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System-level approaches to prevent and manage psychological injuries in Canada and Australia

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Please direct questions and reprint requests to:

Institute for Work & Health
400 University Avenue, Suite 1800
Toronto, Ontario M5G 1S5

info@iwh.on.ca
www.iwh.on.ca

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System-level approaches to prevent and manage psychological injuries in Canada and Australia

Peter Smith, Morgan Lay, Leslie Vesely and Hela Bakhtari

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Executive summary

Work injury prevention and workers' compensation agencies in Canada and Australia have a growing interest in approaches to prevent and manage work-related psychological injuries, due to the increasing number of these conditions, and their greater wage replacement and health-care costs compared to physical injuries. Despite this interest, there have been few formal comparative overviews of approaches taken to prevent and/or manage these types of injuries across different jurisdictions.

The objective of this project was to explore the extent to which workers' compensation systems provide coverage for different types of psychological injuries; the strategies both workers' compensation systems and occupational health and safety (OHS) prevention agencies adopt to address psychosocial exposures in the workplace both before and after injuries occur; and the benefits, challenges and other outcomes of each of these strategies from the perspective of those working in these jurisdictions. The findings from this project will be of interest to policy-makers in other jurisdictions, both within Canada and Australia, and more broadly.

To address these objectives, a modified rapid environmental scan was conducted. This comprised two main activities: a review of health and safety and workers' compensation legislation, regulation and policy on psychological injuries across 22 jurisdictions in Canada and Australia; and 21 interviews (with 32 different participants) across 16 different jurisdictions in the two countries.

The scan of regulation, legislation and policy observed jurisdictional variation in how prevention and management were institutionally organized; the use of presumptive legislation for particular types of psychological conditions and/or occupational groups; and the types of conditions covered or considered to be work-related. In addition, while all jurisdictions provided guidance material for workplaces in both how to prevent and how to manage work-related psychological conditions, the detail contained in this material, the focus of the guidance, and the mode of delivery differed considerably. There was greater variation in Canada than Australia, which, in part, was attributed to the existence of a national organization in Australia that harmonized approaches across the country.

Interviews revealed different strategies currently being employed to prevent and manage psychological injury. These were organized into five key themes that frequently arose in the majority of interviews.

Developments in the prevention of psychological conditions included:

- moving from prescriptive guidance to focusing on organizational readiness to address psychosocial exposures within workplaces;
- transitioning from individually focused strategies to organizational strategies for both prevention and management of psychological conditions; and

- increasing availability of consultation or training to help workplaces apply guidance material.

Specific changes in the claims management process for psychological conditions compared to physical conditions were also described by interviewees. These changes included:

- increased efforts to more quickly connect injured workers with mental health-care services;
- specific training for claims agents and other workers' compensation staff who engage with people with psychological injuries, particularly around trauma-informed approaches; and
- improved communication between parties in the return-to-work (RTW) space, with emphasis on health-care providers and workplaces working together to identify and provide safe and engaging accommodations.

The prevention and management of work-related psychological injuries will continue to be an important priority for workers, workplaces and policy-makers in both the OHS and workers' compensation space due to the increasing numbers of these injuries and their associated costs to compensation schemes, workplaces and the workers themselves. It continues to be important for agencies to work together, and with independent research centres, to both develop and evaluate evidence-based approaches, and to share information across jurisdictions both nationally and internationally.

Introduction

Work injury prevention and workers' compensation agencies in Canada and Australia have a growing interest in approaches to prevent and manage work-related psychological injuries. Work-related psychological injuries can be defined as recognized, medically diagnosed mental health conditions or disorders that are caused, or exacerbated, by either acute events or ongoing exposures as part of a person's work or work conditions. The growing interest in psychological injuries is due to, in part, to the increased recognition and inclusion of psychological injuries, outside of post-traumatic stress, in workers' compensation coverage, and the greater wage replacement and health-care costs for psychological injuries compared to physical injuries [1 2]. Many regulators and prevention agencies, including workers' compensation boards, are developing new legislation, regulations, policy and guidance materials; they are also implementing workplace- and systems-level initiatives to reduce the impacts of psychological injuries. However, there is limited research exploring differences and similarities in approaches across jurisdictions and the benefits and challenges of these different approaches.

Canada was one of the first countries, in 2013, to develop a standard for psychological health and safety in the workplace [3]. The voluntary guidance document, the National Standard for Psychological Health and Safety in the Workplace, was developed in partnership by the Canadian Standards Association, the Bureau de normalisation du Québec and the Mental Health Commission of Canada. It outlined 13 dimensions of the work environment necessary for psychological safety, and described approaches a workplace can take to assess and address these factors [4]. However, creating awareness of the Standard and supporting workplaces that are aware of the Standard to implement it, has been challenging [5]. Barriers to the implementation of the Standard in workplaces include the complexity and number of dimensions, which can be overwhelming for workplaces [6], and the lack of demonstrated reliability and validity of the recommended instrument to assess the 13 dimensions outlined within the Standard [7].

Canada as a country was relatively early to recognize that workplace factors can contribute to psychological injuries, and all Canadian jurisdictions accept claims for psychological injuries attributable to acute traumatic workplace events. Canadian jurisdictions, however, have been less quick to recognize work-related psychological injuries that develop over time, (i.e., chronic stress claims), within their workers' compensation settings. This is because chronic stress often stems from multiple factors and may be more difficult to attribute specifically to work or working conditions.

There is variation in legislation and policy among Canadian workers' compensation schemes with respect to the criteria under which chronic stress claims are accepted, and how chronic stress is defined [8 9]. For example, the province of Manitoba has provided compensation for injuries caused by bullying and harassment for many years and recently expanded the meaning

of traumatic event to include excessive workload. Other Canadian jurisdictions have included chronic stress in their legislation in part to cover harassment and bullying. British Columbia introduced legislation to cover chronic mental stress in 2012 [10], Ontario introduced similar legislation in 2018 [11], and Nova Scotia introduced comparable legislation in 2024.

Jurisdictions providing some coverage for chronic stress include BC, Alberta, Saskatchewan, Ontario, Quebec, and Nova Scotia. All of them have certain criteria that must be met for the claim to be acceptable. In most of these jurisdictions, a diagnosis under the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is required before a claim may be accepted. In many jurisdictions, workplace stressors must also be the "main" or "predominant" cause of the worker's psychological injury. Manitoba has neither of these criteria. In Manitoba, all psychological injuries are adjudicated using the same standard of causation that is used for most physical injuries—the "but for" standard of causation. This means work must be a necessary cause of the injury but need not be the "main" or "dominant" cause.

