

INSIDE THE MINDS OF AUSTRALIA'S WORKPLACES 2026

Making work, work better

The hidden factors shaping
worker wellbeing

We help people get their lives back.

A portrait of Cameron McCullagh, a middle-aged man with a grey beard and mustache, wearing a dark blue suit, white shirt, and a dark red tie. He is standing in front of a large window with a view of greenery outside. The right side of the image has a dark blue overlay containing text and a signature.

Our inaugural report, *Inside the Minds of Australia's Workplaces: Evidence, insight, and collective action for better mental health outcomes*, established why workplace mental health matters to organisational risk, recovery and performance. This year's insights report builds on that foundation, exploring where the risk concentrates, and how Australian workers perceive those risks. **Most importantly, it identifies practical actions employers can take to shift the dial on workplace mental health.**

A handwritten signature in white ink, reading "Cameron McCullagh".

Cameron McCullagh,
Executive Chairman, EML

Executive summary

What the evidence tells us about risk, work and recovery

This latest phase of EML's workplace mental health research builds on the 2025 edition of *Inside the Minds of Australia's Workplaces*¹, significantly expanding the evidence base. The 2026 insights report combines Monash University's analysis of four national datasets with EML's 2026 survey of 4,065 Australian workers and 831 managers and leaders.

The 2026 survey also marks the beginning of an annual research program designed to track how workplace mental health changes over time, building a substantial and growing evidence base on the experiences of Australian workers, employers and workplaces.

Together, the research provides both a population-level view of mental ill-health, work and recovery, and a contemporary picture of the risks, experiences and challenges emerging in Australian workplaces.^{2,3}

Mental health is shaping people's experience of work and influencing whether they stay, leave, seek support, disclose a mental health concern, take time away from work or pursue compensation. The evidence reinforces the need to act earlier, on the workplace conditions that influence psychological health, before their impacts become more significant.

Much of the impact remains hidden from employers

Mental ill-health is widespread, but employers may only see part of the picture.

Nearly half of Australian workers have experienced a mental disorder in their lifetime and more than one in five in the past year,² yet around 45% of workers surveyed are not comfortable disclosing a mental health condition to their employer.³

Even when mental ill-health affects attendance, it may remain hidden: two in five workers reported taking at least one day off because of a mental health problem in the past year, but only around a quarter disclosed why.³

Mental ill-health is also influencing whether people stay in their jobs and the conditions they are willing to accept. More than one in three workers surveyed (34%) had left a job because of its impact on their mental health, while 25% had seriously considered leaving their current role. Almost half (46%) said they would accept a pay cut for a job that was genuinely better for their mental health.³

Collectively, these findings show that mental ill-health affects not only absence and claims, but also retention, workforce participation and employee's career decisions.

Influencing careers and choices

 **34%**

of workers have **left a job** because of its impact on their mental health.³

 **25%**

of workers have **seriously considered leaving** their current role.³

 **46%**

of workers would **accept a pay cut** for a job that is genuinely better for their mental health.³

Work design and control shape risk

The evidence increasingly points upstream to how work itself is designed. Around three-quarters of workers report at least one poor job quality dimension.²

High job demands are the most reported psychosocial risk for both employees and managers.³ However, heavy workloads are only the baseline.



75% of workers report at least one poor job quality dimension.²

High demand is not necessarily harmful in isolation; how much control workers have over how work is organised and carried out can materially shape how that demand is experienced.²

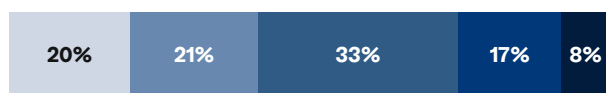
High job demands or workload³



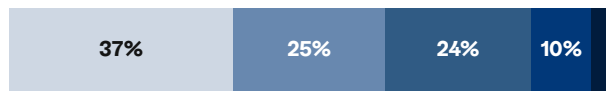
When high job demands collide with low job control, workplace safety risks can escalate. Stacking multiple psychosocial hazards creates a compounding effect that significantly intensifies the threat to mental health.² Around 8% of workers report facing three or four hazards simultaneously, and those under 25 are more likely than any other age group to experience three or more hazards at once.² These findings reinforce the importance of work design, particularly work demands and job control, in managing psychosocial risk.

Frequency of workplace experiences in the past 12 months³

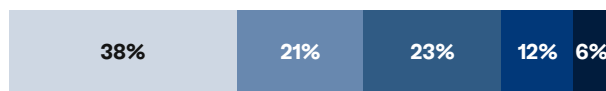
Felt emotionally exhausted by work



Felt lonely or isolated at work



Worked through mental ill-health because they felt they couldn't take time away from work



Never Rarely Sometimes Often Very often

Note: Totals may not sum to 100% due to rounding of individual values

Risk concentrates in identifiable workforce hotspots

Although mental ill-health is widespread, it is not evenly carried. Recent mental ill-health is highest among younger workers, while compensation burden peaks later in working life. This reveals an important disconnect: the workers experiencing the highest levels of mental ill-health are not necessarily those appearing most often in workers compensation claims. Claims data is a useful measure of work-related psychological injury but it shows only part of the mental ill-health in a workforce. Patterns of mental ill-health, help-seeking and coping differ between women and men. To ensure equal reach, support systems must be flexible enough to accommodate these differing profiles.

Work-related psychological injury is concentrated in frontline and community-facing sectors where workers can be exposed to high demands and lower control, but with additional stacking of harmful behaviours, occupational violence or trauma.²

Where the burden is heaviest²

Community-facing sectors account for more than two-thirds of all working years lost to mental health claims. Exposure is highest in these sectors, where high job demands, lower levels of control, and increased exposure to occupational violence, trauma and harmful behaviours contribute to psychosocial risk.

Particularly significant burdens in:



Health and social assistance



Education and training



Public administration and safety

The burden is concentrated in health care and social assistance, public administration and safety, and education and training.² EML's August 2026 survey shows a similar pattern, reinforcing the disproportionate impact of mental health challenges across these sectors.³

Within organisations, middle management is emerging as a significant area of concentrated risk.³

For this group, psychosocial risks may accumulate alongside substantial operational accountability, developing a profile where role overload creates a unique, hyper-concentrated psychosocial hazard environment.

A concentrated risk: middle management³



Accumulation of psychosocial risks and accountability



Creates a profile of role overload



Results in a unique, hyper-concentrated psychosocial hazard environment

The gap between risk awareness and action

Employers and employees largely agree on the source of the pressure. Both identify high job demands and workload as the most common psychosocial hazard. The difference becomes clearer in what happens next.

Fewer than half of managers and leaders believe their organisation has effective systems for identifying and managing psychosocial hazards, and only 21% were aware of a formal psychosocial risk assessment undertaken in the past 12 months.³

One in five expect psychological injury claims to increase, while 58% expect mental health investment to remain unchanged.³

The gap, therefore, is not simply one of perception. It is the distance between recognising risk and systematically acting on it, while employees continue to experience the consequences when risk is not addressed early.

Regulatory expectations about how that duty should be met have become more explicit. Closing the awareness-to-action gap is now imperative for employers to meet their regulatory obligations.

Awareness and systems fall short³



<50%

of managers and leaders believe their organisation has effective systems for identifying and managing psychosocial hazards.



21%

were aware of a formal psychosocial risk assessment in the past 12 months.

Claims are a late, increasingly costly signal

The most recent Safe Work Australia data shows that mental health conditions accounted for approximately 12% of serious claims, defined as accepted workers compensation claims resulting in at least one working week of time lost (excluding fatalities and journey claims), or 17,900 cases.⁴

Over the preceding decade, the number of workers compensation claims for mental health conditions increased by 169.4% - the largest of any major nature of injury group.

Changes to psychological injury eligibility and other scheme settings may alter the volume and cost profile of accepted claims without necessarily indicating a corresponding reduction in underlying distress, workplace exposure or the need for recovery support.²

Duration and cost of mental health claims⁴



34.8 working weeks

compared with 7.4 weeks across all serious injury claims.



\$68,600

compared with approximately \$16,300 across all serious injury claims.

Recovery is also an opportunity for earlier intervention

The recovery evidence reinforces the importance of acting early. Only 76.5% of workers with psychological injuries had returned to work at some point since injury, compared with 90.2% of workers with physical injuries.⁵

Psychological distress can also emerge during recovery from physical injury, potentially remaining unidentified when support focuses only on the primary physical condition.

