those trends when someone's not coming to work on a Monday morning and maybe they've got a drinking issue, whatever, at the weekend, you know? (P02)

The idea that risk arises mainly from life outside of work was also emphasised by a legal expert speaking about the legal duties of New Zealand PCBUs to manage psychosocial risks:

And the reality is, often the individual has either difficulties in articulating where the stress is coming from or, potentially, they get it wrong, right? Sometimes I think it's quite easy to say well, work's stressing me out, but when you actually unpack it, you know it's stresses at home that are coming into the workplace ... I don't think the question is, is work causing this? It's, is work making this worse? (Personal communication, July 2022).

Whereas the impact of a worker's home life on work was often spoken about, the reverse causal chain was conspicuously absent. That is, the possibility that workers' home environments were not problematic but rather constituted a resource which might be brought by workers into their workplace, providing an advantage which either enabled them to cope with work or benefitted the business was never mentioned. Furthermore, although P24 noted the importance that workers "go home feeling valued and feeling engaged," on only one occasion was it specifically acknowledged by a participant that work to home conflict could occur, in this case by P11:

... we had somebody who, on staff, who was particularly interested and keen to pursue the thinking around mental wellbeing and how we might measure it, and make sure that we were helping anyone who was part of the [redacted, organisational name] workforce to actually go home happier rather than taking anything from work and that having an impact outside of work.

7.3.3.2 Managing individual risks

The techniques for managing individual risks included interventions relating to personal skill development; access to mental health promotion resources, such as seminars, guest speakers, and smartphone applications; and the development of systems to encourage individuals to disclose challenges they were facing and avail themselves of the emotional and psychological support of peers, managers, and particularly to access counselling or talk therapy. For example, P06 talked about the role of a workplace to accommodate the challenges posed by workers' home lives and to try to manage these risks by "nurturing" workers through personal difficulties:

You know, I mean if your domestic life is shit and you know, all of a sudden, you find

yourself at 50 and your partner's walked out and you're financially not well dealt to or your kids have gone off the rails, then while you can accommodate aspects, aspects of nurturing someone through that, you can't, you can't fix it.

The strategy of encouraging individuals to mobilise themselves to reduce risk was suggested through various systems (such as those described by P08, P09, and P11) where workers, their peers, or managers were authorised to identify when they or another worker had a personal problem and to seek help or direct others to seek help from people with the skills to support them with those problems. Building quasi-mental health expertise into workers or middle managers was seen as important in understanding the issues workers may be facing:

It's checking people, checking in with people by the management structure at a very personal level about how they how they're doing and issues in their lives, just in general check in. But that making it a practice inside the company so that there's an expectation. We do check in on each other personally, and that there's an expectation that there's trust in that discussion and things will get raised to the extent that it's a work issue or if people want to raise things that are outside work and it's up to them. (P09)

The encouragement for workers to “bring their whole selves to work” (P07, P23) or “full self to work” (P08) referred to the idea, which also features commonly in the New Zealand management grey literature relating to mental health in the context of work (Business Leaders Health and Safety Forum, 2023; Waka Kotahi: NZ Transport Agency, n.d.) that workers were not only authorised, but encouraged by management to bring personal issues or problems to work or to reveal challenges that their home life brings to bear on their mental health so that the organisation might manage these risks through supporting workers to cope.

This was not without difficulties, however, with P23 noting that imploring workers to “bring their whole selves to work” required more work of middle managers:

She said that ... increasingly as a manager in that space that she was required to be an

employer, a mother, a sister, a friend, a confidante, a mentor. You know, she said that she did feel that people, we have moved to a place where we really encourage people to bring their whole selves to work, but in bringing their whole selves to work, it did require more of her as a manager.

Similarly, for many participants (e.g., P02, P04, P05, P07, P08, P12, etc.), providing training and education for employees on topics relating to mental health or wellbeing or encouraging the sharing of personal experiences of dealing with or overcoming poor mental health were described as strategies to manage psychological risk.

7.3.4 TRANSLATION 3: OPERATIONAL RISK

In this translation, participants carrying out the duties of due diligence translated the equivocality of psychosocial risks into an *operational* risk. Here, participants described the organisation or business as the risk subject whose operations were threatened by workers with poor mental health (the risk object; see Table 10, row (d)), which may, in turn, be caused by factors outside of work (see Table 10, row (e)). Thus, the focal risk object was changed from work to workers' mental health. The new causal link made was that participants linked workers' mental health, personal psychological characteristics, and home or personal lives to their compromised ability to work productively, which may cause harm to the organisation. The risk of harm to workers was then translated into a risk of harm to organisational operations.

7.3.4.1 Identifying operational risks

This formation includes risk arising from the psychological realm of workers, such as mental illness, low levels of wellbeing, or psychological impairment. Within this formation, participants tended to reference either "mental health" or "mental wellbeing" as the object of risk that was considered to cause harm and, thus, that which should be the focus of risk management. For example, P03 considered that, "More and more, directors are understanding that in most businesses, mental wellbeing is a risk worthy of some oversight." P08 identified mental health as a "critical risk," and

P11 noted that "... for some of my organisations, mental wellbeing is not a critical risk. So, it's definitely a risk, and it's seen as a risk that needs to be managed, but it's not a critical risk."

Aligned with this perspective of risk, P03 explained that on one of the boards on which they sat, mental wellbeing was perceived as a critical risk to the organisation:

P03 It's [wellbeing] emerged as a critical risk for us only really over the last six months ... So, we've got a bunch of other critical risks, and mental wellbeing has not made the top 10 list until recently. Where we've actually said, well, there are 11 critical risks that the board wants to apply their minds to. So, these are strategic critical risks as opposed to um, ah...., kind of systemic critical risks.

LD So they're not just health and safety risks, they're?

P03 Correct.

LD Risks to the whole organisation?

P03 Correct. And so the mental wellbeing risk is presently a high velocity risk. So it's ... it's increasing. And for that reason, we have determined as a board that it's a strategic risk and a strategic critical risk. So, we want to have it on the list of things that we're monitoring with greater scrutiny than our other ah, high-risk areas.

The idea that "mental wellbeing" presented a risk to the organisation emerged further in the links that participants described between wellbeing, performance, productivity, and profitability. For example, P04 observed that "people that are well, physically and mentally, are probably a lot more productive." P03 described mental wellbeing as a critical risk to the organisation because of its link with high performance:

And how can you create an environment of high performance? And in my experience, it's very difficult to do that, um, if you don't have a good understanding for the kind of attitude that you need to differentiate yourself and attitude is, you know, a combination of mental

wellbeing, purpose, ah ...great leadership, you know? So it's all part of the high-performance teams thing that I'm interested in.

In a similar way, P06 stated that a person's "mindset" could act as an impediment to their work:

... and if they are less than in their 'A' game then there is risk associated with that. And I'm clear on the connection of how ready and fit for work people are, is more than that just whether they can walk and move normally and not do anything stupid, but there's also a part of their mindset.

7.3.4.2 Managing operational risks

Participants spoke about managing operational risks in a similar way that they spoke about managing individual risks. In this risk translation where the mental health or wellbeing of workers was seen as the risk object, techniques for measuring and understanding the risk focused on making workers mental health knowable, visible, and understandable through various strategies. For example, participants described surveys measuring wellbeing, building awareness in workers of their own psychological state, and encouraging workers to monitor the mental health and wellbeing of others by observing their behaviours.

Technologies of measurement that linked mental health with organisational imperatives were also used, so when participants spoke about specific measures or data that they used to help fulfil their duties of due diligence, many participants identified measures of organisational harms. In this respect, sick leave rates, staff turnover, and retention and resignation data were considered to be measures of risk to the organisation. Further, where the mental health or wellbeing of workers were constructed as the risk objects, emphasis was also placed on managing poor mental health or mental illness, particularly through awareness raising, normalisation, encouraging self-management, peer support, and help seeking. For example, in referring to "mental wellbeing risk", P08 suggested a corresponding need to reduce stigma by remembering that "mental wellbeing or mental health" is something that "everyone has." P11 felt that, beyond a greater awareness of "mental wellbeing", people needed to get better at talking about their own mental wellbeing so it could then be managed:

I think there is a whole kind of shift that we all need to make in terms of talking, being able to talk about it and acknowledge it, and see it as something that is, can be managed, or people can be helped to better states of mental wellbeing.

Making workers more comfortable to share their mental health problems and seek help or treatment for them was achieved by senior managers and leaders demonstrating how to do it, thereby authorising others to do so:

Yeah, and I think people are getting more comfortable about it. You know, people, when we have a forum, people will bring their stories about, you know, experiencing depression and experiencing stress, etcetera. Even one of my exec team members was comfortable enough to actually share that with some of the team in saying, ‘Hey, you know, this is how I experience some of the, the difficulty with the stress that was involved with my, my work and the help that I got.’ So I think people are starting to talk about it, but I think it's going to be a long journey. (P04)

In a similar way, some spoke of strategies involving “messaging” (P07), “driving awareness” (P08), and “championing” (P04) of mental health or wellbeing-related issues.

Whereas in section 7.3.1, “support” was seen as a general way by which risk to workers’ health might be averted by ensuring they were supported to carry out their work, in this formation, support referred particularly to looking after individuals who were experiencing low levels of wellbeing, poor mental health, or mental illness. For example, for P17, supporting workers meant not only ensuring access to counselling services but also enabling access to specialist services when required:

So the thing for us is to make sure that we understand the environment that people are working in and make sure they're supported. And that sort of goes beyond EAP, but also where people have specific issues that require specialist support, they get it.

Similarly, for P04, measuring workers’ wellbeing provided information about the amount of mental wellbeing support needed by them:

You know, in terms of purpose, it's making sure that I have a fair and representative understanding of what we're doing in terms of wellbeing support for employees and that I track the mental wellbeing of our employees. I have tools to track and measure the mental wellbeing of our employees and to the extent that they need supports to actually support them with it.

The development of skills amongst workers to identify those workers whose mental health presented a risk was described by P08. Here, quasi-therapeutic interventions were enabled within the organisation:

To actually not, you know, very clearly not to actually diagnose somebody, it's not, ah, it's not by any stretch of the imagination designed to actually take the place of a professional but be somebody that somebody can go to and talk to and feel comfortable and comfortable and safe.

P11 also identified the importance of having managers with an awareness and understanding of, and skills to manage, "mental wellbeing issues." Relatedly, intervening at the point where individual workers were "struggling" was another way that risks arising from workers' mental health could be managed, and was considered a preferable approach to redesigning work by P09:

It's more that we, we take a um, yeah, rather than trying to redesign work, we say, cool, let's put some controls around it which help us find those pockets of the organisation or people who are really struggling and then let's intervene at that point.

Each of these management strategies shared a commonality in their emphasis on the agency and responsibility placed on workers and middle management to either exercise self-discipline in their own mental health or to exercise responsibility for the mental health of others.

7.3.5 TRANSLATION 4: REPUTATIONAL RISK

In this translation, participants carrying out the duties of due diligence translated the equivocality of psychosocial risks into a *reputational* risk. Here, as shown in Table 10, row (f), participants described the organisation or its officers as the risk subject whose reputation was threatened by the organisation's responses to the issue of worker mental health (the risk object). Thus, the focal risk object was changed from work to the organisation's responses to mental health and wellbeing. The new causal link made here was that participants linked the provision of mental health and wellbeing initiatives within the organisation to the reputation of the organisation as a good place to work and the reputation of its officers as good corporate citizens. The risk of harm to workers was then translated into a risk of harm to reputation.

7.3.5.1 Identifying reputational risks

Issues relating to worker mental health and wellbeing were expressed by several participants to be very salient and even a current trend in the business community. Although expressing cynicism toward it, P12 talked about the idea that issues relating to mental health were a current corporate "trend":

I'll be honest with you, I struggled with some of the stuff because I felt what was happening was a whole lot of physical factors were being bundled into, under this guise of, oh, it's mental health now. I mean, one of the things, Louise, that you would ... there's quite a push back amongst a lot of people that says this mental health thing is a trendy thing right now.

Other participants highlighted the current salience of issues relating to mental health and wellbeing amongst senior executives and directors. For example, P09 described worker mental health as "the next area" and explained that "it's sort of firmly positioned in the front of people's minds." P04 felt that "more attention" was being given to mental health, particularly because of growing "obligations," and P02 observed that "mental wellbeing is getting um, quite a lot of prominence in terms of conversation [at the board table]" and added that "now, of course, everyone's talking about mental wellbeing."

P06 described how concerns for the organisation's and board's reputations were raised following a serious bullying allegation: "Yeah well, at the end of ... it's our reputation and our liability, really." Similarly, P06 also spoke about how being known as an organisation that did not manage risks relating to workers' mental health was a reputational issue:

... they realise the challenges of attracting staff, keeping staff, and actually knowing that their reputation is based on the staffs' experience. So, all of them are pretty well sensitised to it. And they see that as an organisational risk. Absolutely, they see it as a governance risk as well.

Similarly, P22 and P04 noted that organisations with poor health and safety records develop a poor reputation as an employer, and then they find it hard to attract staff.

7.3.5.2 Managing reputational risks

As a result of a perception of growing attention in the business community to worker mental health and wellbeing, several participants expressed a sentiment that being seen to be active in this area was important in managing reputational risks to the organisation and also to its senior leaders and directors. For example, P04 described how in relation to the aforementioned matters, "... ultimately, now, if you're going to attract employees, you need to be seen as somebody that does the right thing."

Relatedly, benchmarking, which allowed an organisation to compare itself with others, was mentioned by P04, P09, and P20, and illustrated in this comment by P04:

The usefulness of having a standardised test that you can then benchmark yourself with, with others. So, I know that on the wellbeing, for example, we're in the top five of similar [redacted] companies, the top five percent.

However, benchmarking surveys, such as those described by P04, did not appear to relate to measurements and interorganisational comparisons of psychosocial risk but, in fact, to other constructs, such as worker engagement (see also section 5.7.3).

In highlighting the relationship between the organisation's reputation and psychosocial risk management, P23 noted how psychosocial risk management fitted in with the organisation's desire to be recognised for being "at the front of the curve" and was something that was noticed by others:

I think that [redacted] does have a reputation for being, I'm going to say, at the front of the curve on things. It has a reputation for being quite innovative. And for being really committed to what I would sort of think of as the quality cycle. So, thinking about what are we doing now, how do we do it better? Evaluating whether we did it better than we did before, what could we do better? That constant drive to do things better. And I think that gets noticed.

