

Workplace Adjustments Policy

Version 1.1

This policy applies to:

- All employees covered by the National Disability Insurance Agency Enterprise Agreement 2024-2027 (NDIA EA): full time, part-time, casual (irregular/intermittent), ongoing, non-ongoing.
- All Senior Executive Service employees (SES).

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1. Principles

- 1.1. The NDIA strives to be a world-leading employer of choice and a leading employer for access and inclusion.
- 1.2. The NDIA is committed to ensuring its culture and work practices role model and exemplify an inclusive and diverse workplace that is reflective of the community the Agency serves. This includes enabling people with disability, illness and injury to participate in and contribute their best in the workplace.
- 1.3. All requests for workplace adjustments will be handled in a sensitive and collaborative manner. Where a request cannot be facilitated, the NDIA will endeavour to provide alternative solutions to support you.
- 1.4. This policy is to be read in conjunction with the [Disability Discrimination Act 1992 \(external\)](#) (DDA). The [NDIA HR delegations](#) contains the authorisations for decisions and determinations.
- 1.5. You may be entitled to request a review of decisions and/or actions as per the [NDIA Review Rights Policy](#).

2. Workplace Adjustment entitlement

- 2.1. A workplace adjustment is any form of assistance or adjustment that is necessary, possible and reasonable, to reduce or eliminate barriers at work.
- 2.2. The NDIA provides workplace adjustments to ensure the workplace is accessible and inclusive where you have a disability, illness or injury.
- 2.3. Where it is identified that workplace adjustments are required, the adjustments may further support and empower you to:
 - perform your duties;
 - be considered for transfer, promotion, training or other employment opportunities;
 - access workplace facilities; and
 - participate in work-related programs.

- 2.4. Your request for workplace adjustments will be considered; however, in some cases it may not be reasonably practicable to provide the workplace adjustment as they have been requested. Where your requested workplace adjustment cannot be supported, the NDIA will work with you to find an alternative solution.
- 2.5. Your manager will provide you with support by discussing your needs and implementing your approved workplace adjustments.
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3. Types of Workplace Adjustments

- 3.1. There is no exhaustive list of what types of workplace adjustments you may require. There are many types of disabilities, illnesses and injuries and they affect people in individual ways. Your adjustment needs will be considered individually.
- 3.2. Some examples of different types of workplace adjustments that allow you to do your job safely, access career development opportunities and be included in all aspects of the workplace may include:
- Modification to your physical workplace
 - o Modifications on how you enter, engage with, and exit your workplace, which includes under normal working conditions and during an emergency,
 - o Modifying design of your workstation to accommodate carers, assistants, assistance animals and/or disability aids,
 - o Modifying design to prevent manual handling.
 - Modification to workplace equipment
 - o Modifications to ensure you can access necessary emergency and welfare facilities,
 - o Providing you with assistive technology.
 - Modifying your work environment
 - o Facilitate rest and recovery,
 - o Support sensory requirements.

- Presentation of information
 - Present information in way that is accessible for screen readers.
- Job or task modification
 - o Rostering and scheduling.
 - o Work organisation.
 - o Remote working arrangements.
 - o Working from home arrangements.

4. Recruitment and Workplace Adjustments

- 4.1. To maintain and continue to build a truly inclusive and culturally capable organisation, it is fundamental the NDIA supports employees of all diversity groups, beginning with recruitment processes.
- 4.2. The Agency and any accredited recruitment partners the Agency may engage, will consider all workplace adjustment requests to support every candidate's equitable participation in NDIA recruitment processes.
- 4.3. Further information about how the NDIA supports diverse recruitment is provided on the [Inclusive Recruitment](#) intranet page.

5. Support

- 5.1. Getting the right support is important. You and your manager can:
 - Contact the [P&C Service Desk](#) for advice on workplace adjustments, access and inclusion,
 - Access confidential counselling from the [Employee Assistance Program \(EAP\)](#),
 - Have a [support person](#) present during workplace discussions.

6. Accessing Workplace Adjustments

- 6.1. You are to advise your manager if you require workplace adjustment(s).
- 6.2. In line with the NDIA's culture and values, and the [Disability Discrimination Act](#), your manager must speak with you about what workplace adjustments you may need to perform your duties, if your manager observes, has knowledge of, or is informed that you may have disability.
- 6.3. To support you where you have identified a requirement for a workplace adjustment(s), your manager and/or the Workplace Support or Disability Support Team will consult with you, and your representatives and other duty holders as applicable.
- 6.4. Where additional support is required to explore your workplace adjustments requirements, either yourself or your manager can contact the [P&C Service Desk for further assistance](#).
- 6.5. Some adjustments may require formal assessment. If you are an APS employee, these requests must be submitted to the Workplace Support or Disability Support Team via the [P&C Service Desk](#) (WHS and Workplace Support options). If you are a labour hire worker, please refer to section 11 below.
- 6.6. If you have been provided with workplace adjustments in the office, these will need to be replicated at home, where there is a [working from home](#) agreement in place. Maintaining any required home office equipment is your responsibility. The NDIA may provide you with equipment, this will be considered on a case-by-case basis. Your manager and the Disability Support Team or Workplace Supports Team should be consulted in the first instance regarding provision of equipment for your home office, to assist in assessing the suitability of the provision of equipment. To initiate discussions regarding this, you can submit a query through the [P&C Service Desk](#).
- 6.7. It is your responsibility to confirm that adjustments have been made in your home as required. In some circumstances, the [Job Access Employment Assistance Fund \(external\)](#) may provide funding assistance. Please refer to the Working from Home Procedure for further information.

7. Considering Adjustments

7.1. In deciding whether to approve a workplace adjustment, your manager, supported by the Workplace Supports Team or Disability Support Team, will consider all relevant circumstances, including but not limited to:

- How it benefits you in your role,
- Identification of barriers preventing you from doing your job,
- How the adjustment might affect you, others and the Agency,
- Identification of any potential workplace health and safety hazards and risks to you, and others, associated with implementing an adjustment or not implementing an adjustment. Including eliminating or minimising risks or hazards as far as is reasonably practicable,
- Ensuring the provision, maintenance, and access of workplace facilities, such as toilets, drinking water and washing facilities,
- The inherent requirements of your role and whether you will be able to meet those requirements with the assistance of the workplace adjustment,

The Agency's obligations under the [Work Health and Safety Act 2011 \(external\)](#), and

- The cost, including the proper use and management of public resources under the [Public Governance, Performance and Accountability Act 2013 \(external\)](#).

7.2. A failure to make reasonable adjustments for you, including those categories outlined above, if you have a disability, may constitute direct or indirect discrimination (the precise definitions of which are set out in the Disability Discrimination Act 1992).

7.3. If your proposed adjustments are considered unreasonable to implement, your managers will discuss this possibility with you. Your manager must seek support and advice through the [P&C Service Desk](#) before declining your request for workplace adjustments.

- 7.4. In very limited cases, where you are unable to perform the inherent requirements of your role and no adjustment can reasonably be made to allow you to perform the core requirements of your role, your manager or the Workplace Supports Team or Disability Support Team will consult with you in relation to alternative work options. You can contact the [P&C Service Desk](#) in the first instance for assistance. For completeness, it may not be unlawful discrimination to terminate your employment or engagement if it is found that you cannot perform the inherent requirements of your role either:
- after workplace adjustments have been implemented; or
 - where no workplace adjustments can be implemented.
- 7.5. Should you wish to have the outcome of your Workplace Adjustment request reviewed, you can do so through the [Review Rights process](#), or through an informal process. The informal process will involve teams within People, Culture and Wellbeing Division reviewing the matter with the goal of resolution or provision of alternative supports. To initiate an informal review, please submit a ticket to the Workplace Support or Disability Support Team via [P&C Service Desk](#).

8. Timeframes

- 8.1. The NDIA aims to provide you with your workplace adjustments as quickly as possible.
- 8.2. Decisions about requests for workplace adjustments will be notified in writing within 21 calendar days, by either your manager or the Workplace Support or Disability Support Team.
- 8.3. Due to the complex nature of some workplace adjustment requirements, additional time may be required to consider your requests. In these cases, the NDIA will organise your approved adjustments as soon as practical. You and your manager will also be updated periodically as the workplace adjustments are being considered and implemented where applicable.

9. Reviewing Adjustments

- 9.1. You and your manager should review your workplace adjustments regularly to ensure they are properly implemented and continue to be appropriate for your needs.
- 9.2. The Workplace Support and Disability Support Teams will ensure that any control measures introduced to eliminate or minimise any health and safety risks associated with your adjustments are properly maintained and remain effective, as far as is reasonably practicable. This will include ensuring any such measures are fit for purpose, suitable for the nature and duration of your work, and installed, set up and used correctly.

10. Labour Hire Workers

- 10.1. If you are a labour hire worker (LHW), you should discuss your request for workplace adjustments with your employer (labour hire agency). Your employer should liaise with the relevant NDIA manager on the best way to support you in the workplace.
- 10.2. Your employer is responsible for the provision of your workplace adjustments. For further information, please refer to the Labour Hire Workers: Terms of Assignment or Contract intranet page.
- 10.3. The NDIA will provide workplace adjustments such as basic headsets, networked devices including Laptops and iPads, standard ergonomic chairs, sit/stand workstations and Assistive Technology Software e.g., JAWS, Dragon Naturally Speaking, Zoomtext, Read and Write, Openbook.

11. Suitable Evidence, Document Storage and Privacy

- 11.1. You may need to provide medical evidence to support your request.

- 11.2. You should keep a record of your approved workplace adjustments. The [Workplace Adjustment Passport](#) is the NDIA's endorsed tool that allows you to record your workplace adjustments. The Passport also supports the continuation of agreed workplace adjustments in the event your role or manager changes.
- 11.3. You should take physical adjustments, such as equipment, when moving to a new position within the Agency. If the cost for the equipment has been reimbursed to the Agency through the [Job Access Employee Assistance Fund \(external\)](#), the equipment belongs to you.
- 11.4. The storage and use of your personal information is consistent with the [Australian Privacy Principles \(external\)](#).
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12. Definitions

- 12.1. **Assistant** - the DDA defines assistant in relation to a person with a disability, as one of the following who provides assistance or services to the person because of the disability: a carer; an assist; an interpreter; a reader.
- 12.2. **Assistance animals** - the DDA defines an assistance animal as a dog or other animal that is accredited under a law of a State or Territory that provides for the accreditation of animals trained to assist a person with a disability or accredited by an animal training organisation, and trained to assist a person with a disability to alleviate the effect of the disability and to meet the standards of hygiene and behaviour that are appropriate for an animal in a public place.
- 12.3. **Carer** - the DDA defines carer in the same way as an **Assistant**.
- 12.4. **Direct discrimination** - occurs when a person who has, or is alleged to have, a disability is treated less favourably than a person without that disability would be treated in the same or similar circumstances.
- 12.5. **Disability** - the DDA defines disability as:
- Total or partial loss of the person's bodily or mental functions; or
 - total or partial loss of a part of the body; or
 - the presence in the body of organisms causing disease or illness; or

- the presence in the body of organisms capable of causing disease or illness; or
- the malfunction, malformation or disfigurement of a part of the person's body; or
- a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction; or
- a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour.

12.6. And includes a disability that:

- presently exists; or
- previously existed but no longer exists; or
- may exist in the future (including because of a genetic predisposition to that disability); or
- is imputed to a person.

12.7. To avoid doubt, a disability that is otherwise covered by this definition includes behaviour that is a symptom or manifestation of the disability.

12.8. **Disability aid** - the DDA defines a disability aid in relation to a person with a disability, as equipment (including a palliative or therapeutic device) that is used by the person and provides assistance to alleviate the effect of the disability.

12.9. **Discrimination in relation to carers, assistance animals and disability aids** - the DDA applies in relation to having a carer, assistant, assistance animal or disability aid in the same way as it applies in relation to having a disability, such that any obligation to do something because of a disability applies to a person who has a carer, assistant, assistance animal or aid (unless a specific exemption applies).

12.10. **Indirect discrimination** - indirect discrimination occurs when a policy, practice or procedure is established to apply to all and the impact or

outcome of that policy, practice or procedure unintentionally disadvantages a person with a disability.

- 12.11. **Inherent Requirements** - are the essential activities and tasks that must be carried out to get a job done. Inherent requirements relate to results, or what must be accomplished rather than means, or how it is accomplished.
- 12.13. **Unjustifiable hardship** - the DDA does not explicitly define unjustifiable hardship but does provide some guidance for decision-makers. To determine if a workplace adjustment would incur unjustifiable hardship for the NDIA, the worker's manager and/or the [Workplace Supports](#) and Disability Support Teams must take account of all relevant circumstances of each case, including the:
- nature of the benefit to or disadvantage suffered by any worker,
 - effect of the worker's disability,
 - financial circumstances, and estimated amount of expenditure required to be made, by the NDIA, and
 - the availability of financial and other assistance to the NDIA.

13. Other Relevant Information

- 13.1. Other relevant to this entitlement can be found in the following documents:
- [Public Service Act 1999](#)
 - [Fair Work Act 2009](#)
 - [Disability Discrimination Act 1992](#)
 - [Safety, Rehabilitation and Compensation Act 1988](#)
 - [Safety, Rehabilitation and Compensation Regulations 2019](#)
 - [Privacy Act 1988](#)
 - [Public Service Regulation 3.2\(2\)](#)
 - [Work Health and Safety Act 2011 \(Cth\)](#)
 - [WHS Regulations](#)
 - [APS Values, Employment Principles and Code of Conduct](#)

14. About this Policy

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- 14.1. The Agency will review this policy within 12 months of the policy commencement date.



The content of this document is **OFFICIAL**

Early Intervention, Rehabilitation and Return to Work: A Guide for Case Managers

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Document Control

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2. Purpose

This guide outlines best practice processes to support National Disability Insurance Agency (NDIA) employees, following an incident, illness or injury. The information is to be used as a guide only and is designed to complement the knowledge and experience of Rehabilitation Case Managers (RCMs).

3. Who does this guide apply to?

This guide applies to Rehabilitation Case Managers, who are part of the People and Culture Division, and who are responsible for providing workplace supports to employees of the NDIA. This includes early intervention supports and the management of compensation claims.

4. What legislation is relevant to this guide?

The information contained in this guide is based on the responsibilities of the NDIA under the following legislation:

- *Public Service Act 1999 (PS Act)*
- *Safety Rehabilitation and Compensation Act 1988 (SRC Act)*
- *Superannuation Act 1976*
- *Superannuation Act 1990*
- *Superannuation Act 2005*
- *Fair Work Act 2009*
- *Privacy Act 1988 (Privacy Act)*
- *Work Health and Safety Act 2011 (WHS Act)*
- *Disability Discrimination Amendment Act 2002*

5. Review of employment actions

Employees should speak to their manager in the first instance, where appropriate, in relation to employment related decisions and actions.

Employees can also contact People and Culture's Safe and Respectful team, where appropriate. Employees may be entitled to request a review of decisions and/or actions as per the NDIA [Review Rights Policy](#).

People and Culture Division can provide support and assistance to both employees and managers involved in a review process.

6. Rehabilitation Management Systems

6.1. Rehabilitation Management System

A Rehabilitation Management System (RMS) is the framework of processes and procedures used to ensure that an organisation can achieve its rehabilitation objectives.

A RMS includes a documented statement of senior management's commitment to provide effective rehabilitation to their employees. It assesses the employer's performance against rehabilitation objectives and is used to inform strategic direction. A RMS will help the NDIA to:

- Assist injured employees to achieve a durable return to work (RTW).
- Recognise and strengthen successful steps in workplace rehabilitation.
- Demonstrate compliance with relevant legislation.
- Recognise and understand compliance obligations.
- Provide effective rehabilitation arrangements.
- Promote continuous improvement.
- Ensure good communication with employees.
- Provide for internal and external accountability.
- Put adequate control structures in place to manage risk.

6.2. Audits

The NDIA will undertake audits of the Rehabilitation Management System (RMS) as required by the guidelines.

Further information can be found in the RMS Audit Procedure.

6.3. Rehabilitation Authority

Under the SRC Act, the CEO is the rehabilitation authority for employees who have suffered a workplace illness or injury.

Under section 41A of the SRC Act, the rehabilitation authority (CEO) delegates in writing all or any of its functions and powers under Part III to an officer or person employed by the rehabilitation authority's employer.

6.4. Workplace Rehabilitation Provider

A Workplace Rehabilitation Provider (WRP) is a person or organisation, approved under section 34F of the SRC Act by Comcare to provide workplace and vocational rehabilitation services.

The NDIA procured the services of WRPs under the Occupational Rehabilitation and Medical Services (ORAMS) Deed. RCMs should use a preferred ORAMS provider, unless there are exceptional circumstances not to.

6.5. Employee

These guidelines apply to all employees of the NDIA including non-ongoing employees. Some parts of this policy in relation to the SRC Act apply to former employees, where NDIA is the rehabilitation authority for a

compensation claim. In relation to rehabilitation programs under the SRC Act, all employees are advised of their rights and responsibilities in writing. Employees have a responsibility to attend assessments and undertake the rehabilitation program.

7. Rights and Responsibilities

7.1. The Employee

The employee has a right to:

- Receive appropriate compensation entitlements and rehabilitation for compensable injuries under the SRC Act.
- Privacy in accordance with the Privacy Act.
- Access documents that relate to their claim under s 59 of the SRC Act.
- Seek a reconsideration of certain determinations (as defined under s 60 of the SRC Act).
- Request reasonably practicable adjustments to the workplace; and
- To be supported by a Rehabilitation Case Manager (RCM), and/or a Workplace Rehabilitation Provider (WRP), if required.

Employee responsibilities include:

- Notifying their line manager at the first opportunity after becoming ill or injured.
- Reporting work-related illnesses or injuries via an incident report to the Work Health and Safety team.
- Maintaining ongoing contact with their line manager and RCM throughout the absence and the RTW process.
- Submitting a leave request and associated medical certificates for all absences in line with the leave policy.
- Indicating to their line manager and/or RCM when they require assistance to remain at work and/or RTW.
- Cooperating in the rehabilitation and RTW process.
- Undergoing independent medical assessments as required by the NDIA.
- Actively participating in all rehabilitation and RTW processes; and
- Performing their duties in accordance with *Work Health and Safety Act 2011* and/or medical restrictions.

7.2. National Disability Insurance Agency (The Employer)

The NDIA has a primary duty of care to ensure, so far as is reasonably practicable, the health and safety of its employees under the *Work Health and Safety Act 2011*. This includes ensuring that the health and safety of people is not put at risk from work carried out as part of the conduct of the business.

If an employee's health status presents a risk to the health and safety of themselves and/or others whilst engaged in work, they can be stood down by the appropriate delegate until such time that they are deemed medically fit to return to work.

The Health and Injury Management team will offer support to the employee, including having their capacity for work assessed and their rehabilitation and return to work arrangements established and implemented.

7.3. Line Managers

Line managers of NDIA employees are responsible for the health, wellbeing and safety of their staff. They are required to participate in and monitor the progress of the rehabilitation and RTW of their employees.

Responsibilities include:

- Notifying the Health and Injury Management Team as soon as it is identified that an employee may require support.
- Ensuring that an Incident Report has been sent to the Work, Health and Safety Team if the illness or injury is work related.
- Providing a safe work environment in line with the *Work Health and Safety Act 2011*.
- Maintaining ongoing contact with their employees and the RCM throughout the absence from work and RTW process.
- Actively working with the RCM and other parties to identify suitable duties for ill and/or injured employees.
- Ensuring that leave is approved where required, with appropriate supporting documentation.
- Cooperating in the rehabilitation and RTW process.
- Managing workloads to ensure that team members are not adversely disadvantaged by the absence of the ill or injured employee.
- Ensuring that administrative requirements are completed as required. This may include but is not limited to:
 - o Completing relevant section of claims for compensation within 5 days of receiving it.
 - o Employer Statements.
 - o Statement of Claims.
 - o Incident Reports.
 - o Work Reports for medical assessments.
- Actively working with all relevant stakeholders to identify alternate work arrangements for their employee based on the medical recommendations.

7.4. Rehabilitation Case Manager (RCM)

The RCM is responsible for acting early to prevent, or to provide early assistance to employees with illness or injury. The RCM is also responsible for coordinating and managing the rehabilitation and return to work of employees with an illness or injury, on behalf of the NDIA. As part of this process, they provide guidance to the line manager on the day-to-day management of the rehabilitation and return to work process.

The illness or injury may be compensatory (i.e. any cases where a claim for compensation is lodged, whether accepted, or declined) or non-work related. The complexity of the case can vary. Examples of cases managed by RCMs includes:

- Cases where the employee has both physical and psychological conditions.
- Cases where the employee has a disability and there are additional, long-term support requirements at work.
- Cases where the employee has a psychological condition/s and there are behavioural and or performance issues at work.
- Cases where the employee has a psychological condition/s and there are bullying and/or harassment issues at work.

- Cases where the employee has had a long-term absence from work (3-6 months or longer).
- Cases where the employee has a long-standing illness or injury.

Responsibilities include:

- Initiating and coordinating Workstation Ergonomic Assessments and sourcing recommended ergonomic equipment for employees.
- Initiating, coordinating and monitoring the rehabilitation and/or RTW process in consultation with all stakeholders; including WRPs.
- Assisting line manager/s to access appropriate supports to facilitate the employee's RTW process.
- Providing advice, assistance and professional guidance on absence management.
- Making decisions under delegation in relation to rehabilitation responsibilities under the SRC Act and the PS Act.
- Coordinating s36 Assessments and/or Independent Medical Examinations (IMEs), which may include Fitness for Duty (FFD) Assessments.
- Coordinating Work Trials or Work Placements for compensable injuries, when the ill/injured employee will not be returning to their original (pre-injury) role.
- Overseeing invalidity and partial invalidity processes, where an employee has permanent or partial disability or incapacity due to an injury at work.
- Ensuring that rehabilitation and RTW process are cost effective and within industry standards.
- Ensuring that Comcare have up-to-date claim information, including relevant documentation (e.g. medical certificates, s37 Rehabilitation Programs, reports from treating doctors, WRP Progress Reports, Closure Reports, etc.)