There is encouraging evidence that targeted intervention can improve outcomes. An independent evaluation by Finity Consulting found that participation in **EML's Recovery Pathways program was associated with a statistically significant increase (7.5 percentage-point) in return-to-work at 12 months.** Given the potential long tail nature of mental health claims, the compounding impacts of this saving can be substantial.⁶

From evidence to action

The next phase of Australia's workplace mental health challenge is therefore not awareness alone, but action. The evidence points to three priorities:^{2,7,8}

1. Design healthier work

Identify where high demand combines with low control and where hazards may stack, and then change the conditions employers can influence. Find ways to give employees reasonable control over their work.

2. Equip and support managers

Provide the authority, tools, systems and support to intervene early, not simply awareness training.

3. Identify psychosocial risk and match the response

Integrate claims data with workforce exposure, absence, turnover, disclosure and recovery information to identify where risk is concentrating, then match the response to the issues identified.

The findings expose a critical tension. Employers and employees can often identify the same risks, particularly high job demands and workload.

Yet, recognition does not necessarily mean those risks are being systematically assessed, controlled or addressed before harm occurs.

Much of the impact remains hidden in presenteeism, undisclosed leave, employee turnover and decisions not to seek support or lodge a claim.

If employers and employees can both see the problem, why is so much of its impact still hidden? The sections that follow examine where risk is concentrating, why existing responses may not always reach employees, and which practical actions can move organisations from awareness to earlier and more effective intervention.

Mental ill-health is a workplace issue, but employers may have limited visibility

The Monash analysis confirms the scale of mental ill-health across the working population. Nearly half the working population has experienced a mental disorder at some point in their lives, with more than one in five meeting the criteria for a mental disorder in the past year.¹ For many, mental ill-health is experienced and managed alongside the everyday demands and responsibilities of work.

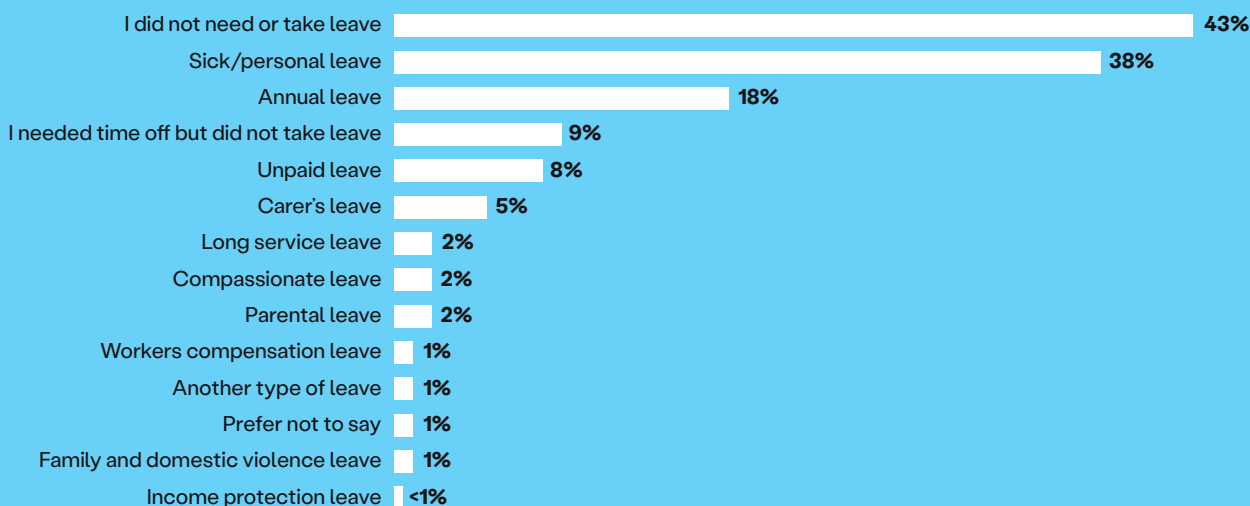
Mental health does not divide neatly into “well” and “unwell”. People may experience different degrees of distress while remaining at work. For employers, the effects include presenteeism (employees who are at work but can’t perform at their usual capacity because of poor mental health), as well as absence and turnover. Presenteeism can have operational consequences in roles where sustained concentration is crucial to safety and productivity, while absence and attrition can further reduce workforce capacity.^{2,9,10}

Much of the impact may remain hidden from employers

In EML’s workplace survey of more than 4,000 workers, 38% reported having a mental health condition in the previous 12 months.³ Yet for many, these challenges remain largely unseen at work. **Around 45% of workers do not feel comfortable disclosing a mental health condition to their employer.**³

Mental health-related absence was widespread, with two in five respondents taking at least one day off work in the past year because of their mental health. Employees often relied on a range of leave types, rather than sick leave alone. Yet despite the prevalence of these absences, disclosure was uncommon, with only a quarter of employees who used sick leave telling their employer that mental ill-health was the reason for their absence. The picture is one of a workforce experiencing significant mental health challenges but largely continuing to work with them.

Types of leave for mental health in the last 12 months³





2 in 5 workers

have taken at least a day off in the past year due to their mental health.³

Only 25%

had told their employer why.³

Presenteeism and retention: the costs employers rarely see

Presenteeism is a key workforce capacity issue. Two in five workers (41%) reported that they had sometimes, often or very often worked while struggling with their mental health because they felt they could not take time off.³

Poor mental health is also affecting retention. One in three workers said they had left a job at some point because

of its impact on their mental health, while one in four had seriously considered leaving their current job for the same reason in the past year.³ Almost half (46%) said they would accept a pay cut for a job that was genuinely better for their mental health.³

For employers, this creates two related challenges: recognising distress that may not be visible and designing support that people will actually use. The evidence suggests that absence and claims alone provide an incomplete picture of workforce mental health.

The wider impact of mental ill-health

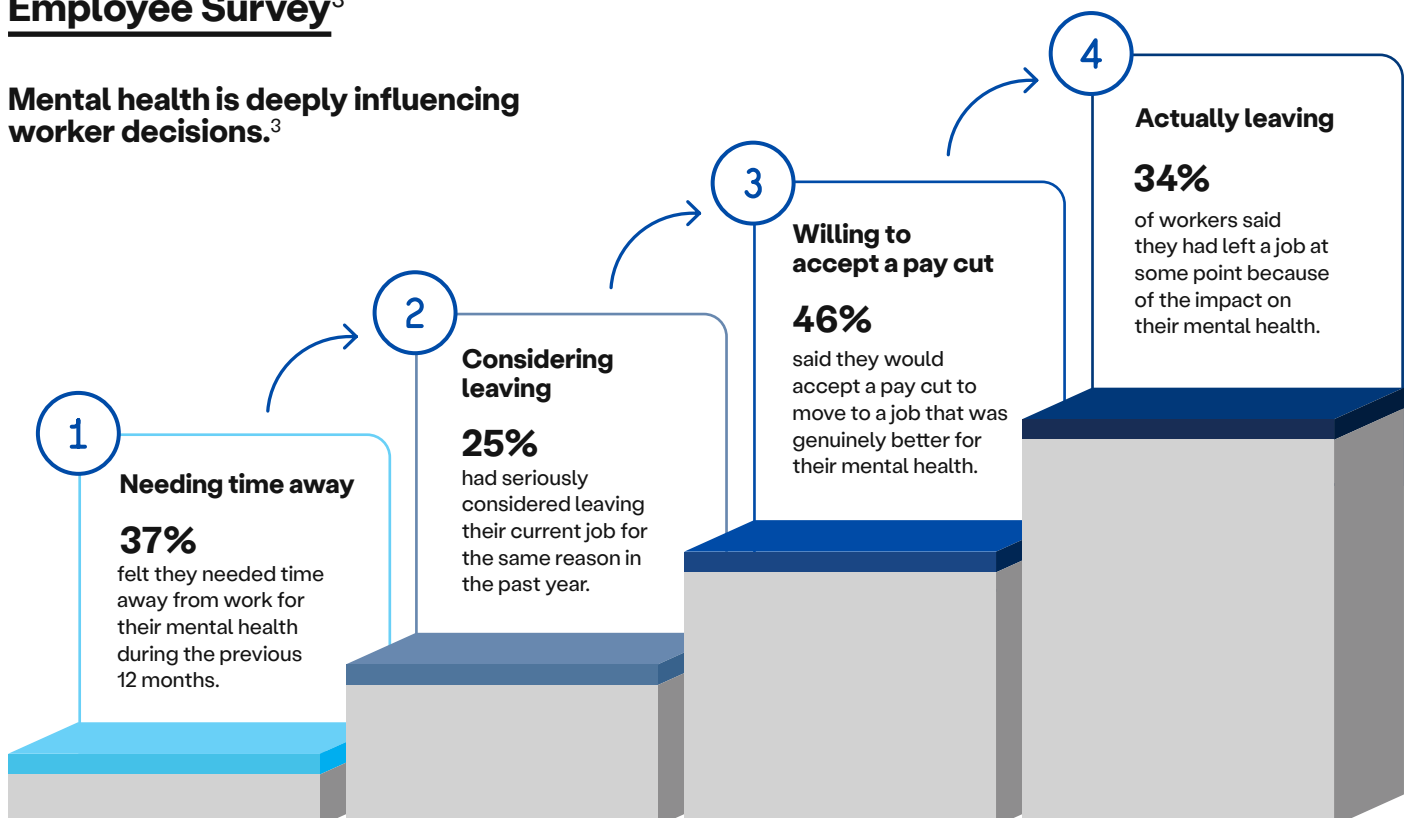
Monash's analysis of Australian Bureau of Statistics data estimates more than 42 million disability days attributable to a mental health disorder each year among employed Australians. These are days when a person's mental health limited or prevented them from carrying out their usual activities. Women account for approximately 26 million of those days and men 16 million.² These are not equivalent to days absent from work: the measure captures days on which usual activities were limited or could not be performed, including on non-workdays. Even so, the estimate illustrates the scale of mental ill-health within the working population before any claim is lodged.