7.4 DISCUSSION AND CONCLUSION

This chapter began by looking at the risks to worker mental health that participants named as they described performing their duties of due diligence. The articulation and naming of risks can offer insight into the nature of the construction of risk objects. "Naming" risks, rather than simply holding a mirror to reality, "gives us a finger to point with" (Foucault, 1970/2002, p. 10) and produces the very "problem" that risk management aims to resolve. In this way, for something to be considered knowable and nameable, it must fall within the remit of the power relationships that enable it to exist, be spoken of, measured, studied, managed, and so on. Dominant discourses, including ones that construct particular risks, "necessarily exclude alternatives and actively work to produce social relations that normalize certain discourses and social relations" (Hardy, 2013, p. 113).

In the selectivity inherent in identifying a risk object, particular material things, processes, or phenomena within an ecology of risks are singled out as those that are considered to cause risk or create harm and those that must be acted upon to manage risk. Thus, when particular risk objects are spoken of, this serves to not only "denote people or things that are perceived to be dangerous, but also to indicate that they are perceived as the key dangerous elements of a larger system" (Kendra, 2007, p. 30). In this way, the process of emplacing risk is imbued with power relations because the emplacement and selectivity of risk necessarily "downplays" (Boholm & Corvellec, 2016, p. 111) other risks objects, or invisibilises other aspects of a system that may cause harm, veiling them from

scrutiny, criticism, and management (Kendra, 2007). By analysing which risks are named and their construction, particular risks become visible and legitimised as the appropriate focus of psychosocial risk management in WHS law. Conversely, other risks are rendered less visible and thus become an obscured or peripheral focus of the law.

The process of risk translation has been shown to occur when organisations are faced with novel risks (Hardy & Maguire, 2020) and entails a displacement of risk from the novel object (in this case, aspects of the design and management of work and its social and organisational contexts) and an emplacement of risk onto other objects that are considered more recognisable or amenable to management (such as workers' behaviours or personal lives). Elsewhere in the literature, a similar process has been referred to as the "reconstitution" (Kendra, 2007, p. 40) of risk objects. The findings in this chapter have shown that risk translation occurred when participants were carrying out their duties of due diligence under the HSWA. I showed that while participants did consider a variety of psychosocial risks arising from the work of the PCBU, they also described a wide range of risks that did not arise from the work of the PCBU or that did not consider workers as the subject of risk (that which may be harmed) as performed their duties. Psychosocial risks were, in many cases, translated into other risks by shifting the meaning or identity of the risk object and/or risk subject.

For example, many participants demonstrated a tendency to shift the meaning of the risk object from work to the worker in noting that if it was not for the problematic characteristics of workers (such as their home lives, health-limiting habits, or lack of resilience), they might cope better, and perform better, at work. The effect of this type of risk translation is that it creates an individualised notion of risk, which "forces individuals to take more responsibility for risks they face, but, ironically, it also authorizes more organizations to intervene aggressively in some individuals' lives in the name of risk" (Hardy & Maguire, 2019, p. 506). Similarly, in speaking about managing risks, many participants spoke not of managing threats to workers' mental health but, rather alternate subjects of risk, such as the organisation where risk was described in terms of types of operational (for example, recruitment and retention, productivity) and reputational risks. In this way, a discourse emerges where worker mental health, rather than being conceptualised and managed as a *consequence* of psychosocial risk

exposure within the organisation, is transformed into a *cause* of risk to the organisation that must be managed. This risk translation shifted the focus of who was potentially negatively impacted by risk from workers to the organisation. Both these translations systematically redistributed responsibility and blame for risk and determined what was seen as an appropriate organisational response in terms of managing risk.

These findings related to risk translation also highlight how risk-related terminology pervades many fields of organisational governance and management, and that addressing risk in broad and amorphous terms, without scrutinising the risk object and subject, can transform the very meaning of risk management. Although not explaining their findings in terms of risks translation, a similar phenomenon has been noted in the area of corporate attention to human rights. Shamir and Weiss (2012) found that in analysing corporate responses to human rights violations which may occur as a result of corporate activity, the dominant risks that were attended to were corporate risks (to profit, reputation, etc.) as opposed to risks of human rights violations. The researchers explained the effect of, and assumptions inherent in, such a transformation:

The language of risk has become dominant in the field. Yet it is not the risk to people that the business case addresses, at least not directly. Rather it is with the risk to corporate profits—presumably posed by direct or indirect corporate involvement in violations of human rights—that the business case is concerned. The underlying assumption seems to be that when a corporation follows and applies the logic of the business-case approach to human rights, it contributes to the actual protection of human rights. (pp. 113–114)

Shamir and Weiss (2012) summarised their findings as signifying a shift away from “risks-to-people ... [toward] ... risk-to-corporations” (p. 129). This shift, Shamir and Weiss (2012) contend, creates a disconnect and distance from the underlying purpose of corporate-related human rights risk, and pushes the activities undertaken by corporate actors in the name of compliance “further away from solving risk-to-people” (p. 131).

More recently, similar findings have been empirically evidenced by McVey et al. (2023), who describe how human rights are “translated” in corporate settings. By “translated”, the authors refer to the way in which the meanings of human rights are developed in corporate settings so that they resonate with dominant corporate value systems, such as profit maximisation and the enhancement of shareholder value, and are therefore rendered more palatable, acceptable, and manageable due to their greater alignment with corporate interests. In the process of rendering human rights a more attractive proposition for corporate engagement, McVey et al. (2023) suggest that human rights norms are “neutralised” (p. 85) because their potential to instigate radical change in corporate actions is reduced.

In the analysis of risk translations, I have shown that the way in which participants conceptualised and constructed risk—that is, what they deemed to be the risk object and subject, and how they constructed a causal relationship between them—determined the repertoire of compliance responses and actions that they deemed appropriate to measure, monitor, and manage these risks. Thus, I have shown that a large proportion of the “risk-talk” (Vera-Sanso, 2000, p.112) and “riskwork” (Power, 2016, p.3) undertaken by officers performing due diligence is carried out with attention to risk objects and subjects which should rather be considered peripheral or at a distance from the core regulatory objectives and purposes of WHS law. Psychosocial risk management becomes entangled in the management of other types of risk that businesses may legitimately wish to manage and thus, a characteristic of the regulatory state becomes apparent, where “control activities can be imagined both to be ‘compliant’ and to facilitate core business processes in an organization” (Power, 2007. p. 41).

While the outcome of risk management of some of those risks may sometimes be fortuitously congruent with the purpose of psychosocial risk management under the HSWA, this assumption, made without critical consideration, appears to lead organisations to assume that managing any sort of risk holding an association with “mental health” or “wellbeing” meets the substantive purpose of the Act.

However, it is noted that participants nevertheless did identify many risks arising from work that could pose a risk to workers’ mental health as illustrated in Figure 2 and discussed in section 7.3.1.

The next chapter, Chapter 8, will focus specifically on these risks arising from work that were named by participants, followed by several broader discussion themes.

8. THE DISPLACEMENT OF RISK AND THE MANAGERIALISATION OF LAW

In this final findings and discussion chapter, I will examine key features of the discursive construction of psychosocial risks. The themes explored in this chapter give attention to the way that the meaning of compliance with the officers' duties is formed through discourse and how these discursive constructions make certain responses intelligible for officers performing their duties of due diligence. A focus on what this discourse does, in terms of providing the limits for what is an appropriate and possible organizational response to WHS regulation, will also be considered. This final discussion chapter therefore focuses on answering the third research question:

How do the ways that officers construct compliance relate to the regulatory intentions of the officers' duties, and what are the implications for managing psychosocial risk?

This chapter will focus on two themes in two parts. First, in section 8.1, I will return to the findings presented in sections 7.2 and 7.3.1. While the previous chapter, Chapter 7, focused mainly on how risks were translated into other risks, in many instances, participants did talk about the risks arising from the work environment—a conceptualisation of risk that ostensibly aligns with the purpose of WHS law. However, in the following analysis, I contend that even where risks arising from work carried out as part of the conduct of the PCBU are spoken of, they are dominated by an individualising and psychologising discourse. I discuss the implications of this discourse at section 8.1.3 in terms of its effect in ameliorating the responsibility and capability of the PCBU to act under WHS law.

In the second part of this chapter, beginning at section 8.2, I will present further implications of the findings of this research framed around a discussion of the managerialisation of the law.

Managerialisation of the law is produced by a change in the meaning of compliance from one that protects workers to one that either maintains status quo or advances managerial interests. The chapter concludes at section 8.3 with a brief consideration of the limitations and prospects of WHS law to address psychosocial risk at work.

8.1 THE INDIVIDUALISATION AND PSYCHOLOGISATION OF RISK

The HSWA focuses on the elimination and minimisation of risks to workers' health and safety arising from the work conducted as part of the PCBU. In the context of worker mental health, this is widely accepted as referring to the management of psychosocial risk, or those risks related to "aspects of work design and the organization and management of work and their social and environmental contexts, which have the potential for causing psychological, social, or physical harm" (Cox et al. 2000, p. 14). However, in the previous chapter, Chapter 7, I identified that when participants described how they understood and carried out their duties of due diligence as required by the HSWA, there was inconsistency in the way they conceptualised risk. Participants evoked a wide range of risk objects and subjects, many of which were not of central concern to WHS law. These included, for example, risks such as those arising from workers' home or private lives, and risks that pose a threat of harm to the organisation. Thus, when performing their duties of due diligence and in facing "novel" risks, participants often translated psychosocial risks into other more familiar risks that were considered more amenable to management.

An analysis of those risks that were considered most salient to participants and the means by which they described identifying and managing them can give insight into the way that a particular problem or problems with work were constructed by officers as they carried out their duties. In other words, "social problems are what people view as social problems" (Best, 1995, p. 4). This emphasises the contingent nature of those things that particular groups might focus on as risks. In this sense, as Ewald (1991, p. 199) writes, "nothing is a risk in itself; there is no risk in reality. But on the other hand, anything *can* be a risk; it all depends on how one analyses the danger, considers the event." Therefore, not everything that poses a danger is thought of as a risk. Instead, of all possibilities, certain things are "selected" (Douglas & Wildavsky (1983, p.7) and rise to the top of those things that society, or certain groups within it, consider to be most threatening, exemplary, salient, or meaningful as potential causes of harm. This socially constructed nature of risks has been acknowledged in broader risk-based regulation literature as well, where:

It has long been recognized that the ways in which risks or problems are constructed and selected for attention is fundamental to their regulation. If the risk or problem is not recognized, it will not even move on to the agenda. If it is recognized, then the way it is constructed will shape the manner in which it is then assessed and managed. (Baldwin & Black, 2016, p. 567)

Thus, this Chapter 8 focuses on analysing which psychosocial risks become “selected” (Douglas & Wildavsky (1983, p.7) and how company officers “analyse the danger” and “consider the event” (Ewald (1991, p. 199). I do this by analysing which risks arising from work were most commonly named by participants, the various features relating to the ways these risks were constructed and organised, and how these ways of organising risk impact on the conduct of the officers’ duties of due diligence. This analysis shows that the common ways that participants talked about risk—even those arising from work—demonstrate a tendency to revert to the same etiological basis: workers themselves. This analysis will be presented further in the following sections 8.1.1 and 8.1.2, which examine the individualisation and psychologisation of risk.

8.1.1 THE INDIVIDUALISATION OF RISK

In this section, I analyse the characteristics of the two risk objects that were most commonly named by participants where risk was identified as arising from the work conducted by the PCBU. Those risks objects included “Interpersonal relationships at work” and “Organisational culture,” as illustrated in Figure 2 in section 7.2 and presented in more detail in 7.3.1.

8.1.1.1 Interpersonal relationships at work

The most common risk that participants mentioned as they described the conduct of their duties was “Interpersonal relationships at work”. This risk was mentioned by 19 out of 24 participants and comprised 25% of the times a work-related risk was mentioned. This category included such things as bullying, harassment, violence, and intimidatory behaviour between workers or between workers and their managers or supervisors.

This frequency by which this type of risk was named is not surprising. Internationally, bullying and harassment are the most commonly reported or observed risks that organisations seek to manage (Robertson et al., 2020) and are the most regulated psychosocial risks in terms of the amount of regulation, rules, and guidance that has been produced (Lerouge, 2017a). This has led to a situation where it has been suggested, in the EU at least, that many stakeholders have come to view psychosocial risk “almost exclusively through the prism of psychological harassment or bullying” (Lerouge, 2017a, p. 17). In New Zealand, the issue of workplace bullying has rapidly increased in salience over the past twenty years (Blackwood et al., 2013), and its increased prominence as a regulatory topic is illustrated by the publication of many pieces of guidance material on bullying and harassment by the health and safety regulator (WorkSafe, 2017, 2018, 2020a, 2020b).

The bullying literature describes causality of bullying and harassment in organisational settings from two perspectives: the individual–dispositions hypothesis (Zapf & Einarsen, 2020) and the work environment hypothesis (Salin & Hoel, 2020). The former emphasises individual-level factors relating to both perpetrators and targets/victims, whereas the work environment hypothesis examines bullying in terms of its association with various organisational factors. In the latter sense, far from being random, bullying and harassment have been found to be more likely in organisations where other psychosocial risks are present, including unreasonable workloads, high job demands, precariousness and job insecurity, laissez-faire management, and lean management strategies, among other factors (Chambers et al., 2018; Nielsen & Einarsen, 2018; Salin & Hoel, 2020). Nielsen and Einarsen (2018), however, point out that matters of causality regarding violence and bullying are not linear and that individual and organisational factors interact and present in combination. Others, such as Zapf and Einarsen (2020), have highlighted the multicausal nature of bullying in that “one may have to take a broad range of potential causes of bullying into account, antecedents and risk factors which may reside within the organization, the perpetrator (the bully), the social psychology of the work group, or indeed the target/victim” (p. 270). Therefore, while there is no doubt that being subjected to bullying, harassment, or violence at work presents significant causes of harm to workers, these hazards hold a unique place in the field of psychosocial risk management in that they are both causes of psychosocial

harm and outcomes of exposure to other psychosocial risks (Bentley et al., 2014; Cox & Griffiths, 2015; Van den Brande et al., 2016).