Monitoring a case for a period of 4-6 weeks after the employee has reached their rehabilitation goal, prior to case closure.

When critical psychosocial incidents occur, the RCM may work with the business area and the Work Health and Safety Team to provide immediate assistance and support to those involved.

7.5. Workplace Rehabilitation Provider (WRP)

The WRP may be engaged to assist the employee in their safe and durable RTW, or if they are already at work, that there have been workplace adjustments to assist them in remaining at work. The WRP will assist with both compensable and non-compensable illness/injuries and will be requested to conduct a Rehabilitation Assessment (non-compensable) or a Rehabilitation Assessment (compensable) to ensure that essential information regarding the rehabilitation and RTW is gathered from all stakeholders.

Responsibilities include:

- Providing expert, objective advice to the RCM to assist the timely, safe and durable RTW of an injured employee.
- Engaging the injured employee, treating doctor and line manager in the development and implementation of a tailored RTW plan or rehabilitation program.
- Actively monitoring the RTW plan or rehabilitation program and regularly talking with all parties to ensure that the goals are achieved.
- Complying with Comcare's criteria and standards for Workplace Rehabilitation Providers.

7.6. HR Business Partners (HRBP)

The HR Business Partnering (HRBP) team provides dedicated and strategic HR services and advice to SES across the Agency.

HRBPs partner with SES to:

- Build a strong organisational culture.
- Connect with subject matter expertise to resolve people matters and improve outcomes.
- Broaden perspectives and deepen contextual understanding of workforce management.
- Strengthen business strategy and workforce performance.
- Support our leaders to deliver change.

7.7. Treating Medical Practitioners

Treating medical practitioners provide medical assessments and treatment and provide advice regarding fitness for work, rehabilitation and work capacity.

Treating medical practitioners play a vital role in the rehabilitation and RTW.

7.8. Legally Qualified Medical Practitioners (LQMP)

Legally Qualified Medical Practitioners (LQMPs) are registered medical practitioners procured under the Occupational Rehabilitation and Medical Services (ORAMS) panel to provide Independent Medical Examinations to employees where required.

The LQMP may be engaged by a RCM to conduct a s36 assessment with examination, to establish an employee's capacity to participate in a Rehabilitation Program under the SRC Act, when the employee has a compensable injury.

The LQMP may also be engaged to conduct a medical assessment under the PS Act, when the NDIA need to establish as employee's fitness for duty and treatment requirements.

The information contained within a LQMP's report can be used as medical evidence for leave coding purposes, without the requirement for the employee to seek additional evidence from their nominated treating doctor.

7.9. Comcare

The SRC Act established Comcare as the Federal Government's workers' compensation authority. Comcare manages compensation claims for Australian Government employees.

Comcare makes determinations regarding liability, incapacity payments, treatment expenses, permanent impairment and non-economic loss, aids and appliances, household services and attendance care services, and approval of other payments and services under the SRC Act.

7.10. Superannuation Funds

The Commonwealth Superannuation Corporation (CSC) may determine that an employee is eligible for medical treatment on the basis that they are permanently or partially incapacitated for work.

Eligibility and payments of benefits differ across the three Commonwealth superannuation schemes – Commonwealth Superannuation Scheme (CSS), Public Sector Superannuation Scheme defined benefit (PSSdb), and Public Sector Superannuation Scheme Accumulation Plan (PSSap).

Employees of the NDIA may be members of other superannuation funds and are encouraged to seek information and advice from their provider as required.

8. Delegations

8.1. Safety, Rehabilitation and Compensation Act 1988 (SRC Act)

For the Commonwealth, Commonwealth Authority or licensee, section 41A of the SRC Act allows the rehabilitation authority to delegate in writing all or any of its functions and powers under Part III to an officer or person employed by the rehabilitation authority's employer.

Rehabilitation Case Manager Delegations

- Sub-sections 36(1) & (3) of the SRC Act – may arrange for assessment of an employee's capability of undertaking a rehabilitation program or shall do so at the written request of the employee. The employee may also be required to undergo an examination.
- Sub-section 37(1) of the SRC Act – determine that an employee should undertake a rehabilitation program.

In determining if an employee should undertake a rehabilitation program, a RCM shall have regard to the requirements of section 37 (3) of the Act. The matters for consideration are:

- (a) *any written assessment given under subsection 36(8)*
- (b) *any reduction in the future liability to pay compensation of the program is undertaken*
- (c) *the cost of the program*
- (d) *any improvement in the employee's opportunity to be employed after completing the program*
- (e) *the likely psychological effect on the employee of not providing the program*
- (f) *the employee's attitude to the program*
- (g) *the relative merits of any alternative and appropriate rehabilitation program*
- (h) *any other relevant matter.*

and:

- a) If an employee is determined to undertake a rehabilitation program (whether it be in respect of the same or a different injury), a RCM shall have regard to whether:
 - 1. the employee completed the program.
 - 2. the program resulted in any improvement in the employee's capacity to work or activities of daily living; or
 - 3. if the employee did not complete that program, whether the employee had a reasonable excuse for failing or refusing to complete that program; and

- b) Section 15 of the *Disability Discrimination Act 1992*

Non-compliance under the SRC Act

Under s36(4) of the SRC Act, where an employee refuses or fails, without reasonable excuse, to undergo an examination in accordance with a requirement, or in any way obstructs such an examination, the employee's rights to compensation under the SRC Act, and to institute or continue any proceedings under this Act in relation to compensation, are suspended until the examination takes place.

Under s37(7) of the SRC Act, where an employee refuses or fails, without reasonable excuse, to undertake a rehabilitation program provided for the employee under this section, the employee's rights to compensation under this Act, and to institute or continue any proceedings under this Act in relation to compensation, are suspended until the employee begins to undertake the program.

In consideration of the above, the RCM must:

- (a) assess the extent of the refusal, the manner in which the employee failed to cooperate or the nature of the obstruction to ascertain the severity of the employee's non-compliance.
 - (b) as soon as reasonably practicable, ask the employee to provide an explanation for such refusal, failure or obstruction; including in that request adequate guidance or instruction as to the evidence required and timeframes for response.
- and
- (c) consider whether the employee had a reasonable excuse for such refusal, failure or obstruction considering the employee's explanation or failure to provide one.

Directors, Branch Managers and the Chief People Officer – People and Culture Division have delegation to suspend rights to compensation and proceedings under subsection 36(4) and subsection 37(7) of the SRC Act.

8.2. Public Service Act 1999 and Public Service Regulations 2023

Independent Medical Examinations and outcomes are managed in accordance with section 20 of the *Public Service Act 1999* and section 11 of the *Public Service Regulations 2023* (Public Service Regulations). RCMs and Directors within the People and Culture Division hold the delegation for this and can direct an employee to undergo a medical examination.

9. Triage

The purpose of the Triage function is to ensure that enquiries received via the [People and Culture Service Desk \(Jira\)](#) or via email to [547E\(d\) - certain operations of agencies](#)@ndis.gov.au are reviewed and responded to in alignment with the support requested by the reporter. Where requests for support are unclear, the team action triage calls to gather further information relevant to the reporter's enquiry.

At the point of Triage, Jira enquiries that are outside the scope of the Health and Injury Management team remit or require tailored support from another business area, are referred internally to the most appropriate business area.

The Triage team work closely with other Teams within the People, Culture and Wellbeing (PCW) division, including the Disability Support Team (DST), Work Health and Safety Team (WHS), People Support Team (PST), Safe and Respectful Team (SART) and the HR Business Partner Team (HRBP).

Enquiries relating to physical or psychological injuries (or risks of injury), will be allocated to a Rehabilitation Case Manager (RCM) for ongoing case management. Insurance and workers compensation claims will also be allocated to an RCM or WPS Team member for follow-up. Similarly, enquiries regarding the mental health and wellbeing of an employee (non-compensable) are allocated to an RCM for the implementation of early intervention supports.

Enquiries relating to workplace supports and adjustments required by new employees who are being onboarding are received by the Triage team, via [s47E\(d\) - certain operations of agencies @ndis.gov.au](mailto:s47E(d)-certain-operations-of-agencies@ndis.gov.au). In some cases, this work is best aligned to the Office of Accessibility and Inclusion, where the employee will be allocated to a Disability Liaison Officer (DLO), for a smooth transition to employment, ensuring access and inclusion supports are implemented.

10. Income Protection Applications

Income Protection applications may be received from the Commonwealth Superannuation Scheme (CSC), AIA or from an employee's private superannuation fund.

The Incapacity Case Management (ICM) Team within the Health and Injury Management team oversee the management of income protection applications. Further details can be found in the [Income Protection Application Process](#).

11. Case Administration and Records Management

11.1. Case Notes and Record Keeping

All phone conversations, discussions, and/or meetings that occur while managing a case or claim for compensation, must be recorded in writing by the RCM as an accurate record, made at the time, or as soon after the event (incident, discussion, phone call, meeting) as practicable.

Case notes will:

- State who the RCM has spoken to, the purpose of the conversation and discussion.
- Contain the date of the conversation/discussion.
- Accurately record any explanations or undertakings that were received or given.
- Capture emerging barriers or trends.
- Contain objective observations.
- Be confined to the facts, and
- Be brief, clear and concise.

Records pertaining to injury reports, RTW, rehabilitation and medical treatment will adhere to privacy and confidentiality requirements as defined in the *Privacy Act 1988*.

Case notes must not:

- State any irrelevant personal observations or views, particularly any comments of a non-factual nature.
- Contain personal information relating to another person unless that information is relevant.

RCMs have a professional, ethical and legal responsibility to ensure follow the guidelines above, noting that case records can be subpoenaed as court documents (e.g. AAT, Fair work.)

RCMs also have an administrative responsibility of ensuring that their case folders in MS Outlook, the shared drive and the active case tracker/spreadsheet are up to date.

RCMs are responsible for using the Workload Resource Tool to accurately categorise each of their cases in the Active Tracker on a weekly basis, and to review this with their Assistant Director during fortnightly case reviews.

The purpose of this tool is to ensure accurate and qualitative reporting of workloads and to enable suitable work allocation to Case Managers.

- **Category A** – High complexity comp or non-comp, performance/conduct/behaviour issues and/or workplace conflict. Spans multiple jurisdictions (internal or external), co-morbidity or disability, in-depth investigation/s (e.g., s71, FOI requests, IMEs, reconsiderations, ART cases), WRP engagement.
- **Category B** – Moderate complexity comp or non-comp (WRP engaged, may involve one or more “Category A” elements, regular stakeholder engagement and meetings).
- **Category C** – Low complexity comp or non-comp (WRP engaged, proactive provider, minimal meetings, monthly progress reports, non-compensable. E.g. ergonomic assessments).
- **Category D** – light-touch comp e.g., nil rehab, long-tail claims, inactive compensation claim, Comcare follow-ups).
- **Category E** – light-touch non-comp, e.g. work coming up in 6 months. Leave coding and medical certificate follow-ups required.

*N.B. Case categories are interchangeable (cases may move between categories at different points of the lifecycle of the case).

For each case, the RCM must also add the employee’s superannuation fund to the spreadsheet.

11.2. Case Handovers

When a case needs to be referred from a DLO to a RCM, or when a case is being permanently handed over from one RCM to another, the DLO or RCM conducting the handover must complete a Case Handover document with all relevant information to provide to the new RCM. They must also ensure that the employee’s case files in MS Outlook and SharePoint are up to date, as well as case notes.

11.3 Case Management Arrangements During Periods of Leave

During periods of leave taken by members of the Health and Injury Management Team (e.g. annual leave), case handover arrangements must be made.

Team members must add all their cases to the Case Handover Template which is saved in SharePoint/R: drive and have a case handover discussion with the Assistant Director (AD), Health and Injury Management, prior to going on leave. When completing the Case Handover Template, the RCM must note any follow-up actions required while they are on leave.

The assisting RCM must update the template with any actions that occur during the primary Case Manager’s absence (e.g. email filed in SharePoint, report received and filed in the “Open Case” folder in SharePoint).

When the primary RCM returns from leave, they can review the actions completed on each case and any follow-up actions required of them.

11.4 Reopening a previously closed case

If a RCM receives a new case and a search in SharePoint reveals that there is historical information relating to that employee, they must move any old SharePoint files into the new case file in a separate folder, noting the date that it was previously closed. For example, *Bloggs, Joe (closed May 2024)*. This practice ensures that all historical case information is contained within the same location for easy reference and searching purposes.

11.5 Naming Conventions

The following naming conventions should be adhered to when naming documents.

YYYYMMDD – employee's initials - document type and date(s)

E.g. 20240510–JS-Medical Certificate 9May-9June

20240510-CS-IME Report from Dr Smith

11.6 Case File Security

All emails relating to a case must be saved to the employee's SharePoint file (under emails). All other documentation relevant to a case must also be saved in their SharePoint file, using the Health and Injury Management team Naming Conventions detailed in **11.5**.

To ensure that there is back-up of all emails and associated information, the RCM should complete the following steps:

- RCM saves the email to SharePoint (under emails).
- RCM makes a note in the Case Notes and attaches the link to the case note.
- RCM then moves the email from the Healthy at work Mailbox to an "Archive" folder under the employee's name. The email should not be deleted.

12. The Comcare Scheme - SRC Act

The rehabilitation and workers' compensation regulatory functions provide an integrated and cost-effective approach to prevention, compensation and workplace rehabilitation across the jurisdiction.

The rehabilitation and compensation components of the Comcare scheme are characterised by:

- A 'no fault' scheme, with limited access to common law.
- An integrated and cost-effective approach to injury prevention, occupational rehabilitation and workers compensation.
- Employer responsibility for the occupational rehabilitation and RTW of injured employees.
- Comcare approval of rehabilitation program providers.
- A comprehensive benefit structure with an entitlement to incapacity payments for 45 weeks at 100 per cent of normal weekly earnings, and a graded reduction thereafter, from between 100 per cent and 75 per cent of normal weekly earnings, depending on the hours worked during a given week.

- Coverage of allowable medical, rehabilitation and related costs associated with the treatment of work-related Injury and diseases.
- Lump sum payments for permanent impairment due to work related injury or disease; and
- Entitlement to incapacity payments until age 65.

12.1. Comcare Premium

The premium is the amount of money that an agency (e.g. NDIA) is required to pay to Comcare to cover the provision of benefits provided to injured employees for things such as income support, medical and home help assistance and other benefits. Comcare will assess each agency's claim performance as an estimate of the lifetime cost of each claim. Lifetime cost means payments to date plus an estimate of future costs for each claim.

Estimates of lifetime costs increase or decrease for each claim, depending on the changing pattern of actual costs and time off work for the claim. While most claimants have only days or weeks off work, some will accumulate many months off work and a small percentage will continue to receive benefits and accumulate time off work over many years.

At the time the claim is accepted, the estimate of the lifetime cost is based on the minimal information available about the claim. This includes the claimant's age, gender, normal weekly earnings, type of injury, and the delay between the injury and acceptance of their claim.

As more information about the development of each claim becomes available, the estimate of lifetime cost for each claim is updated. Important factors in claim estimation include:

- The claimant's cumulative time off work and the pattern of time off work (the number and length of periods off work).
- Whether the claimant is at work or off work, and how long that has been the case.
- If the claimant is on a graduated RTW program, the number of hours they spend at work each week.
- The claimant's pattern of medical and rehabilitation costs; and
- Whether a third-party recovery action has been initiated, and the progress of that action.

The premium responds to trends in the claim performance for the individual agency, as well as trends across the whole system, and is intended to act as a direct financial incentive for agencies to reduce workers' compensation costs by effective health, safety and rehabilitation measures.

To reduce premium rates, the following must occur:

- A reduction the number of claims, by preventing injuries in the first instance; and
- Returning injured employees back to work as quickly as possible (even just a few hours a week), as payments for time off work make up the largest component of the costs.

13. Early Intervention

The NDIA endeavours to identify and respond to early warning signs before an employee develops an injury or illness. Where this isn't possible, the NDIA will take quick and effective action to support the

employee to ensure the best possible outcome. By taking a preventative and early intervention approach to workplace injuries and illnesses, the NDIA:

- Prevents long term absence from the workplace and the development of chronic illness.
- Supports a positive and supportive workplace culture.
- Recognises staff and the value of their contribution to the workplace; and
- Reduces workers compensation costs.

The NDIA has early intervention funding which may be used for medical costs, or to engage a Workplace Rehabilitation Provider (WRP) to provide rehabilitation and return to work (RTW) services.

The success of Early Intervention requires employees to:

- Report any illness or injury to their manager as soon as possible.
- Participate in Rehabilitation Assessments and RTW programs where required; and
- Keep their manager informed about their injury and treatment.

The NDIA's early intervention approach focuses on the following principles:

- A timely and appropriate response, with a focus on workplace interventions.
- Line managers should play a central role in supporting the employee.
- Collaboration between key stakeholders to identify solutions that will maintain the staff member at work or to RTW; and
- Early and professional assessments to assist with identifying employees' needs.

13.1. Early Intervention Funding

The NDIA has established a centralised funding and payment model for approved workplace adjustments and early intervention expenses. The Health and Injury Management Team are responsible for the assessment, approval and payment of workplace adjustments and early intervention expenses for APS employees, with the exception of Auslan and Live Captioning. This remains the responsibility of the employee's business area.

Auslan interpreting and live captioning costs for NDIA employees is funded through a centralised funding model and directed to a centralised funding budget.

The Office of Agency Accessibility and Inclusion (OAAI) will provide you with a purchase order number or work with your business area as we transition to this service.

In the interim please **do not** pay for Auslan interpreting services for staff via credit card.

Please email the [ASU inbox](#) if you do not know how to book and pay for external Auslan interpreters.

The NDIA's early intervention funding may be used for:

- Short-term external WRP services such as Ergonomic Assessments, Early Intervention Rehabilitation Assessments), and RTW services, including Rehabilitation Programs (RP). The duration of this early intervention support is dependent on the circumstances, but usually for a period of up to 12 weeks.
- Reimbursing the costs of medical interventions such as:
 - o General practitioner consultation(s)
 - o Limited treatment by registered allied health professionals. For example, up to six treatment sessions of physiotherapy, psychology or occupational therapy

- Providing support aids, including ergonomic equipment, non-standard furniture, equipment or software.

Generally, early intervention funding will not be provided for

- Investigative medical costs, such as CT scans or MRIs.
- Invasive treatment such as surgery.
- Prescription medication; and
- Massage, unless a medical practitioner makes a referral for remedial massage to a registered allied health professional.

If the employee is out-of-pocket for early intervention expenses, the process for claiming the expenses back is by using the [Staff Reimbursement Form](#). In some circumstances, it may be appropriate for the NDIA to arrange an upfront payment to the service provider.

13.2. Rehabilitation Assessments and Early Intervention Rehabilitation Programs (non-compensable)

If a WRP is engaged to complete a rehabilitation assessment, their report must include the following as a minimum, as detailed in the ORAMS Service Requirements:

- a description of the job role, including a breakdown of the inherent requirements, types and frequency of tasks.
- with employee consent, the provider must contact the treating doctor, line manager and all other relevant stakeholders and the report must contain a detailed summary of these discussions. The provider must make a genuine documented attempt to contact relevant stakeholders.
- information on the employee's medical diagnosis, expected recovery timeframe, and a concise medical history of the employee relevant to the injury.
- identification of any workplace restrictions, work capacity, and potential suitable duties, where appropriate.
- an assessment of an employee's fitness to remain at or return-to-work and recommendations to support recovery and a safe and timely return to work.
- identification of barriers to return to work (including physical, psychosocial and workplace culture) and proposed strategies to mitigate, reduce or eliminate these barriers.
- as directed in the referral, other activities that may be required on a case-by-case basis.
- a summary of the information collected and identified throughout the assessment; and
- an assessment of the employee's capability of undertaking the Rehabilitation (non-compensable), including the WRP's opinion and supporting reasons.

After reading the report, the RCM should determine, with involvement of the WRP, whether the report should be released directly to the employee, or through their treating medical practitioner. In some cases, where there is particularly sensitive information contained within the report, it may be best to release it through the employee's doctor.

If the WRP recommends that the employee engages in a Rehabilitation Program (non-compensable), the WRP must:

- make recommendations (if any) as to the kind of program the employee should undertake in consideration of their job role, the goal/s of the program, the services required and the timeframe to achieve the goal/s; and
- any other information that may assist the Agency in providing or arranging the rehabilitation program for the employee.

Ongoing funding for the program must be tracked by the Rehabilitation Case Manager (RCM). The steps for recording this are outlined below when a Workplace Rehabilitation Provider (WRP) recommends a Rehabilitation Program:

- RCM receives a funding request from the WRP for a Rehabilitation Program.
- RCM saves the funding request to the employee's case file in SharePoint.
- RCM requests funding approval from their Assistant Director and case notes this request.
- Once the funding is approved, the RCM completes the below funding request template and returns it to the WRP.
- When the WRP requests more funding and submits another request, this amount is added to the other funded amount and is reflected as a total amount in the second row "Total costs approved including this request – GST inclusive). This enables the RCM to track how much money has been spent on the EIRP at any given time.