42 million disability days are lost annually to mental health disorders among employed Australians.²

Employee Survey³

Mental health is deeply influencing worker decisions.³





The clearest risk signal is work demand, but it's only part of the equation

“High demands don’t have to damage mental health. What matters is whether workers have the control to manage them. The demand-control dynamic is one of the most powerful levers employers have to create healthier, more sustainable work.”

– Dr Shannon Gray

Senior Research Fellow, School of Public Health and Preventive Medicine



The most widespread job-quality risks

The Productivity Commission’s 2025 review of the National Mental Health and Suicide Prevention Agreement reinforced the case for action beyond the clinical system, including in workplaces.¹¹ For employers, a central question is how the design and organisation of work shape psychosocial risk.

The HILDA Survey analysis for this report examined four dimensions of job quality: demands, control, skills and variety, and job security.

High job demands and low job control were by far the most common poor job quality dimensions, reported



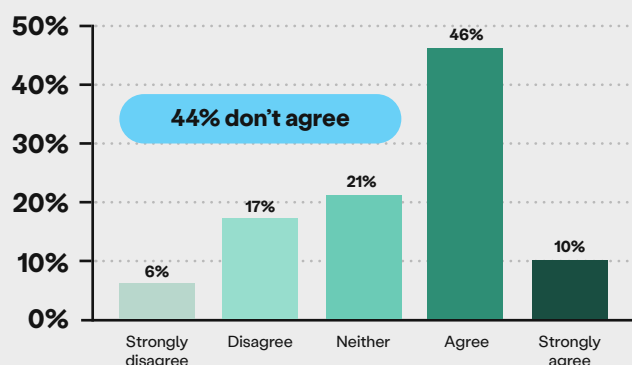
41%

of **managers and leaders** are personally affected by **high job demands**.³

by 44% and 43% of workers respectively, compared with 14% reporting low skills and variety and 13% low job security.²

This is broadly consistent with EML’s August 2026 survey, in which high job demands or workload was the most commonly reported psychosocial hazard. The pressure was also evident among managers and leaders: 41% reported personally experiencing high job demands or workload in the previous 12 months, and only 56% agreed that workloads in their organisation were sustainable over the long term.³

Percentage of managers and leaders who agree organisational workloads were sustainable over the long term.³



Why control changes how demand is experienced

For employers, an important distinction is that some forms of work are inherently demanding. Caring roles, emergency response, customer service and deadline-driven professional work can all involve demands that cannot simply be eliminated.^{7,10}

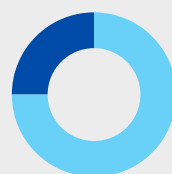
This reflects a long-established finding in occupational health research: how workers experience high demand is influenced by the degree of control they have over their work. High demands are not inherently damaging; their effects depend in part on the conditions in which those demands are experienced, including the control workers have over how work is carried out.²

Current psychosocial hazard guidance reinforces this principle. High demands can create greater risk when workers have limited control over how work is sequenced, how priorities are resolved, when breaks can be taken, and whether managers have discretion to adjust duties before harm escalates.^{7,8} This makes job control an important and, in many settings, modifiable feature of work design.

Monash's industry analysis illustrates this distinction. In professional, scientific and technical services, mental health claims are relatively low, despite job demands being among the highest of any industry. For this workforce group low control is reported as relatively uncommon.² This pattern is consistent with the broader evidence that demand should be considered alongside control and other conditions in which work is performed.

The stacking problem

The number of poor job quality dimensions also matters. Risk can compound when high job demands coincide with low control and low job security or other poor-quality job characteristics. Around three quarters of workers report at least one poor job quality dimension; about 8% report three or four at the same time.² Workers



Approximately

3 in 4

Australian workers report at least one poor-quality job characteristic.²



High demand alone does not determine psychosocial risk.

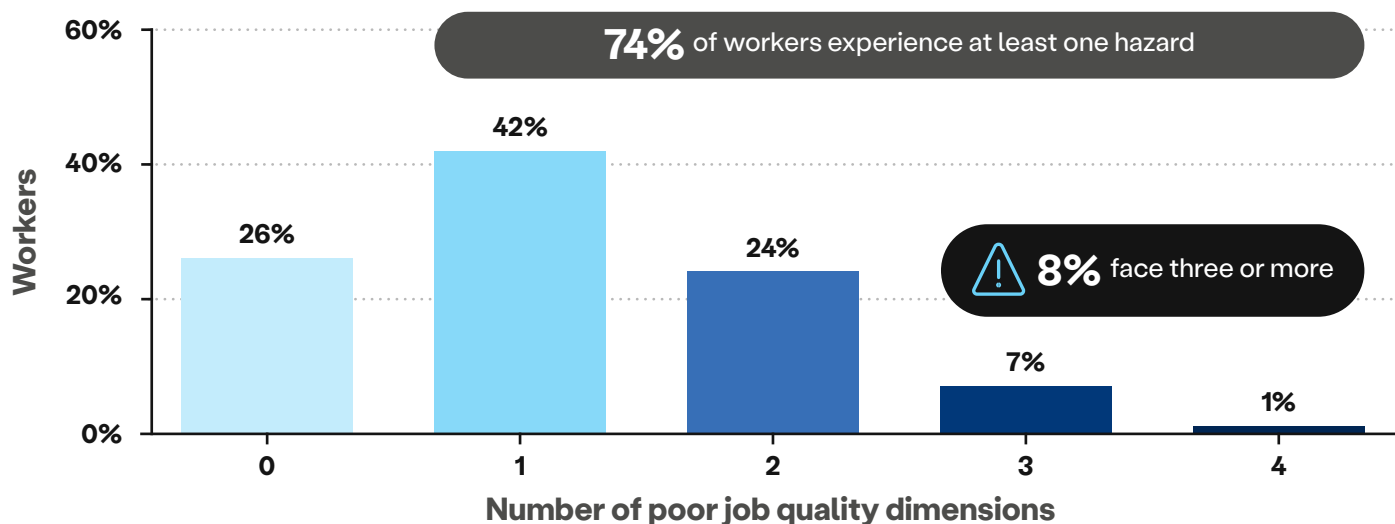
In professional, scientific and technical services, high demands are accompanied by high levels of worker control, demonstrating that risk depends on the combination of psychosocial factors, not workload in isolation.²

under 25 are more likely than other age groups to report three or more dimensions.²

For employers, the next question is clear: how can greater control be built into the work itself. Depending on the role, this may include: clearer decision rights, greater autonomy over scheduling and task sequencing, realistic resourcing and well-defined priorities, reliable pathways for escalating workload or role conflicts, and greater scope for managers and workers to adjust work when demands become difficult to sustain.