The exclusion of workplace psychological injuries due to chronic mental stress as compensable under workers' compensation schemes can reduce the focus and motivation of employers to address the broader workplace conditions that are related to the risk or exacerbation of such conditions [8 12].

Approaches to prevent and manage psychological injuries at work

Research supports an integrated model, comprising three complementary areas of action as necessary to address work-related psychological injuries. These are: 1) reducing psychosocial¹ and physical hazards in the workplace; 2) promoting aspects of work that are associated with more positive mental health; and 3) responding effectively to mental health problems as they manifest in the workplace, including in the return-to-work (RTW) process [13]. Integrating these areas is particularly important when dealing with psychological injuries, where common challenges in the RTW process include a fear of re-injury, difficulty in finding meaningful accommodations to support a gradual and safe RTW, and challenges with trust and communication in the workplace [14].

A study exploring the differences across mental health outcomes in the workplace demonstrated that greater job control and social support is associated with a reduced risk of experiencing symptoms of mental health problems. In addition, greater job control and social support were associated with positive mental health [15]. An Australian study comparing the RTW process for work-related psychological injuries with that of musculoskeletal injuries

¹ Psychosocial hazards are factors related to how work is organized, social factors at work, aspects of the work environment, the availability of equipment and hazardous tasks. It should be noted that psychosocial hazards can be present in all organizations and can arise from a variety of work tasks, work environments and employment arrangements.

observed that the respondents with psychological injuries were less likely to have a supportive supervisor response to the injury, less likely to be given a RTW date by their health-care provider, and more likely to report that their interactions with the workers' compensation system, via their claims agent, were stressful [2]. Further, psychosocial safety climate has been associated with both mental health conditions, but also with wage replacement following a work injury [16-18]. (Psychosocial safety climate refers to the attitudes and commitment of management to psychosocial factors within the workplace, as well as management's communication and consultation with workers about these factors.)

A recent review of how European Union (EU) member states regulate psychosocial exposures at work highlighted a variety of approaches. Some countries, such as Belgium, Sweden, and Finland, have enacted specific legislation addressing psychosocial exposures in the workplace. Other EU member states, including Spain, Greece, and Poland, incorporate references to psychosocial exposures within broader legal frameworks. Meanwhile, member states like Ireland adopt a "soft law" approach, offering recommendations and best practices to workplaces without explicitly including psychosocial exposures within legislation. Approaches across the EU share a common foundation by setting out requirements or guidance for employers on conducting psychosocial risk assessments, accompanied by strategies for mitigating the identified risks. Some EU member states go further by implementing inspection and enforcement mechanisms, mandating in-house expert advice or counselling services, launching targeted awareness campaigns for specific sectors or populations, and fostering collaboration between regulatory bodies and workplace stakeholders [19]. However, generalizing work from Europe to the Canadian context is challenging due to the absence of a work-specific injury compensation system within most European jurisdictions.

Jurisdictional approaches in Australia may offer greater relevance and applicability to the Canadian context. Australian jurisdictions have separate workers' compensation systems and have been increasingly investing in approaches that combine regulation with supportive activities and guidance material addressing psychological injuries and psychosocial exposures in the workplace. In addition, chronic mental stress has been included as a work-related condition within Australian jurisdictions for more than two decades. For example, both Safe Work Australia and SafeWork NSW have released guidance material on how to manage psychosocial risks in the workplace [20 21]. Concurrent with these releases were other changes such as the explicit inclusion of psychosocial hazards within work health and safety regulations at both state and federal levels, and the requirement of employers to proactively manage psychosocial risks in the same way they assess and manage physical risks within their workplace.

To date there have been few formal overviews of approaches taken to prevent or manage work-related psychological injuries in Canada and Australia, both in terms of similarity and differences in approaches. This study addresses these knowledge gaps by exploring the strategies used for work-related psychological injury prevention and support within the context of the unique occupational health and safety (OHS) and compensation system of 13 jurisdictions in Canada and nine jurisdictions in Australia. Specifically, this project set out to understand:

- 1) the extent to which workers' compensation systems include different types of psychological injuries;
- 2) strategies both workers' compensation systems and OHS prevention agencies take to address psychosocial exposures in the workplace both before and after injuries occur; and
- 3) the benefits, challenges and other outcomes of each of the strategies adopted from the perspective of those working within these jurisdictions.

Methods

A modified rapid environmental scan was undertaken to address the three project objectives. Environmental scans integrate multiple strategies to collect and synthesize existing information to inform decision-making related to existing or emerging policy and service delivery issues [22]. Often environmental scans can include three components: A) review of peer-reviewed literature, B) review of grey literature or other sources of literature, and C) key informant interviews and/or focus groups.

Given the timeline for this project and a lack of available peer-reviewed studies specific to the project objectives, the typical environmental scan methodology was modified to focus only on two components: 1) a review of health and safety and workers' compensation legislation, regulation and policy regarding psychological injuries across jurisdictions in Canada and Australia; and 2) key informant interviews within each jurisdiction to better understand strategies implemented to reduce the impact of psychological injuries, and the outcomes of these activities.

Component 1: Review of legislation and policy materials

Publicly available webpages were examined to identify legislation, regulations and policies related to work-related psychosocial hazards, risks and injury. This activity also supported gathering information on the types and availability of guidance materials on preventing and managing work-related psychosocial work injury.

A data collection template was used to ensure a consistent approach to capturing information for all Canadian and Australian jurisdictions. The template components included review and collection of information on OHS and compensation legislation and regulations, workers' compensation policy, guidance material offered by the agencies responsible for workplace injury prevention and compensation, and strategic plans created by these same agencies

pertaining to occupational mental health. The template was tested by all team members, using two jurisdictions in Canada and one in Australia, and then modified to ensure consistent application. Two team members then collected data on the remaining jurisdictions, consulting with other team members as needed.

Based on the information collected in the template the team developed summaries for all Canadian and nine Australian jurisdictions.