SECTION 4: Agency delegate approval – for agency use only

Costs approved to date – GST inclusive	
Total costs approved including this request – GST inclusive	
Comments	
Agency representative name	
Agency representative signature	
Phone	
Date	Enter details
ORAMS Referral ID Number	

14. Workers Compensation Claims

Compensation can be claimed if an APS employee sustains an illness or injury that they believe was caused, or contributed to, by their work. The claim must be lodged with Comcare who will determine liability. The claim will be administered under the Safety, Rehabilitation and Compensation Act 1988.

Where an employee has an illness or injury that has not been accepted as compensable by Comcare, the management of the case is dealt with under the Public Service Act 1999 and APS and NDIA policies.

14.1. New Claim Process

When a new claim for compensation is lodged by an employee, the Rehabilitation Case Manager must submit the employer section of claim form within five working days of the claim being received by the NDIA.

A RCM will sometimes be contacted about a new workers compensation claim by the employee's line manager or by the employee lodging the claim. In these cases, the RCM must respond to and contact the line manager or the employee who has requested their assistance within a 24-hour business period.

Manual claim form:

Step 1

On receipt of a manual compensation claim form, the RCM must check that the employee section of the claim has been completed in full with the requested attachments.

Step 2

The RCM completes the employer section of the claim form.

Step 3

If the claim is not complete, it is the responsibility of the RCM to return it to the employee and/or their line manager for completion. Note the incomplete areas to the employee and/or line manager and ensure that they are aware of Comcare's timeframes (five days from receipt of claim) regarding timely lodgement of claims.

Step 4

The RCM must obtain salary and Normal Weekly Earnings (NWE) details from payroll and ensure that this information is provided to Comcare as part of the claim process.

Step 5

The completed claim can be emailed to Comcare:

General.enquiries@comcare.gov.au

Electronic claim form:

An email will workflow to the Health and Injury Management Team inbox [447E\(0\) - certain operations of agencies@ndis.gov.au](mailto:447E(0) - certain operations of agencies@ndis.gov.au) once a claim is submitted by an employee via the Comcare Online Portal. The RCM must then log into the Comcare Online Forms portal [Comcare Online Forms](#), select "Online Forms Login" and complete the employer section of the form, seeking additional information where relevant.

14.2. Employee, Line Manager and Rehabilitation Case Manager Responsibilities

Employee Responsibilities

When an injury or illness occurs in the workplace, the employee should seek medical attention and obtain a medical certificate. The Comcare 'Medical Certificate for Workers Compensation (SRC132)' is the preferred

certificate as it contains information required by Comcare. However, any original medical certificate is acceptable providing it contains the following information:

- The date of injury and the date medical treatment was first obtained
- A clear medical diagnosis of the claimed condition
- An explanation of how the doctor considers the condition is related to employment
- Any pre-existing or contributory factors to the medical condition
- Any treatment or restrictions required for the condition and the likely duration of the treatment including specialist referrals and rehabilitation
- Any period required off work
- A medical opinion of employee's capacity for work including what duties can be undertaken and any work modifications required
- A review date by the doctor

Once an employee has completed a claim for compensation, they are to provide the claim to their line manager to complete the appropriate section including signature before sending it back to the RCM.

The employee may be entitled to receive income support while they are unable to work or are on a rehabilitation program. This is known as incapacity payments.

To claim incapacity payments, the employee must either submit an online CFTOW form or submit a paper-based form with their corresponding medical certificate. Further guidance on how to complete these claims can be found on the [Comcare website](#).

If an employee suffers a work-related compensable injury two years prior to age pension age, they may be entitled to payments for a maximum of 104 weeks (whether consecutive or not) during which time they are incapacitated.

Line Manager Responsibilities

Line managers have a responsibility to assist in the claims process by completing the appropriate part of the claim form and providing relevant information in relation to the cause of the illness or injury as requested by Comcare under s71 of the SRC Act in line with the stipulated timeframes.

Leave Coding Responsibilities for Line Managers

Line managers also have responsibility for coding leave relating to compensable conditions where the employee is absent from work due to incapacity. A list of leave codes for Essentials can be found in the Health and Injury Management Resource Library.

There are two types of leave that can be accessed for any absence from work associated with a compensation claim that is yet to be determined:

- **Personal Leave Compensation Related without evidence**
- **Personal Leave Compensation Related with evidence**

Both leave types will reduce the employee's personal leave credits until such time that the claim has been determined. The Personal Leave will be re-credited if the employee's claim is accepted and will be re-coded

by payroll to Compensation Leave once they have been notified of the change in claim status by the employee's Rehabilitation Case Manager.

Compensation Leave must be coded by the line manager when an employee has a claim for workers compensation that has been accepted. There are two types of compensation leave:

- **Compensation Leave < 45 weeks** is leave relating to an absence for an accepted claim where the employee has been absent from work for less than 45 weeks.
- **Compensation Leave > 45 weeks** is leave relating to an absence for an accepted claim where the employee has been absent from work for more than 45 weeks.

The 45 weeks of leave accrual commences at the end of the *pre-determination period*. This means that the day after Comcare issue the section 14 determination is the day that the countdown towards 45 weeks begins. This is when *post-determine compensation leave* begins. Section 116 of the SRC Act states that an employee is not entitled to be granted any kind of leave of absence with pay during, or in respect of, any period when the employee is or was on *post-determination compensation leave*.

Once incapacity payments reach 45 weeks, the rate of incapacity compensation payments is reduced by an 'adjustment percentage'. This also impacts on Personal Leave and Annual Leave accruals for the employee, so accurate coding is essential. When the employee has surpassed 45 weeks of incapacity, it may be more beneficial for them to claim their own leave entitlements rather than claiming incapacity from Comcare (e.g. an employee on a GRTW may wish to apply for their own leave for the hours they would normally be working.)

Long service leave continues to accrue both during and at the expiry of the first 45 weeks of compensation leave.

Line managers must appropriately code all leave related to workers compensation in Essentials. Failure to do so may result in the employee being overpaid.

Once a claim reached 40 weeks of **paid** incapacity payments, Comcare will send a notification letter to both the employee and employer. The intention of issuing these letters at this point in time is to enable sufficient time for the line manager to change the employee's leave coding In Essentials from **Compensation Leave < 45 weeks** to **Compensation Leave > 45 weeks**. By coding **Compensation Leave > 45 weeks**, this stops leave from accruing, as the employee is no longer entitled to leave accruals after reaching 45 weeks of incapacity payments, as per s116 of the SRC Act.

Payroll will then manually adjust the employee's accruals based on any hours that they may have worked in the settlement period, as they are entitled to receive leave accruals on actual hours worked. By removing and adjusting the penalties manually, it avoids any change of an overpayment to the employee.

Letters are forwarded to both the employee and employer from Comcare once the payment has been adjusted when paid incapacity payments reach 45 weeks.

Rehabilitation Case Manager Responsibilities

To ensure timely and accurate coding of compensation leave, the RCM should note when the employee's medical certificates are due and remind the employee to send their latest medical certificate with their CFTOW form to Comcare as soon as possible.

To mitigate the risk of employees being incorrectly paid, RCMs must email the compensation payroll team at s47F - personal privacy@servicesaustralia.gov.au when an employee:

- changes between a Totally Incapacitated (TI) and a Graduated Return to Work (GRTW) plan
- has a change in the total weekly hours of a GRTW plan
- returns to pre-injury hours
- ceases claiming incapacity payments.

The following is an example:

Employee Name:	Jane Bloggs
AGS:	12345678
Claim #	123654/1
What changed:	Return to pre-injury hours
Effective date:	22/01/2025

Note: Employees' privacy must be maintained so please **do not** send copies of GRTW plans or any other documents.

14.3. Referral for Rehabilitation Services

Referrals for rehabilitation services are only valid if made by members of the Health and Injury Management Team via the Occupational Rehabilitation and Medical Services (ORAMS) Portal.

The *Occupational Rehabilitation and Associated Medical Services (ORAMS) Service Requirements* document outlines all the assessments, evaluations, examinations and programs that can be requested under the ORAMS servicing arrangements.

Note that referral for rehabilitation services can be made for both compensable and non-compensable cases.

14.4. Arranging Rehabilitation Assessments and Requiring Examinations (s36)

The RCM should refer to the [New Guide for Arranging Rehabilitation Assessments and Requiring Examinations | Comcare](#) when arranging rehabilitation assessments or requiring examinations under section 36 of the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act).

In deciding whether to arrange an assessment or examination under s36 of the SRC Act, the Guide requires the NDIA, as the rehabilitation authority to:

- consider an employee's circumstances or any change in those circumstances

- rely as much as possible on relevant information from an injured employee's treating practitioner
- seek and consider the employee's views about the selection of the person(s) to conduct the rehabilitation or medical examination.

The Guide limits the frequency of rehabilitation and medical examinations to six-month intervals, except in specified circumstances.

For guidance on how to arrange a rehabilitation assessment with or without examination under s36 of the SRC Act and developing the Rehabilitation Program, the RCM should refer to the [New Guide for Arranging Rehabilitation Assessments and Requiring Examinations | Comcare](#). The RCM should also refer to the NDIA's [Standard Operating Procedure – Section 36 Rehabilitation Assessments](#) for further detailed instructions.

14.5. Developing a Rehabilitation Program (s37)

Following a section 36 (s36) assessment, the NDIA (the Rehabilitation Authority) can make a determination that an employee who has suffered a work-related injury resulting in incapacity for work or an impairment should undertake a Rehabilitation Program, which will assist the employee to recover and return to work. This applies to accepted claims for compensation.

For guidance on how to develop a Rehabilitation Program under section 37 (S37) of the SRC Act, the RCM should refer to the NDIA's [Standard Operating Procedure -Section 37 Rehabilitation Programs](#).

14.6. Submission of an Employer Statement under a s71 Notice

Comcare has the authority, under section 71 of the SRC Act to obtain documents and information from an employer relating to a claim. The Comcare Claims Officer will specify the information required, along with a deadline to the NDIA's Rehabilitation Case Manager (RCM) assigned to the claim. The statement provided by the employer in response to the claim must be factual, objective, and supported by documentary evidence where applicable.

The RCM must email the employee's line manager to obtain the information requested on Comcare's s 71 notice. The RCM must compile this information into a Statement of Facts and provide it to Comcare with the additional documentation as attachments.

The SRC Act provides that in some situations, injured workers are excluded from receiving compensation.

Comcare will consider exclusionary provisions under the Act when determining a claim. These areas include:

- A reasonable appraisal of the employee's performance
- A reasonable counselling action (formal or informal) taken in respect of the employee's employment
- A reasonable suspension action in respect of the employee's employment
- A reasonable disciplinary action (formal or informal) taken in respect of an employee's employment
- Anything reasonable done in connection with the employee's failure to obtain a promotion, reclassification, transfer, or benefit, or to retain a benefit, in connection with his or her employment (section 5A (2))

Compensation is also not payable to an injured employee if the injury is:

- intentionally self-inflicted (section 14(2))

- caused by that employee's serious and wilful misconduct (section 14(3))
- the result of that employee making a false representation, connected with their employment, that they did not suffer from a disease (section 7(7)).

If the employee is no longer an employee of the NDIA, but their information that was formerly contained within Essentials is required (e.g. leave history report, etc.), the RCM can email the Workplace Planning and Reporting team at [s47E\(d\) - certain operations of agencies@ndis.gov.au](mailto:s47E(d) - certain operations of agencies@ndis.gov.au).

At times, an employee's Pre-employment Health Declaration Form is required, and needs to be referenced in an Employer Statement. These can be obtained by emailing [s47E\(d\) - certain operations of agencies@ndis.gov.au](mailto:s47E(d) - certain operations of agencies@ndis.gov.au).

Further information about Employer Statements can be found on Comcare's website in the [Guide for Submission of Employer Statements](#).

14.7. Updates to Claim Status

Comcare will advise the employee and RCM of the following in relation to the claim:

- Compensation claim status
- Any delays relating to the claim (if applicable).

Once the claim has been determined, the RCM must email payroll once at pay.compservice.centre@servicesaustralia.gov.au to provide the following information:

Employee name	
Date of birth	
AGS number	
Claim number	
Claim accepted or denied	
Date of determination	
Date of injury (only include if claim the claim is accepted): If accepted, date of incapacity (S19)	
Accepted condition/s (physical/psychological)	
Rehabilitation Case Manager	

14.8 Applying for a Reconsideration of a Determination

The employee or the NDIA can request a reconsideration of a primary determination made under the *Safety, Rehabilitation and Compensation Act 1988 (SRC Act)*. This occurs if either the employee or the

NDIA disagree with the determination that has been made. Either party can also request an alternate dispute resolution method that may allow them to resolve a claims-related dispute.

Reconsiderations are carried out by a Review Officer who was not involved in making the primary determination.

A reconsideration is an internal review of a determination made under the *SRC Act*.

It is not a court process. It is a second look at the information and evidence on the claim to ensure the correct determination was made. The review officer can consider whether all relevant information was obtained and request additional information if necessary.

A reconsideration of own motion is when a Claims Manager initiates a reconsideration of a determination previously made.

Only determinations made under the *SRC Act* can be reconsidered.

This includes determinations:

- to accept or deny your claim for compensation
- to stop payment of compensation
- to increase or decrease your weekly payment of compensation
- made by your employer in relation to your rehabilitation
- to arrange an independent medical examination.

When you request a reconsideration, you can ask the review officer to consider certain documents on your claim file or provide new information relevant to your claim.

You have **30 days** from when you receive the determination to make a request for reconsideration or you need to apply for an extension.

Ideally, all information that you intend to submit should be provided in your reconsideration request, as once a reconsideration request is made, Comcare has 30 days in which to make a decision, and this timeframe cannot be extended. It is best practice to lodge all supporting information at the time of submitting your request.

For an employee or employer who cannot make a request for reconsideration within 30 days of receipt of a determination, they can apply for an extension of time (EOT). A request for an extension of time to make a request for reconsideration can be made over the phone or to this email, and should outline the reasons for the request and the date the extension is sought until for our team to consider

Further information about reconsiderations can be found on Comcare's website here:

[Applying for a reconsideration of a determination | Comcare](#)

14.9 Actions required when a non-compensable condition becomes compensable

Where a case that was initially non-compensable becomes compensable, funding relating to the compensable case must be recovered from Comcare. Refer to [Accounts Receivable Procedures](#) on the intranet.

14.10 Workplace Rehabilitation Provider Service Codes

Comcare have several WRP Service Codes, which are used for billing purposes depending on the type of service or assessment provided. The codes can be found on [Comcare's website](#).

The Service Code to be used for the consultation period during which a s37 Rehabilitation Program is under development is **Code 90** – non-billable charges of XXX (number of hours on consulting). Once the s37 Rehabilitation Program is signed off and in place, the WRP should then add a line on **Code 92** – development of Rehabilitation Program of XXX (number of hours on consulting). **Code 92** should also be used for any Rehabilitation Program Alterations,

In addition to this, **Code 90** is to be used for return-to-work support services (i.e. third-party services such as vocational counselling not provided by the WRP, external training, etc.) and **Code 94** is to be used for WRP travel, where applicable.

14.11 Managing non-compliance

Under section 36(4) of the SRC Act, an employee can be found to be non-compliant if they fail, refuse, or obstruct, without reasonable excuse, to attend or participate in a rehabilitation examination or assessment with the purpose of determining their capability to undertake a rehabilitation program.

Under section 37(7) of the SRC Act, an employee can be found to be non-compliant if they fail, refuse, or obstruct, without reasonable excuse, to undertake and participate in their rehabilitation program.

Non-compliance under the SRC Act can lead to suspension of compensation entitlements excluding compensation for medical treatment. The authority to make a determination to suspend compensation under the SRC Act is with the appropriate delegate from the rehabilitation authority.

Non-compliance may include, but is not limited to:

- failure to attend a rehabilitation assessment or examination.
- failure to comply with the requirements of a rehabilitation program.
- failure to seek suitable work.

A person delegated by the rehabilitation authority may make the decision to suspend benefits under the SRC Act. This delegation sits with EL2 level or above within the People and Culture division.

14.12 Superannuation and leave accrual for employees on incapacity payments or income protection

Incapacity payments from compensation are not a pension and in general do not include any superannuation entitlements. However, this depends on the Superannuation Scheme that the employee belongs to. It is the responsibility of the employee to check with their Superannuation fund to determine if payments will be made during periods of compensation leave.

Similarly, if an employee is in receipt of any income protection payments through a personal insurer, employer superannuation contributions would not be paid to the employee. This is because income protection is not paid by the employer, but by the insurer.

Section 130 of the Fair Work Act 2009 (the Fair Work Act) bars the accrual of any National Employment Standards (NES) leave (including 'sick leave' as paid personal leave and 'recreation leave' as paid annual leave) during a period when an employee is absent from work because of an injury for which the employee is receiving workers' compensation. However, it does not bar accrual of NES leave during such a period if permitted by a compensation law.

Section 116 of the SRC Act is a compensation law that permits the accrual of sick leave and recreation leave entitlements during each of the first 45 weeks of post-determination compensation leave; and the accrual of long service leave entitlements during the whole of the post-determination compensation leave period. Annual leave and personal leave cease to accrue once 45 weeks of incapacity has been reached, except for public holidays (annual and personal leave do accrue on these days).

Compensation Leave <45 Weeks counts as service.

14.13 Suitable Duties for Compensation Cases

Employees may not always be able to return to their pre-injury duties or hours straight away, therefore, managers will need to identify and provide suitable duties to accommodate any medical restrictions, with a focus on the duties that the employee can do, the inherent requirements of the job and the workplace adjustments that can be provided.

The NDIA has an obligation, under section 40 of the SRC Act, to provide suitable duties for employees who have a compensable injury or disease and are undertaking or has completed a rehabilitation program.

Suitable duties mean duties which are appropriate to the employee's capacities, skills, age, training, language, and experience and in consideration of medical limitations. Providing suitable duties may involve:

- Modification of current duties
- Alternative duties, and/or
- Modified hours while on a RTW plan.

RCMs may also consider a Work Trial as part of a Rehabilitation Program. If an employee cannot return to the NDIA, the RCM should investigate alternative strategies to ensure successful RTW. A 'work trial' involves the placement of the injured or ill employee with a host employer for a defined period (generally not in excess of three months), however the employee continues to be employed and paid by their respective area within NDIA.

The RTW hierarchy states the goal of a Rehabilitation program, starting with the aim of returning the employee to their original duties at the same workplace. Where the goal is not attainable, the program goals to be implemented under the hierarchy are as follows:

- same employer, same job (same duties)
- same employer, similar job (modified duties)
- same employer, different job (different duties)
- new employer, same job (same duties)
- new employer, similar job (modified duties)
- new employer, different job (different duties)

For non-compensable cases, employees are required to actively pursue redeployment opportunities.

Step 1

In consultation with the WRP, line manager and the ill/injured employee (if appropriate), evaluate the medical evidence to decide whether the employee should return to the same (or similar) job in the same workplace. If it is not possible to continue with the Rehabilitation Program - go to Step 2.

Step 2

Based on the medical evidence, decide if it is possible for the employee to perform modified duties in the same workplace:

- Discuss the possibilities with the line manager and employee.
- Based on medical evidence, agree on any modifications required – the provision of ergonomic equipment, limiting keyboard work, working from a quiet room etc.
- Assist the work area with providing and required workplace modifications. This needs to be actioned quickly to enable the RTW to occur as soon as the employee is medically fit to return to the workplace.
- Continue with the Rehabilitation Program.

If modified duties/same workplace is not possible – got to Step 3.

Step 3

Based on medical evidence, decide if it is possible for the employee to undertake alternative duties in the same workplace:

- Discuss the possibilities with the line manager and the employee to assist in identifying suitable duties.
- Agree on suitable duties to be performed by the employee.
- Continue with the Rehabilitation program and ensure that the employee is closely monitored.

If different duties/same workplace is not possible – go to Step 4.

Step 4

Based on medical evidence, decide if it is possible for the employee to perform the same or modified duties in a different workplace within NDIA:

- Discuss the possibilities with the line manager and the employee (if appropriate) to assist in identifying any suitable positions/duties.
- Based on medical evidence, identify any modifications required for the employee to undertake the duties of an appropriate position, or to perform suitable duties in a different workplace.
- Assist the work area with providing any required workplace modifications to enable the employee to undertake the duties of an identified position or undertake suitable duties, in the alternate workplace.
- Continue with the Rehabilitation Program and ensure that the employee is closely monitored.

If same or modified duties/different workplace is not possible – go to Step 5

Step 5

Based on medical evidence, decide if it is possible for the employee to perform a different job in a different workplace within NDIA.

- Discuss the possibilities with the line manager and the employee (if appropriate) to assist in identifying any suitable positions/duties.
- Determine the position to be filled, and/or the suitable duties to be performed by the employee.
- Continue with the Rehabilitation Program and ensure that the employee is closely monitored.

If the medical evidence advises that the employee cannot perform the same, modified, or new duties within their current or other NDIA workplace – go to Step 6.

Step 6

At this stage, the RCM should investigate a work trial placement. Where an employee, for medical reasons, is unable to return to NDIA, an option to be explored is a placement for the injured employee with a host employer. In such circumstances, the employee continues to be paid by NDIA, with NDIA being responsible for rehabilitation and any compensation matters.

This option provides the injured or ill employee with the opportunity to explore more permanent opportunities whilst building new skills and allows the employee to establish a positive working relationship with a potential new employer.

Step 7

Conduct reviews monthly in order to:

- Review outcomes of the Rehabilitation program or placement.
- Determine further rehabilitation or RTW activities; and
- Ensure all activities and decisions are noted in the case notes.