Poor job conditions are the norm, not the exception

Number of poor job quality dimensions reported by workers (%)²





Risk concentrates in identifiable workforce hotspots

The risks associated with mental ill-health in the workplace are not uniform. The evidence shows important variation by age, gender, and industry. The Monash findings show higher levels of mental ill-health, loneliness and poor job quality among younger workers and in frontline service sectors. These workers tend to be in roles characterised by lower control, less security and greater customer-facing exposure.²

Mental ill-health is highest among younger workers

The prevalence of mental ill-health varies significantly by age. In this cross-sectional analysis, reported mental ill-health peaks among the youngest workers and steadily declines across older age groups. Specifically, 50% of workers aged 16–24 have experienced a mental disorder in their lifetime, and 40% met the criteria in the past year.

Among workers aged 65 years and over, 35% reported having experienced a mental health disorder at some point in their lives. However, recent experience was much less common, with only 9% reporting a mental health disorder in the past year, compared with 40% of the youngest workers.² Several factors may contribute to this pattern.

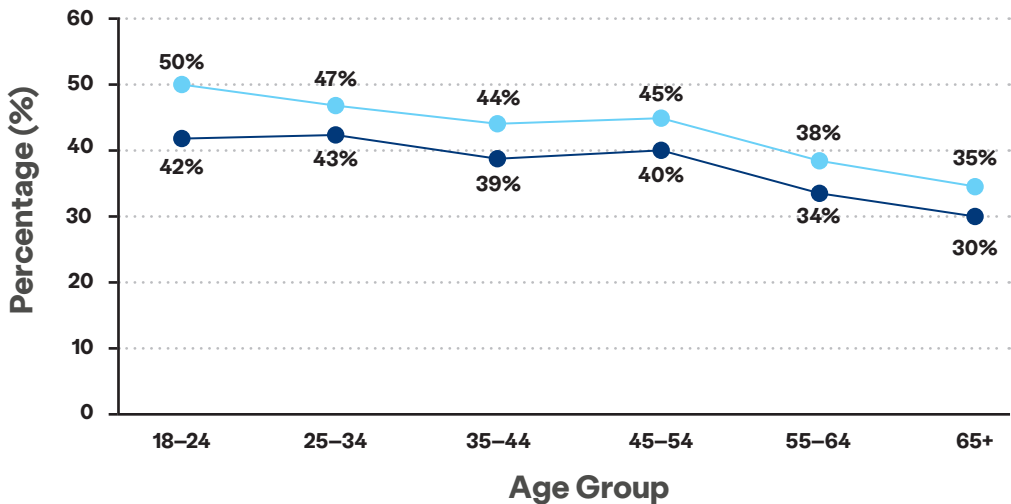
Mental ill-health may genuinely be more prevalent among younger Australians, while lower stigma may also make younger cohorts more willing to recognise and report mental health conditions.

A “healthy worker” effect may be present among older demographics, with some people experiencing poor mental health having already exited the workforce.²

EML findings reflect the national pattern of mental ill-health by age^{2,3}

- Monash analysis of Australian Bureau of Statistics data: percentage of workers with a lifetime mental disorder by age.
- EML 2026 Survey: Employees who have been told by a doctor or other health professional that you have a mental health condition, such as anxiety or depression.

Diagram: Experiencing mental health conditions



EML’s 2026 survey reinforced the age-related patterns reported by Monash, with mental ill-health most commonly reported among younger workers.

Mental health, help-seeking and coping differ by gender

The findings indicate that patterns of mental ill-health, help-seeking and coping differ between women and men. Anxiety (18%) and affective disorders (7%) are the most prevalent types of mental health disorders experienced by workers in the past 12 months. Women show higher prevalence of both anxiety and affective (mood) disorders, while substance use disorders are more prevalent among men (5% compared with 3% among women).²

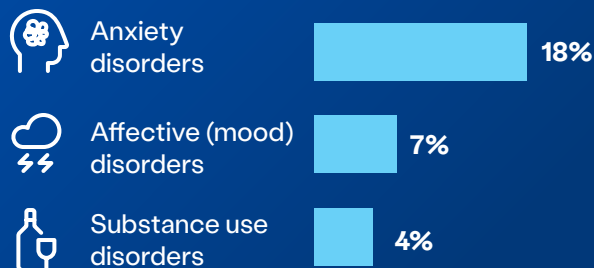


Women are twice as likely as men to have seen a health professional for their mental health and are also more likely to have been dispensed mental health medication. A single pathway to support will not reach everyone equally.²

Women are more likely to seek support from family or friends compared with men (49% compared with 36% of men). Men, by contrast, are more likely to report using drugs or alcohol as a coping strategy (21% compared with 13% of women), a pattern that may carry particular operational implications in high-risk industries.²

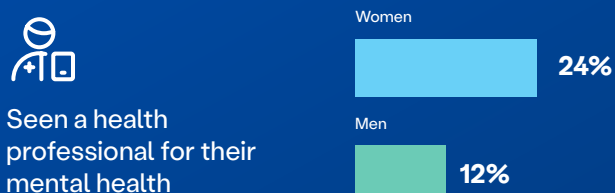
For employers, the implication is that a single pathway to support will not reach everyone equally. Workplace responses need to account for differences in help-seeking and coping, including workers who may be less likely to seek formal support or whose distress may be expressed through potentially harmful coping strategies.

Anxiety is the most prevalent disorder experienced by Australian workers²

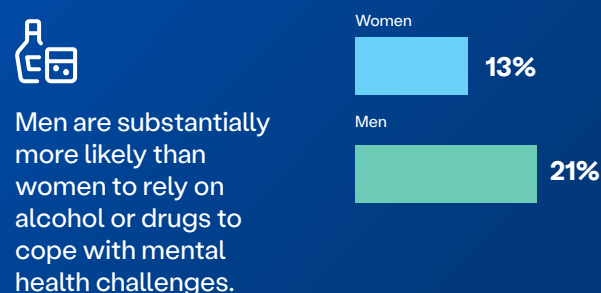


Help-seeking behaviours²

Women actively seek help more than men for their mental health conditions.



Coping behaviours²



Middle management: concentrated pressure and accountability

Within organisations, middle management is emerging as a key area of concentrated risk. **Twenty-two per cent** of managers report losing sleep because of work “often or very often”, compared with 14% of employees without management duties.³ Middle managers often shoulder a

disproportionate share of organisational pressures while having relatively limited control over key decisions, resulting in a significant psychosocial risk burden.

Managers have decision-making authority, but it is often constrained by competing demands from strategy, change and day-to-day operations. The result can be accountability that exceeds control, a combination in which psychosocial hazards accumulate.

Case Study

A Business Manager in a small to medium growing aged care organisation is responsible for multiple priorities across different functions.



The challenge

- Priorities are continually added by multiple stakeholders with differing or conflicting expectations.
- No effective mechanism to deprioritise existing work or resolve competing demands.
- Expectation that AI will create significant productivity gains, without recognition that much of the role involves judgement, stakeholder management and navigating ambiguity.
- Accountable for delivering an expanding portfolio of work but with limited control over workload, priorities or trade-offs.



The result: a high-demand, low-control role

Demands keep growing

More requests, more priorities. More expectations.

Limited control.

Fewer levers to influence priorities, workload or trade-offs.

Sustained pressure.

High accountability. Constant trade-offs. Little reprieve.



The impact

- Sustained stress and mental load.
- Reduced capacity for strategic thinking and decision quality.
- Stakeholder frustration and relationship strain.
- Risk of delays, errors and compliance exposure.
- Burnout risk and turnover of key talent.

What needs to change

1

Align demand and capacity

Introduce transparent prioritisation and realistic workload planning.

2

Clarify decision rights

Define who decides, who approves and who owns the trade-offs.

3

Establish priority mechanisms

Use a structured process to add, assess and deprioritise work.

4

Reduce and simplify where possible

Remove low-value work and simplify process and reporting.

5

Support judgement and stakeholder work

Recognise the complexity of the role and provide real support, not just tools.