Component 2: Key informant interviews

In the second component of the study, a person was identified within each jurisdiction to participate in a 45- to 60-minute semi-structured interview on the jurisdiction's approach to work-related psychological injuries. Interview participants were identified using existing networks at the Institute for Work and Health, including direct connections with regulators, prevention organizations and workers' compensation agencies, as well as intermediaries. A snowball sampling method was used to identify potential interviewees in jurisdictions where the team did not have contacts. In some jurisdictions where multiple organizations were responsible for different parts of the prevention and management of psychological injuries, multiple persons with the jurisdiction were approached.

Prior to the interview, participants received a copy of the jurisdictional summary for review and a copy of the interview questions (see Appendix A). Interviews were held virtually using video conferencing software and were recorded for note-taking purposes, with the consent of the interviewee(s). In addition to the interviewer, another member of the research team joined each interview to take notes and summarize the conversation. Interviews were conducted with individual participants or with multiple participants at their request. As noted above, in some cases, multiple interviews were conducted in the same jurisdiction with representatives from different agencies, or with multiple respondents within the same organization, to get a more fulsome understanding of their regulatory, prevention and compensation practices. In total, 21 interviews were conducted with 16 jurisdictions, and 32 participants. This included 13 interviews with 12 jurisdictions in Canada, involving 17 interviewees and eight interviews with four jurisdictions in Australia, speaking with 15 interviewees. Table 1 outlines the jurisdictions represented by interviewed participants.

Table 1. Canadian and Australia jurisdictions interviewed

Canada		Australia	
Alberta	X	Australian Capital Territory	
British Columbia	X	Commonwealth	X
Federal ²	X	New South Wales	X
Manitoba	X	Northern Territory	
New Brunswick	X	Queensland	X
Newfoundland and Labrador		South Australia	X
Northwest Territories	X	Tasmania	
Nova Scotia	X	Victoria	
Nunavut	X	Western Australia	
Saskatchewan	X		
Ontario	X		
Quebec	X		
Prince Edward Island	X		
Yukon			

Analysis

Synthesis of the information collected in the review of public materials and interviews was completed in two ways. The completed jurisdictional scan templates were summarized into a series of charts in order to compare legislation and guidance resources across jurisdictions. Uncertainties in the data were flagged for review and discussion by team members. In parallel, all research team members reviewed the interview notes and recordings separately to build familiarity with the content and identify any trends in the data. The team met to discuss their observations and to come to a consensus on disagreements; team members also worked together to develop themes based on the research objectives. Notes were reviewed, and potential overlaps between jurisdictions were identified. To gauge the consistency and depth of

² In Canada certain industries and workplaces are federally regulated. The *Canada Labour Code* covers these industries (for example, air transportation and banking) as well as the federal public sector, Parliament, and private-sector firms and municipalities in the Territories. The *Canada Labour Code* is administered and enforced by the Labour Program at Employment and Social Development Canada (ESDC).

the themes and subthemes, all team members contributed supporting evidence and observations into a shared document. Themes and subthemes were adjusted and refined based on the degree of supporting evidence and distinctness. Given the rapid nature of the project, full qualitative analysis including in-depth review and coding of interview transcripts and jurisdictional scan materials was not completed.

Results and discussion

Component 1: Approaches taken across jurisdictions

The review of publicly available material involved a comparison of the jurisdiction's institutional arrangement (i.e., the division of prevention and compensation responsibilities among governing authorities), the degree to which psychological health was addressed in legislation and regulations (including psychological injury presumption legislation), available guidance material for preventing and managing psychological injuries (including the target audiences for different material), the presence and description of key objectives of public occupational mental health strategies, and any recent or upcoming changes pertaining to psychological health in the workplace. The information contained in this section is summarized in Table 2.

At a fundamental level the review of legislation and regulation examined how responsibilities for prevention and management of workplace injuries were organized. Across the 22 jurisdictions³ there was a range of institutional arrangements. Thirteen jurisdictions, nine in Canada and four in Australia, had a single organization responsible for both prevention and compensation. Conversely, in nine jurisdictions, four in Canada and five in Australia, the prevention and compensation responsibilities were split between two organizations, each with distinct leadership, strategic plans and funding. Where the distinction between responsibilities for prevention and management was ambiguous, the research team focused on the primary responsibility of each organization within a jurisdiction. For example, WorkSafe Saskatchewan is the product of a partnership between the Ministry of Labour Relations and Workplace Safety and the Workers' Compensation Board. However, the Ministry is ultimately responsible for "setting, promoting, and enforcing employment and occupational health and safety standards." As such, it was determined that the responsibilities for prevention and compensation in Saskatchewan were in different provincial organizations.

Examination of OHS legislation revealed differences in how psychological health and safety is defined and how responsibility for the management of workplace psychosocial hazards is articulated. No Australian or Canadian jurisdictions defined psychological health and safety in their OHS act. However, in seven Canadian jurisdictions the OHS act specified that its purpose

³ For the purpose of describing jurisdictions the Northwest Territories and Nunavut were combined.

was to protect both the physical and psychological safety of workers or included psychological health in their definition of health. In contrast, all jurisdictions in Australia had OHS legislation that included psychological health in their definition of health. Furthermore, all Australian OHS regulations, except in Victoria, included a section defining psychosocial risks and hazards and outlining employer responsibilities for managing them.

Identifying the presence of presumptive legislation pertaining to psychological injuries provided insights into how jurisdictions understand the relationship between these types of injuries and work in particular occupations or industries. Within a workers' compensation presumptive legislation refers to the process of acceptance of a workers' compensation injury claim based on a medical or psychiatric diagnosis, without the link between the condition and a workplace event or exposure having to be proved. In Canada, ten jurisdictions have this type of presumptive legislation that assumes specific mental illnesses arose from the workplace (Appendix B). Five extend this presumption to first responders (e.g., police, firefighters, paramedics), while five generalized the presumption to workers in any profession. The presumptive legislation of six jurisdictions covers a post-traumatic stress disorder (PTSD) diagnosis and four cover any diagnosis in the *Diagnostic Statistical Manual (DSM) of Mental Disorders*. As noted in the table, the situation in Quebec differs slightly from other jurisdictions. In Quebec mental disorders, specifically post-traumatic stress injuries, are included within a schedule of presumptive conditions. However, even with a diagnosis of this condition, a worker is still required to demonstrate the exposures that led to this condition occurred at work, and applications for compensation are determined on a case-by-case basis. This makes the presumptive legislation in Quebec different from those of other jurisdictions in Canada, and from the definition of presumptive legislation used above. Five jurisdictions in Australia have presumptive legislation for PTSD, four of which cover first responders, and one which extends this presumption to a broader category of 'relevant workers', including public sector employees and those employed by government business enterprises or state-owned companies. For all Canadian and Australian jurisdictions, the presumption is contained within the main compensation act, except in Yukon which combined its OHS act and compensation act in 2021.