14.14 Medical Redeployment

If the employee's capacity has not resulted in a return to pre-injury duties and it is likely that this incapacity will continue, it is recommended that the RCM advise the work area that the employee should be considered for medical redeployment status, and profile the case for suitable employment via a work trial.

If the case relates to an accepted compensation claim, the decision to deem an employee as a medical redeployee commences the suitable employment profiling process.

The RCM and/or WRP should seek to empower the employee to be proactive in their own job-searching and provide them with the skills and confidence required to do so. Vocational rehabilitation services should be tailored to the employee based on their assessed needs to help them achieve a meaningful and sustainable employment outcome.

14.15 Work Trials

Work Trial Phase

The work trial phase may achieve several outcomes for the injured employee. It may enable an injured employee to gradually increase their capacity for work in an environment better suited to their physical or psychological restrictions. It may provide an injured employee with an opportunity to gain new skills and the opportunity to demonstrate capacity and capability for certain duties and/or work hours. It may allow the injured employee to gain work experience and a recent employment referee if they have been unable to work for some time.

With these goals in mind, a work trial placement should always be time limited to the achievement of these goals, and actively monitored and reviewed to ensure it remains a valuable activity for the injured employee. Extension of a work trial placement beyond 12 weeks requires justification of the continued benefits to be gained from the extension.

At the conclusion of a temporary work trial placement, the employee and the host manager can make an informed decision in relation to permanent redeployment, if this is deemed appropriate.

Australian Public Service Work Trials

If a suitable position cannot be sourced within NDIA, consideration should then be given to sourcing a work trial placement within another APS Agency. It is recommended that an offer of a worksite assessment be arranged prior to the commencement of any work trial placement. Independent Medical Examinations.

14.16 Closure of a compensable case and/or return to pre-injury hours

Upon closure of a compensation case and/or a return to pre-injury hours, the RCM must notify Payroll as soon as possible and complete all other administrative tasks, including finalising case notes, closing the case on the case tracker and moving the case record into "closed case files."

The RCM must also refer to the Case Closure Checklist in the Case Notes template, and ensure that they complete all steps, documenting this in the case notes. See Case Closure Checklist below for reference:

Case Closure Checklist	
Ensure that all relevant files, records and documents have been saved in SharePoint.	☐
Ensure that all case notes are up to date.	☐
Check that all relevant files, records and documents have been saved in SharePoint.	☐

Email all stakeholders to advise that the case is now closed Case closure email template to EE FINAL.docx	☐
Close the JIRA ticket.	☐
Move the Outlook folder to "CLOSED".	☐
Move the File Structure folder to "CLOSED".	☐
Email your AD advising that the case has been closed, so the AD can update the MASTER TRACKER. State the reason why your case is being closed. E.g. EE returned to PIH, EE has resigned, WPS no longer required.	☐

A WRP is required to provide the RCM with a Closure Report and complete an online form to close the s37 Rehabilitation Program. This form is lodged on the WRP's Portal with Comcare. For this to be completed online, the WRP requires the employee's written consent on an official consent form.

If the employee does not provide their consent, the WRP will be required to manually complete the closure report form found on Comcare's website and then submit a Closure Report to the RCM. In this scenario the employee's details are not entered into the portal as they didn't provide consent.

14.17 Resignation of an employee with an active compensation claim

If an employee who has an active claim for compensation resigns, the RCM must complete the SRC266 - Cessation of Employment Form. The RCM must ensure that payroll has completed the NWE section of this form before sending it to Comcare.

15. Managing non-compensable Cases

When required, rehabilitation programs need to be developed for ill and injured employees who are not the subject of a compensation claim, or where a claim has not yet been lodged or determined. These procedures support both the employee and the NDIA by ensuring that rehabilitation occurs in a timely manner by acting early.

Step 1

Referrals are received from the employee, line manager or another area of People, Culture and Wellbeing via the HR Service Desk. This will be triaged and allocated to a RCM.

Step 2

The RCM contacts the line manager to gather information:

- Is the employee at work?
- If not, do they have medical certification?
- Have they been advised of the rehabilitation process and are they willing to participate?
- What is the nature of their condition?
- Is the condition work related?

Step 3

RCM contacts the employee to send the Combined Consent Form, gather information, discuss the rehabilitation process, and advise them of the next steps. After speaking with the employee, the RCM should consider whether the case is suitable for in-house case management, where engagement of an external WRP is not required.

Note: The RCM must not proceed until the signed consent form has been received and filed appropriately in the employee's case file.

Step 4

If a rehabilitation assessment is required, and the RCM needs to engage a WRP, they should review the ORAMS portal to select an appropriate provider and to obtain service costs. They should then do the following:

- Obtain funding approval from the delegate for the associated costs by sending an approval email to them, copying in s47(2) - certain operations of agencies [\[redacted\]@ndis.gov.au](mailto:[redacted]@ndis.gov.au) (see email approval table below).
- Provide an overview of the rehabilitation/return to work process to the employee and line manager.
- Select a WRP from the ORAMS portal and make the referral once funding approval has been approved by the delegate.

Selecting a WRP may also be beneficial if the case becomes compensable in the future. The choice of WRP should be influenced by their:

- Level of expertise with the injury/illness suffered by the employee.
- Gender or ethnicity if this is relevant to the employee.
- Location; and
- Availability

RCMs are to record all case activity on the case notes template.

Subject line: "FOR APPROVAL: Assessment - Surname, DD/MM/YY"

Assessment	
Employee Surname	
Employee First Name	
Category	Rehabilitation Case Management
Assessment Type	Choose an item.
Location (full address)	
State	Victoria
ORAMS Region / Location	VIC Metro
Provider Name	IPAR
Cost Centre Code	90383 - Workplace Support Centralised Funding
GL Code	41626 - Workplace Assessment
Cost	\$

s47E(d) - certain operations of agencies

If a workplace adjustment (e.g. ergonomic equipment) is recommended by the WRP after completing an assessment, funding approval for the equipment must be sought using the [WPS Workplace Adjustment Requests](#) form. When this form is submitted, it will flow through to the delegate.

Once the delegate has approved the Workplace Adjustment Form, it will feed into the Business Operations and Performance (BOP) spreadsheet. The item(s) will then be ordered by the BOP team.

The RCM will receive confirmation when the request has been approved or rejected, or when more information has been requested.

Further details about this ordering process can be found in the [Ordering Ergonomic Equipment PowerPoint presentation](#).

Step 5

Following the Rehabilitation Assessment, a Rehabilitation Program is developed by relevant stakeholders. The elements of a sound RTW program may include:

- Structured graduated return to work details
- Workplace assessment/s
- Contact with line manager and health practitioners
- Work related issues which may impact on a successful RTW
- Pre-injury duties
- The availability of suitable duties
- Any potential barriers to RTW

Stakeholders include:

- Employee
- Line manager
- WRP
- Medical practitioner/s
- HR Business Partners (HRBPs)

When developing the Rehabilitation Program, consider:

- Any written assessment provided by a medical practitioner or rehabilitation provider.
- Any potential improvement in the injured or ill employee's opportunity to be employed after completing the plan.
- The relative merits of any alternative and appropriate Rehabilitation Program.
- The expertise required to assist the injured or ill employee to return to sustainable work as quickly and safely as possible.

The Program should also include administrative details such as regular meetings with the line manager, WRP (and RCM if required), to confirm progress towards the rehabilitation goals.

Step 7

Once the Rehabilitation Program has commenced, the RCM must monitor the employee's progress and review on a regular basis until the rehabilitation goals are achieved. Regular contact should also be maintained with the line manager during this time.

The WRP is expected to maintain regular contact with the employee and their medical provider and to keep the RCM informed of the employee's progress. The WRP is also expected to provide regular updated RTW plans to key stakeholders. The RTW plans reflect any improvement in the employee's condition and their increased work capacity, as certified by the employee's medical practitioner.

Step 8

When the employee has been medically cleared to return to pre-injury hours and duties, the WRP completes a final review then provides a Closure Report. The RCM may arrange a final meeting with relevant stakeholders prior to proceeding to formal closure of supports. In some cases, a monitoring period of 4-6 weeks may be required to ensure the employee does not relapse.

Step 9

If the employee was not found fit to undertake a Rehabilitation Program, the RCM should consult with their Assistant Director for guidance on management of the case.

Step 10

If the employee continues to be unfit for work based on medical evidence, it may be appropriate to consider an Independent Medical Examination to establish the employee's capacity for employment.

16. Independent Medical Examinations (IME)

The RCM should refer to [Independent Medical Examinations: A Guide for Employees and Supervisors](#) for additional information about IMEs. Further information is below.

16.1. IMEs for non-compensable injuries

Where a non-compensable condition is affecting an employee's performance or ability to remain at work, the employee can be directed by a NDIA delegate to attend a medical examination for a health assessment under section 20 of the *Public Service Act 1999* and section 11 of the *Public Service Regulations 2023* (Public Service Regulations).

11 Direction to attend medical examination

(1) *This section applies if:*

(a) *an Agency Head believes that the state of health of an APS employee in the Agency:*

(i) *may be affecting the employee's work performance; or*

(ii) *has caused, or may cause, the employee to have an extended absence from work; or*

(iii) *may be a danger to the employee; or*

(iv) has caused, or may cause, the employee to be a danger to other employees or members of the public; or

(v) may be affecting the employee's standard of conduct; or

(b) an APS employee is to be assigned new duties, and the Agency Head believes the employee's state of health may affect the employee's ability to undertake the duties; or

(c) an APS employee is to travel overseas as part of the APS employee's employment.

Note: Examples of absences that could be treated as extended absences are:

(a) an absence from work of at least 4 continuous weeks; and

(b) a combined total of absences from work, within a 13-week period, whether based on a single or separate illness or injury, of at least 4 weeks.

Delegation for Independent Medical Examinations (to assess an employee's fitness for duty) are listed below in the current Schedule of HR Delegations, which have been updated due to the new *Public Service Regulations 2023*.

Column 1: Item	Column 2: Subject	Column 3: Power, function and/or duty	Column 4: Position(s)	Column 5: Source(s)
19.2	Fitness for duty	Where any of the circumstances in s11(1) of the PS Regs apply, direct an employee in writing to undergo an examination, within a specified timeframe, by a nominated medical practitioner to assess the employee's fitness for duty and direct the employee to provide a report of the examination within a specified timeframe.	SES Band 1 or above for employees under their control; and APS 5 or above in People and Culture.	PS Regs s11(2)

F19.3	Nominate a medical practitioner	Nominate a registered medical practitioner to assess an employee's fitness for duty in the NDIA.	SES Band 1 or above for employees under their control; and APS 5 or above in People and Culture.	PS Reg 10 and 11
13.7 (Listed under Recruitment)	Medical – health clearance	For APS employees whose engagement in the NDIA is subject to a condition dealing with health clearances ¹⁹ , direct an employee, in writing, to undergo a medical examination by a nominated medical practitioner to assess the employee's fitness for duty and/or provide a report of the examination within a specified timeframe.	EL2 or above for employees under their control; and SES Band 3; and APS5 or above in People and Culture.	PS Regs 1020

An IME is a medical assessment conducted by a Legally Qualified Medical Practitioner (LQMP) who is nominated by the RCM and who is not the employee's treating doctor. Therefore, they can provide an unbiased opinion. The LQMP will consult with the employee's treating doctor if required.

The purpose of an IME is to provide advice to the NDIA on an employee's fitness for duty, including their ability to comply with their mutual responsibilities under NDIA's Enterprise Agreement (EA) and Public Service Act responsibilities. It provides a basis for managing the case.

Failure to comply with a direction to attend an IME may result in action under the NDIA's Code of Conduct.

Types of IME (non-compensable) reports

There are five types of IME (fitness for duty) reports that an RCM may seek from a LQMP for a non-compensable injury. These include:

- An **initial assessment report**, which is provided by the LQMP after the first assessment with the employee.
- A **review assessment report**, which is provided by the LQMP after a re-assessment assessment with an employee. The review assessment is often recommended by the LQMP after a certain period has passed since the initial assessment (e.g. six-month review).
- An **integrated assessment report**, which contains the opinions of two different medical subspecialty areas. The LQMPs (one of whom can be an occupational physician) undertake two separate examinations and discuss their findings to reach agreement. They then provide either *one report* addressing all the requirements and detailing their expert agreed opinions, or *two separate reports* detailing their individual expert agreed opinions that collectively address all the requirements.
- A **supplementary report** is a report that can be requested by an RCM if new or additional information is provided to the NDIA. This information is usually provided by the employee or their treating doctor after they have had time to review and consider the LQMP's initial report and recommendations. The new or additional information may change the opinion of the LQMP. There is an additional cost for this report, and the RCM and provider should reach agreement on any additional costs for the inclusion of the new information, as well as suitable timeframes for the supplementary report to be provided. The request for a supplementary report can be booked via MedEbridge if using MLCOA; or MEDirect. The referral can then be made in the ORAMS Portal.
- A **clarification with a superseding report** can be requested by an RCM if they receive an IME report where the LQMP has not appropriately addressed the questions posed. Therefore, the RCM requires them to clarify their responses. The RCM must contact the provider directly to request a clarification with a superseding report. There is no additional cost for this.

Steps to book the IME (non-compensable)

Step 1

Obtain the price from the ORAMS Portal

Step 2

Seek internal funding approval for the cost of the service, from an Assistant Director.

Step 3

Create a booking on MedEbridge if using MLCOA; or MEDirect

If using MEDirect, bookings may also be made via ORAMS Representative Georgie

1300 001 633

s47F - personal privacy

Georgie georgie@medirect.com.au>

Step 4

Create an ORAMS referral in the portal, within the referral input examination details.

Step 5

Once the ORAMS referral is completed, save to the file structure (which substantiates the ORAMS pricing when the invoice is received).

Step 6

Complete the following documents:

- An appointment letter for the employee, with the following attachments:

[Policy - Review Rights.docx](#)

[IME Guide for Employees and Supervisors.docx](#)

- An email to the Manager outlining the details of the appointment and requesting relevant information, which may include a Work Report, Timeline of Events, etc.

Provide a copy of all documents to the employee and the treating GP, if requested.

Step 7

Develop the IME letter and questions for the LQMP, include all relevant information and attachments (e.g., Work Report, Timeline of Events, leave summary, Position Description, Rehabilitation Assessment report, medical certificates).

Step 8

Provide the draft IME letter via the SharePoint link, to an Assistant Director or Director for review, 48 hours prior to the due date.

Step 9

The Assistant Director or Director reviews the letter for accuracy, completeness and compliance with standards. If changes are required, they must request that the RCM revises it.

Step 10

Once the letter is reviewed and deemed to be the final copy:

- The Assistant Director or Director signs the letter
- The RCM converts the signed letter to PDF format
- The RCM uploads the finalised letter, along with the required attachments to MedEbridge.

Step 11

Ensure all correspondence, inclusive of emails and documents, are case noted and saved to SharePoint throughout the process.

Step 12

Once a copy of the report has been received from the LQMP, develop outcome letters/emails for the employee, the treating GP and line manager. Ensure that a copy of the report is released to the employee in line with the LQMP's recommendations. If appropriate, ensure that a RTW plan is also developed.

Step 13

If an employee is deemed unfit for the inherent requirements of their role, they will need to be placed on personal leave and immediately removed from the workplace, if at work. If the employee has exhausted their personal leave entitlements, the RCM can discuss with the business area the types of supports available. This could include paid miscellaneous leave, or engaging a WRP, for a definite period (e.g. 2 or 4 weeks) to support finding financial alternatives (e.g. income protection insurance or Centrelink payments).

Step 14

If the business area is not supportive of paid miscellaneous leave, the RCM may request an escalation via their Assistant Director. If approved, the AD can escalate to a Delegate of PC&W for consideration. Noting, it must be recorded in the request that they have discussed this option with the business area and include the reasons why it was not supported. This will allow the Delegate of PC&W to consider whether the business area's decision should be overturned.

16.2. IMEs for compensable conditions

Where a compensable condition is affecting an employee's performance or ability to remain at work, the employee can be directed by a NDIA delegate to attend a medical examination for a health assessment

under the s36 of the SRC Act. Further information and guidance for arranging a s36 assessment can be found in the [Standard Operating Procedure – Section 36 Rehabilitation Assessments](#).

A s36 assessment is conducted by Legally Qualified Medical Practitioner (LQMP) who is nominated by the NDIA and is not the employee's treating doctor. Therefore, they can provide an unbiased opinion. The LQMP will consult with the employee's treating doctor if required.

The purpose of a health assessment under s36 of the SRC Act is to provide advice to NDIA on an employee's ability to participate in a rehabilitation program, including their ability to comply with their mutual responsibilities under both the SRC Act and Public Service Act.

Failure to comply with a direction to attend an s36 assessment may result in suspension of compensation payments. Recommendations and information in the s36 report will be managed in accordance with the SRC Act.

A NDIA delegate should consider the following before directing an employee to attend an examination:

1. The adequacy of the information and opinions provided by:
 - a. any available reports from medical practitioners or other treatment providers relating to the employee's injury or fitness for work; and
 - b. any previous rehabilitation assessments.
2. The nature of the employee's injury.
3. Any apparent restrictions on the employee's capacity to work and activities of daily living; and
4. Whether the employee has failed or refused to undertake or complete a rehabilitation program without a reasonable excuse.

Steps to book the IME (compensable)

Step 1

Arrange an appointment with a LQMP for a s36 assessment.

Step 2

Complete the following documents:

- Comcare's 116 Form

- An s36 appointment letter for the employee¹
- A letter to the manager outlining the details of s36 appointment and requesting a Work Report.

Provide a copy of all documents to the employee, the treating GP and Comcare.

Step 3

Develop the s36 IME letter and questions, include all relevant information (i.e. 116 Form, workplace statement, rehabilitation assessments, medical certificates) and supply to the LQMA in accordance with the timeframes required. Ensure that a copy of the information sent to the LQMP is also supplied to the employee, the treating GP and Comcare.

Step 4

Once a copy of the report has been received from the LQMP, develop outcome letters/emails for the employee, the treating GP and line manager. Ensure that a copy of the report is released to the employee in line with the LQMP's recommendations. If appropriate, ensure that a suitable Rehabilitation Program is also developed. Ensure that a copy of the documents is provided to Comcare.

17. Partial Invalidity

In non-compensable cases and where an employee is under age 65, a partial invalidity pension (PIP) may be payable by the Commonwealth Superannuation Corporation (CSC) to Commonwealth Superannuation Scheme (CSS) and Public Sector Superannuation defined benefits (PSSdb) members who experience a decrease in salary due to permanent physical or psychological incapacity. The decrease in salary may be due to a reduction in working hours or a reduction in classification (or both).

If contributory service is between eight and twenty years and, in the opinion of CSC, the condition(s) by reason of which the salary was decreased, was in existence prior to joining the Fund, a reduced partial pension will be payable (*where contributory service is less than eight years, in the above circumstances there is no entitlement.)

If compensation is payable/being paid, there is no entitlement to partial invalidity pension.

A PIP is a separate supplementary benefit and is not deducted from any future super entitlements.

To access a PIP, an ongoing decrease in salary due to the medical condition is to be demonstrated to the CSC.

Step 1

The RCM must be satisfied that the injured employee has been maintaining the same hours and/or reduction in classification for at least six months and that the medical condition is stable and/or is not likely

¹ That letter should identify the assessor or panel, date, time and place of the examination; and setting out the reasons for, and rights to request a review of the determination.

to improve significantly. The RCM must also be satisfied that genuine attempts to return the injured employee to pre-injury hours and/or duties have been made.

Step 2

The employer refers the injured employee to a CSC Approved Medical Practitioner (AMP) for an IME to assess their fitness for duty.

If the IME recommends Partial Invalidity, follow the steps below.

Step 3

Ensure that the appropriate application to is provided to the employee, based on their superannuation fund. Once the employee has completed their section they are to forward the form to the RCM for completion.

Step 4

The RCM sends the following documents to PSS or CSS for determination:

- Covering letter
- Application form
- Position Description
- Evidence of reduction in hours and/or classification
- Medical documentation, including IME Report
- Leave records.

Step 5

If a PIP is approved and a certificate has been received, the RCM must forward the information to payroll to action.

18. Invalidity Retirement

Invalidity retirement refers to termination under the *Public Service Act 1999* on the grounds of an employee's inability to perform duties because of physical or mental incapacity. Invalidity Retirement is only considered when all other options for managing illness and injury have been exhausted.

The decision as to whether an employee should be invalidity retired is based on medical advice. An employee can only be invalidity retired when the employee has been medically deemed to be totally and permanently incapacitated for employment (i.e. the employee's ill health, whether physical or psychological, makes it unlikely that they will engage in gainful employment for which they are reasonably qualified by education, training or experience). The CSC will consider medical recommendations and issued an Invalidity Retirement Certificate (IRC) if they are satisfied that an employee can be retired on invalidity grounds.

Age parameters apply for invalidity retirement, depending on the CSC fund that the employee is part of:

Commonwealth Superannuation Scheme (CSS) employees under age 65 will need an IRC for invalidity retirement.

Public Sector Superannuation Scheme (PSS) employees under age 60 will need an IRC for invalidity retirement.

Public Sector Superannuation Accumulation Plan (PSSap) employees under age 60 will need an IRC for invalidity retirement.

Employees over these age limits complete the age retirement application form and should provide medical evidence.

Documentation required for an IRC application to CSC varies, depending on the scheme which the employee is covered under. This is outlined below.

Required for **all** schemes:

- Any medical records
- Duty statement
- Any other relevant medical documents, including rehabilitation reports, graduated return to work reports, and any other treating doctor or independent specialist reports.