Industry risk concentration

Accommodation, food services and retail trade stand out as sectors with a concentration of risk. These industries tend to employ relatively young workforces but also show evidence of risk conditions occurring together. **They combine several work characteristics associated with psychosocial risk at once: customer-facing work, lower control, lower security, irregular hours and less organisational support.**^{2,3}

In these frontline service sectors, the Monash analysis indicated around 27–30% of workers reported mental ill-health in the past year. Sixteen per cent of workers in these sectors reported three or more poor job quality dimensions, compared with 8% overall.²

Younger workforces in frontline service sectors combine several risk conditions²



Customer-facing work



Lower control over work



Lower job security



Irregular/unsocial hours



Less organisational support

The healthcare and social assistance sector stands out as a sector carrying a particularly high burden. Safe Work Australia data shows that it accounts for the highest volume of serious mental health claims nationwide.¹² The burden is compounded by longer claim durations, while the Monash analysis highlights a disproportionately high concentration of psychological injuries and lost working years in this industry.²

The healthcare and social assistance sector experiences a disproportionately high burden¹²



Sustained demands



Low control or support in some roles



Exposure to violence, bullying and trauma



Fatigue and emotional strain

EML's August 2026 survey provides further insight into these workplace pressures. Forty-two per cent of healthcare and social assistance workers reported high demands or workload as a psychosocial hazard.³ Workers in the sector also reported elevated indicators of workload pressure and distress.³ These findings are consistent with exposure to sustained demand and fatigue, lower control or support in some roles, and exposure to violence, bullying, and trauma.^{2,11}

Loneliness: an additional dimension

Loneliness adds a related consideration. Overall, 14% of all workers reported feeling lonely or isolated in the past four weeks. However, this rate more than doubled to 32% for workers with a mental disorder within the previous 12 months.²

Loneliness is also unevenly distributed across the workforce. Among workers aged 16–24 who had experienced a mental disorder in the previous 12 months, 40% reported feeling lonely.²

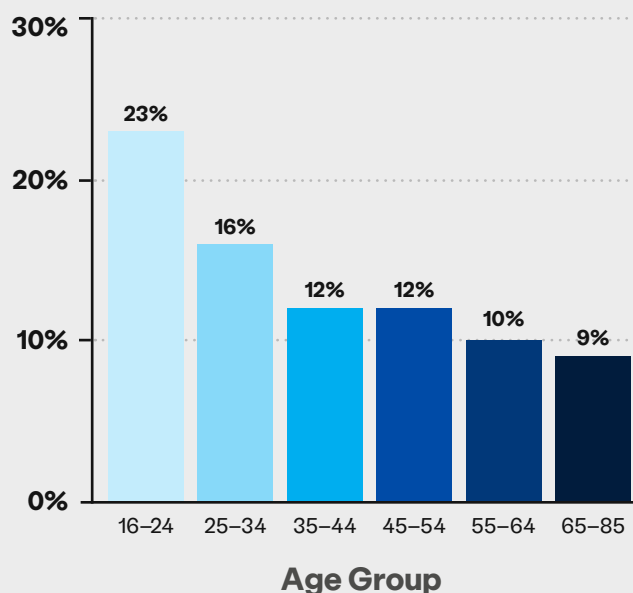
Elevated loneliness is also evident in the more casualised accommodation, food service and retail sectors, where building deeper workplace relationships may be more difficult.²

While loneliness should be treated as an associated experience rather than a proven cause for mental ill-health, the workplace context remains relevant. How work is organised may shape opportunities for connection. Fragmented or transitory roles may offer fewer stable points of contact. Similarly, hybrid and remote work may also reduce opportunities for workplace connection.^{2,13} For employers, the implication is to consider how work design can enhance reasonable opportunities for social connection, particularly for younger workers and those in less stable roles.

While wellbeing initiatives have a role, they are no substitute for minimising harm in the first place by addressing workplace conditions that contribute to psychosocial risk. The priority is to identify where harmful exposures are concentrated and target preventative action accordingly.^{2,7}

Prevalence of loneliness by age group (%)²

Percentage of workers who felt lonely in the past four weeks



Evolving obligations

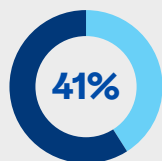
The evolving legal and regulatory context has made the implications of this evidence more immediate. While the underlying duty to manage psychosocial risk is not new, regulatory expectations about how that duty should be met have become more explicit across jurisdictions. Psychological health is increasingly being managed with the same systematic risk-management discipline applied to physical safety. Wellbeing policies, Employee Assistance Programs and annual awareness sessions can provide useful support. They are not, however, a substitute for identifying where psychosocial risk is concentrated and actively addressing the conditions of work that contribute to it.

Consistent with the themes identified in the research, regulators have articulated specific psychosocial hazards, including high job demands, low job control, poor support, low role clarity, poor organisational change management, inadequate reward and recognition, poor workplace relationships, and harmful behaviours such as bullying, harassment and violence.⁷

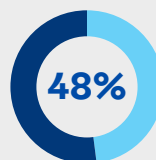
Effective psychosocial risk management requires organisations to identify hazards, assess and control the risks they create, and monitor whether those controls are working.⁷ **EML's August 2026 survey suggests significant gaps across each of these areas, from basic awareness through to formal risk management.**



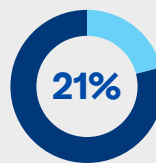
had previously heard the term "psychosocial hazard".³



of managers and leaders were unaware of employers' legal duty to identify and manage psychosocial risks.³



of respondents believed their organisation had effective systems in place to manage psychosocial risks.³



were aware of a formal psychosocial risk assessment undertaken in the previous 12 months.³

Bridging this gap requires a shift from passive awareness to systematic intervention. To meet modern regulatory standards, organisations must move beyond superficial wellbeing initiatives and embed robust, data- driven hazard controls directly into their operational frameworks.

"Although employers and employees frequently recognise factors that impact their own psychosocial wellbeing at work, explicit knowledge of 'psychosocial hazards' remains low. Addressing this vocabulary gap through training could enable organisations to fulfil emerging regulatory requirements and support worker mental health."

– **Dr Michael Di Donato**

Research Fellow, School of Public Health and Preventive Medicine



MONASH
University

Claims are a late, increasingly costly signal

Mental health-related claims have continued to increase in both volume and severity over time. Recent Safe Work Australia data indicated that mental health conditions accounted for 12.2% of serious claims in 2024–25, or 17,900 claims. This represents an increase of 169%, or around 11,300 claims, over the preceding decade, the largest increase of any injury category.⁴

Monash's analysis of the national compensation dataset identifies that claims are concentrated in particular occupations and industries, including public administration and safety, healthcare and social assistance, and education and training.² The leading recorded mechanisms of injury align closely with recognised psychosocial hazards, including work-related harassment or bullying, work pressure, occupational violence and exposure to traumatic events.⁴

Managers and leaders do not expect these trends to change substantially in the near future. In EML's August 2026 survey, 21% expected workers compensation claims for psychological injury in their organisation to increase over the next 12 months. Among those expecting an increase, 42% identified workloads and understaffing as the main factor likely to drive it.³

These claims are also concentrated in industries with elevated psychosocial hazards. Community and personal service workers recorded the highest

Psychological injury mechanisms²



Work-related harassment and/or workplace bullying



Work pressures



Exposure to workplace or occupational violence



Exposure to a traumatic event

occupational rate, at 56 working years lost per 10,000 FTE.² Community-facing sectors account for more than two-thirds of working years lost. This is equivalent to more than 9,000 full-time working years lost in these industries in a single year because of mental health claims alone.²

Community-facing sectors carry the largest burden

More than two-thirds

of working years lost are accounted for by community-facing sectors.²

Equivalent to

9,000+

full-time workers

being absent for an entire year due to mental health claims alone.²

Nationally, mental health conditions account for 17.2% of serious claims among women, more than twice the 8.2% share among men.⁴ Women make up around three-quarters of the health care and social assistance workforce and around seven in ten workers in education and training, two of the leading sectors carrying a substantial mental health claims burden.^{2,14} Evidence suggests that this difference needs to be considered alongside the characteristics of the work itself, including high demands, low control and exposure to psychosocial hazards such as violence, bullying and harassment.² The pattern suggests that gender, occupation and industry can combine to concentrate exposure to psychosocial risk.