Guidance material on psychological health and safety developed by Australian and Canadian jurisdictions was examined to help understand how they support workers and workplaces to understand responsibilities related to preventing and managing psychosocial hazards. In general, Australian jurisdictions included more detailed information on psychosocial hazards than Canadian jurisdictions. Most jurisdictions in Australia (7/9) referenced Safe Work Australia in their psychological health and safety resources, specifically their *Code of Practice: Managing Psychosocial Hazards at Work* [20], which outlines 14 common psychosocial hazards. Australian jurisdictions provided a range of examples (between five and 23) of different types of psychosocial hazards in their guidance documents. Outside of harassment, violence and bullying, common psychosocial hazards included fatigue, isolated work, low job control and lack of job clarity (see Appendix C for more details). In Canada, most jurisdictions (10/13) referenced *The National Standard for Psychological Health and Safety in the Workplace*. Canadian

jurisdictions listed between zero to 15 psychosocial hazards on their websites, typically focusing on harassment, violence, and bullying.

The team assessed the extent to which jurisdictions in Canada and Australia either had a dedicated mental health strategy, and/or at least one key objective addressing mental health in their general strategic plan. Addressing workplace psychological injuries as part of a jurisdiction's strategic plan can shed light on their organizational priorities, approach, and future plans. In Canada, only British Columbia had a specific mental health strategy: a stand-alone document outlining a vision, focus areas, and initiatives that will be undertaken to support workers and employers in building psychologically safe and healthy workplaces. Six jurisdictions had at least one key objective in their strategic plan addressing mental health, five of these strategies were created by the compensation board and one by the prevention authority. In Australia, three jurisdictions had a dedicated mental health strategy, two created by the organization responsible for compensation and prevention, and one by the prevention authority. Four jurisdictions included mental health in their general strategic plan. Two of these plans were published by a joint compensation and prevention organization and two were created by the prevention authority. To note, this data is based on publicly available documents. Interviewees in many jurisdictions mentioned they had internal strategic approaches or key performance indicators related to psychological injuries that were not publicly disseminated.

Table 2. Summary of jurisdictional scan: approaches to prevent and manage psychological injuries.

Jurisdiction	Prevention and compensation responsibilities are within one organization	OHS Act includes <i>mentions</i> of psychosocial exposures and/or psychological health	Mental health injury claim (chronic or acute) requires a DSM diagnosis	Presumptive legislation	Dedicated mental health strategy
CANADA					
Alberta	X	✓	✓	✓	X
British Columbia	✓	X	✓	✓	✓
Canada	X	✓	✓	X	X
Manitoba	✓	✓	X	✓	X
New Brunswick	✓	X	✓	✓	X
Newfoundland & Labrador	✓	X	✓	✓	X
Northwest Territories & Nunavut	✓	X	✓	X	X
Nova Scotia	✓	X	✓	✓	X
Ontario	X	X	✓	✓	X
Prince Edward Island	✓	✓	✓	✓	X
Quebec	✓	✓	✓	✓ ⁴	X

⁴ In Quebec, mental disorders, specifically post-traumatic stress, are included under a specific schedule related to occupational disease presumptions (<https://www.legisquebec.gouv.qc.ca/fr/document/rc/A-3.001,%20r.%208.1?langCont=en>). However, there is no specific list of occupations where a presumption would apply, and all applications are reviewed on a case-by-case basis. This makes Quebec's presumptive legislation different from presumptive legislation in other Canadian provinces and territories.

Jurisdiction	Prevention and compensation responsibilities are within one organization	OHS Act includes <i>mentions</i> of psychosocial exposures and/or psychological health	Mental health injury claim (chronic or acute) requires a DSM diagnosis	Presumptive legislation	Dedicated mental health strategy
Saskatchewan	X	✓	✓ ⁵	✓	X
Yukon	✓	✓	✓	✓	X
AUSTRALIA					
Australian Capital Territory	✓	✓	✓	✓	✓
Commonwealth	✓	✓	✓	✓	X
New South Wales	X	✓	✓	X	✓
Northern Territory	✓	✓	✓	✓	X
Queensland	X	✓	✓	✓	X
South Australia	X	✓	✓	X	X
Tasmania	X	✓	✓	✓	X
Victoria	✓	✓	✓	X	✓
Western Australia	X	✓	✓	X	X

⁵ In Saskatchewan, there are two separate psychological injury policies. One of the policies is applicable when the presumption of psychological injury at section 28.1 of *The Workers' Compensation Act, 2013* applies. This presumption requires a DSM diagnosis. The other policy regarding psychological injuries states that a DSM diagnosis may not be required for acceptance of a psychological injury claim when the causal relationship between the worker's employment and the injury is determined to be evident. The policy also states the Workers' Compensation Board will still require evidence to determine whether a claim can be accepted; however, a formal DSM diagnosis may not be required at the beginning of the claim as part of the adjudication process.

Component 2: Themes arising from key informant interviews

There were five main areas, or themes, identified throughout the participant interviews. Readers should note that in this report, ‘themes’ refers to discussions or reflections on specific areas that arose frequently in the majority of interviews. Themes were identified by the research team after review and discussion of the interview notes, but this was not a formal thematic analysis of interview content.

The use of legislation versus guidance material and codes of practice

The use of legislation and guidance material in addressing the prevention and/or management of psychological injuries were explored in interviews. Participants described that legislation and guidance materials play an important but distinct role. In many cases the type and scope of guidance materials developed was shaped by the nature of a jurisdiction’s legislation and regulation. Legislation typically set enforceable minimum standards, focusing on situations that are easier to define such as workplace harassment, violence, and discriminatory actions. Psychological injuries such as chronic stress or burnout, for example, often fall outside the current scope of legislation or regulation, particularly in Canada, because these conditions are harder to diagnose and attribute to work, and the exposures that lead to these conditions are harder to define and measure. Further, the language contained in legislation or regulation may not always fully describe what is desirable in practice. Some interviewees expressed a tension between providing legislative guidance (what workplaces are required to do) and guidance materials (what workplaces are encouraged to do), as it may cause confusion for employers if both are provided on the regulator’s or compensation authority’s website. Although there was general recognition that workplaces need to go beyond the minimum legal standard to fully address psychological injuries, guidance materials typically focused on the more limited scope of psychosocial hazards identified in legislation.