Notwithstanding this complexity, it has been noted that general duties type legislation provides an appropriate framework by which psychosocial risks, such as bullying, harassment, and violence, may be prevented at work (Blackwood et al., 2013; Cox, 2017; Cox & Lippel, 2020). There is reasonable consensus amongst field experts that while a comprehensive approach to bullying, harassment, and violence at work should provide support and recourse for victims, the WHS approach suggests an emphasis on primary prevention with a view to understanding and intervening in the precipitous root causes within the work environment (Chan-Mok et al., 2014; Cox & Lippel, 2020; D’Cruz et al., 2019; Potter, O’Keeffe, Dollard et al., 2019). Despite this, the prevalent way of thinking about these sorts of phenomena within both organisations and the law courts is in terms of the pathological behaviour of individual workers—a conceptualisation that operates at the exclusion of a consideration of organisational antecedents and contexts in which they are more likely to occur (Blackwood & Jenkins, 2018; D’Cruz et al., 2019; Walden, 2017). Indeed, internationally, the focus on addressing these problems within organisations has persistently remained on recourse and remedy at the expense of their prevention:

Campaigns for adoption of laws against bullying and harassment tend to focus on the tragic consequences for targets and the injustice created when they are left without adequate recourse or remedy. Individual recourse is undeniably an essential component of an overall legal framework for managing bullying and harassment. However, until now, insufficient attention has been paid to legislative frameworks for prevention of bullying and harassment. (Cox & Lippel, 2020, p. 655)

Noting that even where WHS law emphasises prevention, Cox (2017) found that in Quebecois court cases, there was a tendency to focus on acts of bullying and on dealing with bullying complaints, resulting in the systematic exclusion and avoidance of the underlying organisational risks giving rise to bullying and harassment. The result was that:

... at best, an employee's request for an Occupational Health and Safety intervention will probably result in action aimed at forcing the employer to adopt a policy on dealing with psychological harassment complaints, rather than examination of work organisation or human resource management techniques that create an environment conducive to harassment. (Cox, 2017, p. 225)

In focusing on acts of bullying and subsequent recourse and remedy, several authors have pointed out that in the application of the general duties provisions of WHS laws, such a focus appears paradoxical to, and inconsistent with, the law's intent to prevent harm. For example, Chan-Mok et al. (2014) found that in the Australian courts' application of WHS law to bullying cases, bullying was considered to need to have already occurred for it to have been reasonably acted upon. The authors considered that this was antithetical to the underlying premise of WHS law of prevention through risk management, noting that:

The requirement (from regulatory policy and guidance material) for targets to experience an unspecified number of harmful workplace bullying experiences is contrary to the objectives of health and safety law ... the object of the OHS Act is to ensure safety and health by not exposing workers to risks health and safety while at work [*sic*]. The requirement of multiple repeated exposures to harmful behaviour, in policy and in academic concepts, therefore is contrary to the object of the law ...” (Chan-Mok et al., 2014, p. 452)

In those findings, and in the findings of this research, the discourse that constructs bullying as an object of risk management—that is, by focusing on identifying and managing incidents of bullying and acting upon the victims and perpetrators of violence—is built upon a conceptualisation of causality which hinges on the individual behaviour of workers and excludes wider organisational determinants. This was evidenced in this research in the findings presented in section 7.3.1, which showed that whilst bullying was often spoken about, it was primarily framed as a behavioural or psychological problem of workers, and organisational antecedents were almost never mentioned. The possibility that bullying might be linked to organisational precipitants or that harmful worker

behaviours may be emergent properties of the design, organisation and management of work was not the dominant or even a common way that bullying was conceived of amongst participants. Whilst many participants did pay attention to risk factors within the work environment that have been evidenced to give rise to bullying and harassment, such as workload and job demands, only in one case did a participant link these to situations of bullying.

The construction of bullying almost exclusively in terms of poor behaviour of workers has several implications. It at once narrows the consideration of the broader organisational antecedents of these behaviours and limits preventative strategies to behavioural-based approaches aimed at imploring workers not to bully, to be more caring and supportive of each other, or to the enactment of reactive measures. These were reflected, for example, in the way that participants recounted the way they assured that the PCBU of which they were an officer was effectively managing these risks through strategies such as sending the message that bullying was “not tolerated”, or in reactive strategies, such as disciplinary measures, performance management procedures, or ensuring that conflict or dispute resolution processes were available. While such actions may be considered part of a comprehensive approach to bullying and harassment within an organisation, the sole focus on these behavioural-based and reactive measures marginalises and systematically avoids any examination of the organisational antecedents of bullying. Further, as strategies that simply respond to harms that have already occurred, they are also paradoxical to, and inconsistent with, the intent of WHS laws, which aims to prevent harm through the elimination and minimisation of risks to workers’ health and safety. In the broader regulatory literature, it has been noted that a focus on harm that has already occurred “corrupts” the risk-based and preventative model of WHS legislation and, as such, “risk analysis loses its power as a driver of the regime” (Black & Baldwin, 2010, p. 208).

8.1.1.2 Organisational culture

The second most commonly mentioned risk arising within the context of work was “Organisational culture”. This risk was mentioned by 17 out of 24 participants and comprised 23% of the times a work-related risk was mentioned. This risk factor has been consistently named and reproduced in both the academic and grey literature by way of its inclusion in the well-known and often reproduced

taxonomy of psychosocial hazards (see section 3.4; Cox et al., 2000; Jespersen et al., 2016; Leka & Cox, 2009). It is therefore established that in the context of psychosocial risk, culture includes such things as “poor communication, low levels of support for problem-solving and personal development, [and] lack of definition of organisational objectives” (Cox et al., 2000, p. 44). Elsewhere in the literature, the same category is referred to as “Organisational culture and function” (Leka & Cox, 2009), albeit containing the same descriptors.

The critical literature on organisational culture identifies that, much like the words “wellbeing” and “diversity” discussed in Chapter 5, the meaning and deployment of “culture” in organisational contexts is enormously varied and is “a tricky concept as it is easily used to cover everything and consequently nothing” (Alvesson, 2013, p. 3). Nevertheless, Alvesson (2013) suggests that the idea of organisational culture is generally represented in management discourse in two ways. The first, considered to be the dominant way in which culture is thought of, takes a functional view, representing culture as one of many variables that may affect outcomes within an organisation. This representation of culture assumes that, as a variable, culture can be deliberately and purposefully managed, manipulated, or controlled to affect organisational goals (Barley et al., 1988). In this way, the functionalist view assumes that building the “right” sort of singular and unified organisational culture will cause certain desired organisational outcomes or trigger changes in line with managerial goals or purposes. This dominant view suggests that culture is treated as if it were a “clear and known entity that creates unity and harmony within an organization and solves problems” (Alvesson, 2013, p. 141).

In contrast to this view of culture and drawing from anthropological and sociological notions of the concept, the alternate view explains that culture, rather than being something an organisation has, is rather what an organisation is—that is, an organisation *is* a culture (or is constituted of multiple cultures). In this view, culture is considered an emergent property of the organisation and can be conceived as a root metaphor where “organizational reality is also viewed as organic, emergent and pluralistic, not managerially imposed and fixed” (Alvesson, 2013, p. 22). Accordingly, this “root

metaphor” view of culture tends to “play down the pragmatic results that can help management increase effectiveness” (Alvesson, 2013, p. 22).

The use of culture as a concept to explain WHS problems and outcomes is extremely popular. Silby (2009), for example, found that from 2000 to 2007, there was a four-fold increase in academic and grey literature regarding the idea of culture as it applied to health and safety at work. It is therefore not surprising that organisational culture was the most often named psychosocial risk in a European study conducted during this time period that examined stakeholder perceptions of risks relevant to the legal requirement to manage psychosocial risk (Natali et al., 2008). In that research, a survey of risk perceptions of stakeholders regarding the application of psychosocial risk management in accordance with the European Directive 89/391, researchers found that organisational culture was perceived by employers, trade unions, and government officials to be the largest cause of work-related stress, although closely followed by job demands (Iavicoli et al., 2011; Natali et al., 2008).

In this research, I found that participants’ conceptualisations of culture aligned with the dominant functionalist perspective, referring to culture as a variable that both gave rise to risk as well as one which ameliorated it. This was illustrated in the way that participants described how they acted upon organisational culture by undertaking management strategies aimed to “change” (P12, P13, P21), “set up” (P17), “set” (A15), “drive” or “shift” (P17), “create” (P02), “grow” (P22, P21), “align with” or “move” (P07), “transform” (P02), “run” (P09, P17), “embrace” (P18), “build” (P22), or “develop” (P22) an organisational culture in order to manage psychosocial risk. Other participants described a need to “ensure” (P18) that a particular “type” (P21) of culture was present in the organisation in order to manage risk or, conversely, that a risk-causing type of culture was absent. It was also reflected in the employment of strategies that were described by participants to measure or survey culture as an indicator of risk, suggesting that culture was considered a feature of an organisation that can be measured and then acted upon to create better WHS outcomes.

The tendency for participants to commonly refer to culture as a health and safety risk or variable appears to be long standing yet long contested, with Cox and Flin (1998, p. 189) observing twenty-five years ago that:

The common presumption appears that the attainment of a good safety culture contributes to, if not represents, the solution to all health and safety-related problems: a philosopher's stone to cure all ills. This presumption needs to be challenged.

In line with this, culture was often spoken about by participants in vague and general terms with no reference to any underlying risks or hazards and was therefore constructed as a risk in and of itself. In this way, culture appeared to be used, as Guldenmund (2000) has previously noted when referring to its use in a safety context, as an “umbrella” concept—those being concepts that are “so global and abstract, they can also run the risk of becoming virtually meaningless” (p. 216).

Since the 1980s, culture has been increasingly invoked as a silver bullet that can simultaneously explain, predict, and prevent negative health and safety outcomes (Cox & Flin, 1998; Myers et al., 2014; Silbey, 2009), despite the lack of evidence that it does (Dekker, 2019). Accordingly, in the field of WHS, the concept of culture—often written about as either organisational culture or safety culture—when conceptualised as a variable that impacts upon the health and safety outcomes of an organisation, is a contentious and contested topic. Critical perspectives analysing what the discourse of organisational- or safety culture does when used as an explanatory concept in WHS tend to focus on two effects: first, how the ideas encapsulated by culture show a tendency to occlude other risks and allude to undefined risks, and second, how a discourse about culture tends to revert to reductionist or behavioural explanations (Borys, 2019; Dekker, 2019; Silbey, 2009).

In the first sense, those critically analysing the deployment of the idea of culture in the field of WHS have suggested that culture, rather than explaining causation and leading to the amelioration of risks, tends to act as a heuristic that creates “superficial and simplified representations of organizational life” (Antonsen, 2009, p. 183). In this way, culture acts to obscure the often more complex, diffuse, or political causes of risk by acting as a rug under which all sorts of risk and responsibility might be

swept. For example, in writing about the use of culture to explain safety within an organisation, Silbey (2009, p. 351) notes that “culture as the ultimate, intermediate, or proximate cause often leaves unspecified the particular mechanism that shapes the safe or unsafe outcomes of the organization or technology.” Similarly, Antonsen (2018) notes that a focus on safety culture as a risk management strategy “can be an excuse for not investing in new technology and developing technological design” (p. 134).

As a tool for conceptualising risk and responsibility, culture has implications for assigning responsibility and blame for negative outcomes in ways that “obscures the different interests and power relations enacted in complex organisations. Although it need not, talk about culture often focuses attention primarily on lower-level workers who become responsible, in the last instance, for organisational consequences, including safety” (Silbey, 2009, p. 343). In the same way, Myer et al. (2014) warn against reductionist explanations of culture as it relates to safety, such as “the way we do things around here” (p. 25), describing such explanations as tropes that divert those with the authority and responsibility to change systems of work away from a more informed or rigorous analysis of causality. Therefore, culture can be used as a diversion from substantive change, as Silbey (2009) notes: “rather than address the structural and historical conditions that either sustain or impede safe organizational performance, culture becomes a supplement, the detritus of social transactions” (p. 363).

The second critique is where culture is used in reductionist terms synonymous with worker behaviour. This was seen in this research (see section 7.3.1.1) where participants talking about culture often invoked aspects of the way that workers behaved and related toward each other, such as where culture was implicated in situations where risk was seen to arise from workers or their supervisors being unsympathetic, uncaring, unsupportive, or not open. The proposed solution to these risks (described by participants in section 7.3.1.2) was the installation or encouragement of a “caring” or “supportive” (P02) culture, the sanctioning of behaviours that did not align with such cultures, role modelling desirable behaviours, and telling workers that it was safe for them to “speak up” about their mental

health.²⁷ In this sense, participants' reference to organisational culture gives the appearance of attending to organisational causes using sociological explanations of ill health, but a closer examination indicates a reversion to a conception of culture defined by the individual or collective behaviours of workers as the risk to be managed. Thus, the discourse of culture as both a risk and as a risk management strategy limits its reach to the behaviours and actions of individuals within the organisation and excludes the wider organisational context.

Indeed, researchers examining the use of culture as it has been applied to safety within organisations have suggested that a conceptualisation of culture in terms of what a collection of individuals do or do not do may simply be a discursive rebranding of behaviour-based strategies to manage work health and safety (Hopkins, 2016b). Culture, when conceptualised as the sum of worker behaviour, can be seen as representative of a “constant gravitational pull back to human agency” (Dekker et al., 2013, p. 278). In this way, the multiple, complex, and often diffuse systematic causes of risks may be occluded by the attribution of responsibility to individuals' behaviour under the banner of culture (Bergström & Dekker, 2019). This reductionist model, whereby the behaviour and attitudes of workers are highlighted as the key point of leverage in a complex system, has been critiqued particularly in the context of safety where “the fashion for ‘safety culture’, insofar as it relies on a campaign for hearts and minds, is at best wishful thinking and at worst a thinly disguised version of the blame-the-worker strategy which we've been combatting for years” (Hopkins, 2016b, p. 32).

Those who have critically examined this reductionist deployment of organisational culture have suggested that organisations focusing on managing health and safety risks might best steer away from focusing on culture as either cause or solution to WHS risks (Borys, 2019). Indeed, Antonsen (2018) has noted that “the initial enthusiasm that surrounded the concept of safety culture around the year 2000 has now (fortunately) waned and has been replaced by a more realistic and mature approach in terms of theoretical grounding and methodical approach” (p. 12). In this sense, Antonsen (2018) and

²⁷ It should be pointed out that the inclination of workers to “speak up” may be curtailed by psychosocial risks such as precarious and insecure working conditions (Rho et al., 2023). Such conditions have recently been exacerbated by the extension of the “90-day trial” in New Zealand to all businesses.

others (for example, Bergström & Dekker, 2019; Borys, 2019; Dekker, 2019; Hopkins, 2016a) have impressed a need to focus on understanding the complexities of organisational life, the nature of risks and deeper causal mechanisms, and the work required to change organisational and management structures and practices based on these understandings. Resultantly, and in accordance with Alvesson's (2013) description of the "root metaphor" theory, culture change may occur as an emergent property of those actions to change structures and practices. In other words, the view of culture as a variable that might be manipulated to achieve particular organisational outcomes is rejected by these authors, along with the performance of "ontological alchemy" (Dekker, 2012, p. 378), which dresses culture up as a deep organisational construct but discursively reveals it to be a variable defined by the simple sum of the aggregate behaviours of workers.