Required for **CSS** and **PSS**:

- Treating doctor's report dated within last six months.
- Accredited Medical Practitioner (AMP) report dated within the last six months.
- Recommendation by compensation provider.

Required for **PSSap**:

- Reports from at least two registered medical practitioners dated within the last twelve months.
- Employee's resume.
- Documents related to compensable conditions (e.g., Comcare decisions or medical reports).

If the employee is approved for an IRC by CSC, a copy of the IRC and decision are sent to the NDIA and the employee.

The invalidity retirement date should be set by the employer in consultation with the employee. The benefit cannot be accessed until a termination date has been set. The delegation for invalidity retirement is held by EL2 and above in the People and Culture Division.

Invalidity retirement may be considered for compensable injuries however, Comcare need to be consulted as part of the process. Comcare's support for an invalidity retirement is not essential for an application to CSC.

For employees with a terminal illness, the usual documents are required for an application, however, you can seek a report from the employee's treating medical specialist instead of an Approved Medical Practitioner (AMP).

An employee who is retired due to permanent invalidity will be required to pay tax on their superannuation.

If a Rehabilitation Case Manager is assisting an employee to apply for an IRC, the RCM can contact the Commonwealth Superannuation Corporation (CSC) by emailing employer.service@csc.gov.au for any enquiries. This may also include requesting an estimate of what their benefit would be.

For PSSap, if a member is deemed TPD, they can withdraw lump sums and won't have pension options available. They can, however, set up an account-based income stream where their approved benefit would remain invested in super and they can commence drawing down periodic withdrawals usually on either a fortnightly, monthly, quarterly, or yearly basis.

For contributing PSS members under age 60 they have a choice to receive:

- a full pension, no lump sum
- an invalidity pension plus a lump sum up to the value of their member component, with the remaining benefit paid as an indexed pension; or
- a lump sum only, no pension (LBM or terminal illness only. For LBM there will be no prospective service).

For both PSSap and PSS, if the member is under preservation age, tax would also apply.

18.1. Invalidity Retirement for Compensable Injuries

Step 1

The RCM must be satisfied that the injured employee has been absent from work for at least six months and that the medical condition is stable and/or is not likely to improve significantly. The RCM must also be satisfied that genuine attempts to offer suitable employment to the injured employee have been made.

Step 2

The employer refers the injured employee to a CSC approved medical practitioner for an Independent Medical Examination (to assess the employee's fitness for duty).

If the outcome is a recommendation of invalidity retirement, follow steps 3 onwards.

Step 3

The RCM requests, in writing, that Comcare support an application for invalidity retirement. The employer provides documentary evidence (i.e., IME Report and any other relevant medical documentation) to support the request. Comcare has 28 days to provide a response regarding an application for invalidity retirement.

Step 4

Comcare will review the medical evidence to determine whether they support the application.

Step 5

Comcare will advise the RCM, in writing, of the decision to support (or not support) the application.

Step 6

If supported by Comcare, the employee completes the invalidity retirement application form based their superannuation fund.

Step 7

The completed form, along with all relevant evidence (including Comcare's response) is forwarded to CSC for determination.

Step 8

If an IR certificate has been received, the RCM is to inform the employee of this and request a nominated separation date in writing. Once this has been received, complete a "Notice of Termination of Employment" (under subsection 29(1) of the Public Service Act 1999) to be signed by the delegate (EL2 or above in the People and Culture Division) which includes:

- The employee's medical history.
- A copy of the IR certificate.
- The date of termination specified in the notice.
- A separate "Notice of Termination of Employment" letter to the employee for the delegate to sign.

Step 9

Once the letter to the employee has been signed by the delegate, provide the original to the employee and a copy to Comcare.

Step 10

The IRC must be emailed to payroll (payroll.services@servicesaustralia.gov.au) as soon as it is received. If employee is not ceasing employment immediately, they may be in receipt of Pre-Assessment Payments (PAP). Entitlement to PAP ceases on the pay day after the date on the IRC. Payroll must be informed immediately to ensure that the employee is not overpaid.

18.2. Invalidity Retirement for non-compensable injuries

Step 1

The RCM must be satisfied that the injured employee has been absent from work for at least six months and that the medical condition is stable and/or is not likely to improve significantly. The RCM must also be satisfied that genuine attempts to offer suitable employment to the injured employee have been made.

Step 2

The employer refers the injured employee to a CSC approved medical practitioner for an Independent Medical Examination (to assess the employee's fitness for duty).

If the outcome is a recommendation of invalidity retirement, follow steps 3 onwards.

Step 3

The employee completes the IRC application form, based on their superannuation fund. Once the employee has completed their section, they are to forward the form to the RCM for finalising.

Step 4

Forward the completed form, along with all relevant evidence to CSC for determination.

Step 5

If an IR certificate has been received, the RCM is to inform the employee of this and request a nominated separation date in writing. Once this has been received, complete a "Notice of Termination of Employment" (under subsection 29(1) of the Public Service Act 1999) to be signed by the delegate (EL2 or above in the People and Culture Division) which includes:

- The employee's medical history.
- A copy of the IR certificate.
- The date of termination specified in the notice.
- A separate "Notice of Termination of Employment" letter to the employee for the delegate to sign.

Step 6

Once the letter to the employee has been signed by the delegate, provide the employee with the original copy.

Step 7

The IRC must be emailed to payroll (payroll.services@servicesaustralia.gov.au) as soon as it is received. If employee is not ceasing employment immediately, they may be in receipt of Pre-Assessment Payments (PAP). Entitlement to PAP ceases on the pay day after the date on the IRC. Payroll must be informed immediately to ensure that the employee is not overpaid.

19. Other Relevant Information

19.1. Leave

Leave can be disruptive to the rehabilitation and RTW process as such, NDIA does not encourage employees taking any kind of leave (other than maternity or personal leave) whilst they are on incapacity payments or undergoing a graduated RTW for either a compensable or non-compensable illness or injury. Employees are required to have a conversation with their RCM prior to booking any leave outside of maternity or personal leave to deem if the leave is appropriate.

19.2. Dispute in Medical Evidence

Concerns regarding the validity or authenticity of medical evidence provided should be referred to the People and Culture's Employee Relations Team for appropriate investigation and action. If the medical evidence relates to a compensable illness or injury, the matter should be referred to Comcare.

19.3. Reduction of Classification

The appropriate delegate may reduce an employee's classification in accordance with s23 (4)(f) of the *Public Service Act 1999* on the ground that the employee is unable to perform duties at the higher classification level because of physical or mental incapacity if:

- The employee's health precludes a transfer at their substantive level, or
- It is considered that it would be in the interests of the efficient administration of NDIA to transfer the employee at leave, and
- Any medical restrictions have been considered.

Any reduction in classification is to result in duties which the employee:

- Is qualified to perform
- Can perform (either immediately or within a reasonable period)
- Could reasonably be expected to perform.

An employee cannot be assigned duties at a lower classification without their consent, other than in exceptional circumstances such as those described above. Such a reduction cannot be for a specified time (i.e. it is an ongoing reduction).

The delegate must inform the employee in writing of a reduction of classification and the reason for the reduction of classification.

By agreement between the NDIA and the employee (and with their written consent), an employee can be assigned duties at a lower classification for a temporary period. In these cases, the substantive classification of the employee remains the higher classification.

If, based on agreement, the employee's reduction in classification is for an ongoing period, any subsequent move by the employee to a higher classification is a promotion and must be a process based on merit.

It may be necessary to provide training to help the employee perform efficiently in the new position.

20. Privacy

The NDIA is legally obliged to protect the privacy participants and past and present employees by placing restrictions on the use and/or disclosure of personal information. All information, including medical information will be managed in accordance with the Privacy Act 1988.

The NDIA has several key documents relating to privacy:

- The NDIA's [Privacy Policy](#), which provides you with information about how the NDIA handles, and protects, personal information;
- The NDIS [Information Handling Operational Guidelines](#), which explains how the NDIA collects, stores, uses and shares personal information, including sharing information outside the NDIA; and
- The NDIA's [Privacy Management Plan](#). The implementation of a Privacy Management Plan is a requirement under section 9 of the [Privacy \(Australian Government Agencies – Governance\) APP Code 2017](#) (the Code) developed under section 26G of the [Privacy Act 1988](#) (Cth). The NDIA's Privacy Management Plan is a document that identifies specific, measurable goals and targets that the NDIA is taking to meet its ongoing privacy compliance obligations.

The [Information Law and Privacy team](#) can be contacted for specific advice relating to privacy matters.

20.1. Information Handling and Consent

In the Health and Injury Management area, relevant information relating to an employee will be provided to those individuals or organisations who have a need to access the information if it directly:

- Relates to an employee's work and/or
- Impacts on the way the employee interacts with people in the workplace.

Access should not extend automatically to managers but should follow the need-to-know principle.

When there is a need to engage a WRP in relation to a claim for compensation, there is no requirement for the employee to provide their written consent on a separate Consent Form. By lodging their claim, they are consenting to the provision of rehabilitation and/or return to work support under the SRC Act, which may involve consulting with their treating doctor/s and engaging the services of external rehabilitation providers.

For non-compensable claims, there are two separate consent forms that the employee must sign before the RCM can consult with their treating doctor/s or engage WRP services. These are the *Authority and Consent for the Collection and Release of Medical Information* and *ORAMS Employee Consent Request* forms.

20.2. Privacy Breaches

Any potential or actual breaches of privacy should be reported to the NDIA's Privacy Team at privacy@ndis.gov.au. The responsibilities of the Privacy Team include:

- Responding to the privacy incident including, which includes coordinating remediation to address the incident.
- Working with the NDIA relevant area to action the required remediation.
- Assessing privacy incidents against the Australian Privacy Principles (APPs) to consider whether a breach has occurred and the nature of the breach.
- Seeking legal advice as needed, including advice on whether a Notifiable Data Breach has occurred, particularly where there is a potential risk of harm.
- Recording privacy incidents on the NDIA's Privacy Incident Register once closed.
- Notifying affected individuals where necessary.



Demystifying Psychosocial Safety

[ndis.gov.au](https://www.ndis.gov.au) | October 2025

1



Agenda

1. Information session – To improve understanding
2. Your safety is paramount – if content is triggering, please take care
3. This session, explain the interconnectedness between:
 - Psychosocial Safety Climate &
 - Psychological Safety
 - Look at the psychosocial hazards



Have you heard of lead and lag indicators?

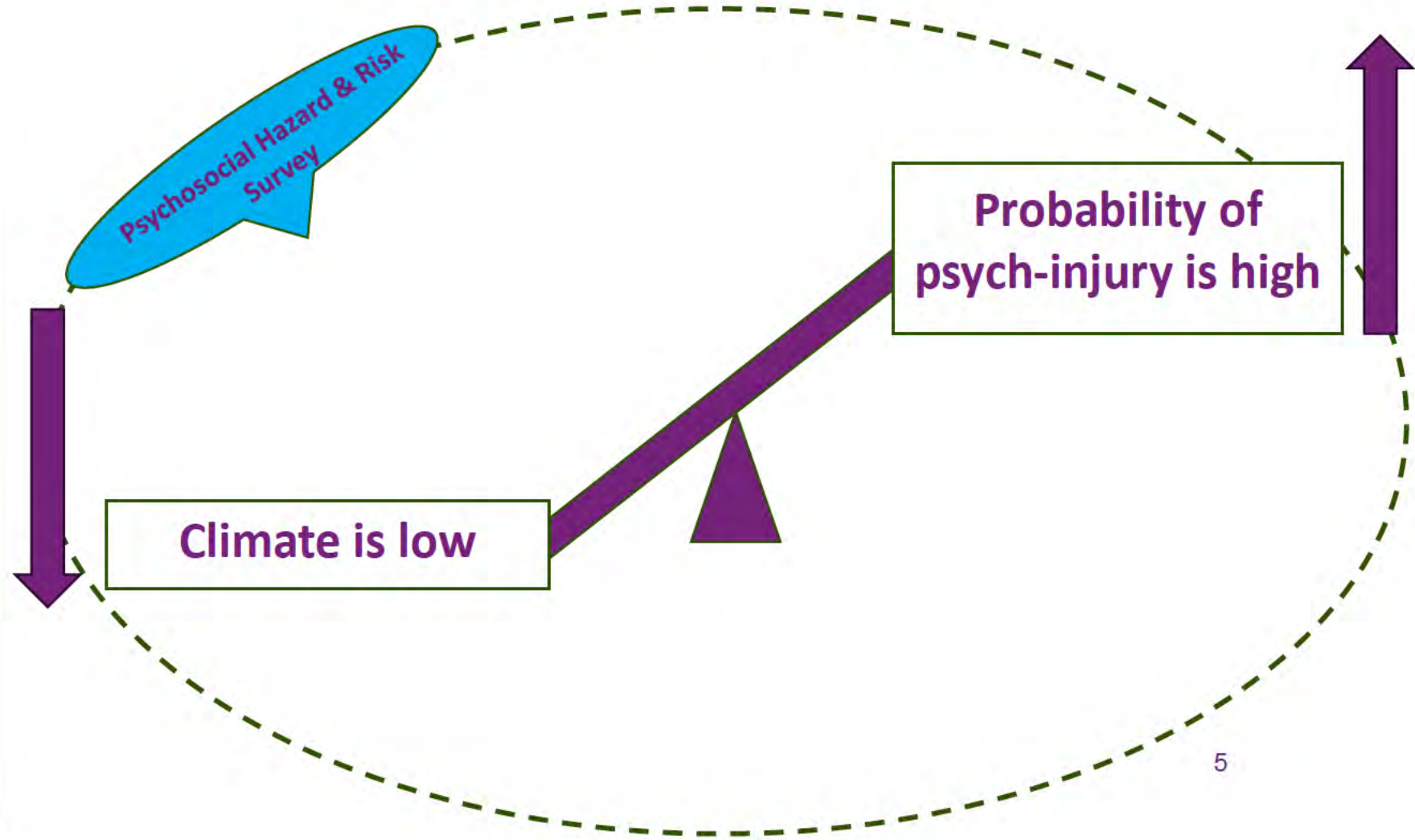
In relations to safety, which is the better one to use, and why?



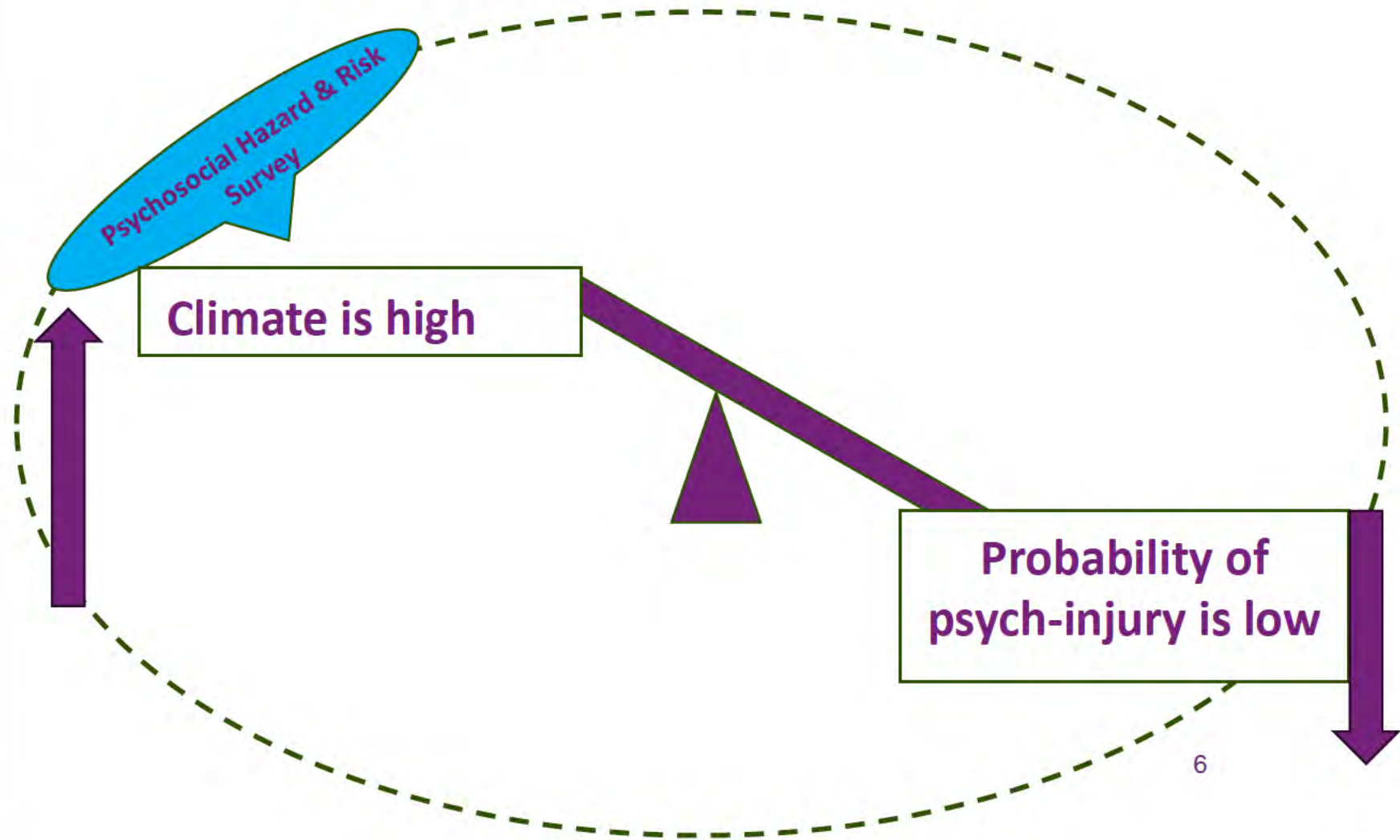
Making it safe for everybody



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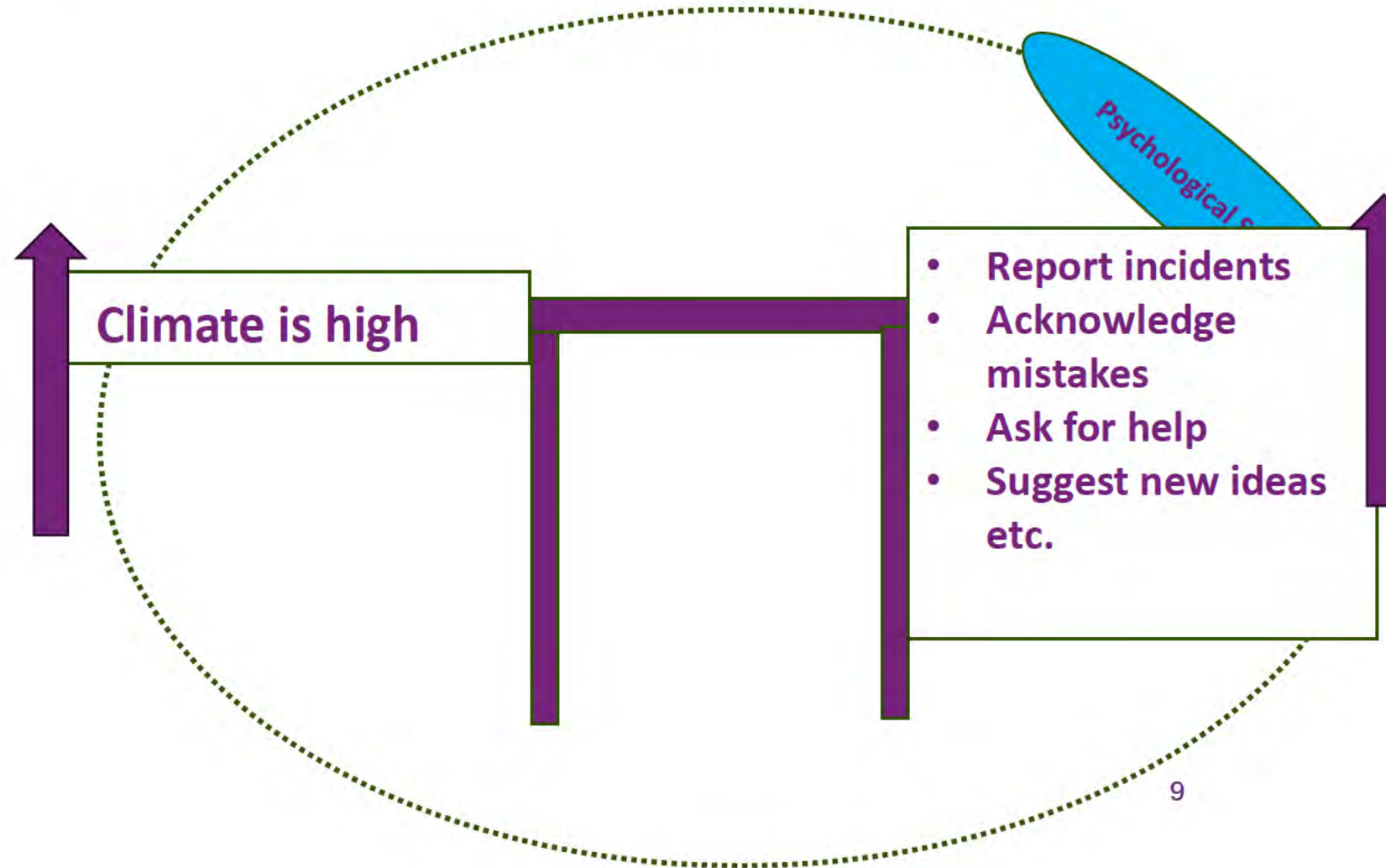
However, another element is needed.