The jurisdictional scan also documented large variation in guidance materials offered to workplaces and workers. Guidance material ranged from short one-page information sheets to longer documents that covered examples of a broad number of psychosocial risks and options for mitigation strategies, to web-based resources focused on a particular topic (e.g., good work design). Videos were also used in many jurisdictions, including short videos on specific topics and/or series of videos or microlearning opportunities on psychosocial injury prevention and mitigation approaches. While guidance materials were broader in scope and more often reflective of best practice than legislation, there did not appear to be a uniform approach taken across jurisdictions in relation to the content of such material. For example, in interviews participants noted that while the National Standard on Psychological Health and Safety in the Workplace was seen to be relatively comprehensive in its guidance, some interviewees felt it was too prescriptive in the type and number of hazards. As a result, it could be overwhelming for workplaces looking to take their first steps in improving their psychosocial environment.

Participants noted a deliberate move in many Australian jurisdictions towards less prescriptive approaches. Rather than attempting to outline a complete list of psychosocial factors, these approaches provide examples of psychosocial hazards and case studies or focus on particular hazards that are associated with the greatest number of claims in their jurisdiction. These approaches recognize that psychosocial hazards vary across industries and workplace sizes. Further, there was also recognition that organizational readiness—especially management commitment to psychologically safe work, and processes to ensure worker participation—is as important, if not more important, than comprehensive hazard identification.

Some jurisdictions have begun to develop more tailored approaches to help bridge the gap between general guidance and practical implementation within the workplace. For example, participants in some jurisdictions noted that current prevention activities included advisory and consultative services that can work directly with employers to identify and address psychosocial hazards. The services can be requested by employers, and in particular high-risk sectors, they are also offered to targeted employers based on their claim history. A few jurisdictions were also developing training for workplace inspectors to identify psychosocial hazards and provide guidance to workplaces on how to address these hazards, similar to what was done for physical hazards in the workplace. In these cases, there was acknowledgement that inspections around psychosocial hazards differ from physical hazards in both their scope and the training and skills required.

Finally, among Canadian jurisdictions in particular, there was a recognition of the challenges created by the inter-jurisdictional variation in guidance materials and resources. While in Australia many jurisdictions based their own guidance material and resources on Safe Work Australia's Code of Practice, a similar national code of practice does not exist in Canada; nor is there an organization, such as Safe Work Australia, that has a specific focus on harmonization and consistency of approaches to OHS and compensation across jurisdictions. Participants in Australia recognized the benefits of minimizing inter-jurisdiction variation and creating consistency in both guidance material and the recommended evidence-informed resources. Doing so strengthened and created consistency in the recommended minimum workplace approaches to OHS, including psychological health and safety, over the long term.

Strategies to improve the management of psychological injuries in workers' compensation settings

Participants from different jurisdictions told us about a range of strategies and programs in the claims management process designed to respond to the unique nature of psychological injuries. These programs included tailored claims management processes, strategies to expedite access to mental health supports, and efforts to reduce the psychological impacts of physical injuries.

A common practice described by participants was the creation of specialized claims management processes for psychological injuries. In several Canadian provinces, workers' compensation authorities had specialized mental health or psychological injury teams. These

teams have smaller claims loads than agents who are focused on physical claims; they are also often staffed by agents with specialized trauma-informed training, in-depth knowledge of relevant legislation, and a mandate to manage claims in such a way to avoid retraumatizing the injured workers. At some workers' compensation authorities, intake and claims management staff also developed familiarity with the psychosocial risks and injuries most prevalent in particular industries. In Australia, where claims management is often conducted by independent companies hired by the compensation authority, participants discussed having specialized mental health consultants for complex psychological injury claims; these consultants receive extra training, including on the unique dimensions of RTW for workers with work-related psychological injuries. In both Canada and Australia, many jurisdictions made additional efforts to support the mental wellbeing of the compensation staff working on complex psychological claims.

Nearly all interviewees mentioned the challenge of long adjudication times for psychological injuries. Previous research has noted that determining work-relatedness for psychological claims often takes longer than for physical injuries [2 23], which was still the case in many jurisdictions discussed in interviews. This is especially true in jurisdictions where job-related presumptions for post-traumatic stress injuries don't exist, where a DSM diagnosis is needed for eligibility, and/or where compensation is extended to include chronic mental stress. The impacts of the lengthy determination process on RTW can be further exacerbated by challenges in accessing mental health supports during the adjudication process. In response to these challenges, some jurisdictions in Canada and Australia employed strategies to improve access to mental health assessments and provide supports while a claim is being diagnosed and/or adjudicated, even if these supports were not delivered by providers who could make a formal diagnosis.

Participants shared that a common barrier to expedited claims adjudication and timely access to required medical treatment was the challenge of accessing trained psychiatrists and psychologists. To address this challenge, some jurisdictions in Canada established contracts with specialized psychiatrists for independent medical examinations. Another jurisdiction mentioned they created a network of psychiatrists able to provide expedited assessments. This network has reportedly decreased wait times for assessments from months to weeks. In one province, a range of strategies were employed to widen the pool of psychiatrists working with the compensation authority. The strategies included one-on-one outreach to psychiatrists across the province, individualized supports to help psychiatrists register to work with the compensation authority, professional development opportunities, and higher-than-average compensation. The struggle to identify appropriate health-care professionals and access supports to address work related psychological injuries extended beyond the adjudication phase, impacting the RTW process after a claim was accepted. In response, jurisdictions in Canada and Australia have made changes to their fee schedules to include a range of health-care professionals, including occupational therapists, counsellors, and social workers, who can be called upon to support claimants with psychological injuries, where appropriate.