8.1.2 PSYCHOLOGISATION OF RISK

A recurring theme in this research has been that the way in which risk is constructed determines and legitimates certain possibilities for acting upon that risk. Continuing this theme, this section 8.1.2 focuses on the psychologisation of risk. Specifically, it looks at how psychosocial risks were often reasoned by participants as arising from, or amenable to, management at the site of the individual worker's psychological self. Further, not only was the psychological health of workers seen as a key risk in that workers with poor mental health were considered to present risks to the organisation and other workers, but acting upon the individual's psychological health (as opposed to acting on the work environment or the work carried out as part of the conduct of the PCBU) was consistently seen as a primary lever by which psychosocial risks could be managed. A clear example of this primacy was in the frequency with which participants spoke of therapeutic interventions, primarily, counselling, as a risk management strategy. This demonstrates that the issue of psychosocial risk has been problematised at the site of the individual worker with the possibilities for acting shaped accordingly.

Miller and Rose (1988) and Rose (1996) consider the way that individuals and experts increasingly understand and articulate themselves and others, and their problems, in psychological terms. They observe how these ways of thinking have become particularly salient in the field of work (Miller &

Rose, 1988, 1990; Rose, 1999a). In this way, particular phenomena, problems, practices, and activities “have ‘become psychological’ in that they are *problematized* – that is to say, rendered simultaneously troubling and intelligible – in terms that are infused by psychology” (Rose, 1996, p. 60). According to Rose (1996), this can be seen in the expansion of “psy” thought (that encompassed by psychology, psychiatry, and psychoanalysis) and the increasing “territory” (p.56) which it has taken up across multiple social institutions (for example, the family, the military, the courts, and the workplace). This expansion has occurred through various strategies, including:

... fashioning a mode of perception in which certain events and entities come to be visualized according to particular images or patterns ... the circulation of a language in which problems come to be articulated in certain terms ... establishing problem-solutions linkages: connections between the nature, character, and causes of problems facing different individuals and groups – doctors and teachers, industrialists and politicians – and certain things that can count as actual or potential solutions to these problems.

In other words, by defining various “problems” and employing a range of explanatory mechanisms for these problems by way of psy discourse, a particular remit or scope is defined as to what might be considered as intelligible solutions to those problems. Psy discourse relegates the definition of those problems and the nature of their solutions to the psychological realm. The expansion of this psychological ways of problematising, also known as psychologisation, is seen in the tendency of psychological ways of thinking to “infuse and even to dominate other ways of forming, organizing, disseminating, and implementing truths about persons” (Rose, 1996, p. 59). This “infusion” sees psychological explanatory schemes permeate into fields that do not belong to the traditional theoretical and practical terrains of psychology (Vos, 2012).

Relatedly, psychocentrism describes the tendency, particularly within Western neoliberal societies, to rationalise human problems in terms of individual pathologies rather than as problems of society and its organisation. Thus, a psychocentric perspective incorporates psychologisation (and other agnates, such as psychiatrisation (Beeker et al., 2021)) in its overall focus on the dominance and effect of psy

discourse, but, in particular, in the way that psy discourse produces a view that “human problems are due to a biologically-based flaw or deficit in the bodies and/or minds of individual subjects” (Rimke, 2016, p. 5). In this respect, the study of psychocentrism provides a lens to critically examine technologies and assemblages, which “de-politicize, pathologize, individualize, and police the social fragmentation, inequality, and suffering neoliberal policies produce” (Defehr, 2016, p. 20). In terms of the application of psychocentric thought to people at work, psychocentric views tend to gloss over the asymmetrical nature of the employment relationship (Godard, 2014). Thus, according to Godard, (2014), psychocentric ways of thinking about work- and worker-related problems provide an attractive proposition to business (and also business schools) because the approach situates work-related problems in individual workers’ characteristics or attitudes and does not require that business deals with the economic and political issues, conflicts, and questions that arise in the context of labour relations.

In this research, I found that participants often viewed psychosocial risk and its meaning within WHS law from a psychocentric perspective. This was expressed in a number of ways, such as those identified in Chapter 7 in Table 6 (a), (c), and (d) and described in sections 7.3.2, 7.3.3, and 7.3.4. In summary, these psychocentric tendencies were epitomised in identification of workers’ mental health as the “problem” or “risk” to be solved or addressed by WHS law. The centring of the individual’s psychological self as the dominant risk was also highlighted in the sentiment expressed by some participants that suggested that workers could cope with work if only they were more psychologically resilient. Thus, these risks were translated into not just individualised risks but were made intelligible as psychologised risks.

Not only did participants conceptualise workers’ mental health as the problem to be addressed by WHS law, but, as a result, they often considered that the workers’ psychological self, as opposed to the work environment, was the appropriate place to enact strategies of risk management. Accordingly, risk management actions and strategies that focused on encouraging and authorising workers to assess their own mental health, talk about their mental health, reveal ill-health to peers and supervisors, manage their mental health, assess others’ mental health, and access psychological treatment or

support, or which focused on measuring workers' mental health or wellbeing, were frequent (see sections 7.3.2.2, 7.3.3.2, and 7.3.4.2). In this way, workers' mental health, as opposed to work, was framed as the dominant problem to be solved and the central organising principle for participants responding to their duties under the HSWA.

This psychocentric discourse at once has disciplining effects, but, also, in situating the locus of causality in the mind or psyche of the worker, consigns the problem to the private sphere whilst simultaneously relieving those in the senior most positions of management from a consideration of the role of work itself in creating risk. This absolves management of their responsibility to act upon aspects of work. This discourse therefore decontextualises and depoliticises workers' health from the work that they do and narrows the opportunity for risk management to those strategies which involve acting upon workers themselves. As Cushman (1995, p. 337) points out:

If we psychologize and medicalize every human action by ridding it of any significant political cause, we condemn ourselves to denying the effects of the macro structures of our society. Therefore we will leave those structures intact while we blame the only positions in our cultural clearing that show up as responsible, culpable entities: the individual and the dyad. If we cannot entertain the realistic possibility that political structures can be the cause of personal, psychological distress, then we cannot notice their impact, we cannot study them, we cannot face their consequences, we cannot mobilize to make structural changes, as we will have few ideas about what changes to make.

The literature on psychosocial risk management, although generally not using the terms “psychocentrism” or “psychologisation”, evidences the influence of these discursive phenomena, mainly in terms of the individualisation of psychosocial risk management and the lack of focus on primary prevention (expressed through a tendency to act on the mental health of workers instead), which were mentioned in the literature review in sections 3.5.4 and 3.5.5. In shifting from a primary prevention perspective to a secondary or tertiary prevention perspective (see section 3.5.5, Table 6), the construction of risk changes to one where the object of risk is no longer work but is displaced by

workers' mental health. As pointed out in the literature review in sections 3.5.4 and 3.5.5, these tendencies are some of the major challenges or ways of thinking that undermines psychosocial risk management and the successful implication of WHS law relating to the management of risks arising from work.

Rose (2018) suggests that the wider inclination to problematise societal problems in the language of psychology and to manage the health of people and populations using psychological expertise is by no means a new one. Neoliberal rationality, according to Rose (2018), is often used as a sweeping explanation for the contemporary "epidemic" (p. 49), or perception of an epidemic, of mental ill health and concomitant psychological discourse in schools, workplaces, and hospitals. However, Rose (2018) also points out that the psychological sciences were not borne out of neoliberalism but out of political and social events of the nineteenth century. These events differentiated the psychological sciences from other ways of explaining mental ill health, which, at various times in the past, were more based in morals, religion, philosophy, or medicine. Others, like Cosgrove and Karter (2018), have similarly noted that there is considerable debate and contestation about exactly how much explanatory power can, or should, be accorded to the concept of neoliberalism, in particular to describe the current societal concern with mental ill health.

In unpicking the various manifestations of neoliberal rationality, Rose (1996, 1999a, 2018) offers a more nuanced understanding of the circumstances that have given rise to the increasing dominance of the problematisation of mental ill health, many of which, he argues, cannot be entirely pinned to neoliberalism per se. For example, Rose (2018) lays out a constellation of factors that have culminated in the tendency to use psychocentric discourse to frame our understanding of unhappiness or discontent, including: the ever-widening diagnostic categories of mental illness, differential access to and use of social capital, a widening poverty gap, the discourse of welfare dependency, and ideologies and practices of responsabilisation and individualisation. Rose (2018) also observes the effect of these conditions on the discourse of unhappiness and distress, where "an individual's own perceptions and reports of their mental distress are shaped by the increasing availability and acceptability of the language of mental disorder" (p. 65). Resultantly, human responses to adversity

become shaped by the language of mental health and, thus, the types of human experiences and behaviours that are considered disordered increases (Haslam, 2016). Indeed, according to Rose (2018, p. 53), it is these “socio-political and ethical dynamics” that interact to at once increase levels of psychological distress and, at the same time, increase the willingness and likelihood of both individuals and professions to place that distress under the description of mental ill health, rather than, for example, discontent with poor working conditions or the experience of poverty. Thus, as an increasing array of human experience and behaviour is pathologised, and the more that the language of mental health is used to code the discontent, unhappiness, adversity, injustice, or stress people experience, the wider the scope for intervention by psychologically framed technologies.

8.1.3 SUMMARY OF THE INDIVIDUALISATION AND PSYCHOLOGISATION OF RISK

As pointed out in section 2.1.4, the social constructionist epistemological perspective to risk pays attention to which risks are constructed as facts as well as examining why other risks are ignored, subverted, or de-escalated (Luhmann, 2002). Drawing on this perspective, I looked at which types of risk were most commonly spoken about by participants conducting their duties and found that the two types of risks most commonly named were interpersonal relationships between workers (and sometimes supervisors and middle managers) and organisational culture. In the sections above at 8.1.1 and 8.1.2, I discussed how these risks show particular characteristics in their discursive construction, which led to a limitation of accountability of management and a tenuous and flimsy connection to managerial power and control.

One of the complexities of psychosocial risks, or indeed any health and safety risk, is in the multicausal nature of the harms that result from them. This means, inherently, a single causal factor can rarely be identified as the precise “thing” that gives rise to ill health (such is the nature of risk: if risks were certain, they could not be a risk). However, what can be drawn from this analysis is that when confronted with an infinite range of potential risk factors, in many cases, the risks that officers focus on in executing their duties are those that defer to worker cause or responsibility. Thus, officers and the organisation generally are released from any responsibility for risks arising from the system of

work that they control. Indeed, the responsabilisation of risk to individuals forms a theme throughout several key social constructionist perspectives on risk (see section 2.1.4) and has been empirically evidenced elsewhere in the field of WHS. For example, MacEachen (2000, p. 315) reported in the case of repetitive strain injuries that managers “dwelt on individual rather than occupational determinants of health.” The individualisation of risk also constitutes a key theme in the literature on psychosocial risk and the legal responses to it (see section 3.5.4), which is summed by Walden’s (2017) observation that when it comes to WHS law and mental health:

The focus and spotlight is, therefore, in most cases—and especially in respect of the employer’s traditional common law duty of care in respect of health and safety—placed squarely on the individual personality and psyche, with the onus on the employee to demonstrate their particular susceptibility to psychiatric/psychological problems ... rather than emphasising employers’ broader responsibilities proactively to provide a work environment that is not damaging to employees’ collective mental health, dignity and well-being. (p. 103)

Discourse, as a “set of rules, divisions and systems of a particular body of knowledge ... [determines] ... the limits of thought and language” (Arribas-Ayllon & Walkerdine, 2017, p. 120). In considering how the discourse about psychosocial risks makes certain objects thinkable and governable and provides the scope of what can be known, said, or practised, it can be seen that even when participants named work-related risks, the tendency was to frame these mostly in terms of risk which focus on worker behaviours or psyches. The effect is the use of language that limits the types of risks that officers might consider when executing their duties. This limiting tends to marginalise consideration of those risks that implicate or impinge upon management prerogative and simultaneously amplifies those risks arising from workers themselves; thus, the infusion of power relations becomes explicit. In this respect, while other types of risk arising from the conduct of the PCBU were mentioned, they did not form the dominant way in which participants conceptualised psychosocial risk. The focus on individual worker behaviour and characteristics, and the tendency to manage risk by acting on these variables, obscures other causes of risk and protects these risks from scrutiny as to their part in

affecting the health of workers, thus preserving status quo conditions, which may harm workers' health.

8.2 THE MANAGERIALISATION OF THE LAW

The key precept of risk-based self-regulation is that organisations themselves, within the scope of the principles or standards given by legislation, determine the objectives of regulation, their organisational tolerance of risks, the impact and probability of risks, and the methods they will adopt to manage or control those risks (Black & Baldwin, 2010). Metaregulation describes the officers' duties in that the HSWA requires that officers give scrutiny and oversight to an organisation's self-regulatory activity, ensuring its appropriateness and effectiveness. While these risk-based decisions and actions are presented as technical, the conduct of each of these risk-related steps can alternatively be thought of as political (Jasanoff, 1998; Parker, 2002). This is because each aspect of risk-based self-regulation is socially shaped and influenced by the norms of the organisation and the broader institutional environment (Black & Baldwin, 2010). Haines (2021, p. 93) describes the competing demands of regulatory purpose and corporate goals as an "entanglement ... [which is] ... often shaped by the tension between and within economic and social goals, tension that can be resolved either by supporting or challenging the status quo." Research has suggested that the choices and interpretations that actors within self-regulating systems make suggest that regulatory objectives in corporate settings are very often colonised by the logic and discourse of managerialism, which limits the impact of regulation in achieving its purpose(s) and thus maintain the status quo (Edelman, 2016; Edelman et al., 2001).

Managerialism does not appear to have a universally accepted definition. However, Klikauer (2015) suggests that it involves the expansion of management ideology into wider realms of human society through ideas such as competition, capitalism, efficiency, expertise, and so on. Managerialist values, tenets, and beliefs are often accepted as a comprehensive worldview (Klikauer, 2015) and that which is good, normal, and true but also as a view that tends to conceal the fundamental profit motive. The laws regulating organisations are said to be managerialised when the law becomes infused with

managerial or business values. It occurs when legal rules are “filtered” (Edelman, 2016, p. 25) through managerial lenses and involves a

reconceptualization of law so that it is more consistent with principles of good management ... law tends to be interpreted, framed and reimagined in ways that elevate managerial ideals above legal ideals ... Managerialization may allow organizations to navigate around elements of the law that conflict most with business values. (Edelman, 2016, p. 25).

In other words, managerialised conceptions of the law work to make any conflict between the purpose of the law and the operational imperatives of the company disappear (Parker, 2002).

In this final section of this discussion, I suggest that the cumulative findings of Chapters 5, 6, 7, and 8 show that the officers’ duties of due diligence as they apply to psychosocial risks demonstrate a managerialised conception of the law. In the previous chapters, I analysed the various ways that participants fulfilled their duties of due diligence. In Chapter 5, I reported on a tendency to uncritically accept symbolic structures as indicia of compliance. In Chapter 6, I identified a tendency to destabilise and debase the meaning and possibility of psychosocial risk management and, in Chapter 7, a tendency to translate psychosocial risk to those which are peripheral to the purpose and objectives of the HSWA. In the first part of this Chapter 8, I have argued a tendency to individualise and psychologise psychosocial risks. Collectively, these findings suggest that the law protecting workers’ mental health from risks arising from work shows evidence of managerialisation. This occurs because, taken together, each of these mechanisms discursively frames psychosocial risks and the responses made by organisations in terms of business practice consistent with managerial values, and in ways that mean that the way that work is designed, organised, and managed remains frequently unquestioned and undisturbed.