Psychological Safety

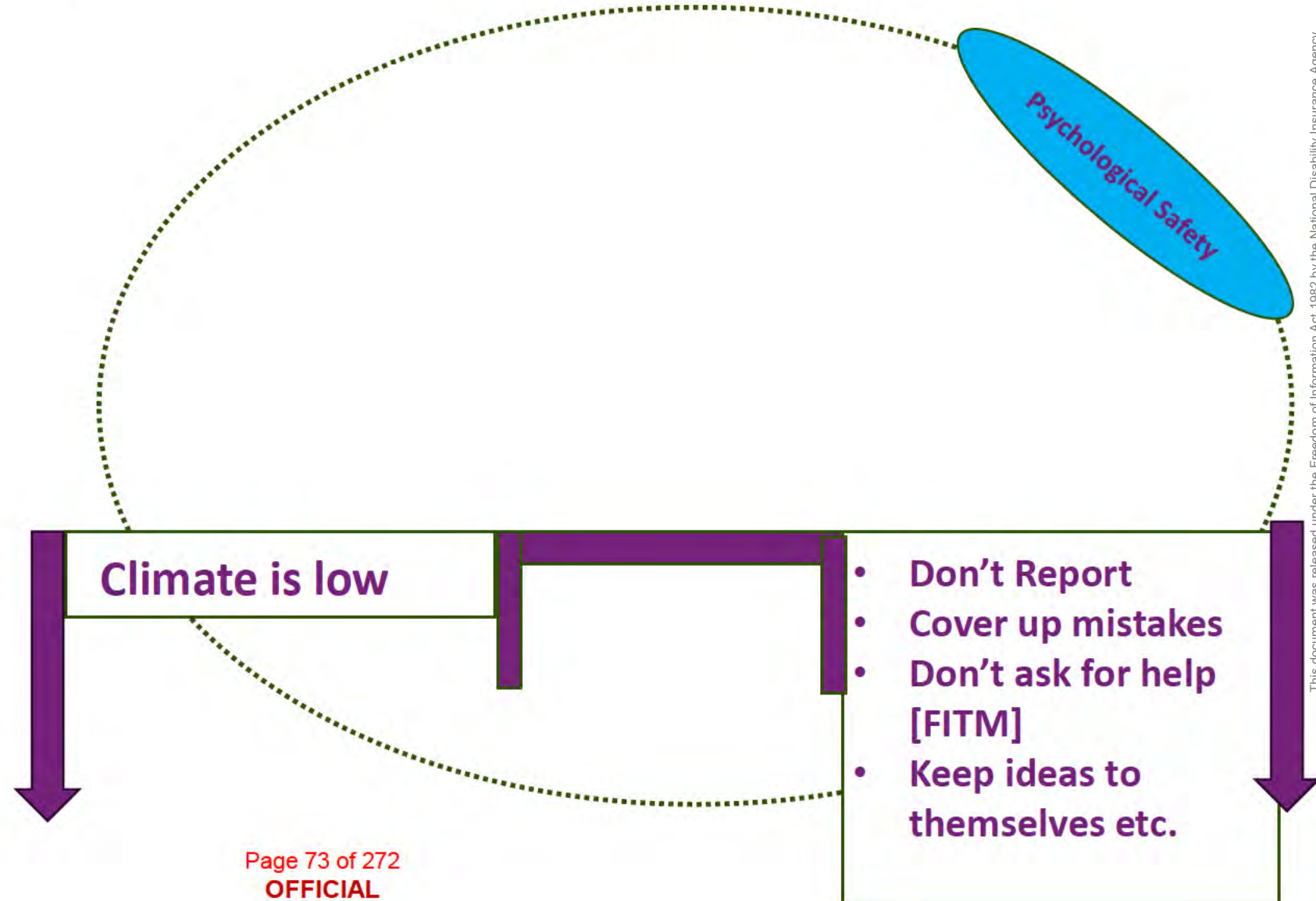


A psychologically safe environment

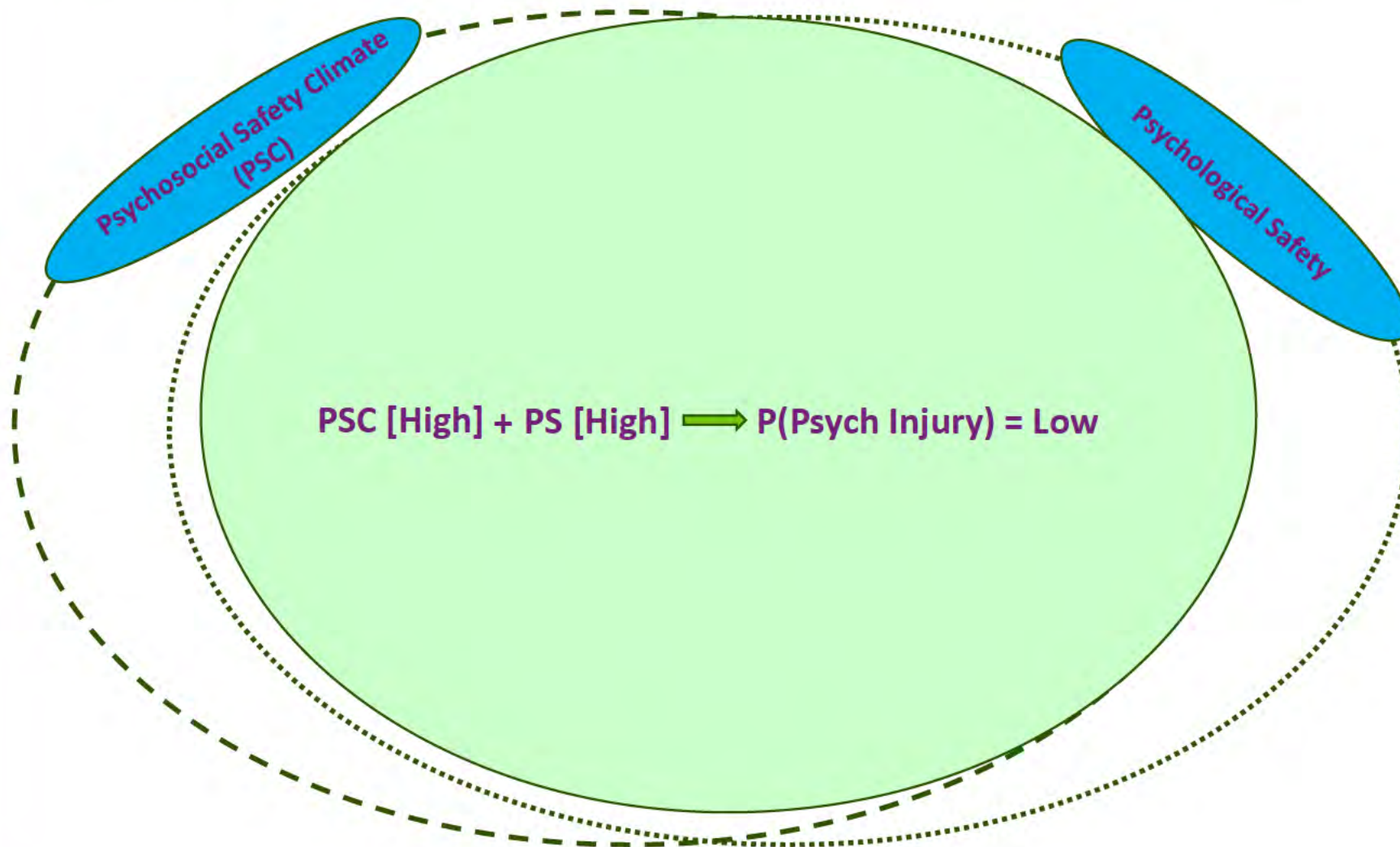


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A psychologically safe environment

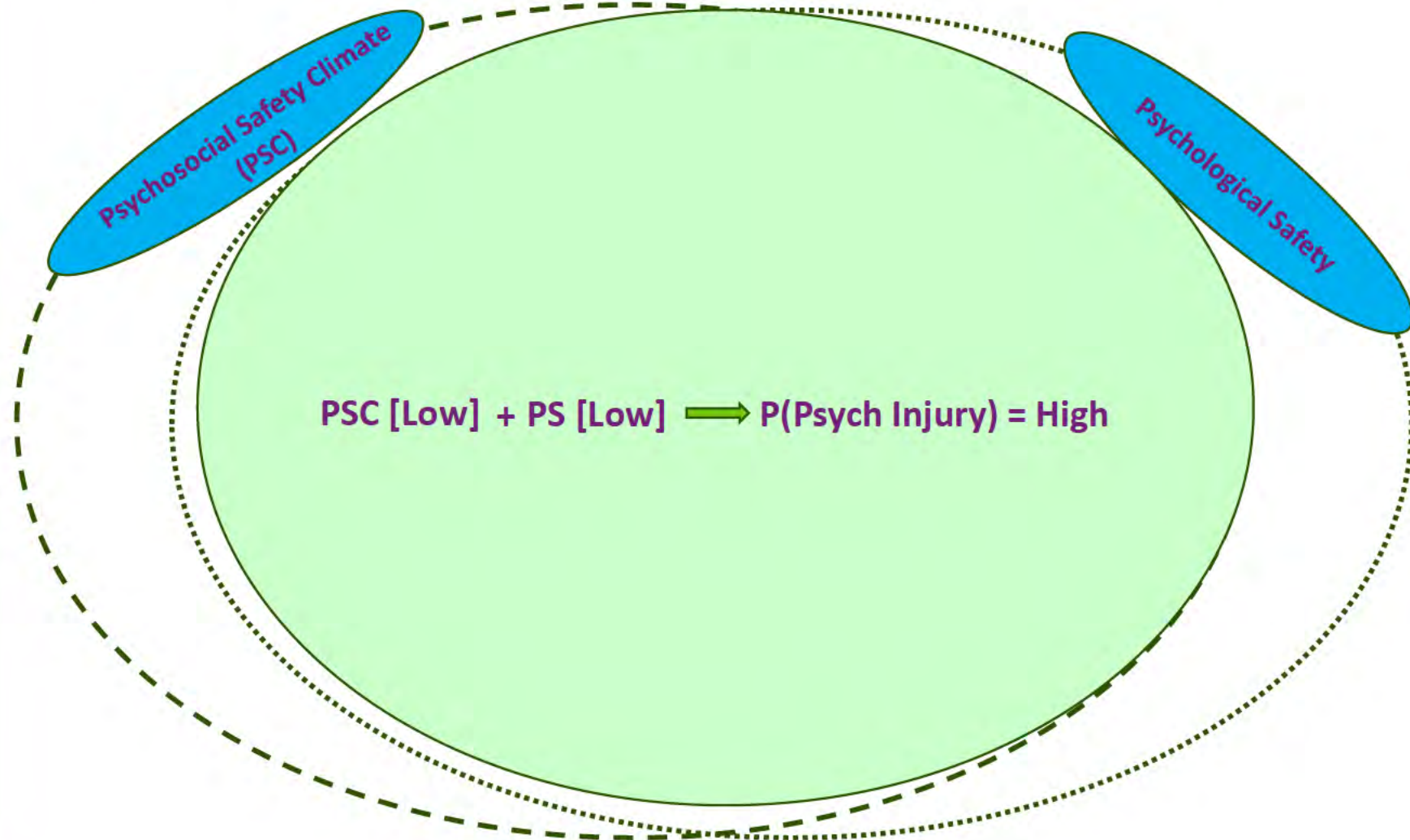


We need both these climates to be high.



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We need both these climates to be high.





Let's briefly look at the psychosocial hazards



The different psychosocial hazards

1. High Job Demands
2. Low Job Control
3. Poor Organizational Change Management
4. Traumatic Events or Material
5. Poor Support
6. Lack of Role Clarity
7. Poor Organisational Justice
8. Poor Physical Environment



9. Inadequate Reward/Recognition

10. Violence and Aggression

11. Remote/Isolated work

12. Poor Workplace Relations

13. Bullying

14. Harassment



15. Intrusive Surveillance

16. Fatigue

17. Job insecurity



Interconnectedness of hazards

- High Job Demand & Poor Physical Environment
- High Job Demand & Lack of Role Clarity



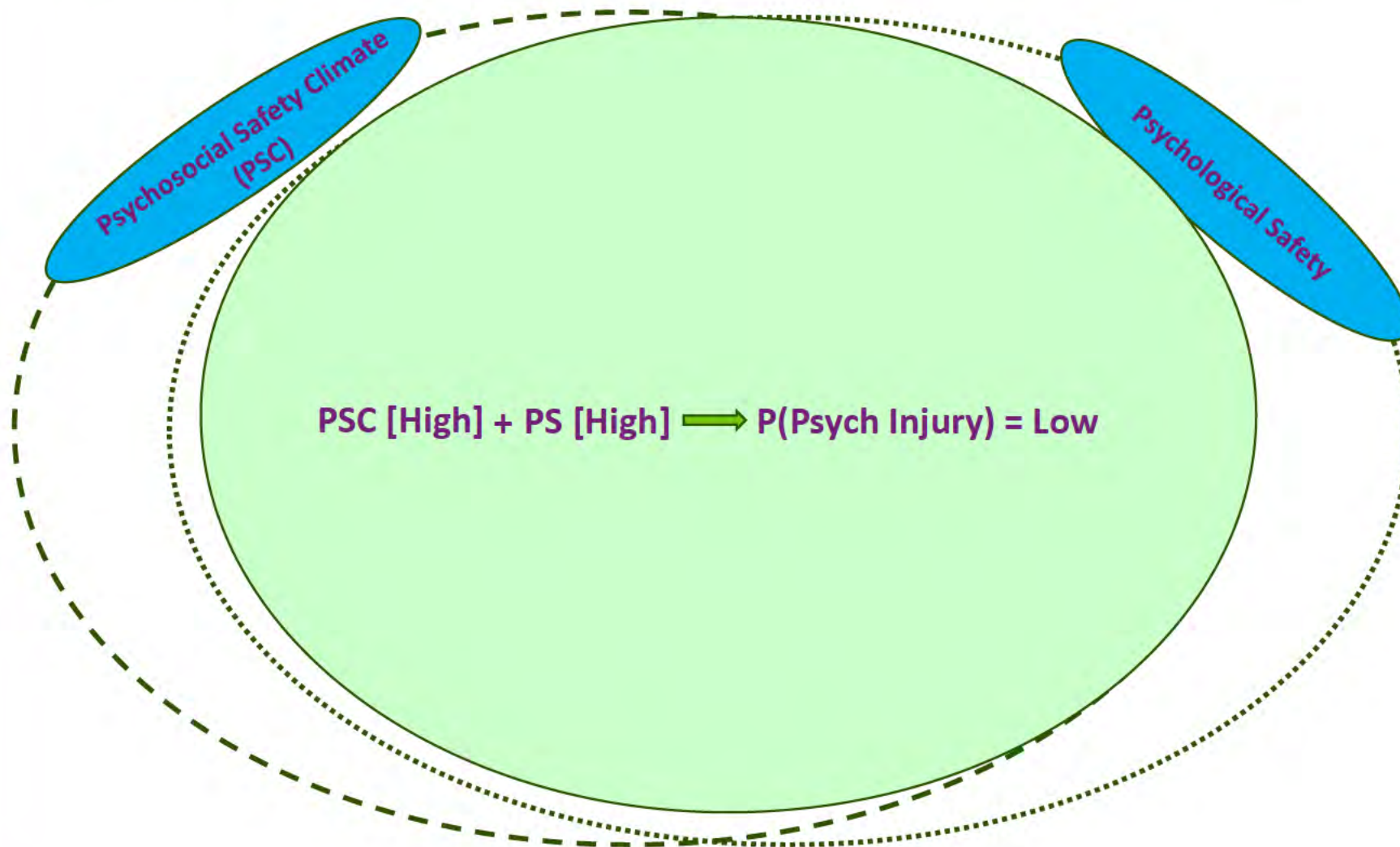
Cumulative Effect

- High Job Demand
- Able to cope (resilience)
- Tipping point



How can I remember all of this?

We need both these climates to be high.



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What can workers do?

- F** 1. Does it feel right ?
- R** 2. Report it
- O** 3. We have an Obligation.
- G** 4. We have Got your back.



Thank You Questions?



Resources

- [Workplace Psychosocial Safety Guidelines](#)
- [Safe and Respectful Workplace Policy](#)
- [Procedure for Responding to Bullying, Harassment and discrimination](#)
- [NDIA Reporting Unacceptable Behaviour Fact Sheet](#)
- [Safe & Respectful Workplace FAQs \(Frequently Asked Questions\)](#)
- [Procedure for Responding to Sexual Harassment](#)

National Disability Insurance Agency



1800 800 110



ndis.gov.au



enquiries@ndis.gov.au



Find us on Facebook/NDISAus



Follow us on Twitter @NDIS

For people with hearing or speech loss



TTY: 1800 555 677



Voice Relay: 1800 555 727

For people who need help with English



TIS: 131 450



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Comcare

INSPECTOR REPORT

COMCARE REFERENCE NUMBER	MC00041978
PCBU DETAILS	Name: National Disability Insurance Agency ABN: 25 617 475 104 ACN:
REPORT ISSUED TO	Name: Joanne [REDACTED] Position: A/D WHS Cc:NDIA-WorkHealthandSafety@ndis.gov.au

BACKGROUND

1. On 20 March 2026 a proactive work health and safety inspection was commenced with the National Disability Insurance Agency (NDIA) as part of *Regional Engagement Program 2025-26 – Risk Management Program*.
2. The purpose of the inspection was to monitor compliance with the *Work Health and Safety Act 2011 (Cth)* (WHS Act) and the *Work Health and Safety Regulations 2011 (Cth)* (WHS Regulations).
3. The scope of the inspection was to examine whether persons conducting a business or undertaking (PCBU) has implemented a system for *Risk Management* that allows it to achieve legislative compliance and ensure that the PCBU's stated requirements are in use and systematically reviewed to ensure they deliver the PCBU's intended WHS outcomes.

OUTCOMES

4. Based on the information reviewed during the inspection, I did not identify any non-compliance with the WHS Act/WHS Regulations with respect to the scope of the inspection.

Information and advice

5. The PCBU must ensure risks to health and safety are eliminated so far as is reasonably practicable, or if not reasonably practicable to do so, are minimised so far as reasonably practicable: s 17 of the WHS Act. PCBUs should have regard to Part 3.1 of the WHS Regulations and the Code of Practice: How to Manage Work Health and Safety Risks when managing risks to health and safety. The PCBU must monitor and maintain control measures, particularly any interim controls, to ensure that they remain in use and effective.
6. Learnings regarding control measures as a result of the inspection should be applied across the organisation where applicable.
7. Comcare draws NDIA attention to their duties to consult, so far as is reasonably practicable, with workers and HSRs on work health and safety matters. Comcare encourages PCBUs to share inspector reports, or to provide access to relevant content or information regarding hazards and



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associated risks, with their workers, including HSRs. PCBU must, so far as is reasonably practicable, 'consult with workers who carry out work for the business or undertaking who are, or are likely to be, directly affected by a matter relating to work health and safety' (s47).

8. Compliance with this duty may be assisted by sharing health and safety information from inspector reports with relevant workers and/or their representatives. PCBU should also note that HSRs are empowered to receive information relevant to their work groups, and that as a function of their role, may request access to inspector reports, or relevant information within them. Comcare encourages PCBU to have regard to their consultation duties, and to their obligations to HSRs under the WHS Act when responding to such requests (see s49, 70(1)(a), 70(1)(c), 71 and 79(3)).

COMPLIANCE ASSESSMENT

9. Prior to the inspection, NDIA was requested to provide a copy of any policies and procedures related to WHS Risk Management, including but not limited to:
- Policies and procedures to demonstrate these arrangements are in place:
 - WHSMS/HSMA including - WHS Policy, WHS Risk Management Framework
 - Roles and responsibilities of workers to:
 - Identify WHS hazards – physical, psychosocial, reputational, financial
 - Assess risks – risk matrix with definitions (hazard, risk) and likelihood and consequence,
 - Implement control measures – allocation of responsibility for implementation of control measures,
 - Monitor control measures for effectiveness – review of existing controls (Risk Register review schedule in consultation with workers/their representatives), triggers for review outside of periodic/planned reviews
 - Evidence of WHS training and instruction relevant to the workplace (Hazard Identification, risk assessment and control)
 - Evidence of consultation on a WHS risk with another PCBU
 - Last two WHS Committee meeting minutes where workers have participated in decision making in relation to managing WHS hazards identified and the application of appropriate control measures
 - Completed WHS Inspection Checklist – with evidence of corrective actions
 - Two operational risk assessments – including evidence of consultation at meetings
 - Current list of HSRs
10. On 29 April I undertook a virtual site inspection with representatives of the NDIA. This inspection was carried out as a planned engagement.
11. I undertook actions to make relevant Health and Safety Representative/s aware of my attendance at the workplace and afford the opportunity to engage in the inspection process. I did engage with the relevant Health and Safety Representative.
12. Based on the documentation provided prior to the inspection and the information reviewed during the inspection, I did identify elements within the Comcare *Risk Management* checklist that could

not be demonstrated. As discussed during the Inspection, NDIA should consider developing policies, procedures or processes that demonstrate the application of the following:

- a. a process for the management of shared or cross jurisdictional WHS risk,
- b. guidance for keeping records of the risk management processes in accordance with WHS Legislation.

During the review of the risk assessments, it was discussed that NDIA should consider:

- c. following the processes as outlined in their documentation,
- d. implementing a process to review control measures including:
 - i. triggers,
 - ii. timeframes,
 - iii. obligations,
 - iv. version control.