Many participants recognized that early intervention and timely treatment were key to successful eventual RTW, and some offered treatment options to injured workers while their claim was being adjudicated. Typically, these supports were offered at no cost to the worker, even if the claim was ultimately denied. Often these mental health supports were provided by a wide range of professionals including social workers and counsellors. The programs provide time-limited support while workers navigate the workers' compensation claim process; this includes early support in managing psychological injury and an opportunity to support work attachment while the claim is being determined. In one Australian state this type of mental health support was available to all claimants (psychological and physical) and extended to adult family members of injured workers.

Beyond claims that were primarily psychological in nature, interviewees were asked about strategies in place to identify and address physical injury claims that include or develop a psychological component. In response to the challenge of identifying these cases, particularly before they become severe or serious, some participants described implementing training to ensure case managers, or other groups involved in the RTW process, are alert to the interconnected nature of physical and psychological risks. Others noted that specialized case managers became involved once a claim was identified as having a psychological component. In one Australian jurisdiction, compensation legislation explicitly requires the insurer to minimize risk of a worker developing a psychological injury arising from a physical injury. In response, the compensation authority described a proactive strategy wherein they assess the injured worker's pain, sleep and coping at regular intervals to catch potential psychological distress as early as possible. The authority also offers workers in these situations access to service providers, where the focus is on communication and discussion, not on a mental health diagnosis.

Challenges with evaluating impacts

In addition to questions about the resources and programs in place to prevent and manage psychosocial injuries, interviewees were also asked about the impact of these interventions and any measures used to evaluate their success. For the most part, participants described using traditional indicators captured in administrative data to evaluate the impact of policy, program and resource changes. These include claim volumes, proportion of claims that are psychological, number and costs of health care, the number of days of wage replacement provided for accepted claims, and rates of sustained RTW following psychological injury.

Many jurisdictions collected metrics on the processing time from claim submission to adjudication decision for all injuries. They would then compare these metrics for psychological injuries and physical injuries, and also for psychological injuries as a group over time. Participants often described using these administrative metrics to evaluate progress and advocate for more institutional resources to be dedicated to prevention and/or management activities for psychological injuries. A smaller number of participants indicated that their jurisdictions have integrated information on injured workers' function and symptoms, either for particular claim types or generally. This allows for a more nuanced understanding of approaches

to address mental health stigma. (For example, if there has been a reduction in symptom severity with submitted claims, this might indicate that the work-related psychological injuries are submitted to the compensation agency earlier in the injury process). A few participants also noted that capturing metrics on symptoms, both function and RTW are important as these outcomes do not always overlap with each other (e.g., symptom and function improvement does not always lead to RTW and vice versa).

Although dedicated mental health strategies were present in six of the jurisdictions (as indicated earlier in Table 2), interviewees rarely referred back to the mental health strategy or associated key indicators as a source of performance assessment.

Often impacts were not measured for prevention activities. When they were measured, the impacts of interest were often related to the number of downloads or queries, the use of material, or the level of learning and self-efficacy related to the use of training resources. Interview participants recognized the challenges of linking specific prevention activities to lagging indicators such as claim volumes, given the complexity and number of steps between prevention activities and change in lagging outcomes. Participants also discussed the few instances where prevention or compensation agencies partnered with academic research centres to develop tools and evaluate pilot programs [24-26]. These evaluations, predominantly in the prevention space, allowed for the benefits of these activities to be measured and provided assurance that program impact was as intended before efforts and investments were made to bring them to scale. There was also interest in understanding the level of awareness related to the resources that are available within the workplace community.

The benefits of collaboration to address and manage psychological injuries

Across interviews, participants noted the value of collaboration in preventing and managing work-related psychological injuries. Strengthening connections between the regulator, prevention and compensation organizations, workers, industry and health-care providers was repeatedly mentioned as a key ingredient to increasing awareness of psychosocial hazards, developing relevant resources, and creating a supportive and successful RTW process.

Participants from different jurisdictions agreed that a key element to addressing work-related psychological injuries was collaboration between organizations responsible for prevention and those responsible for compensation and management of injuries once they occur. The nature of this collaboration differed based on the nature of the authorities. In regions where authorities for regulation, prevention and compensation were distributed across multiple organizations, deliberate efforts were required to set priorities, coordinate efforts and measure progress. Where prevention and claims management were tackled within the same organization, interviewees noted that improved inter-departmental coordination was still necessary. An example of the value of sharing information and working together was a situation where a worker did not feel safe to return to a workplace and the prevention organization was able to step in and provide supports to the workplace on addressing the psychosocial work

environment for all workers; another was the use of claims data to inform prevention activities and priorities.

Interviewees also emphasized the necessity of engagement with industry representatives and workplaces. Industry associations were noted as important partners in spreading awareness about new legislation or regulations and helping to emphasize the importance, and feasibility, of addressing psychosocial hazards in the workplace. A number of jurisdictions also remarked on the role industry bodies play in informing guidance material and in tailoring existing materials so that the language used and focus of information is relevant to their clients. Where prevention and compensation authorities often developed general guidance materials, they relied on industry to modify available resources to best fit their workplaces and workforce. In the interviews, participants noted that in industries where psychological injury claims are most common—for example, first responders, health care and social services—more resources have been developed and senior leadership exhibit higher levels of commitment to the issue.

To build relationships with workplaces and industry representatives, some compensation authorities launched communities of practice that routinely bring together health and safety leaders to discuss challenges and case studies related to the prevention and/or RTW of psychological injuries. While interview participants noted challenges in maintaining momentum and attendance within these communities of practice, they also highlighted that the communities provided a forum for information sharing within and across sectors. Other jurisdictions described groups (such as internal advisory committees, industry-specific workplace collaborations and psychological injury-specific working groups) or outreach activities that were being used to build relationships and facilitate dialogue with workplaces or industry representatives.

A number of interviewees also highlighted the need for continual communication between health-care providers, workplaces, workers, and the workers' compensation authority throughout the RTW process. Establishing clear roles and expectations early in the process, maintaining open channels of communication and providing opportunities for capacity-building were noted as necessary ingredients to a successful RTW experience.