Claiming behaviours

While mental health claims have increased in the last decade, EML's August 2026 survey points to a substantial gap between reported work-related mental health harm and workers compensation claims. Only 29% of workers said they would be likely to lodge a workers compensation claim if work seriously harmed their mental health. The most commonly cited reasons for avoiding the claims system were the difficulty proving a psychological injury and fear of career consequences.³

This suggests that even though mental health claims are increasing in number and severity, they capture only part of the broader experience of reported work-related mental ill-health. At the same time, one in five managers or leaders expected their organisation's investment in mental health to increase over the next year, while the majority, around three in five, expected it to remain unchanged.³



Reluctance to lodge a workers compensation claim may be particularly relevant to interpreting claims patterns among younger workers. While the prevalence of diagnosed mental health conditions peaks in younger age groups, younger workers have comparatively low rates of mental health claims.⁴

This divergence may be partly explained by attribution. While population-level data captures mental ill-health regardless of its cause, claims data specifically tracks psychological injuries accepted or recorded as work-related within the workers compensation system. While younger workers might be more reluctant to lodge formal claims, they may also experience different underlying drivers of mental ill-health than their older colleagues. Additionally, higher claim rates among older workers may reflect cumulative exposure to workplace stressors, alongside greater opportunity or confidence to recognise and report work-related mental health impacts.²



29%

of workers said they would be likely to lodge a workers compensation claim if work seriously harmed their mental health.³

Why most workers would not lodge a claim



Difficulty of proving a psychological injury

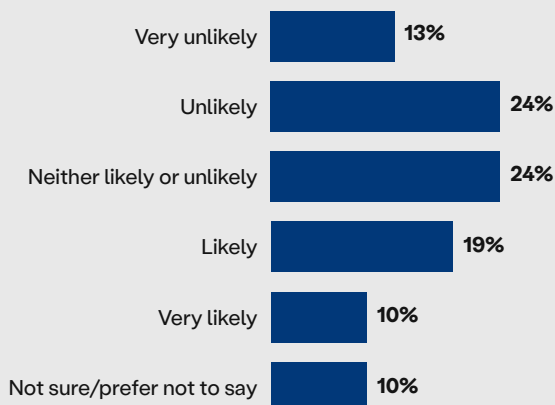
Many workers believe it's hard to prove a mental health injury, with unclear criteria and lack of objective evidence.³



Fear of career consequences

Workers worry a claim could damage their reputation, affect career progression or put their job at risk.³

Compensation claim intent if work harmed mental health



Younger workers Different patterns, different pressures²



-  May be less likely to lodge formal claims.
-  May experience different underlying drivers of mental ill-health.
-  Barriers to claim may include stigma, job insecurity, lack of awareness or confidence.

Older workers Different context, different enablers²



-  Higher claim rates may reflect greater cumulative exposure to workplace stresses.
-  Longer exposure increases the potential impact on mental health.
-  Greater opportunity or confidence to recognise and report work-related impacts.

Scheme settings are also changing, with the nature, extent and maturity of the reform cycle varying by jurisdiction. In New South Wales, workers compensation reforms commenced on 1 July 2026.¹⁵ Victoria has also tightened mental injury eligibility requirements, with changes applying to new mental injuries that occur on or after 31 March 2024.¹⁶ Queensland and Tasmania are also reporting growth in mental injury claims, which tend to involve longer claim durations and higher costs.^{17,18} Queensland has examined these pressures through its statutory scheme review, while Tasmania has identified mental health claims as an increasing source of scheme complexity.

More restrictive compensation scheme settings may reduce growth in accepted claims without necessarily reducing the underlying workplace exposure or incidence of psychological distress. As Monash notes, some of the associated cost and impact may instead shift to other income support systems, such as life insurance and personal illness cover.² EML examined this broader transfer of cost and complexity in its 2026 report, *The Complexity Premium*.¹⁹

How the stories diverge³

1

What gets reported



Many experiences of mental ill-health never become formal claims. Reporting is influenced by stigma, awareness, and confidence.

2

What gets recognised



Not all mental ill-health is recognised as work-related; by individuals, managers, or systems. Recognition shapes whether it becomes a claim.

3

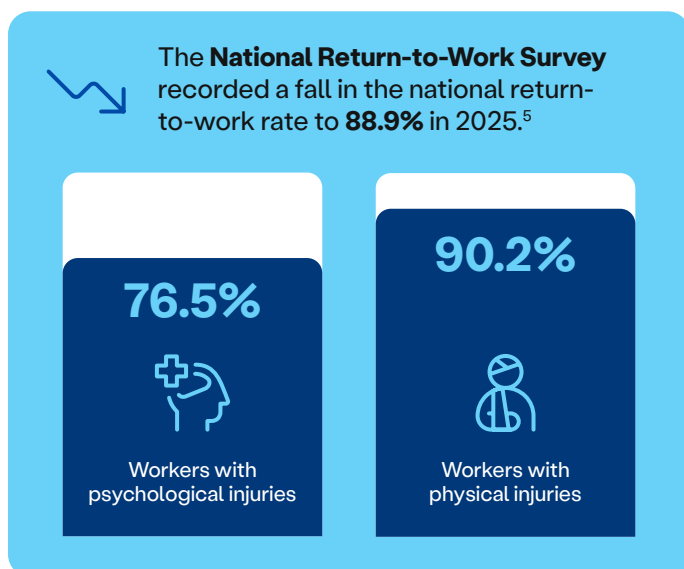
What gets attributed to work



Attribution to work depends on evidence, context and policies; impacting whether a claim is lodged, accepted and supported.

Recovery is also an opportunity for intervention

Return-to-work outcomes have declined nationally, from 91.6% in 2021 to 88.9% in 2025.⁵ Return-to-work outcomes are substantially lower for psychological injuries, with a return-to-work rate of 76.5%, compared with 90.2% for physical injuries.⁴



Mental health claims are associated with substantially higher compensation costs. Safe Work Australia reports median compensation paid of \$68,600 per mental health claim, which is more than four times the median compensation paid for all serious claims.⁴

These costs are compounded by time taken to return-to-work and subsequent wage replacement costs. The median duration of a mental health claim is currently 34.8 weeks, almost five times the median duration for all serious claims and with the implication that half of all claimants were absent from work for 8 months or more.⁴

Distress is not limited to mental health claims. When surveyed, 12% of people with physical injury claims were experiencing severe psychological distress. Secondary psychological injuries that develop during recovery can delay recovery and increase claim costs. The evidence supports earlier identification and appropriate support during recovery, including when the original injury is physical.^{2,20} Early warning signs can also prompt action on the organisational conditions that shape risk, supporting prevention as well as recovery.

These cases may be less visible in the system when their claim remains classified as physical. Classifying claims as either physical or psychological can make psychological distress less visible and reduce recognition of the need for support.²

Monash's analysis found that 56% of severely distressed physical-injury claimants had not accessed a mental health service.²

Addressing this distress often requires action alongside access to clinical services, and employer action early in the recovery process matters. Early contact, return-to-work planning, suitable duties and responsive management are associated with better outcomes, particularly where support begins before a claim is lodged.^{2,20} While improving recovery and return-to-work outcomes remains a priority for mental health claims, addressing workplace conditions that contribute to psychosocial risk through more effective prevention must be an equally clear objective for employers.

56% of workers who have a physical injury and are severely distressed had not accessed a mental health service.²

The claims process itself can influence recovery. Reducing worker uncertainty, particularly regarding key decisions and outcomes, represents a highly modifiable factor associated with secondary psychological injury. Minimising this uncertainty and shortening wait times are therefore important, as recent Australian research links both factors to poorer mental health outcomes and a negative claim experience.^{2,20}

To help address these challenges, the Monash analysis notes an industry shift toward specialised psychological claims teams equipped with reduced caseloads, trauma-informed training, and early intervention frameworks.² It also identifies an opportunity to offer early psychological support within physical injury claims where distress is identified. Claims involving workplace conflict, including bullying and harassment, are a primary focus of EML's Recovery Pathways program.⁶



Case Study

Recovery Pathways

An EML innovation: Early intervention that drives better outcomes



In July 2024, EML launched Recovery Pathways in New South Wales, providing early intervention support from Recovery Pathways Specialists trained in mediation and conflict resolution for psychological injury claims involving workplace conflict, the leading recorded mechanism in mental health claims. The specialists work alongside case managers, workers and employers to help resolve conflict, facilitate early access to treatment and address barriers to return-to-work.



An independent actuarial review by Finity Consulting in 2026 found evidence that participation in the program was associated with a statistically significant (7.5 percentage-point) improvement in return-to-work at 12 months.⁶

“There is evidence that the Pathways Program leads to statistically significant improvement in work capacity.”