These findings suggest alignment with the wider literature on organisational responses to WHS laws requiring that workers’ health is protected from work-related psychosocial risks. For example, a recent large-scale study (Jain et al., 2022) of EU member states and candidate countries drew on multiple sources of data and extant surveys regarding the impact of WHS legislation on psychosocial risk

management within enterprises in those countries. While the study found that the presence of legislation in those countries specifically addressing psychosocial risks was associated with more enterprises having developed a work-related stress action plan, the substantive impact of these action plans in actually addressing psychosocial risks was questionable. Whilst the existence of action plans was found to be associated with increased job resources, there was no evidence of an association between action plans and decreased job demands—in fact, a weak association was found between the presence of action plans and a reported *increase* in job demands. Therefore, although the findings of Jain et al. (2022) lend support to the idea that specific legislation on psychosocial risks and work-related stress has some effect in propelling organisations toward taking some kind of action on psychosocial risks, it also suggests that the actions they do take may be generally ineffectual. Moreover, the study suggests that efforts made to manage psychosocial risks are more likely directed at resourcing individuals than reorganising work or implementing better job design.

Other studies also conducted in Europe similarly found that while a high proportion of organisations see the fulfillment of legal obligations as the primary driver for managing psychosocial risks and report taking actions to change the way that work is organised, they tended, in practice, to address risk by way of interventions targeting individuals and their behaviours, such as training and counselling, managing interpersonal relationships at work by way of implementing conflict resolution procedures, or generally interventions at the secondary and tertiary level (Irastorza et al., 2016, Leka et al, 2023), which are suggestive of a reactive approach responding to stress or harms. Together, these studies suggest that much of the “riskwork” (Power, 2016, p.3) undertaken by organisations in the name of legal requirement for psychosocial risk management is largely symbolic or ceremonial in that while it gives the impression of complying with WHS law—and while stakeholders may purport that it meets the objectives of WHS law—it is often inconsistent with the law’s purpose and intent to prevent harm, and unlikely to represent any meaningful change to the way that the work of a PCBU is organised, designed, managed, or carried out.

Noting that the officers’ duties and the inclusion of mental health in the HSWA (passed in 2015) is a relatively new phenomena—at the time of writing, approximately eight years old—it may appear

reasonable to suggest that the managerialised way in which the law is being constructed is indicative of New Zealand PCBU's, officers, or senior managers being in a low state of WHS maturity when it comes to dealing with psychosocial risk under general duties type legislation. However, even in jurisdictions where the law has existed for longer, researchers report similar findings (Irastorza et al., 2016; Jain et al., 2022), suggesting that this construction of compliance is not simply or only a case of lack of knowledge or a product of low maturity. Rather, research in other fields of law suggests that the managerialisation of the law, instead of gradually being corrected or brought into alignment with the purposes of the law, often rather builds through a process of institutional isomorphism (DiMaggio & Powell, 1991; Edelman, 2016).

Institutional isomorphism is a process of increasing homogeneity of organisational structure, culture, and output occurring in response to uncertainty and constraint (DiMaggio & Powell, 1991). It entails a process of institutionalisation where, over time, through “congealed taste or fashion which escapes conscious design” (Power, 1999, pp. 122–123), organisations become more similar, and particular ways of thinking about various organisational concerns, including legal compliance, become dominant across multiple organisations. The phenomenon of institutional isomorphism occurs through three overlapping mechanisms: coercive, mimetic, and normative isomorphism, which stem from political or regulatory influences, responses to uncertainty, and professional and moral influences, respectively. Institutional isomorphism suggests that homogeneous ways of thinking and acting within and across organisations acquire even more validity as certain actions, systems, processes, and structures are reaffirmed through documentation, formalisation, training, and so on as proper, natural, and desirable and, thus, become institutionalised. Alvesson (2022, pp. 129–130) offers a number of examples:

Organizations adopt the right arrangements, structures, and language for what is regarded as desirable (e.g., appearing to be ‘politically correct’). They signal environmental awareness, arrange for corporate health services, present a strategic plan, establish management groups (teams), have at least two female board members, appoint a group to handle ‘knowledge management’ [...]. Few want to risk being one of the few companies (over a certain size) that

does not have a CSR [corporate social responsibility] manager and a CSR policy. There is always something that can be highlighted in terms of ‘sustainability’. Small firms are, to a certain extent, let off the hook, as they can’t be expected, in the eyes of mass media, to display all the good things resourceful organizations can develop.

In terms of legal compliance, institutionalised conceptualisations of compliance become embedded across institutional fields, and, over time, difficult to change, particularly when the “state’s legal system gradually assimilate business constructions of what the law entails” (Gilad, 2014, p. 136), which is illustrated when the legal system defers to the adoption of symbolic structures as indicia of compliance. Thus, particular ways of thinking about and responding to the law become institutionalised through a process of isomorphism occurring via the proliferation of symbolic structures that are uncritically accepted by those deploying them, and, ultimately, even the regulator or the courts as activity that achieves compliance with the law.

Thus, it is concerning when, in this research, participants recounted receiving compliance advice, declaring that “You could do just about anything you want in the space at the moment. It’s so new that you almost couldn’t go wrong” (P13). The lack of specificity amongst participants but also, apparently, their advisors around which approaches to the “problem” of worker mental health are concomitant with WHS law compliance risks affirming those approaches that are not, and, therefore, adding to the discourse that *any* response to the issue of worker mental health is appropriate and effective compliance with WHS law. Legal endogeneity theory and the process of institutional isomorphism suggest that rather than being “corrected” over time, managerialised ideas may, in fact, become entrenched because changing widely accepted ways of thinking about problems requires an uncomfortable redistribution of blame and responsibility and, in this case, a shifting of compliance attention to the risk object of work.

8.2.1 SYMBOLIC POWER AND MANAGERIALISATION

In the preceding section 8.2, I noted that particular ways of thinking about compliance can become entrenched throughout organisational, professional, and legal fields, and then hard to change. Using

the theory of institutional isomorphism mentioned above, Alvesson (2022) suggests that a contributing factor to the spread of certain managerial ideas is that modern organisations are increasingly highly sensitive to what other organisations do, and, in a context of social pressure for organisations to change for the broader social good, are devoting more and more of their time and energy to appear beautiful in the fashion show of organisational legitimacy. In this sense, Alvesson (2022) describes how it has become very important for actors in organisations to develop structures or implement superficial practices akin to a window display, with the purpose being to “look good” (p. 144) and appear stylish, especially to external stakeholders. These structures and practices serve a legitimising function in signalling attention to concepts and ideas that appear desirable, legitimate, and stylish at any given time. The critical factor in these displays, however, is that they are symbolic or ceremonial only and rarely penetrate the inner workings of the organisation. Alvesson (2022) explains:

... organizations are permeated by a split between legitimizing, formal structures and arrangements which primarily have a ceremonial function and work organizations characterized by productivity and efficiency. The formal structures appear to be relevant to core activities, but the structures are often divorced from actual production; the ceremonial activities do not interfere with the productive activities (p. 133).

Institutional isomorphism results in the homogenisation of superficially beautiful practices over time as organisations mimic and imitate each other. The normative aspect of isomorphism suggests that this occurs not only because these practices become management fashions but because “being able to refer to ‘this is what everyone else is doing’ is a safe move” (Alvesson, 2022, p. 129). This phenomenon was apparent in this research, where many participants described how their approaches to compliance were influenced by other corporate actors, often conceptualised in terms of actions undertaken in the name of “wellbeing.” For example, many participants expressed how they considered what other companies or officers were doing to respond to their legal obligations to management risks to workers’ mental health and discussed and compared approaches to mental health and wellbeing with colleagues in their professional network (see section 5.1). Most tellingly, participants expressed reputational concerns relating to the wellbeing offering made by their company, compared their

organisational wellbeing programmes to other organisations, and considered the reputational implications of having (or not having) a wellbeing programme, wellbeing manager, or wellbeing committee within the business (see sections 5.7.2 and 7.4.5). The isomorphic influence of the wellbeing concept was also seen in the way that several participants described the recent renaming of Health and Safety Managers to “Health Safety and Wellbeing Managers,” the Health and Safety Committee to the “Health, Safety, and Wellbeing Committee,” and the Health and Safety Report to the “Health, Safety, and Wellbeing Report.” The strength of the desire to signal attention to wellbeing was epitomised in P02’s observation that whereas talk of “culture” had previously been dominant in the field of health and safety, “now, of course, everyone’s talking about mental wellbeing.”

While Alvesson (2022) writes about the isomorphism of business responses made in the name of corporate social responsibility—“few want to risk being one of the few companies (over a certain size) that does not have a CSR manager and a CSR policy” (p. 130)—it is apparent that Alvesson’s ideas can be extended to concepts such as wellbeing and culture in organisational responses to WHS laws. Structures and practices relating to worker mental health, particularly those conceptualised and deployed through the lens of “wellbeing” (see section 5.7.3) or “culture” (see section 8.1.1.2) appear to be becoming more important for organisations to have in order to *signal* that they are beautiful organisations than it does to enact substantive change to affect the conditions of work that may place workers’ health at risk. The fashion element of these symbols was noted by P12, who observed with some cynicism that mental health was a “trendy thing right now” and is reflected elsewhere in the preponderance of companies now using the terms “wellbeing” and (organisational) “culture” on their websites and in annual reports (Purver et al., 2022; Vlahos & Douglas, 2023). The rapid and ubiquitous uptake of these terms suggests that organisations are indeed demonstrating institutional isomorphism (DiMaggio & Powell, 1991) and that the use of these “beautiful words”²⁸ (Alvesson,

²⁸ In this context, Alvesson refers to those “beautiful” words attached to the concept of “diversity”: “Diversity is also sold by using harmonious and beautiful words that attract people with aesthetic values and metaphors such as ‘rainbow cultures’ and ‘mosaic workplaces’. Against the ugly world of differentiation, exclusion, discrimination, and conflict, we find much more appealing social relations made possible through the new diversity management, with a fair amount of grandiose promises.” (Alvesson, 2022, p. 138)

2022, p. 138) implies legitimacy in their signalling attention to WHS matters. Ultimately, however, the use of these words in corporate structures, practices, and publications to suggest compliance often appears superficial and expedient, both politically and operationally, requiring less challenge to and scrutiny of deeper organisational structures and practices than does the more difficult and rather less fashionable task of ensuring that work is designed, organised and managed in ways that eliminate or minimise risk to the mental health of workers. The use of these beautiful words works much the same way as diversity rhetoric and has often been shown to operate in “promising rainbows and offering dreams of attractively coloured but substance-less utopias that have little to do with the darker side of identity politics” (Alvesson, 2022, pp. 138–139).

Further, the connotations that sit within terms like wellbeing and culture make them seductive in their rectitude and positivity. It is difficult to argue culpability, as Johnstone (2003) has pointed out, against an employer who, in matters of health and safety, appears to be a “good corporate citizen” (p. 113). In the context of this research, the good corporate citizen might be, for example, the officer who deems compliance synonymous with the authorisation of workers to bring their “whole self” or “full self” (see section 7.3.3.2) to work, who valorises and funds free therapeutic interventions, or advocates for workers and supervisors to be kind, care for, and support each other. Indeed, those critiquing such responses may well find themselves being labelled as uncaring or harsh, highlighting the relationships of power within this managerial discourse to imbue these actions with goodness and virtue.

In a similar way to the idea of workers bringing their “whole self” to work, Fleming (2009) considered how the common “liberation management” invocation to workers to “be yourself” at work seems positive in that it “prima facie appears to be a liberalizing gesture to erstwhile oppressive regimes of control and dated managerial ideologies” (p. 28). In empirically analysing who is asked to be themselves at work and why, Fleming (2009) suggests that the increasing authorisation and encouragement of workers to bring private or personal aspects of their life into the sphere of production creates a situation where more aspects of workers become visible to the managerial gaze. The result of this “visibility” is that aspects of workers’ private and personal lives are then problematised in the context of production. As a further effect, Fleming (2009) notes that the insidious

positivity “prescribed by this management approach detracts from existing controls rather than precipitating their demise” (p. 32).

This observation can similarly be applied in the context of psychosocial risk management, which, as this research shows, often focuses on pathologies of the individual or problems arising from their private lives. Such focus, especially when it comprises the totality of an organisation’s approach to psychosocial risk management or when they are framed as compliance with WHS law, dissociates and decouples the risk of harm to workers from the underlying systems of work. It may also therefore serve to pacify demands, or the legal requirement, for better management or better material conditions of work. Further, such a focus excludes a consideration of who may benefit and who may be harmed from the extant system remaining unchanged. In concordance with Fleming’s (2009) observations, these strategies obscure the fundamental structure of the employment relationship, which exposes the employer and employee to different types of risk: “The employer involves his own patrimony or the patrimony of the company whereas the worker ‘risks is[*sic*]/her neck’” (Lerouge, 2017b, p. 392). The result is that risks arising from the actual work that people do and the context in which they do it, along with the inherent vulnerabilities of workers’ positioning in the employment relationship, fade into the background.

The recently coined term “wellbeing washing” (Jackson et al., 2022; Jarden & Roache, 2023) appears to be very relevant to the idea of symbolic compliance with WHS law as it relates to psychosocial risk. Wellbeing washing has been used to describe the halo effect emanating from organisational actions undertaken in the name of wellbeing that are unquestionably accepted as virtuous, positive, and good. This halo effect occurs notwithstanding the fact that the actions may be either superficial and ambiguous (Jarden & Roache, 2023) or primarily serve other (for example, managerial) interests. These other interests “may actually threaten rather than enhance individual and collective health” (Jackson et al., 2022, p. 4) because those who fail to perform wellbeing or conform to the wellbeing agenda may find themselves alienated or pathologised in the workplace. The increasingly widespread and uncontested symbolic power of concepts such as wellbeing, particularly when conceptualised solely or predominately as worker-directed or individualised strategies, may be progressively acting in

the same way that the symbolic power of “diversity” was described in section 5.7.4. In this way, such concepts as wellbeing may cause an array of stakeholders both within organisations but also within the institutions that oversee and critique organisational responses to the law, such as regulators, legal advisors, and even academics, to overlook psychosocial risks arising from work in a similar way that diversity rhetoric causes these actors to “overlook evidence of discrimination and inequality” (Edelman, 2016, p. 133).