A few participants described activities initiated by compensation authorities to build awareness and capacity among workplaces and with health-care providers about the RTW process. For example, a number of jurisdictions noted that workplaces were often not aware of their responsibilities, or confident in their abilities, to support investigations related to a psychological injury claim; or they underestimated the importance of their actions and role in the RTW of an employee. In response, the agency in that jurisdiction offered training to workplaces to ensure they understand their responsibilities regarding RTW. Some participants indicated that their jurisdictions also had opportunities to build awareness and familiarity among psychiatrists and psychologists about work-related injuries, work reintegration, and the accommodation and RTW process to enable recovery at work. For example, a few compensation authorities have adopted structured timelines and reporting expectations to ensure treatment

plans consider symptom reduction, along with markers of improved functionality and work-readiness.

Continued areas for improvement in system-level approaches

The final theme emerging from interviews brings together a composite of issues that were raised when thinking about continued areas for improvement in the prevention and management of psychological conditions. These were: addressing mental health stigma, moving beyond individual-level approaches, and integrating approaches to preventing and managing both physical and psychological injuries.

Participants noted the continued need to address mental health stigma. This area was prominent among compensation agencies with a focus on post-traumatic stress injuries, although it was by no means exclusive to these settings. While compensation and prevention agencies recognized the importance of early intervention, there are still challenges concerning the disclosure of the mental health impacts of work, particularly in male-dominated industries. Much of this was attributed to stigma around mental health in these contexts. In some jurisdictions, a purposeful shift from promoting mental health to preventing psychological injury had been undertaken to help reframe the issue and overcome mental health stigma. In another jurisdiction, workers with physical injuries who may be reporting early signs of mental health problems were offered general supports (e.g., someone to have a conversation with) without specifically mention of mental health or the need for a formal diagnosis.

Participants based in jurisdictions in both Canada and Australia noted challenges in identifying evidence-based programs or services among the many programs targeting mental health that are available and promoted by different organizations. Some jurisdictions reported moving away from individualized training or resiliency programs; this was due to their lack of effectiveness compared to those with more of an organizational focus, an observation also supported in the scientific literature [27 28].

Participants acknowledged the need to adopt a holistic approach to addressing the impacts of work-related psychological injuries, given that aspects outside of the work injury or the workplace can impact RTW. Many of the interviews acknowledged the wide-reaching impacts of psychological injuries and recognized the need to provide support for the families and communities of injured workers. One jurisdiction had designed initiatives to address the wider implications of a work-related injury, such as providing financial advisory services to injured workers. This same jurisdiction also offers services to help connect injured workers with supports within their community such as cultural services, housing support services, and family and legal services.

Finally, while jurisdictions acknowledged that physical and psychological injuries can require different prevention and management approaches within workplaces, they also reflected that approaches can be integrated given effective prevention for both types of injuries are underpinned by similar characteristics in the workplace, such as senior management

commitment and worker participation. In addition, certain exposures in the workplace can have both physical and psychological consequences, and often the presence of physical limitations can have psychological impacts and vice versa.

Conclusions

The broad objectives for this project were to better understand differences in jurisdictional approaches in Canada and Australia to prevent and manage psychological injuries, and the benefits and challenges associated with these differences. By comparing and documenting similarities and differences in approaches across jurisdictions, this project can help inform priorities for future policy and program development as well as opportunities for evaluation.

An examination of publicly available information across 22 jurisdictions (13 in Canada and nine in Australia) revealed variation in:

- the institutional organization of prevention and claims management (e.g., single versus multiple organizations);
- the use of presumptive legislation for particular types of psychological injuries and/or occupational groups; and
- the types of psychological injuries covered or considered to be work-related.

In addition, while all jurisdictions provided guidance material for workplaces in both how to prevent and manage psychological injuries, the detail provided with this information, the focus of the guidance, and the mode of delivery differed to a considerable extent. Variation appeared greater in Canada than in Australia, which in part is attributed to the existence of a national organization with a specific mandate to harmonize approaches in the latter.

In interviews, key developments in the prevention of work-related psychological injuries included:

- an increasing focus on building organizational readiness rather than providing prescriptive guidance;
- an evolution from individually focused strategies to organizational strategies, and
- an increasing availability of consultation or training services to help workplaces implement changes when they are ready.

Interview participants also noted specific changes in the claims management process for psychological injuries compared to physical injuries, which include increased efforts to connect injured workers with mental health services as soon as possible, even if providers cannot provide a formal diagnosis of the condition; specific training for claims agents and other workers' compensation staff who engage with people with psychological injuries; and efforts to improve communication between parties in the RTW space, in particular health-care providers.

Participants from many jurisdictions described significant commitment to improving the prevention and management of psychological injuries. Despite the range of programs and activities in place, the interviews generated very few examples where these strategies had been independently evaluated, although internal evaluations were more regularly conducted and sometimes shared within informal jurisdictional networks. Psychological injuries are likely to remain, and even grow, as drivers of workers' compensation claim volumes and wage replacement and health-care costs across all jurisdictions. There continues to be important opportunities for the independent evaluation of different programs and activities, and opportunities to more broadly share information about what works (and what does not) across jurisdictions nationally and internationally.

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Appendices

Appendix A: Interview questions

Below are the key questions we will focus on during the interview. We may skip or ask additional specific questions depending on the conversation and particular areas of interest.

1. Can you briefly describe the approach taken in your jurisdiction to reduce work-related psychological injuries and their impacts?
2. Before the interview, we provided a summary of publicly available information on your jurisdiction's legislation, regulation and guidance materials on psychological injuries. Are there any parts of the summary we provided you with that were incorrect or incomplete?
3. An integrated approach to addressing workplace mental health suggests three complementary components to reduce the number and duration of psychological injuries. These are: 1) reducing psychosocial and physical hazards associated with mental health harm in the workplace; 2) promoting aspects of work that are associated with more positive mental health, and 3) responding effectively to mental health problems as they manifest in the workplace, including in the return-to-work process when an absence occurs.

Does your current approach to psychological injuries address each of these areas? Can you give examples?

4. Can you tell us about the approach you take when you receive a psychological injury claim? How has it evolved over time?
5. What is your approach to developing guidance material on the psychosocial work environment and psychosocial injuries? Do you focus on developing general materials for a variety of work settings or do you create resources particular to certain industries or organizational sizes?
6. In your work to date, are there programs or approaches that have been particularly effective? Could you describe these activities and what are the metrics you use to evaluate success?
7. Are there activities that have not been effective, but provided valuable learnings? Could you describe these activities and how you ascertained that they did not work?