13. Based on the information reviewed, NDIA has implemented policies, procedures or processes to manage Risk Management. The following elements were demonstrated to Comcare during the Inspection to show that NDIA was:

- a. identifying components of a risk management framework that sets out the organisational arrangements for implementing, monitoring, reviewing and continually improving risk management practices,
- b. defining when the PCBU's risk management approach is to be used,
- c. using a process that is endorsed by the PCBU's accountable authority,
- d. defining the PCBU's risk appetite/risk tolerance,
- e. outlining the key accountabilities and responsibilities for managing and implementing the PCBU's risk management framework,
- f. identifying when risk assessments should be carried out,
- g. defining the process for the identification of hazards,
- h. defining the process for the management or control of the identified risk/s,
- i. outlining how the PCBU reviews the controls to ensure they remain effective,
- j. outlining the PCBU's process to train workers in the risk management framework,
- k. including key definitions relating to WHS risk management,

During the review of the risk assessment, NDIA demonstrated that:

- l. it documents how consultation on control measures has been decided, approved/endorsed,

The examples provided of consultation with another PCBU demonstrated that:

- m. consultation has occurred with another PCBU on a WHS matter,
- n. consideration of feedback occurred.

14. A review of NDIA's incident register demonstrated that:

- i. incidents and hazards are being reported and investigated,



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- ii. root cause/s are being identified,
- iii. controls are being applied,
- iv. there is a process in place to review control measures.

15. Discussions with an HSR, a worker and a contractor demonstrated that:

- a. They were able to identify the policies and procedures for risk management,
- b. They were consulted on the controls to be implemented,
- c. They have received training or instruction to enable them to:
 - i. identify hazards,
 - ii. assess risk/s,
 - iii. implement control measures,
 - iv. monitor control measures to ensure they remain effective.

16. It is important to understand that the outcomes of this engagement should not be considered a validation of NDIA policies and procedures or their effectiveness. NDIA should ensure that the requirements of the Code of Practice (CoP): *How to manage work health and safety risks* are met.

17. The inspection is now closed however should an incident relating to *Risk Management* occur anywhere within the organisation in the future, Comcare will look to confirm that NDIA has ensured policies and procedures are effective and are maintained so that they remain effective.

REPORT ISSUED BY	Inspector	Paul s47F - personal privacy
	Inspector ID number	238
	Email	s47F - personal privacy paul@comcare.gov.au
	Phone	02 6112 9667
	Date	20 May 2026
	Signature	s47F - personal privacy



DISCLAIMER

This report contains information that may assist you to take steps regarding your obligations under the WHS Act. You must refer to the Commonwealth *Work Health and Safety Act 2011* (WHS Act) and the *Work Health and Safety Regulations 2011* (WHS Regulations) to understand your duties and obligations. Comcare's external website contains links to WHS legislation. Comcare does not accept liability for any errors or omissions or for any loss or damage suffered by you or any person which arises from your reliance on this report or for any breach by you of your obligations under the WHS Act. Where a Comcare inspector has inspected a particular workplace, it is not a representation by Comcare that the particular workplace is in any way free of hazards.

IF YOU DO NOT AGREE WITH A DECISION

If you disagree with the outcome of this inspection, you may seek an internal reconsideration of the inspector's decision. A request for a review should be sent to statutory.oversight@comcare.gov.au including any additional information or evidence you have to support your request. Comcare will review your request and advise of the outcome in writing within 20 business days.

If you would like to clarify any aspect of this report, you can contact the inspector directly.

Comcare has a range of publications and fact sheets to help explain your responsibilities and provide guidance to make your workplace safer. The Compliance and Enforcement Policy provides guidance as to how Comcare approaches regulation. To access these, visit our website.

PRIVACY STATEMENT

Your privacy is important to us. Comcare will only collect, use or disclose personal information in accordance with the Commonwealth *Privacy Act 1988* and if it is reasonably necessary for, or directly related to, one or more of our functions, powers and/or activities. These include functions and activities under the following Commonwealth legislation: *Safety, Rehabilitation and Compensation Act 1988*, the WHS Act, the *Seafarer's Rehabilitation and Compensation Act 1992*, and the *Asbestos related- Claims (Management of Commonwealth Liabilities) Act 2005*. If Comcare does not collect personal information from you, for the purposes of its legislated functions or related functions, we may not be able to respond appropriately.

Comcare is the Commonwealth agency authorised by the WHS Act to collect personal information relevant to the exercise of functions and powers under the WHS Act, WHS Regulations and the administration and evaluation of Comcare's WHS programmes. Any personal information collected in these forms will be used for those purposes.

In exercising our functions and powers, Comcare may disclose personal information, subject to confidentiality of information provisions under the WHS Act, to the following bodies and agencies, including but not limited to:

- Comcare's internal and external legal advisers
- the Safety, Rehabilitation and Compensation Commission
- a court or tribunal
- state or territory work health and safety regulatory agencies
- personnel engaged by Comcare to conduct research related activities
- enforcement agencies or bodies
- state and territory Coroners
- Commonwealth, state or territory industry regulators
- any other person assisting Comcare in the performance of its functions or exercise of its powers, including contractors and consultants
- any other person where there is an obligation under law to do so (for example but not limited to, responding to the direction of a court to produce documentation).

For further information on how Comcare handles personal information, please read the Privacy Policy on Comcare's website. To request a change to your personal information or to make a complaint, please phone or email privacy@comcare.gov.au.

a. www.comcare.gov.au | 1300 366 979



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Practical guidance for **MANAGERS** and **SUPERVISORS**



Work **DEMANDS** Set the standard.



Preventing PSYCHOLOGICAL harm

Work demands are one of the most common sources of workplace stress and psychological harm. Workers who experience high work demands such as excessive workloads, resource constraints or time pressures can often feel overwhelmed or unable to cope. Those experiencing low work demands like, repetitive or monotonous tasks, can often feel disengaged or underutilised.

In either case, when work demand issues are not effectively managed workers are far more likely to experience work-related stress. Extreme or long-lasting stress is harmful and can lead to serious illness or injury to workers.

Poor health outcomes from work demands are far less likely in organisations with a supportive culture that rewards workers, promotes early reporting of issues and proactive risk management. Employers have an obligation to implement systems and processes that identify and effectively manage psychosocial risks to prevent harm to workers.

Work demands – definition

Work demands may include role overload, unrealistic time pressures, ambiguity or conflict, cognitive and emotional demands of the job, conflict arising from tasks, relationships, change management, a lack of organisational justice and a worker's sense of fairness at work.



The role of managers and supervisors

Managers and supervisors must address health and safety issues raised by workers and take active steps to monitor and minimise workplace risks. The best way to do this is through ongoing consultation with your team and following your organisation's policies and procedures for managing risks to health and safety at work. Under the Work Health and Safety (WHS) Act, health is defined as both physical and psychological health, which can be impacted by psychosocial hazards such as work demands.

When issues regarding safety systems arise or new hazards are identified, report them to more senior levels of the organisation for resolution. You can be a role model for your team and help foster a workplace culture that supports psychological health by monitoring workload levels and ensuring tasks align with workers' skills and capability.



Work demands – impacts

Worker impacts

- Depression
- Anxiety
- Fatigue
- Burnout
- Anger and/or mood swings
- Problems sleeping
- Diminished performance
- Disengaged or withdrawn from work.

Organisational impacts

- Poor workplace culture
- Negative or strained work-team relations and team dynamics
- Increased worker injury and illness
- Reduced productivity
- Higher employee turnover
- Increased absenteeism
- Customer or client complaints.



Work demands - examples

Time

- Unrealistic timeframes or time pressures
- Long work hours or shift work

Cognitive – low and high

- Low: highly repetitive or monotonous tasks
- High: long periods of vigilance for infrequent events, complex or challenging decision making, or low role clarity

Workload

- Low - long periods of insufficient work
- High - Unrealistic or unachievable amounts of work

Emotional

- Responding to distressing situations or aggressive clients
- Exposure to traumatic events or work-related violence
- Poor workplace relationships

Physical

- Sitting or standing for long periods
- Unpleasant or hazardous conditions (e.g. hazardous chemicals, or dangerous equipment)

Environmental

- Remote and isolated work
- Poor environmental conditions (e.g. extreme temperatures or noise, air quality)

Organisational change (e.g. downsizing, site relocations or new processes)

- Insufficient consideration of potential impacts
- Inadequate stakeholder and worker consultation
- Not enough practical and emotional support for workers

Organisational justice or sense of fairness

- Inconsistent application of policies and procedures
- Bias in decision making
- Poor management of underperformance
- Low recognition and reward

Latest data shows:

24%

Work pressures accounted for 24% of all accepted psychological claims.

31%

Percentage of costs associated with psychological injury claims.

25

Average number of weeks off work (incapacity weeks) for psychological injury claims.

Source: Comcare claims data 2021-22

88%

Percentage of disease claims for mental health conditions in the public administration and safety industry (government, police, fire, emergency services).

Source: Safe Work Australia Workers Compensation Statistics 2019-20





Work demands – risk factors

Risk factors cover two categories:

Context (how the work is organised)

- Organisational function and culture
- Leadership
- Organisational change management
- Interpersonal relationships at work
- Role in organisation
- Career development
- Decision latitude and control
- Resource allocation.

Content (what the job involves)

- Work environment and equipment
- Task design
- Workload
- Work schedules
- Worker skills, capabilities and training.



Managing risks

Step 1: identify sources of harm

- **Inspect your workplace.** Observe how the work is carried out, how workers interact, noting any rushing, delays, or backlogs.
- **Review relevant information and records.** This can include incident reports, workers' compensation claims, staff surveys, absenteeism and staff turnover data to gather information from workers, supervisors and managers.
- **Ongoing communication and consultation.** Talk with workers, managers and health and safety specialists and share information about hazards and risks.
- **Encourage feedback.** Give workers a reasonable opportunity to express their views, raise issues and contribute to the decision-making process where possible.

Step 2: assess and prioritise the risk

- **Understand the nature of the harm.** This involves asking important questions about the level of risk, its likely causes and likelihood of it happening to prioritise how and when to take action. Please note, this step may not be necessary if you are dealing with known risks to psychological health and safety that have known control measures (see next section).
- **Ongoing communication and consultation.** This can include discussions with workers, HSRs, worker representatives, conducting focus groups (6-10 workers) and staff surveys to identify potential risks, whether risks are impacting workers and understand the source of the risk.



Supportive leadership = supportive workplace culture

Poor health outcomes are much less likely to result from work demands in a workplace with supportive leaders that are approachable and responsive to dealing with worker concerns and demonstrate an understanding of the issues faced by their teams. Supportive leadership helps create a supportive workplace culture that promotes early reporting of issues and proactive risk management. Supportive leadership can include checking on work related matters and creating a safe environment to discuss personal matters that may be impacting a worker's ability to respond to or cope with work demands.



Implementing effective control measures

Step 3: control risks focusing on job design



Time demands

- Ensure staffing levels align with expected outputs and workers have enough time to complete tasks.
- Ensure workers take breaks and allow for sufficient time between rostered shifts.
- Give workers the opportunity to provide input into work pace and timing.
- Set realistic and achievable targets.
- Monitor workloads during peak periods, such as Christmas.
- Regularly review workloads to ensure workers have sufficient support.
- Help employees develop personal work plans to help them prioritise tasks.
- Encourage workers to speak up at an early stage if they feel their workload is excessive.



Cognitive or emotional demands

- Rotate tasks and schedules where possible to provide job variety and to lessen the impact of repetitive and monotonous tasks.
- Give workers some control over the way they do their work, including work pace and order of tasks.
- Ensure there is enough time for regular breaks that provide a 'time-out'.
- Have support systems in place for workers that make complex or difficult decisions, e.g. a second person to assist.
- Provide training and ongoing support to workers on how to diffuse difficult or confronting situations.
- Consider training and regular check-in procedures for workers.



Physical demands

- Allow regular breaks and rotate repetitive manual tasks between workers where possible.
- Make the physical environment as comfortable as possible, such as changes to the workstation, equipment, or the way the job is done.
- Substitute heavy manual tasks with machinery to reduce physical workloads where practicable.
- Ensure workers are well trained and physically capable of doing the work.



Organisational change demands

- Reassess workload during change and reallocate or reprioritise as needed.
- Consult workers about potential impacts and listen to their views.
- Engage workers through regular consultation and communication during changes, including supports available.



Organisational justice demand

- Inform workers about dispute escalation and resolution mechanisms that are available via the organisation's WHS unit or Human Resources. Encourage feedback from workers on organisational processes and procedures, and performance management.
- Provide ongoing training in issues management and dispute resolution.

Tip for managers

Role model expected behaviours, such as taking breaks and not sending emails outside agreed hours.



Step 4: monitor and review controls

You should continue to work with your employer to monitor and review control measures to minimise the risk of work demands and ensure they remain effective. Where necessary, you may need to revise the approach, including when a new hazard or risk is identified or a control measure is not adequately minimising the risk. It is also important before a significant workplace change, e.g. systems or process change. Consultation with workers and their Health and Safety Representatives (HSR) is critical throughout each step of the risk management cycle, including monitoring and review.



For more information

Comcare

Preventing harm

- [Working Well – An organisational approach to preventing psychological injury](#)
- [Psychosocial hazards](#)

For managers and supervisors

- [Office Safety Tool - Senior managers and executives](#)
- [How managers can support worker mental health](#)
- [Comcare Regulatory Guides](#)
- [People at Work](#) - free psychosocial risk assessment tool for workplace leaders.

Mental health

- [Your mental health responsibilities at work](#)
- [Comcare mental health initiatives](#)
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Safe Work Australia

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- [Safe Work Australia Model Code of Practice - Managing psychosocial hazards at work](#)

Codes of Practice

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- [Managing the Work Environment and Facilities Code of Practice 2015](#)

Additional resources

- [Working Together: Promoting Mental Health and Wellbeing at Work – Australian Public Service Commission and Comcare.](#)
- [Management Standards on Stress – UK Government Health Safety Executive.](#)
- [Workload Management: An Environmental Scan of current and emerging practices – Victorian Public Sector.](#)
- [Psychological health and safety in the workplace – Prevention, promotion, and guidance to staged implementation – National Standard of Canada.](#)

Comcare's role

As the national work health safety and workers' compensation authority, Comcare's legislated functions include securing the health and safety of workers and workplaces through responding to incidents, educating employers, and encouraging leaders to foster a positive workplace culture. We recognise work demands and other psychosocial hazards can cause workers psychological or physical harm and we are committed to supporting our jurisdiction of more than 400,000 workers and 200 employers.





Australian Government
Comcare

Practical guidance for **WORKERS**



Work **DEMANDS** Set the standard.



Preventing PSYCHOLOGICAL harm

Work demands are one of the most common sources of workplace stress and psychological harm. Workers who experience high work demands such as excessive workloads, resource constraints or time pressures can often feel overwhelmed or unable to cope. Those experiencing low work demands like, repetitive or monotonous tasks, can often feel disengaged or underutilised.

In either case, when work demand issues are not effectively managed workers are far more likely to experience work-related stress. Extreme or long-lasting stress is harmful and can lead to serious illness or injury to workers.

Poor health outcomes from work demands are far less likely in organisations with a supportive culture that rewards workers, promotes early reporting of issues and proactive risk management. Employers have an obligation to implement systems and processes that identify and effectively manage psychosocial risks to prevent harm to workers.

Work demands – definition

Work demands may include role overload, unrealistic time pressures, ambiguity or conflict, cognitive and emotional demands of the job, conflict arising from tasks, relationships, change management, a lack of organisational justice and a worker's sense of fairness at work.



Worker duties and obligations under the *Work Health and Safety Act 2011*

Workers must take reasonable care for their own health and safety at work and to ensure they do not adversely affect the health and safety of others. This includes raising any issues or concerns with managers as early as possible, including any issues or concerns with psychosocial hazards such as, work demands.

Remember under the WHS Act, health is defined as both physical and psychological health. If you need extra support or guidance, talk with your manager or supervisor in the first instance. If this is not possible, reach out to your health and safety representative at work, a colleague or support service (e.g. Employee Assistance Program).



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- Decision latitude and control
- Resource allocation.

Content (what the job involves)

- Work environment and equipment
- Task design
- Workload
- Work schedules
- Worker skills, capabilities and training.



Things to look out for

While many workers can experience either high or low work demands, the following groups are considered at greater risk of psychological or physical harm:

- New or younger workers
- Workers with an existing disability, injury or illness
- Workers who have been exposed to a traumatic event
- Workers who are currently experiencing difficult personal circumstances.
- Workers from a culturally or linguistically diverse background
- Workers in public facing roles, e.g. frontline workers.

Stress and work demands

It is important to note that stress is not the same as work demands or work pressures. Workers can experience stress for many reasons, such as when workplace demands are greater than the resources available, however workers can usually cope with demanding work when:

- Demands are not excessive and ongoing
- Managers, supervisors and colleagues are supportive
- Workers are given an appropriate level of autonomy
- Safety systems intervene early to moderate work demands and reallocate tasks when workers are struggling.

Other psychosocial risks

Other psychosocial risks can also be contributing factors to work demands, including:

- **Low job control.** Workers have little control over how or when their job is done, or work is tightly managed (e.g. scripted call centres). This can include jobs where workers are not involved in decisions that impact their clients, have no say in the timing of breaks or changing tasks, and are unable to refuse dealing with aggressive clients (e.g. police services).
- **Low role clarity.** Workers are in roles where there is uncertainty about or frequent changes to tasks and work standards or important information about tasks, priorities and targets is not available or shared. This can also include conflicting job roles, responsibilities or expectations.



Psychosocial risks are often interrelated

Psychosocial risks should not be viewed in isolation. Workers may be exposed to multiple work demand types and psychosocial hazards. Some may always be present and others only occasionally. For example, poor workplace relationships (emotional demand) can be the result of related risks such as remote and isolated work (environmental demand), bias in decision making (organisational justice demand) or low role clarity (See Other psychosocial risks section).



For more information

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- [Beyond Blue](#)

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ACTIONS for workers

If you are feeling overwhelmed or unable to manage the demands of your work, this can become detrimental to your health and potentially impact the rest of your team. Here are some actions you can take to help manage the risk and support those around you:

- **Raise issues early.** Talk with your manager or supervisor about your workload and discuss any concerns as soon as possible to ensure tasks can be reallocated or reprioritised. If relevant, discuss personal issues that may be contributing to the impact of work demands.
- **Take regular breaks.** Ensure you take the opportunity to step away from your work during rostered or scheduled breaks – and encourage your colleagues to do the same.
- **Ask for help (and offer help).** Reach out to your manager when you are feeling overwhelmed or unable to cope and support your colleagues when they need help.
- **Foster a supportive workplace culture.** Early reporting and supporting colleagues also contribute to a positive work environment where teams actively promote respectful relationships and work-life balance.
- **Access training and education.** Speak to your manager about available training to help you manage the demands of your job, such as how to diffuse difficult situations or courses that focus on time or project management.
- **Escalate when needed.** If you're unable to speak directly with your manager or no action has been taken, follow internal resolution procedures and explore other available options e.g., make a report via Human Resources, talk with your Health and Safety Representative (HSR) or consult a union representative.
- **Reach out for further support.** Access support services available via your employer such as the Employee Assistance Program (EAP) or services available via external providers such as Beyond Blue (See **For more information** section).



Worker feedback = safer workplaces

Workers should share their views and participate in consultation opportunities in their workplace. For example, be proactive in team meetings and provide input into the way work gets done, such as work pace, and clarify roles and responsibilities. Workers can also participate in staff surveys or workshops where possible and submit feedback via your organisation's WHS systems. Remember consultation with workers and their Health and Safety Representative (HSR) is also a legal requirement for employers under the WHS ACT, so far as reasonably practicable.



 Session Details

The example for this session will focus on **vicarious trauma**.

Details			
Location	MS Teams	Facilitator	WHS Snr Advisor - Colleen
Start Time	11 February 2026 02:00 PM Australia/Sydney Time	Finish Time	11 February 2026 02:45 PM Australia/Sydney Time
Capacity	40/1000	Status	Completed

MONTH	TOPIC	THEME	COURSE DESCRIPTION	EXAMPLE	ACCESSIBLE DOC	PRESENTER	Assistant	DURATION (Mins)	DATE	SESSION TIMING	TIME	NO. ATTENDEES
Feb W2	How to lodge a WHS Speak Up	Psychosocial	Psychosocial hazards are aspects of work which have the potential to cause psychological or physical harm. They can come in many different forms, including workplace stress, change fatigue, workload, low job control and more. These hazards can have a significant impact on your mental and physical health and your overall wellbeing.	Vicarious trauma	YES	Colleen	Adele	45	11/02/2026	Afternoon	2pm	24

WHS - How to undertake a LM Investigation (Psychosocial)

Safety and Wellbeing

DESCRIPTION

SESSIONS



Course information

Duration45m

Course Description: These sessions focus on a demonstration on how to investigate safety incidents, what is the role of the line manager, what do you look for and how do you conclude the incident has been suitably investigated. . There are several sessions available, please review the schedule and enrol in the one most suitable for you.

Psychosocial hazards are aspects of work which have the potential to cause psychological or physical harm. They can come in many different forms, including workplace stress, change fatigue, workload, low job control and more. These hazards can have a significant impact on your mental and physical health and your overall wellbeing.