8.3 CONCLUSION: THE LIMITATIONS TO, AND PROSPECTS FOR, THE OFFICERS’ DUTIES AND PSYCHOSOCIAL RISK MANAGEMENT

Drawing on a Foucauldian understanding of power, an analytics of government aims to surface and make explicit the ways in which we govern and are governed. As Dean (2010, p. 47) explains, by elucidating the “rationality and thought that inhere in regimes of practices [...] an analytics of government can remove the taken-for-granted character of these practices.” The purpose of performing such analysis is to:

open the space in which to think about how it is possible to do things in a different fashion, to highlight the points at which resistance and contestation bring an urgency to their transformation, and even to demonstrate the degree to which that transformation may prove difficult. (Dean, 2010, p. 48)

With this in mind, this study’s detailed examination of the way in which officers conceptualise and carry out their duties with a particular focus on risk indicates the various taken-for-granted ways that compliance becomes managerialised, and the managerialised view entrenched. This occurs when widely shared beliefs about the law, mental health, causality, risk, and responsibility dictate the meaning of compliance in a way that is often less effective, or ineffective, at addressing causes of risk arising from the work carried out as part of the PCBU. As a result, the status quo is maintained within the organisation through the protection of managerial prerogative. This highlights the way that institutionalised ideas about compliance are formed through the “interplay” (Stryker, 2019, p. 1235)

of legal or regulatory and business logics, and points to the constraints of risk-based regulation in a self-regulatory system that asks organisations to respond to risks that may challenge the very institutional logics by which they, as corporations, operate.

Baldwin and Black (2010) have similarly discussed how, at the heart of corporate regulation, there exists a fundamental divergence between corporate and statutory purposes, resulting in a distortion of the goals of regulation when firms self-regulate:

Regulators think of objectives with reference to statutory purposes but firms will see internal controls as properly directed at ensuring that the firm achieves the objectives it sets for itself—namely profits and market share. The risks the regulator is concerned with will, indeed, not always be the same as the risks the firms are focused on. Firms are ultimately concerned with ensuring their own survival and growth and, if publicly listed, maximizing their returns to shareholders, despite the inroads of corporate social responsibility initiatives. The firms' risk-management systems may be adequate for achieving the firms' own objectives but they may not be adequate for achieving the regulator's objectives. Such divergencies mean that regulators can never rely on the firms' own systems either for implementation or for undistorted feedback or results. (p. 202)

It may, therefore, seem futile, in a regulatory environment characterised by self-regulation where the interests of those charged with ensuring compliance with the law are also entrusted with determining its meaning, that any chance of effective psychosocial risk management is realisable. Further, in the current absence of clear regulatory guidance, tripartite debate, or consideration from the courts, the dominant discourse of risk that systematically creates an individualised, psychologised, and managerialised view of the law risks “gazumping” (Parker, 2002, p. 146) those more substantive efforts that appear currently stymied or peripheralised.

Despite these barriers and limitations to effective self-regulation on the matter of the officers' duties and psychosocial risk, Edelman (2016) suggests that, in situations where self-regulation has been effective, those tasked with overseeing regulation, or devising compliance responses within

organisations have had to adopt either, or both, a sceptical or an activist stance. Where the various forms of managerialisation that have become embedded in the law and that relegate the law ineffective are scrutinised, and widely shared beliefs about compliance are examined for their substantive impact on achieving the goals of the law, the power of regulation to achieve its substantive purposes may be recognised. Edelman (2016, p. 238) asserts that: “When legal institutions distinguish between organisational practices that are substantive and those that are merely symbolic ... legal endogeneity promotes social change.”

This change was sometimes the case. Although not the norm, there were research participants who did express an attention to structural and organisational elements of work that gave rise to risks to workers’ mental health. Several participants did critically question, for example, the substantive impact of adding in “wellbeing” to the name of a committee or, indeed, the substantive impact of the committee itself. They questioned the utility of commonly used metrics to understand risk, gave examples of where work was materially reorganised in a way that eliminated or minimised the risk of harm to workers, and otherwise highlighted the challenge inherent in both ensuring that the organisation protects the mental health of workers while also maintaining shareholder primary or production imperatives. All of which are precisely the critical lens that the officers’ duties of due diligence require. However, some also expressed the challenge for them in doing so was that this way of thinking sat counter to the meaning made of the law by many of their peers, again highlighting that this way of conceptualising the problem was not the dominant way of thinking across this powerful group of corporate actors. This also highlights, of course, points of resistance and contestation and therefore a rejection of a singular or unified meaning of compliance. Indeed, it has been noted that taking a contrary view of compliance to that of other corporate actors, particularly where that position “intensifies the threat to management prerogative” (Edelman et al., 1991, p. 91), is a politically tenuous position for those who do so and may place “an intolerable burden on the internal corporate staff responsible for self-regulation to resolve conflicts between regulatory and business goals” (Parker, 2002, p. 136), thus paradoxically exposing those same people who hold WHS responsibilities for complying with WHS laws to psychosocial risk themselves.

These findings also highlight the need for regulatory tools and strategy, coupled with clear and accessible regulatory guidance for officers to assist and direct them in fulfilling their duties, particularly as they apply to psychosocial risk. This finding is backed up by a recent review of the officers' duties of due diligence in the Australian context. In that review, Johnstone and Tooma (2022) noted that, overall, the officers' duties had not been appropriately capitalised upon as a regulatory tool for bettering WHS outcomes with their potential impact having been stymied by a lack of guidance and interpretive material. Further, a relative lack of enforcement, particularly of larger companies where officers are removed from day-to-day operations, had resulted in continuing ambiguity as to the courts' interpretation of the duties, especially as they relate to independent directors:

The reluctance of regulators to pursue officers of large companies for breaches of the officer duties means that we continue to have no jurisprudence on the interpretation of the duty in relation to large companies where officers, particularly directors, are not involved in day-to-day management of the operations. (Johnstone & Tooma, 2022, p. 374)

Further to the production of better guidance, Johnstone and Tooma (2022) suggest a code of practice for this duty should detail specifically that which officers should be expected to do relative to each hazard identified in Work Health and Safety Regulations—echoing the yet unfulfilled recommendation of New Zealand's decade-old Taskforce Report (Jager et al., 2013). Noting that there are now WHS regulations for psychosocial risk in Australia, such a code of practice for both psychosocial risk and the officers' duties might have a powerful effect in focusing the construction of compliance with the law toward the law's specific intent. Additionally, they suggest that the proactive and independent nature of the duties needs to be better capitalised upon and suggest that the conduct of each officer's duty should be annually reviewed and verified (Johnstone & Tooma, 2022).

This Chapter 8 discussed key features relating to the discursive construction of psychosocial risk. In examining those risks that were most commonly named by participants, I explored how psychosocial risks tended to individualise and psychologise risk and discussed how these discursive constructions make certain responses intelligible for officers performing their duties of due diligence. The

implications of this were framed as having the effect of managerialising the law. In this way, this chapter paid particular attention to what discourse does in terms of limiting and defining what may be considered appropriate and possible for officers and the organisations they govern to do in order to comply with the law. The next chapter, Chapter 9, concludes this thesis by summarising the overall approach, findings, and answers to the research questions.

9. CONCLUSION

This research aimed to critically examine the way in which New Zealand officers of large companies described fulfilling their duties of due diligence as they apply to psychosocial risk. In doing this, I examined how ideas about compliance and psychosocial risks are socially constructed and organised and considered the implications this has for the prevention and management of psychosocial risks in accordance with WHS law. To achieve the research aim, I interviewed 24 officers of large New Zealand companies about the conduct of their duties and then analysed, using discourse analysis, the ways in which officers conceptualised and practised their legal duties as they applied to psychosocial risk. I examined how the meaning of compliance was constructed through the lens of risk and assessed the implications of these conceptualisations and constructions relative to the regulatory purpose of the Health and Safety at Work Act and the specific duties of officers therein.

This chapter concludes the thesis by providing an overview of the research and findings related to each of the three research questions (section 9.1). In section 9.2, I discuss the specific and general contributions that the research has made to scholarship in this field. These contributions will be set out in terms of the original contributions to knowledge, the extensions to extant knowledge, and the practical and policy implications. In section 9.3, I discuss the limitations of this research, and suggest areas for further or future research. Finally, in section 9.4 I provide concluding comments.

9.1 OVERVIEW

Given that this research sits at the intersection of a number of bodies of literature, two literature review chapters were presented. The first, Chapter 2, covered risk, regulation, and work health and safety, and the interrelationship between those topics. These topics set the context for understanding the officers' duties of due diligence, which were introduced at the end of the chapter. The second literature review chapter, Chapter 3, then narrowed the focus to an examination of the literature on psychosocial risk at work and its regulation. These two chapters concluded by noting that no research has examined company officers' perspectives or responses to their specific legal duties in New

Zealand, and very little was known about how officers conceptualise or exercise their duties. This gap was identified as the focus for this research.

Next, the methodology chapter (Chapter 4) outlined the social constructionist epistemology taken in this research. Importantly, I noted that when applying this perspective to regulation, the social constructionist approach does not view compliance as simply a response that organisations and actors within them make in reaction to a fixed and accepted understanding of law but, rather, as a “complex, ambiguous process in which the meaning of regulation is transformed as it is interpreted, implemented and negotiated” (Parker & Nielsen, 2017, p. 218). The methodology chapter then outlined the adoption of a Foucauldian analytical approach used to capture this process and to answer three research questions:

1. How do officers conceptualise, express, and carry out their duties under the Health and Safety at Work Act with specific regard to psychosocial risk?
2. How do constructions of risk shape how officers respond to this duty?
3. How do the ways that officers construct compliance relate to the regulatory intentions of the officers’ duties, and what are the implications for managing psychosocial risk?

Semistructured interviews were carried out with 24 participants, predominately online, which were transcribed and uploaded into NVivo for coding. A coding strategy was undertaken informed by Willig’s (2008) ‘Procedural Guidelines for the Analysis of Discourse’, and multiple coding rounds were conducted in accordance with Salañda’s (2021) suggested approach. Data synthesis was facilitated by using the Framework Analysis (Ritchie & Spencer, 1994) technique.

The findings and discussion of this research were combined and presented across four chapters, beginning at Chapter 5. In that chapter, I addressed the first research question, which was structured to systemically examine and discuss participants’ responses to each of the “elements” of due diligence as they are set out in the HSWA in section 44(4)(a–f). The findings indicated considerable heterogeneity in the ways that participants conceptualised and carried out their duties. This heterogeneity was discussed in light of the ambiguous nature of WHS law, and the absence of an authoritative voice

providing interpretive guidance for officers around the application of WHS laws to workers' mental health. In response to this ambiguity and perceived lack of guidance, participants tended to defer to the presence of *symbolic* structures within the PCBU as indicia of compliance, with very few participants suggesting a *substantive* interpretation of the law. In addition, a particular discourse of compliance was observed that delegitimised legal compliance with the HSWA by framing it in terms of being administrative, bureaucratic, and ineffective, suggesting a *procedural* interpretation of the law. In this context, the meanings and implications of "going beyond compliance", as an alternative to compliance, were explored.

Chapter 6 retained a focus on the first research question but examined how the performance of due diligence regarding psychosocial risks was dominated by representations of psychosocial risks and their management as problematic and dilemmatic. Through analysing the ways that officers described these problems and dilemmas that they faced when carrying out their duties, I identified and discussed several themes characterising their description. I suggested that these themes collectively represented psychosocial risks in one of two ways, both having particular implications for compliance. First, psychosocial risk was predominately represented as arising from places outside of managerial control—either outside of the work environment, such as workers' home, family, or private lives, or as a result of the subjective experience and/or personal (and problematic) characteristics of individual workers. Second, by amplifying select elements of complexity and uncertainty related to psychosocial risk, the extant science and knowledge of psychosocial risks and their management was represented as new, unestablished, and lacking consensus. These representations were considered to collectively decouple and undermine the link between hazards arising from work and harm to workers, and therefore delegitimise the possibility that such risks might be managed. I concluded the chapter by suggesting that the overall presupposition of uncertainty and unmanageability amongst officers exercising their duties points to a discursive construction of psychosocial risks as novel risks.

Chapter 7 considered how officers responded to these novel risks, and, in doing so, addressed the second research question. In that chapter, I systemically analysed how officers constructed and organised risk, a fundamental organising concept in the HSWA. By identifying the various objects and

subjects of risks that officers named, I identified that a wide array of risk objects and subjects were attended to by officers as they fulfilled their duties. In this process, psychosocial risks were “translated” into risks with which participants were more familiar, were more amenable to management, and entailed less conflict with managerial ideals and objectives.

A prevalent way that this translation occurred was where worker mental health, rather than being conceptualised and managed as a *consequence* of psychosocial risk exposure, was transformed into a *cause* of risk to the organisation. I therefore demonstrated that the way in which participants conceptualised and constructed risk, what they considered as the risk object and the risk subject, and how they constructed a relationship between them, set the conditions of possibility for the compliance responses and actions that were used to measure, monitor, and manage these risks. While this and other translations provided officers with a clearer path for action, the impact of this risk translation meant that the meaning of risk was changed, having implications regarding the responsibility to do something about those risks, and the blame for giving rise to them. Furthermore, I showed that while the outcome of risk management of some of those translated risks may be fortuitously congruent with the purpose of psychosocial risk management under the HSWA, this assumption, made without critical consideration, appears to lead organisations to assume that managing any sort of risk associated with mental health at work meets the substantive purpose of the HSWA.

Chapter 8 was the final chapter presenting the research findings and discussion and addressed the third research question. In this chapter, I discussed two dominant ways that officers constructed risks that led to psychosocial risk being individualised and psychologised. These ways of dealing with risk were contrasted with the regulatory objectives of the HSWA, and I discussed how these ways of constructing compliance often served to ameliorate the responsibility and power of officers and, in turn, the PCBU, to act under WHS law.

In the second part of Chapter 8, I discussed how, cumulatively, the emergent view of compliance with the officers’ duties showed many aspects of managerialisation, a process where the meaning of the law is deflected away from its regulatory intention. This occurred simultaneously through the

discourse of compliance that individualised and psychologised risk but also through a redirecting of compliance-related activity on to managerial concerns, such as operational matters, reputational concerns, and so on. The chapter concluded by noting that this evidence of the managerialisation of WHS law highlights the inherent tension in corporate regulation. This is expressed as a tension between economic and social goals, which results in legal obligations being “filtered” through managerial and business values as they are operationalised. Thus, the law is realised in a way that limits its potential to achieve its purpose. This concurs with research elsewhere that highlights the inherent limitations of corporate self-regulation but also, in drawing detailed attention to the processes and mechanisms by which this occurs, provides space to “think about how it is possible to do things in a different fashion, to highlight the points at which resistance and contestation bring an urgency to their transformation, and even to demonstrate the degree to which that transformation may prove difficult” (Dean, 2010, p. 48).