What good looks like: priorities for action

For employers, the evidence points to a clear agenda. Organisations should design healthier work, equip managers to respond well, and build recovery systems that identify psychological distress and appropriately match responses early.

Design healthier work

Reducing avoidable demand matters, but in many roles greater control may also provide an important point of intervention.

Finding ways to provide reasonable control to employees should be a key element of job design.

Enabling clearer decision rights, providing autonomy over scheduling, sequencing work better, resourcing realistically, reducing conflicting priorities, providing reliable escalation, and ensuring managers have the capacity to modify work early. Small changes to work design can have meaningful effects, including in roles where the scope for change is constrained. As noted in the Monash analysis, Curtin University's Design for Care project provides one example. In the project, aged care staff began using central whiteboards to display resident updates and daily tasks. This simple action made priorities and responsibilities more visible across the team. The change immediately improved team communication, autonomy and efficiency, and formed part of a job-design process associated with reduced burnout over the following year.²⁴

Hazard	Objective	Practical Control
 High job demands	Sustainable workload	Review resourcing, priorities, deadlines and workload allocation; monitor demand and capacity; build mechanisms to redistribute work and respond to peak periods
 Low job control	Appropriate autonomy and influence	Clarify decision rights, increase employee influence over how work is planned and delivered, and enable decisions at the lowest appropriate level
 Poor support	Supportive work environment	Build practical manager capability to provide support, coaching and regular check-ins; strengthen peer support networks; establish clear pathways for advice, escalation and issue resolution
 Poor role clarity	Clear job accountabilities and performance expectations	Clarify roles, responsibilities, accountabilities, priorities, performance expectations and decision-making authority
 Bullying, harassment and violence	Safe and respectful workplace	Set and reinforce behavioural standards, provide psychologically safe reporting pathways, investigate concerns promptly, and apply consequences consistently
 Job insecurity	Reduce damaging workforce uncertainty	Communicate organisational changes early, provide transparency about workforce planning, and maximise employment certainty where reasonably practicable

Equip and support managers well

Managers directly shape the daily employee experience of workload, control, support and role clarity. They are also well positioned to notice early behavioural changes in distressed team members. A randomised controlled trial in Fire and Rescue NSW found that providing managers with just four hours of mental health training was associated with a reduction in work-related sickness absence by an average of 6.45 hours per employee over the following six months, with a reported return on investment of ten dollars for every dollar spent.²¹

Recent Australian research emphasises that a supervisor's response to mental health disclosures is critical.² Given that people managers often experience substantial workplace pressure themselves, supporting them to respond effectively requires targeted attention to their own psychological safety. Manager capability must extend beyond merely recognising warning signs. Leaders require personal support alongside the practical authority, organisational systems, and tools necessary to redesign work and confidently navigate early conversations.^{2,7,12}

Identify psychosocial risk and match the response

Managing psychosocial risk is both a regulatory responsibility and a strategic organisational priority, and effective management requires more than a compliance-led approach.⁶ Recent Institute for Work and Health research describes a shift from a focus on individual resilience toward organisational structures, and an "organisational readiness" approach that prioritises senior management commitment and worker participation over prescriptive hazard checklists.²²

Proactively identifying and mitigating these hazards can support better organisational outcomes, including productivity, work quality, and safety. The survey highlights the contrasting role work can play in mental health: 32% of participants said work had a positive impact on their mental health, while the same proportion reported a negative impact.³

Validated tools can support the process when assessment leads to work redesign and follow-through. Examples include the Psychosocial Safety Climate (PSC-12) measure, which provides one way to assess organisational conditions for psychological health and safety.²³ Australian Public Service agencies can also draw on the ADDRESS model (Autonomy, Define, Demands, Recognition, Exposure, Support and Strengths) to identify and respond to psychosocial hazards.²⁵

To optimise long-term outcomes, employers should take an integrated approach across prevention, early intervention and recovery.

Australia's National Workplace Initiative supports this strategy: protect people from work-related harm,

promote positive mental health through good work, and respond effectively when mental health concerns arise.⁸

From awareness to design

The task now is to translate awareness into better work design, evidence into earlier action, and claims experience into stronger prevention and recovery, applying what we know through everyday decisions that make work safer, support recovery and strengthen organisational performance.

A structured approach is required across three distinct stages: primary prevention, early intervention, and recovery and rehabilitation.^{7,8,20}



Primary prevention (addressing the source)

Effective management relies on proactively addressing work conditions that create or increase psychosocial risk, rather than waiting to respond after issues emerge.



Early intervention (responding to distress)

Because many employees may not disclose mental health concerns, early support systems cannot depend solely on formal disclosure. Recognising signs of distress and acting promptly may help reduce long-term operational and personal risks.



Recovery and rehabilitation (supporting return-to-work)

For individuals experiencing established mental ill-health, physical workplace injuries, or absence, providing good work and effective recovery support remains vital.^{8,21} At this stage, optimising outcomes requires proportionate distress checks and tailored, modified duties.



What employers should do next

For employers, this report offers important insights for action. It provides evidence-based indicators into where psychosocial risk is concentrated, what may be driving mental health-related claims and absences, and why some cases escalate or persist. These insights can help organisations strengthen prevention strategies, target resources effectively and focus on the workplace factors most likely to influence outcomes. Importantly, the findings encourage organisations to look beyond claims data alone. By combining claims and absence trends with a deeper understanding of work design, workforce exposure and recovery capability, employers can identify opportunities to act earlier, address risk at its source and create healthier workplaces.

The evidence also creates an opportunity to move the conversation upstream. Claims and absence evidence remains important, but it can be read alongside information about work design, workforce exposure and recovery capability to identify where action may be possible before harm becomes entrenched.^{7,12}



Employers can change the trajectory. The right questions can help minimise harm, strengthen recovery and reduce the human and financial cost of psychological injury.



Move the conversation earlier



Knowing the language of psychosocial risk is not enough. The task for employers is to move from awareness into effectively identifying, assessing and controlling risks at work.

Claims data is a lagging and incomplete indicator of workplace health. Used alone, it provides an incomplete picture: claims generally capture harm after it has emerged and do not capture workers who leave without making a claim.

Psychosocial hazards such as high workload, low control, poor support, and harmful behaviours may accumulate over time. Consequently, by the time a psychological injury appears in claims data, the contributing conditions may have been present for some time.

Claims data captures only part of the workforce experience. Not all workers experiencing mental ill-health make a workers compensation claim, and workforce impacts may also be reflected in turnover and other employment decisions. Survey findings indicate that one-third of workers reported having left a job due to mental health impacts, and nearly half reported that they would accept a pay cut to transition to a psychologically safer role.³



Measure and analyse what matters

Workers compensation claims provide a lagging measure of psychological injury. It's important that employers complement claims data with proactive workplace signals. A more complete picture can be built by considering two complementary types of information:

- **Leading indicators (work-design information)**

Clients should use work-design data as early warning signals. This can include where high demand, low control, poor support, customer exposure, violence, bullying, trauma or insecure work are combining in ways that may increase psychosocial risk. Additionally, administrative data on absenteeism and turnover can provide complementary organisational signals which, when considered alongside work-design and claims data, may help build a more complete picture of emerging psychosocial risk.

- **Lagging indicators (claims optimisation data)**

Claims data can complement these leading indicators by showing where harm has occurred and where patterns may warrant closer examination. This involves drilling down into claim duration, mechanism, frequency, concentration, and recovery trajectories to identify opportunities to strengthen prevention and recovery.

Ultimately, the analytical focus must shift from diagnosing what has already produced a claim to evaluating what the broader workforce evidence suggests is actively developing before a claim occurs.



Identify concentration

To implement targeted and effective prevention, advisers should look beyond broad, organisation-wide mental health policies and identify where psychosocial risks are concentrated. National evidence underscores that risk is unevenly distributed across the workforce, revealing that the specific groups and work settings experiencing the highest mental health burdens are not consistently the same as those driving the greatest compensation costs.²

Consequently, relying on a generic, company-wide well-being score may obscure these variations. By synthesising structural demographic data, such as occupation, industry, and age, with operational and behavioural indicators like work design, absence, attrition, and claims experience, advisers can identify concentrations of risk that may otherwise be obscured. This support targeted intervention at the roles, teams or work environments where risk is concentrated, rather than reliance on uniform organisation-wide initiatives.