Appendix B: Summary of presumptive legislation for psychological injuries across jurisdictions

Jurisdiction	Is there presumptive legislation?	If yes, when was it introduced?	If yes, who is covered by the presumption?	If yes, what condition(s) does the presumption cover?
CANADA				
Alberta	Yes	2012	Presumptions apply to correctional officers, paramedics, police, firefighters, emergency dispatchers, and peace officers.	DSM mental disorders (including PTSD)
British Columbia	Yes	2018	Presumptions apply to community integration specialists, coroners, emergency response dispatchers, harm reduction workers, health-care assistants, nurses, parole officers, probation officers, respiratory therapists, shelter workers, social workers, transition house workers, victim service workers, and withdrawal management workers.	DSM mental disorders
Manitoba	Yes	2015	Presumptions apply to all employees.	PTSD
New Brunswick	Yes	2021	Presumptions apply to firefighters, paramedics, and police officers.	PTSD
Newfoundland & Labrador	Yes	2019	Presumptions apply to all employees.	PTSD
Northwest Territories & Nunavut	No	N/A	N/A	N/A
Nova Scotia	Yes	2018	In the case of PTSD, presumptions cover the following: continuing-care assistants, correctional officers, emergency-response dispatchers, firefighters (municipal and federal, paid and volunteer), nurses, paramedics, police officers, and sheriffs.	PTSD
Ontario	Yes	2016 (with an amendment in	Presumptions apply to police officers, firefighters (full-time, part-time, volunteer), paramedics, emergency medical	PTSD

Jurisdiction	Is there presumptive legislation?	If yes, when was it introduced?	If yes, who is covered by the presumption?	If yes, what condition(s) does the presumption cover?
		2018 to include nurses)	attendants, correctional officers, dispatchers (emergency), workers involved in crime scene examinations, and nurses.	
Prince Edward Island	Yes	2018	Presumptions apply to all workers within the compensation system.	DSM trauma- or stressor-related disorder (including PTSD)
Quebec	No	2021	In Quebec mental disorders, specifically post-traumatic stress, are included under a specific schedule related to occupational disease presumptions (https://www.legisquebec.gouv.qc.ca/fr/document/rc/A-3.001,%20r.%208.1?langCont=en). However, there is no specific list of occupations where a presumption would apply, and all applications are reviewed on a case-by-case basis. This makes Quebec’s presumptive legislation different to presumptive legislation in other Canadian provinces and territories	Post-traumatic stress
Saskatchewan	Yes	2016	Presumptions apply to all employees.	DSM psychological injuries (including PTSD)
Yukon	Yes	2022	Presumptions apply to all employees.	PTSD
AUSTRALIA				
Australian Capital Territory	Yes	2023	Presumptions apply to the Commissioner of the Australian Federal Police, the Deputy Commissioner of the Australian Federal Police, AFP employees (all within the meaning of the Australian Federal Police Act 1979), firefighters, ambulance officers (including paramedics), emergency services communications operators, members of an emergency service (within the meaning of the Emergencies Act 2004 (ACT)), the Australian Border Force Commissioner, and APS employees in the Australian Border Force.	PTSD
Commonwealth	Yes	2023	Presumptions apply to Australian Federal Police, Australian Border Force, firefighters, ambulance officers (including	PTSD

Jurisdiction	Is there presumptive legislation?	If yes, when was it introduced?	If yes, who is covered by the presumption?	If yes, what condition(s) does the presumption cover?
			paramedics), emergency services communications operators and other persons engaged under the Australian Capital Territory Emergencies Act 2004.	
Northern Territory	Yes	2020	Presumptions apply to first responders, for Schedule 2, meaning a person with specialized training (such as a paramedic, police officer, firefighter, correctional officer or other emergency personnel), who attends the site of an incident and provides assistance in situations: (a) involving actual or potential injury to persons or damage to property; and (b) which may also include risk to the first responder; and (c) where time may be of the essence to save lives or property.	PTSD
Queensland	Yes	2021	Presumptions apply to first responders and “eligible employees” (i.e. workers employed by specific government departments whose roles involve repeated or extreme exposure to graphic details of traumatic incidents).	PTSD
Tasmania	Yes	2019	Presumptions apply to “relevant workers” (meaning, workers employed by the Crown or appointed under an Act of the State, employees of Government business enterprises, employees of State-owned companies).	PTSD

Appendix C: Summary of guidance materials across jurisdictions

Jurisdiction	Where are guidance materials located?	Exposures covered in materials	Is there industry-specific guidance?	Is there guidance tailored to small businesses?
CANADA				
Alberta	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	No	No
British Columbia	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	No	No
Canada	Prevention site	Violence, harassment and other psychosocial exposures	No	No
Manitoba	Workers' compensation and prevention site	Violence and harassment	No	Yes
New Brunswick	Workers' compensation and prevention site	None	No	No
Newfoundland & Labrador	Workers' compensation and prevention site	Violence and harassment	No	No
Northwest Territories & Nunavut	Workers' compensation and prevention site	Violence and harassment	No	No

Jurisdiction	Where are guidance materials located?	Exposures covered in materials	Is there industry-specific guidance?	Is there guidance tailored to small businesses?
Nova Scotia	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	No	No
Ontario	Workers' compensation and prevention site	Violence and harassment	No	No
Prince Edward Island	Workers' compensation and prevention site	Violence and harassment	Yes (e.g., agriculture)	Yes
Quebec	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	No	No
Saskatchewan	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	Yes (e.g., retail salespersons and salesclerks, paramedics)	No
Yukon	Workers' compensation and prevention site	Violence and harassment	No	No
AUSTRALIA				
Australian Capital Territory	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	No	No
Commonwealth	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	No	No

Jurisdiction	Where are guidance materials located?	Exposures covered in materials	Is there industry-specific guidance?	Is there guidance tailored to small businesses?
New South Wales	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	Yes (e.g., construction)	Yes
Northern Territory	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	No	No
Queensland	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	Yes (e.g., construction)	Yes
South Australia	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	No	No
Tasmania	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	Yes (e.g., construction)	No
Victoria	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	Yes (e.g., healthcare)	Yes
Western Australia	Workers' compensation and prevention site	Violence, harassment and other psychosocial exposures	Yes (e.g., mining)	No



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Institute for Work & Health
400 University Avenue, Suite 1800
Toronto, Ontario M5G 1S5

info@iwh.on.ca
www.iwh.on.ca