9.2 CONTRIBUTIONS

These findings are important and relevant in a regulatory context where businesses are responsabilised for regulatory outcomes by way of decentred or self-regulatory strategies. In such a context, the “managerial turn” (Power, 2007, p. 42) describes how the power to determine the meaning of compliance has shifted from a centralised authority to one where it is held by regulated actors and enacted through diffuse points of governance. Given that this expression of regulation has proliferated over the past fifty years, it is important to understand how these regulatory strategies work (or do not). In this regulatory context, a demand becomes apparent for empirical research that aims to understand how, why, and in what forms corporate actors respond to regulations and the (often plural) ways in which compliance is given meaning, understood, conceptualised, and operationalised.

Research taking a social constructionist approach pays particular attention to how relationships of power work in creating understandings about compliance and how these relationships might result in one understanding being more socially acceptable or legitimate than others (Parker & Nielsen, 2009). Constructionist research into compliance is important because it examines or highlights the often

taken-for-granted ways that commonly accepted views of compliance can promote the substantive purpose of the law or serve to limit the possibilities of the law to achieve its social goals. As Parker and Nielsen (2011, p. 8) remind us, “the way that compliance is constructed should be a core concern of social science theory building.”

With these points in mind, this thesis provides four original contributions to knowledge and extends current knowledge in several ways. Furthermore, as a result of the findings of this study, I also suggest several implications and recommendations for policy and practice. These contributions are summarised in Table 11 and elaborated upon in the following three sections 9.2.1 to 9.2.3.

Table 11

Research Contributions

Type of contribution	Description of contribution
1. Original contributions	a. First empirical research to examine compliance responses to the officers’ duty of due diligence in New Zealand.
	b. First empirical research to examine how company officers conceptualise psychosocial risk in the context of fulfilling their duty of due diligence.
	c. First empirical study examining company directors and executive management views on psychosocial risk.
	d. First research to apply the idea of Edelman’s (1999, 2016) theory of legal endogeneity and elements of Hardy and Maguire’s (2020) “risk translation” in a New Zealand WHS context.
2. Extensions of extant knowledge	a. Contributes evidence to support the claim that the concept of wellbeing, particularly as it is used in organisational contexts, is emerging as a “contested terrain” (Jackson et al., 2022, p. 2).
	b. Contributes to a small body of research examining the application of New Zealand’s Health and Safety at Work Act 2015 to psychosocial risks.

Type of contribution	Description of contribution
	c. Extends understandings of the challenges of and limits to corporate self-regulation.
3. Policy or practice implications	d. Findings may assist organisations wishing to critically evaluate their worker health-related, wellbeing, or psychosocial risk management strategy, or their governance strategies as they apply to WHS law, Environmental Social and Governance or Corporate Social Responsibility approaches.
	e. Findings may contribute to, or inform the development of, regulatory guidance materials, codes of practice, or further regulations for psychosocial risk management in New Zealand.
	f. Findings may contribute to, or inform the development and operationalisation of, regulatory tools or strategy required to guide and hold officers accountable to their duties.

9.2.1 ORIGINAL CONTRIBUTIONS

This research is the first empirical study that examines how New Zealand company officers fulfil their duties of due diligence, and the first to address the research gap around how New Zealand company officers understand and carry out these legal duties in relation to psychosocial risk. This is of value given that at the time of their inception, the due diligence duties were lauded as holding significant potential to improve WHS outcomes in New Zealand. Furthermore, the topics of psychosocial risk and worker mental health are of increasing salience in the New Zealand business and regulatory communities, so this research provides timely insight into the way in which the intersect of legal duties and psychosocial risk management is currently playing out.

Although von Thiele Schwarz and Lornudd (2022) have suggested, at a high level, why and how corporate boards should and can influence employee health and wellbeing, overall, there is a lesser

understanding of the board's role in health as opposed to safety. Arguably, there is an even poorer comprehension of the board's role in protecting workers from psychosocial harm (Ebbevi et al., 2021; Lornudd et al., 2021), particularly as it is required by law. Thus, this research contributes the first empirical evidence specifically relating to how those in governance and senior most management roles understand the application of WHS law to workers' mental health.

In using Edelman's (1999, 2016) theory of legal endogeneity and Hardy and Maguire's (2020) framework of risk translation, this is the first research in New Zealand to examine the application of these theories and frameworks to WHS compliance responses in New Zealand. These theoretical perspectives are valuable in that they provide insight into how both the notions of compliance and risk are constructed within a group of regulated actors, and how these constructions may alternately achieve, promote, mediate, or avoid social change.

9.2.2 EXTENSION OF EXTANT KNOWLEDGE

The concept of wellbeing was a salient topic throughout this research, but a comprehensive analysis of the discourse of wellbeing was beyond the scope of the thesis. The analysis that was conducted, however, does provide empirical substantiation to the extant critical literature on this topic. In particular, the research contributes empirical evidence relating to the ways in which the discourse of wellbeing is deployed in the governance of the workplace and, thus, lends support to the contestation that wellbeing, particularly in the field of work, is emerging as a "contested terrain" (Jackson et al., 2022, p. 2).

The findings of this research also contribute to the existing body of knowledge of how organisations and actors within them respond to decentred self-regulatory strategies and, more specifically, to existing knowledge regarding how organisations respond to legal duties to manage psychosocial risks. In doing so, this research contributes to an understanding of the challenges, barriers, and potential limits to the regulation of psychosocial risks at work. Understanding the ways in which organisations respond to such a regulatory strategy is important in the modern context where regulation generally relies on the co-option of business to achieve regulatory goals. In this respect, this research highlights

the limitations of self-regulation by showing how discourse can produce meanings of compliance that preserve the status quo rather than challenge or provide remedy to the negative societal outcomes that the regulation was intended to address.

Although there is a large body of evidence internationally that examines organisational responses to legal duties to manage psychosocial risk, in New Zealand there is only a relatively small body of research on this topic. This is likely because as a regulatory topic, psychosocial risk management has only recently emerged as a salient issue for New Zealand businesses. This research adds to this corpus, incrementally increasing knowledge of and insights into the operationalisation of psychosocial risk management in the New Zealand context. This, in turn, has practical implications, which will be outlined in section 9.2.3.

9.2.3 PRACTICAL OR POLICY IMPLICATIONS

Parker and Neilson (2009) note that social research into compliance is important as it may contribute to the understanding of the impact of policy. As a result, such research also has an important aspect of policy evaluation and accountability. With this in mind, this research makes several practical and policy contributions.

For regulators and other regulatory stakeholders, this research contributes findings that are relevant to the development of regulatory tools and strategy relating to both the officers' duties and psychosocial risk in a health and safety legal framework. In particular, the findings suggest that better regulatory tools are required to guide officers (and PCBU's) in their duties. The development of appropriate regulatory tools in New Zealand may, in turn, contribute to the avoidance or resolution of some of the problematic aspects of compliance with WHS law as they apply to psychosocial risk and which were highlighted in Section 3.5.

For company officers, this research may help bring a greater critical awareness of the way in which they, and the organisations they govern, comply with WHS law, and how common ways of understanding risk, mental health, and compliance may obscure harmful risks to workers or delegitimise efforts to manage them. In this respect, the findings may be of relevance and interest to

organisations and officers who are committed to eliminating harms to workers, either through WHS legal frameworks or through the adoption of alternatives to shareholder profit maximisation strategies. These latter strategies may include the shareholder welfare maximisation perspective (Hart & Zingales, 2017) or perspectives attentive to Corporate Social Responsibility or Environmental, Social, and Governance matters, which, among other variables, may be concerned with health or social outcomes for workers (Torres et al., 2023; Jain, Ripa & Torres, 2024). Relatedly, the findings of this research may be useful for those organisations aspiring to governance perspectives that place relatively more emphasis on the management, internalisation, or avoidance of negative externalities that occur as a result of their operations (Awatere et al., 2017; Mika & O'Sullivan, 2014).

9.3 LIMITATIONS AND FUTURE RESEARCH

While this research has contributed to a greater understanding of the way in which officers of large New Zealand companies understand and carry out their duties of due diligence as they apply to psychosocial risk, there are nevertheless limitations that must be kept in mind. Some of these limitations that I have identified give rise to opportunities for future research, which are therefore included in this section.

9.3.1 SIZE OF PCBUS

In Chapter 4, I highlighted several limitations to the scope of this study, most notably that it focused only on officers of large New Zealand companies. Thus, there is scope for further research to examine how officers of small New Zealand companies approach their duties. Such research would be important, given the large number of small businesses in New Zealand and given that small businesses face particular challenges in complying with WHS law (Bluff, 2017b; Lamm & Walters, 2003)

9.3.2 FOCUS ON PRIMARY DUTY OF CARE

This research focused mainly on how officers ensured that the PCBU was compliant with the primary duty of care. However, the officers' duties require that officers ensure the PCBU is compliant with

any duty it owes under the Act, and many of these duties were not, or only peripherally, examined in this research. Accordingly, there is further scope to consider how officers perform due diligence relating to other obligations of the PCBU. A particularly interesting focus here would be to consider the obligation of the PCBU relating to worker engagement, participation, and representation outlined in Part 3 of the HSWA. A number of worker engagement and participation strategies were spoken about by officers in the course of this research, and, in many cases, these strategies were found to relate to the recruitment of workers to monitor other workers' mental health. In other WHS contexts, Gray (2009) has written about the co-option of work health and safety representatives in monitoring workers' safety behaviours instead of representing workers. Further research may therefore be warranted to examine the nature of employee engagement and participation in psychosocial risk management with particular consideration of whether employee engagement and participation risks becoming more about "policing" other workers' mental health as opposed to understanding and representing worker interests in WHS risk management systems, processes, and decisions.

9.3.3 PARTIAL APPLICATION OF THE THEORY OF LEGAL ENDOGENEITY

In this research I applied elements of Edelman's (1999, 2016) theory of legal endogeneity at several points throughout to provide a framework to discuss how the law becomes managerialised as it is operationalised through symbolic attention to the law. Edelman's work on legal endogeneity, however, articulates a complete circular process, parts of which have not been considered in full in this research. The theory not only considers how practices, routines and structures within organisations responding to legal obligations influence and create managerialised conceptions of the law (as I have considered in this research), but also takes into account the roles of legal professionals, advisors, service providers and other stakeholders in shaping the meaning of compliance through the provision of professional advice and creation of compliance-related literature. Related to this, there appears to be an ever-increasing proliferation of services and individuals offering work-related mental health and wellbeing advice or services, and, with the increasing regulatory attention to mental health as a WHS issue, many now claim to provide expertise and services in relation to the fulfilment of legal duties and responsibilities. Given that the theory of legal endogeneity also emphasises the role of these

compliance professionals in shaping the meaning of law, researchers might explore the growth of psychosocial risk and wellbeing service providers and their influence in determining the meaning of WHS law as it relates to mental health.

In completing the process, legal endogeneity also suggests that regulators and the judiciary often tend to defer to the symbolic structures of compliance put forward by organisations and professionals, and, therefore, these managerialised views can become reinforced by the regulator and the courts and thus reincorporated into the meanings made of law by stakeholders through professional orthodoxy, regulatory guidance, and jurisprudence. For example, in relation to Civil Rights laws in the United States, Edelman (2016, 2018) and Krieger et al. (2015) have detailed how judges simply deferred to the mere presence of symbolic structures to infer a substantive outcome of non-discrimination without scrutinising those structures for their actual impact. In this sense, the application of legal endogeneity was limited in this research for the simple reason that there is yet not significant regulatory guidance²⁹ or sufficient relevant case law in New Zealand. If case law regarding the officers' duties and psychosocial risk in New Zealand emerges over time, there will be opportunity to extend the study of the construction of compliance by examining the responses of the regulator, lawyers, health and safety professionals, and the courts. In particular, in applying the theory of legal endogeneity, it will be insightful to determine if the courts accept a procedural or symbolic interpretation over a substantive interpretation of duties as they relate to psychosocial risk (for example, if the court accepts the presence of a symbolic structure as indicative of compliance, regardless of whether that structure is evidenced to substantively eliminate or minimise risk to workers).

9.3.4 METHODOLOGICAL LIMITATIONS

Three potential methodological limitations are discussed below, including limitations relating to the nature of the purpose sample, coder reliability, and lexicon.

²⁹ Draft regulatory guidance on psychosocial risk management was released for public consultation by WorkSafe in November 2023 as this conclusion was written. See footnote 21, p. 84.

The sample of participants for this study was purposive and was therefore not intended to be representative of the population of company officers in New Zealand. Therefore, there may be conceptualisations of compliance amongst officers in New Zealand that have not been reported in this research. Further, the themes and issues discussed in this research are those that I selected in accordance with the epistemological position outlined in the methodology chapter in order to address the research questions. Accordingly, there are themes and issues that I found during this research that are not presented or reported on here because they were peripheral or non-related to the research questions, or not central to the discussion.

Due to the independent nature of doctoral research, I did not employ a second coder when coding the researcher interviews, so intercoder reliability cannot be put forward here as a marker of rigor as it is often suggested to be in qualitative research (O'Connor & Joffe, 2020). However, in noting this, I also point out that Hardy et al. (2004) contend that reliability and validity are not key indicators of quality in discourse analysis and are more relevant markers of quality of other forms of qualitative analysis with different epistemological underpinnings, such as content analysis. Markers of reliability and validity therefore contrast sharply with “the focus on the interpretive accuracy and reflexive examination that characterizes discourse analysis” (Hardy et al., 2004, p. 20).

Finally, the issue of lexicon presents a potential limitation to this and also to other research examining similar topics. The issue of the diverse lexicon in the field of psychosocial risk management and work-related mental health, and the confusion of stakeholders regarding these concepts, were introduced in the literature review (3.5.2). In that section, I noted that a diverse and equivocal array of terms are commonly used to describe concepts associated with psychosocial risk management, and these terms, as well as referring to different constructs, are sometimes conflated or defined and deployed in inconsistent ways, leading to both a lack of clarity and a shift in focus. Indeed, Leka et al. (2017, p. 2) have pointed out that “there is often confusion in relation to this terminology in scientific publications, policy documents and practical guides that complicates understanding, interpretation of the legal texts by courts, institutions and stakeholders, and as a result effective management of psychosocial risks in the workplace.”

The implications of this diverse and sometimes-confused lexicon in terms of the conduct of this research was discussed in the methodology section with regard to the pilot interview (4.4.4.1), its use in the participant information (4.4.2) and in interviews (4.4.4.1). In practice, anticipating the issues with lexicon in this subject area, and as described in 4.4.2, I was always careful not to imply to participants that I was studying the broad topic of anything related to mental health at work, but the application of legal duties as they apply to workers' mental health. In line with this, the interview questions were based on legal obligations and the inclusions of the officers duties as described in the legislation itself. However, although the ways in which the challenges of lexicon were made explicit in the methodology section, it is valuable to restate this here in the limitations section to highlight the difficulties that the ambiguous, univocal, and imprecise use of concepts and language in the field of work-related mental health and psychosocial risk management presents not to just to effective regulation and compliance, but to the study of these phenomena, too. This, in turn, can only reinforce the need for greater regulatory clarity for stakeholders.