Improve recovery capability

From an employer perspective, effective recovery depends on both the quality of the return-to-work plan and how early and effectively it is executed. To support this process, employers may engage with advisers or consultants to review their recovery frameworks while allied health providers provide clinical and functional insights to ensure planning and contact occur early, suitable duties are genuinely workable, and psychological barriers are identified and addressed.

The potential value of this targeted, early intervention is illustrated by EML's Recovery Pathways program, which intervenes early to address workplace conflict and was associated with improved 12-month return-to-work outcomes.⁶

Ultimately, employers can consider how early support is structured within a claim, whether it addresses identified barriers to recovery, and measure long-term outcomes where appropriate.



Clarify the roles in prevention and recovery

Different participants bring different levers and skills to prevention and recovery. Employers have the most direct influence over work design and culture, while insurers and claims partners can support recovery and provide insight into emerging risk patterns.

Employers can draw on support from brokers, risk consultants and other advisers to better understand where action is needed, what sits within their control, and where external expertise may add value. This can help organisations identify risks earlier, strengthen prevention efforts and reduce the likelihood of distress progressing to prolonged absence or a more complex recovery.



Conclusion

Workplace mental health is shaping whether people stay, leave, disclose concerns or seek support, yet much of its impact remains hidden through presenteeism, undisclosed leave and turnover. Risk is concentrated where high demands combine with limited control, poor support or other psychosocial hazards, while claims provide only a late and incomplete signal.

The next phase of workplace mental health requires more than awareness. It requires organisations to translate evidence into everyday decisions about how work is designed, managed and supported. For employers, insurers, advisers and recovery partners, the practical challenge is to use the information and tools available to identify risk sooner, intervene more precisely and measure whether action is making a difference.

Better work design, stronger risk management and earlier support will not remove every source of mental ill-health. They can, however, reduce avoidable harm, strengthen recovery and create healthier, more sustainable workplaces. The evidence is clear enough to support action. The priority now is to apply it.

About this edition and its evidence

This Insights Report is the first in a planned series of annual updates building on EML's 2025 report, *Inside the Minds of Australia's Workplaces: Evidence, insight, and collective action for better mental health outcomes*. That report considered the scale of workplace mental ill-health and its implications for people, risk and performance. This update focuses on where mental ill-health is concentrated, how work design can influence risk, what happens when mental ill-health becomes a workers compensation claim, and the factors associated with better recovery outcomes.

The findings attributed to Monash in this report are drawn from analysis by Monash University's Healthy Working Lives Research Group of four national datasets: the Australian Bureau of Statistics' National Study of Mental Health and Wellbeing; the Household, Income and Labour Dynamics in Australia (HILDA) Survey; the National Dataset for Compensation-based Statistics; and the National Return-to-Work Survey.² The National Study of Mental Health and Wellbeing is new to this update, extending the analysis beyond job quality and compensation claims.

Where official Safe Work Australia statistics are available, particularly for claim volumes, durations and costs, and for return-to-work rates, this report cites those published figures and notes any material difference. Throughout, this report distinguishes between findings drawn from the Monash analysis, evidence drawn from external sources, and EML's own interpretation and recommendations.

Recovery evidence includes an independent actuarial review of EML's Recovery Pathways program, commissioned by EML and conducted by Finity Consulting.⁶ The pilot program was not implemented as a randomised experiment, so the evaluation used statistical methods to adjust for observed differences between participating and comparison claims. Finity's estimate assumes no unmeasured factors influence program referral or return-to-work outcomes. The findings reflect program-level experience in a single jurisdiction and complement, rather than replace, the population-level evidence.

The report also includes new workplace research commissioned by EML and conducted by Taverner Research Group in August 2026.³ It comprises a survey of 4,065 Australian workers, and a companion survey of 831 Australian managers and leaders directly responsible for five or more employees. The findings reflect self-reported experiences and perceptions and are presented as indicative, not population estimates.

The evidence base

Survey (National coverage)

Data set

When

1

EML's 2026 Survey

Annual survey of Australian workers, managers and leaders on mental health and workplace support.

4,065
workers

831
managers and
leaders



2026

2

National Study of Mental Health and Wellbeing (NSMHW)

National household survey providing a comprehensive picture of mental health, wellbeing and service use.

30,586
people

~20,000
employed
persons



2020–2022

3

Household, Income and Labour Dynamics in Australia (HILDA) Survey

Longitudinal survey tracking the economic and social wellbeing of Australians. The sample described in this report is of persons who were employed at the time of the survey.

15,987
people



2023

4

National Dataset for Compensation-Based Statistics (NDS)

National workers compensation claims data covering accepted claims.

1,331,155
claims



2018–2024

5

National Return-to-Work Survey (NRTWS)

National survey of workers with recent work-related injury about recovery and return-to-work.

13,333
workers



2018, 2021,
and 2025

Glossary

Absenteeism	Absence from work due to illness, injury or other unplanned reasons. In this report, absenteeism includes time away from work associated with mental ill-health.
Disability day	Days when a person's mental health limits or prevents them from carrying out their usual activities. Disability days are not equivalent to days absent from work, as they can include non-workdays and days when usual activities are restricted rather than completely prevented.
FTE (Full-Time Equivalent)	A standardised measure of workforce size based on hours worked. It converts part-time and casual work into the equivalent number of full-time workers.
High job demands	Aspects of work that require sustained physical, cognitive or emotional effort. Examples can include excessive workloads, time pressure, competing priorities, emotionally demanding work and insufficient resources.
Job control	The level of influence workers have over how, when and in what order their work is performed. This can include control over scheduling, task sequencing, work methods, breaks and decisions affecting their role.
Job design	The way tasks, responsibilities, relationships and working conditions are structured. Good job design seeks to balance organisational needs with workers' capacity, control, support and safety.
Leading indicators	Information that may help identify emerging psychosocial risk before harm or a claim occurs. Examples include workload, job control, absenteeism, turnover, exposure to harmful behaviours and employee feedback.
Mental health claim	A workers compensation or insurance claim involving a mental health condition or psychological injury that is accepted or recorded as work-related under the relevant compensation scheme.
Mental health condition	A broad term for conditions that affect a person's thoughts, emotions or behaviour. In this report, the term may include diagnosed anxiety, affective or mood, and substance-use disorders.
Mental ill-health	A broad term covering mental health difficulties ranging from psychological distress to a diagnosable mental health condition. A person may experience mental ill-health while continuing to work and manage usual responsibilities.
Poor job quality	Work characterised by one or more potentially harmful conditions, such as high demands, low control, limited use of skills, low variety or low job security. Multiple poor-quality conditions may occur together and compound psychosocial risk.
Presenteeism	When a person continues working while experiencing illness or poor mental health but cannot perform at their usual capacity. Presenteeism may affect productivity, concentration, safety and overall workforce capacity.
Psychological distress	Emotional or mental strain that may include symptoms such as anxiety, low mood, restlessness or difficulty coping. Psychological distress does not necessarily indicate a diagnosed mental health condition.
Psychological injury	A mental health condition caused or aggravated by work. In a workers compensation context, eligibility and terminology vary according to the applicable legislation and scheme requirements.
Psychological safety	A workplace condition in which people feel able to speak up, raise concerns, ask questions or seek support without fear of humiliation or adverse consequences.
Psychosocial hazard	A hazard arising from the design or management of work, the working environment, workplace interactions or behaviours that may cause psychological or physical harm. Examples include high job demands, low job control, poor support, bullying, violence and exposure to trauma.
Psychosocial risk	The risk of harm arising from exposure to one or more psychosocial hazards. The level of risk can be influenced by the nature, duration, frequency and combination of those exposures.
Return-to-work	The process of supporting a worker to resume work following an injury or illness. This may involve returning to the same or modified duties, hours, role or workplace.
Secondary psychological injury	Psychological distress or a mental health condition that develops during recovery from another injury, including a physical injury. It can delay recovery and increase claim complexity and cost.
Serious claim	A compensation claim involving an accepted condition that results in at least one working week of time lost, excluding fatalities and journey claims, in accordance with the definition used in national workers compensation statistics.
Working years lost	A measure of the total time lost from work due to compensated injury or illness, expressed as full-time equivalent years. It reflects both the number and duration of claims. The previous report used this definition to connect claim frequency and duration in a single measure.

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