9.3.5 OTHER RELATED LEGAL FIELDS

Near the end of this research, in August 2023, the New Zealand Companies Act (1993) was amended at s131(5) to clarify that, in their duty to act in good faith and in the best interest of the company, directors “may consider matters other than the maximisation of profit (for example, environmental, social, and governance matters)”. The nonbinding phrasing encapsulated by the word “may” (instead of “must,” or “shall,” for example) suggests that this amendment will not trigger a wave of changes in the name of ESG but, rather, remove any objection to doing so in terms of legality under the Companies Act. Nevertheless, as organisations become increasing aware of shareholders', investors', and stakeholders' concerns over the social and environmental impact of operations, there is scope for research to continue to critically evaluate the expression of organisational responses (if any) made relative to this amendment, particularly as they relate to worker safety, health, mental health, or wellbeing.

9.3.6 RESEARCH ON WELLBEING

The idea of wellbeing pervaded a large proportion of the discourse on compliance with the HSWA as it applied to psychosocial risk. However, the scope of this research did not allow for a more intensive or singular examination of the discourse of wellbeing in corporate settings. Although concern with wellbeing is ancient (Jarden & Roache, 2023), this research suggests that the concept is being increasingly deployed in corporate settings where it is viewed by organisational actors as a variable that can be implicated in causing and solving many organisational problems—compliance with WHS law being one such problem. Thus, organisational discourse and practices carried out in the name of wellbeing, and its agnates, such as “wellness”, “flourishing,” and “thriving,” may present a field ripe for critical analysis. In this respect, I concur with the research agenda, which has been suggested in the literature, relating to examining wellbeing, particularly in the context of work, as a “field of power” (Jackson et al., 2022, p. 6).

9.4 CONCLUDING COMMENTS

The duties of due diligence in the HSWA require officers to ensure there are appropriate processes and systems to understand, monitor, respond to, and manage risks to workers arising from the work of the PCBU. Furthermore, because officers influence and control the imperatives of production and the distribution and deployment of company resources to achieve those imperatives, the duties direct officers to attend to how their decisions, actions, and inactions themselves are a powerful determinate of the experience of work for workers and the risks that those workers face. Acknowledging this, in the lead up to, and at the time of, their inception, the officers’ duties promised to be a powerful regulatory lever to affect WHS outcomes in New Zealand.

This research took a Foucauldian approach to examining the conduct of these duties and analysed how officers constituted certain problems and risks; the language that they used to describe, understand, and react to these problems and risks; how they were constructed in terms of their causes; how attributions of blame and responsibility were made for them; and how the possibilities of what could be done about them were either created or delimited. Collectively, these features constructed what was

considered governable in that, as a governmentality perspective holds, “problems are construed in ways that make them subject to practicable solutions” (O'Malley, 2008, p. 56). In this respect, this research has shown how certain ways in which officers conceptualise, express, and carry out their duties, and how they conceptualise risk, limits the potential of law to achieve the substantive outcomes which align with its intent and purpose.

To better achieve the object of the law to eliminate and minimise risk to the mental health of workers, duty holders must distinguish between compliance responses which simply constitute symbolic attention to the law, which redistribute blame and responsibility for work-related mental health problems, and which do not address psychosocial risk, with those that achieve a substantive impact on the conditions of work that put workers' health at risk. In short, officers and other regulatory actors must be cognisant of the “wellbeing washing” (Jackson et al., 2022; Jarden & Roache, 2023) of notions of compliance with legal duties relating to the protection of workers' mental health and, in doing so, disrupt the heuristic that equates the presence of symbolic structures with the actions required to eliminate or minimise risks to workers' mental health.

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APPENDIX A – PARTICIPANT INFORMATION SHEET



MASSEY
BUSINESS
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Understanding the due diligence duties as they apply to the management of mentally healthy work.

PARTICIPANT INVITATION & INFORMATION SHEET

Researcher Introduction

Tēnā koe, my name is Louise Thompson, I am a PhD candidate at Massey University's School of Management. I am undertaking research to examine the approach(es) company directors and senior managers in New Zealand take when applying health and safety duties to mentally healthy work.

Project Description

The Healthy and Safety at Work Act (2015) requires that officers (such as company directors and senior executives) exercise due diligence to ensure the company of which they are an officer is meeting its obligations under the Act. Relatively little is known about how this duty is, or can be, exercised with respect to mentally healthy work. This research will examine ways in which New Zealand officers understand and exercise this duty with view to identifying emerging norms and standards of practice in order to provide better guidance to those organisations and boards wishing to promote mental health at work.

Participant Identification, Recruitment and Processes

I invite participation from company directors or senior executives of large companies (50+ employees), who have interest, experience or opinion on the due diligence duties as they apply to mentally healthy work, and who are willing to participate in a one-hour interview. Interviews will be conducted in person or by video conference (e.g. Zoom, MS Teams), and participants will be offered a small gift of appreciation for their time and contribution to the research.

Data Management

- Interviews will be digitally recorded and transcribed. A transcription of your interview can be sent to you and you will have 10 working days to edit and return to me. If I do not hear from you within this time frame, I will assume that you approve the inclusion of your data in the research.
- Where possible, no information which could identify you, other individuals or any organisation will be included in the research.
- I request that you do not to disclose any highly confidential business information or known illegalities at interview. Confidential or sensitive business information will be omitted from transcripts and will not be used in the research.

- Recordings and transcripts will be securely stored separately from participant consent forms and will be destroyed upon completion of the research.

Participants' Rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- decline to answer any question and ask any questions about the study at any time during participation.
- withdraw from the study within two weeks of interview.
- review and edit transcripts of interviews.
- provide information on the understanding that your name will not be used and, where possible, other information which may identify you will not be used.
- be given access to a summary of the project findings when it is concluded.
- ask for the recorder to be turned off at any time during the interview.

Project Contacts

You may contact the researcher to express interest in participation and the researcher and/or supervisor(s) if you have any questions about the project. Researcher: Louise Thompson (PhD Candidate): Ph 027 520 0063 or email l.thompson1@massey.ac.nz. Supervisors: Associate Professor David Tappin: Ph 021 363 384 or email D.C.Tappin@massey.ac.nz, Professor Bevan Catley: Ph 06 9517921 or email B.E.Catley@massey.ac.nz.

Ethics

This project has been reviewed and approved by the Massey University Human Ethics Committee: Northern, Application NOR 21/86. If you have any concerns about the conduct of this research, please contact A/Prof Fiona Te Momo, Chair, Massey University Human Ethics Committee: Northern, telephone 09 414 0800, x 43347, email humanethicsnorth@massey.ac.nz

APPENDIX B – PARTICIPANT CONSENT FORM



Understanding the due diligence duties as they apply to the management of mentally healthy work.

PARTICIPANT CONSENT FORM - INDIVIDUAL

I have read and I understand the Information provided to me in the Participant Information Sheet.

I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study within two weeks of interview.

1. I agree/do not agree to the interview being sound recorded.
2. I wish/do not wish to have my transcripts returned to me.
3. I agree that if I do not approve or return an edited transcript within 10 working days of it being emailed to me, it will be considered as approved for inclusion in the study.
4. I agree to participate in this study under the conditions set out in the Information Sheet.

Declaration by Participant:

I _____ [print full name] hereby consent to take part in this study.

Signature: _____ Date: _____

APPENDIX C – ETHICS APPROVAL



3/02/2022

Dear: Louise Thompson

Re: Ethics Application - NOR 21/86 - Understanding the due diligence duties as they apply to the management of mentally healthy work

Thank you for the above application that was considered by the Massey University Human Ethics Committee:

Human Ethics Northern Committee at their meeting held on **Thursday, 9 December 2021**

On behalf of the Committee I am pleased to advise you that the ethics of your application are approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely



Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

APPENDIX D – INTERVIEW QUESTIONS

Preliminary Questions (if information is not already held)

- What roles do you hold (as a company officer)?
- In which organisations/companies do you hold this/these role/s?
- How many employees?
- Are you a member of any particular governance or leadership membership organisations? (e.g. Institute of Directors, Governance NZ Inc, The New Zealand Corporate Governance Forum, Business Leaders' Health and Safety Forum, etc)

Preliminary Comments

As you're likely aware, the duties in the Health and Safety at Work Act (2015) apply to both physical and mental health and safety. I'm interested to understand how mental health and mentally healthy work is approached in terms of your duties as an officer, in this case, (name role). This research is not aimed at assessing whether you're compliant in your duties or in assessing whether you're doing them right or wrong, but in trying to look at the different ways in which officers understand their duties, enact them or carry them out, and any key issues that arise or salient experiences that occur in doing so. If you wish to provide specific examples to illustrate points we talk about, that is useful.

Interview Questions

Q1 Why did you choose to participate in this research, and what is your interest in this subject area?

Q2 Do you think there are any particular issues or challenges in interpreting and applying the provisions of the Health and Safety at Work Act to mental health or mentally healthy work? (If yes, why)

Q3 What do you see is the mandate or scope of practice a chief executive /director/trustee in creating a mentally healthy workplace?

Q4 Can you explain in your own, general terms how you understand the officers' duty of due diligence in the HSWA is, and what its overall purpose is?

Q5 In your role as an officer, how do you learn about and keep up to date with knowledge and trends in the management and governance of mentally healthy work, psychosocial risk management, or the management of risks to the mental health of workers?

Q6 What steps or actions do you take to learn about and understand the nature of work within (company) and the hazards that may arise from that work that may impact on the mental health of workers?

Q7 What, if any, sort of information do you receive or seek, about risks to the mental health of workers? (E.g. reports, metrics, indicators, incident data, risk analysis, evaluations).

Appendices

Q8 Could you describe how you get assurance that there are appropriate processes or systems within the company, to receive and respond to information about incidents, hazards and risks to workers' mental health?

Q9 Can you describe how you get assurance that there are appropriate *resources* available, and that those resources are used, to manage risks to workers' mental health?

Q10 How do you get assurance that the resources that are made available to manage risks to workers' mental health are *effective* in causing the outcome that the resourcing intending to achieve?

Q11 Due diligence requires that officers assure themselves that the PCBU is compliant with the HSWA. How do you get assurance that the company is compliant with it's (i.e. PCBU's) duties under the *Health and Safety at Work Act 2015*?

Q12 How do you *verify* that the systems and processes in place to identify and respond to risks to mental health are in place, used and effective?

Q13 What do you see as the role of the regulator, WorkSafe, in regulating mentally healthy work?

APPENDIX E – CODING PROMPTS

Research Questions		
<ol style="list-style-type: none"> 1. How do officers conceptualise, express, and carry out their duties under the Health and Safety at Work Act with specific regard to psychosocial risk? 2. How do constructions of risk shape how officers respond to this duty? 3. How do the ways that officers construct compliance relate to the regulatory intentions of the officers' duties and what are the implications for managing psychosocial risk? 		
Willig's (2008) Procedural Guidelines for the Analysis of Discourse		Willig's questions contextualised for this research.
Stage	Willig's framing questions	
Stage 1: Discursive Constructions	<p>How is the discursive object constructed through language?</p> <p>What type of object is being constructed?</p>	<p>In what ways do officers construct their legal duty to:</p> <ul style="list-style-type: none"> ○ Know ○ Understand ○ Monitor ○ Resource ○ Comply ○ Verify
Stage 2: Discourses	<p>What discourses are drawn upon?</p> <p>What is their relationship to each other?</p>	<p>What kind of discursive resources are being used to construct the meaning of compliance?</p> <p>What do these constructions take for granted, what do they assume?</p>
Stage 3: Action Orientation	<p>What do the constructions achieve?</p> <p>What is gained from deploying them here?</p> <p>What are their functions?</p> <p>What is the author doing here?</p>	<p>What do these constructions mean in terms of compliance?</p> <p>What is gained and what may be lost as a result of constructing compliance in this way?</p> <p>What is legitimised/delegitimised, or allowed/disallowed'?</p>
Stage 4: Positionings	<p>What subject positions are made available by these constructions?</p> <p>What can be said and done from within these subject positions?</p>	<p>What subject positions are created through the exercise of due diligence?</p>

Appendices

Stage 5: Practice	What possibilities for action are mapped out by these constructions?	What does this mean in terms of carrying out each element of the due diligence duties? <ul style="list-style-type: none">○ What specific means do they use?○ What strategies or practices are used?○ What systems, structures or processes do they use?
Stage 6: Subjectivity	What can potentially be felt, thought, and experienced from the available subject positions?	What may be the potential consequences of the discourses that are used for those who are positioned by them, in terms of both their subjective experience and their ability to act in the world?

APPENDIX F – EXCERPTS FROM THE HSWA

18 Meaning of officer

In this Act, unless the context otherwise requires, officer, in relation to a PCBU,—

- (a) means, if the PCBU is—
 - (i) a company, any person occupying the position of a director of the company by whatever name 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).

44 Duty of officers

- (1) If a PCBU has a duty or an obligation under this Act, an officer of the PCBU must exercise due diligence to ensure that the PCBU complies with that duty or obligation.
- (2) For the purposes of subsection (1), an officer of a PCBU must exercise the care, diligence, and skill that a reasonable officer would exercise in the same circumstances, taking into account (without limitation)—
 - (a) the nature of the business or undertaking; and
 - (b) the position of the officer and the nature of the responsibilities undertaken by the officer.
- (3) Despite subsection (1), a member of the governing body of a territorial authority or regional council elected in accordance with the Local Electoral Act 2001 does not have a duty to exercise due diligence to ensure that any council-controlled organisation (as defined in section 6 of the Local Government Act 2002) complies with its duties or obligations under this Act unless that member is also an officer of that council-controlled organisation.
- (4) In this section, due diligence includes taking reasonable steps—
 - (a) to acquire, and keep up to date, knowledge of work health and safety matters; and

Appendices

- (b) to gain an understanding of the nature of the operations of the business or undertaking of the PCBU and generally of the hazards and risks associated with those operations; and
- (c) to ensure that the PCBU has available for use, and uses, appropriate resources and processes to eliminate or minimise risks to health and safety from work carried out as part of the conduct of the business or undertaking; and
- (d) to ensure that the PCBU has appropriate processes for receiving and considering information regarding incidents, hazards, and risks and for responding in a timely way to that information; and
- (e) to ensure that the PCBU has, and implements, processes for complying with any duty or obligation of the PCBU under this Act; and
- (f) to verify the provision and use of the resources and processes referred to in paragraphs (c) to (e).