There are two (2) sessions throughout 2026 focussing on psychosocial hazards and include the following examples:

1. Vicarious trauma - 18 February 2026 1pm

2. Workplace stress change management - 17 June 2026 10:30am

Target Audience: All Line Managers

Course Contact: Work Health and Safety team - ndia-workhealthandsafety@ndis.gov.au

Accessibility: If you have any accessibility requirements that need to be met, please contact the WHS team via email on ndia-workhealthandsafety@ndis.gov.au at least one week prior to your chosen session

Copy link

Enrol

MONTH	TOPIC	THEME	COURSE DESCRIPTION	EXAMPLE	ACCESSIBLE	PRESENTER	Assistant	DURATION (Mins)	DATE	SESSION TIMING	TIME	NO. ATTENDEES
					DOC							
Feb W3	How to undertake a LM Investigation	Psychosocial	Psychosocial hazards are aspects of work which have the potential to cause psychological or physical harm. This session will focus on what the role of the line manager is, what to look for and how to undertake the investigation required.	Vicarious trauma	YES	Colleen	Chelsea	45	18/02/2026	Afternoon	1pm	10

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This document was released under the Freedom of Information Act 1982 by the National Disability Insurance Agency.



How leaders contribute to a safe workplace.

Supporting Staff with Speak Up reporting

[ndis.gov.au](https://www.ndis.gov.au) | HaLPO 2025

1

Acknowledgement of Country

Before we begin, I would like to acknowledge the Traditional Owners and Custodians of the Country on which we meet today, and their continuing connection to land, sea, and community. I pay my respects to their Elders, past present and emerging.

I would like to extend that acknowledgement and respect to any Aboriginal and Torres Strait Islander peoples here today.



Managing Psychosocial Hazards

The psychosocially safe workplace – What leaders need to know



Agenda - Managing Psychosocial Hazards

1. Psychological safety – History
2. Relationship between high performing teams and mistakes
3. Brief case study
4. Your responsibilities in relation to psychological safety
5. Your input into Speak-ups



Leadership?

1. Influence, inspire, and bring out the best in others,
2. See the 'big picture', help others connect the dots, and fill in gaps,
3. Motivate and influence teams to work towards achieving a common goal, and
4. Invest in the whole (people and systems needed to succeed).



Psychological Safety – History

Relationship between High Performance Teams and mistakes?

1. Amy Edmondson
2. Researched high performing teams
3. Interested in team performance & error rates
4. Found that high performing teams recorded more errors
5. This does not sound right?
6. She realized that high performing teams were more willing to report and discuss mistakes.
7. Psychologically safe environment is crucial for learning, innovation and performance.

Psychological Safety – Defined

1. The shared belief that a team/person is safe from interpersonal risk taking.
2. Meaning they will not be punished or humiliated for speaking up on incidents, ideas, questions, concerns, mistakes etc.

Remember

1. There is a link between inter-personal risk and business risk



Remember

1. There is a link between inter-personal risk and business risk
2. If you don't believe me, let's look at a case study that you may be familiar with.

Enter – Boeing 737 Max



Infrastructure for psychological safety



1. Systems – Org Responsibility
2. Culture – Team-level Responsibility





How to Complete a Line Manager Investigation



Agenda – Line Manager investigation and Speak Ups

1. Speak up reporting
2. Why do we report?
3. Speak up myth busting
4. What happens once you receive the speak up
5. Demo of undertaking the Line Manager investigation – mental stress / burn out
6. How to contact the WHS team

Speak Up Reporting



“Speak Up” is the term used for all Agency **reporting streams**.



As a part of your duty of care to yourself and others in the workplace, all workers are **required** to report incidents, hazards and near misses.



Today's focus is on Work Health and Safety Speak Up reporting in the NDIA risk management platform - **Insight**.

Why Do We Report?

- ✓ To ensure the **safety and wellbeing of workers** and to ensure the appropriate **supports** are in place.
- ✓ To ensure **corrective actions** are in place to prevent the event from occurring again where practicable.
 - ✓ This also applies for near misses and hazards, reporting before an incident takes place will help to **prevent an event from occurring**.
- ✓ To **collect data** that highlights the nature of hazards and risks encountered by workers which contributes to the development and improvement of policies, procedures, and guidelines.

Myth busting Speak Up reporting



If you are in a co-located site – **YES**, we ask that you let the Service Australia's Service Centre Manager know & lodge a Speak Up



If you are labour hire – **YES**, we ask that you let your labour hire company know and you lodge a Speak Up report.



There will be a negative impact to me if I report – **NO**, there is a no blame policy when reporting aligning with the NDIA value “**we take care**” We encourage you to report all incidents, hazards & near misses.

Note: If no one knows about an issue, then it cannot be fixed/resolved.

What happens once you receive a Speak Up?



Once a Speak Up report has been lodged you as the listed line manager will receive an email notification.

From ▾

To

Cc

Subject

The email subject line will read

WHS Hazard OR WHS Incident Submitted INC- 9019

For example:

WHS Incident Submitted INC-9019

In the body of the email will be a [hyperlink](#) for you to select it will lead you to the speak up report.

Line Manager Responsibilities

There are several steps to take upon receipt of a Speak Up report, noting there can be multiple follow up actions:

1. Find out **how** the impacted worker is
2. Are there any **urgent supports** needed? Follow up with other areas of the business e.g. Workplace Supports for Early Intervention Support. *If such follow up has occurred note details in the Speak Up to keep WHS Advisor informed of what actions have taken place.*
3. Has the hazard been **eliminated or isolated**? Or reported to other business areas such as Property or Security for relevant actions. *Again, if there has been interaction with other business areas note these details in the Speak Up to keep the WHS Advisor informed of what actions have taken place.*
4. **Discuss** the report with the impacted person or the person who reported the Speak Up.





Line Manager Investigation: LIVE DEMO

Mental Stress

WHS Team - Contact Information



Email: s47E(d) - certain operations of agencies [ndis.gov.au](mailto:s47E(d)-certain.operations.of.agencies@ndis.gov.au)



Teams message/call: If you know who your State WHS Advisor is.



Submit Jira Ticket via Service Desk: [Ask a question about Health, Safety and Wellbeing - People and Culture - Service project](#)



For URGENT enquiries or Notifiable Incidents - WHS Hotline Mobile: 0408 021 137 21

Questions?





Managing Psychosocial Hazards

The psychosocially safe workplace – What leaders need to know

[ndis.gov.au](https://www.ndis.gov.au) | October 2025

1



Agenda

1. Information session – To improve understanding
2. Specifically for leaders
3. Your safety is paramount – if content is triggering, please take care
4. This session:
 - We know the basics, now we focus on leadership
 - Below the line aspects of leadership
 - Above the line aspects of leadership

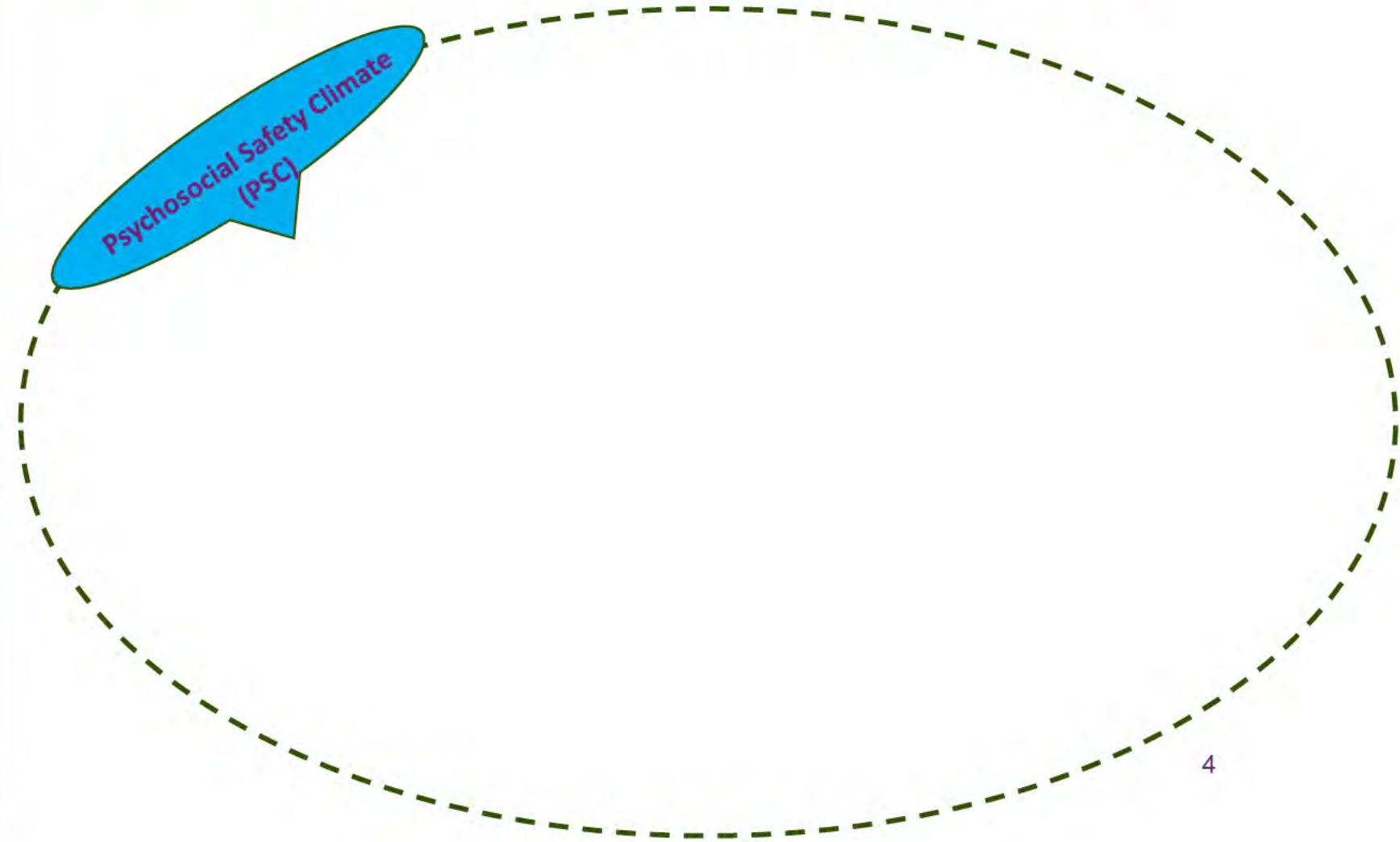


Leadership?

1. Influence, inspire, and bring out the best in others,
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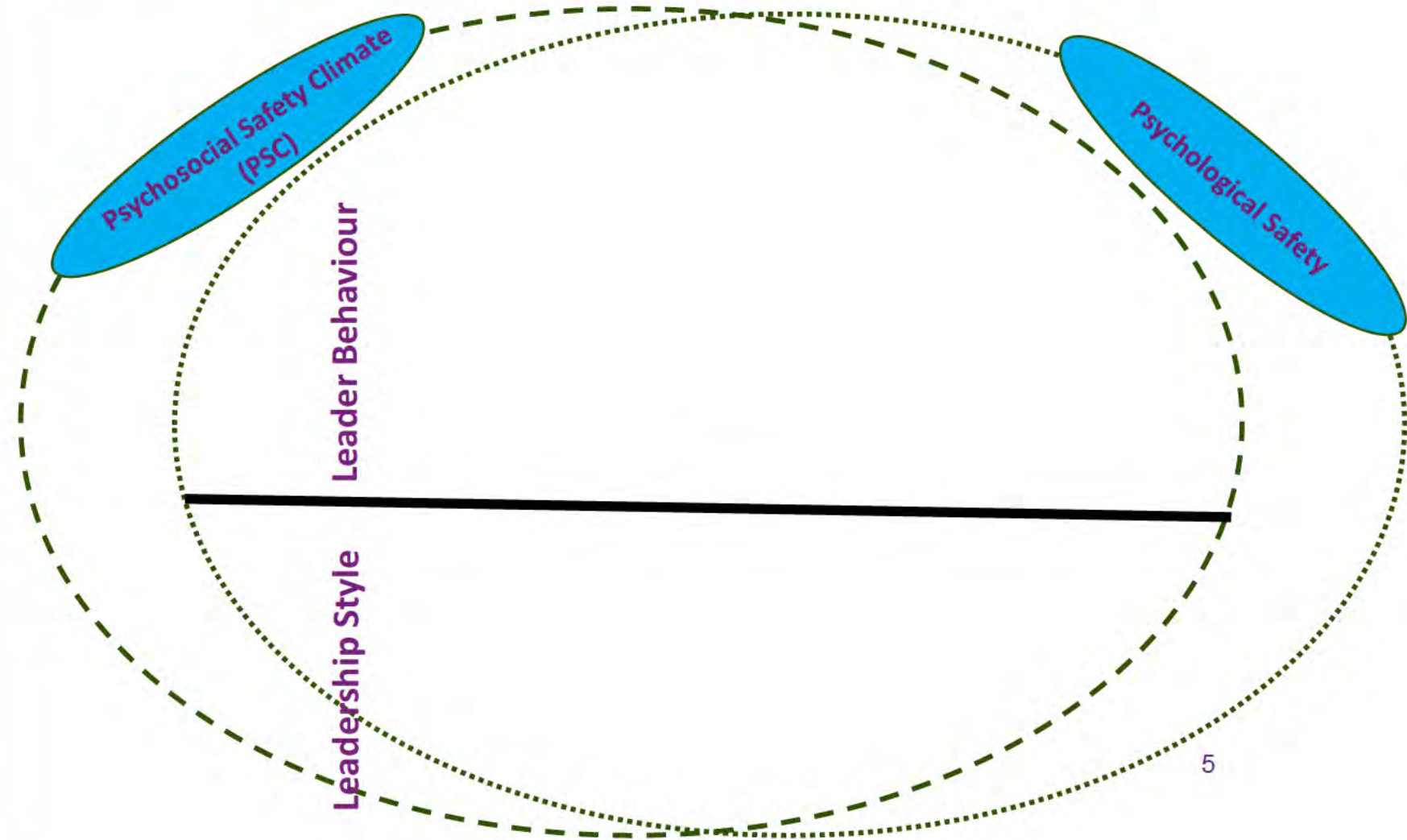
Making it safe for everybody



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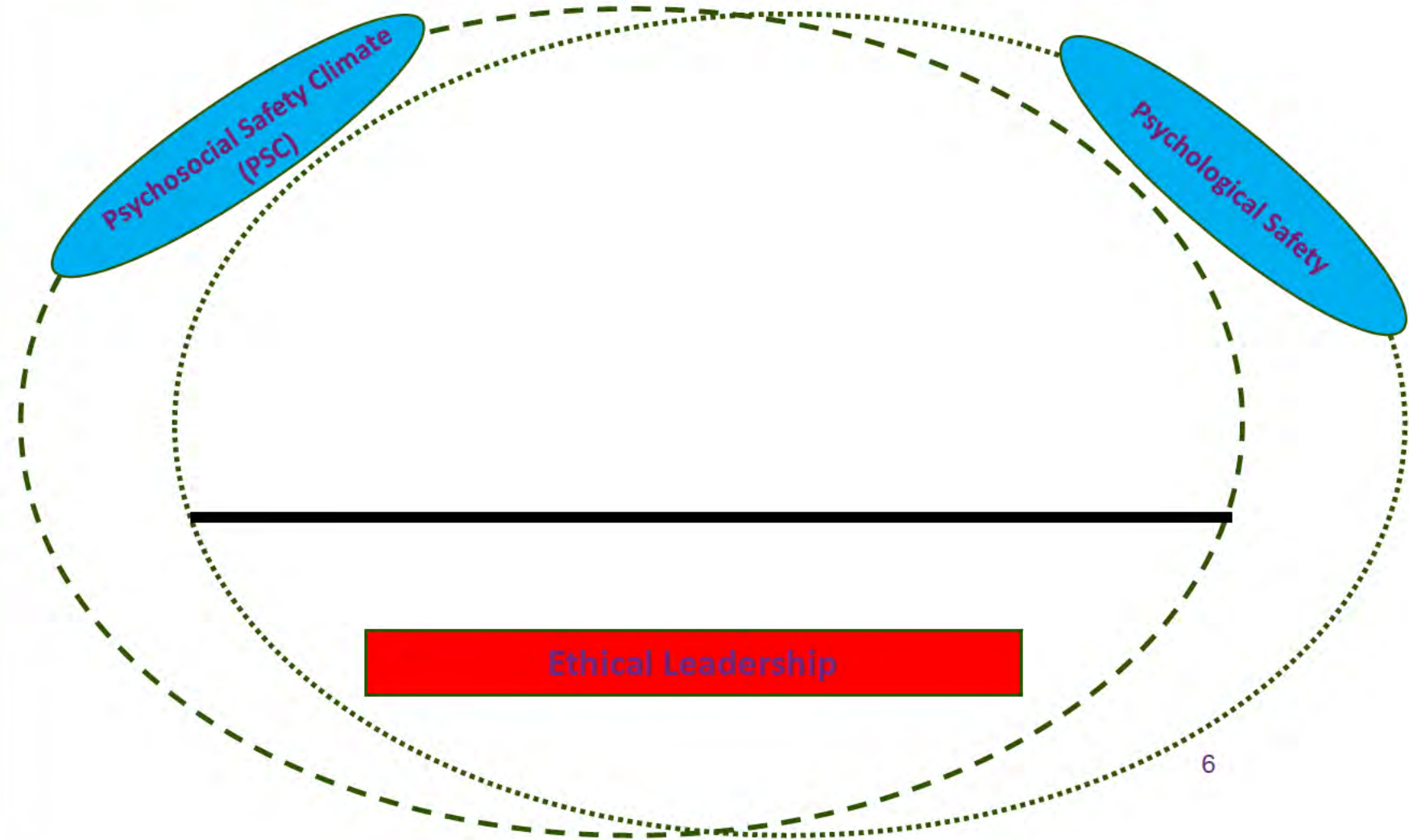
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Making it safe for everybody



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Making it safe for everybody



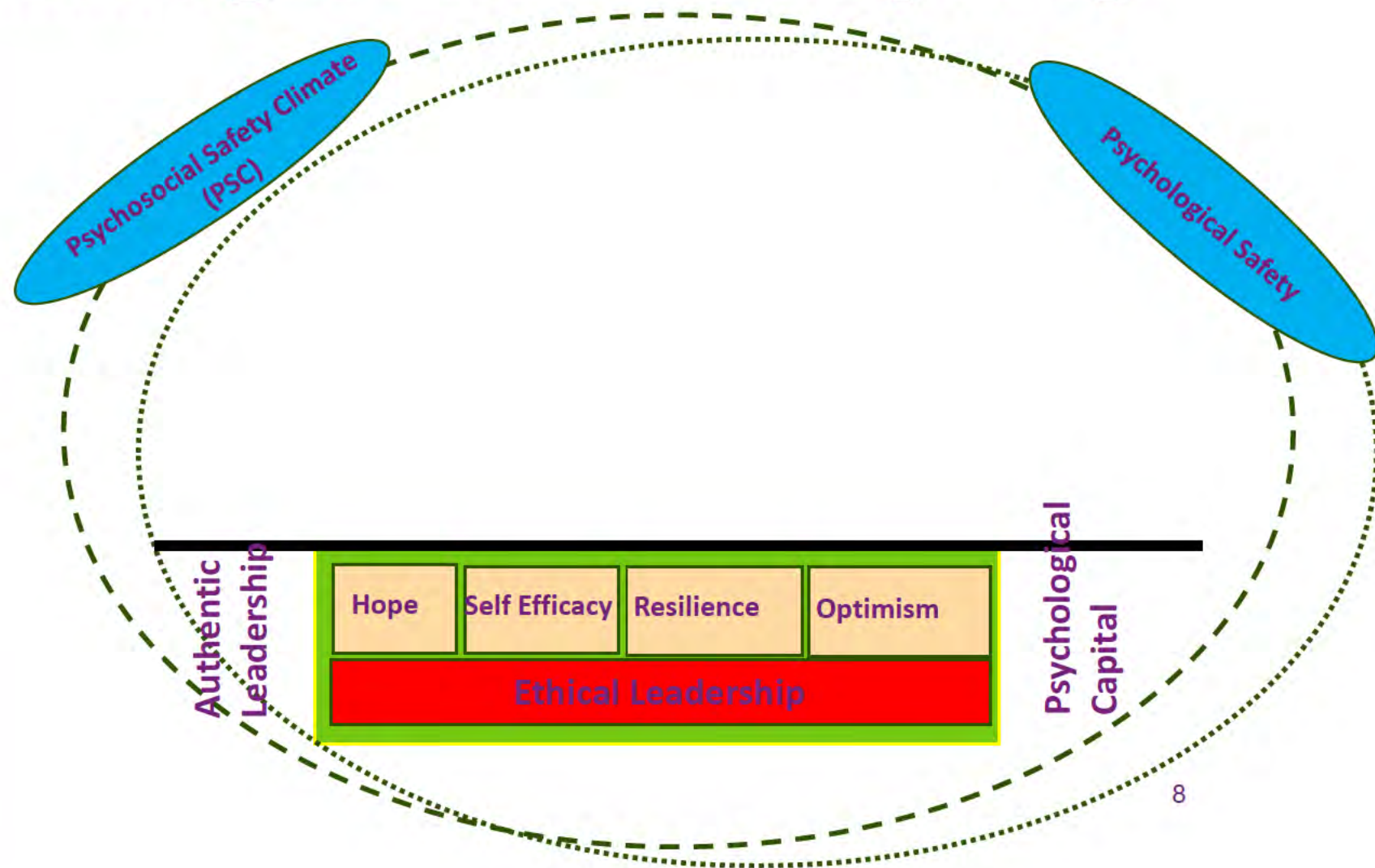


What is Ethical Leadership?

Leadership behaviour that is characterised by:

- honesty
- Integrity
- fairness
- altruism
- consistency of values with espoused values, and
- promoting ethical guidance

Making it safe for everybody



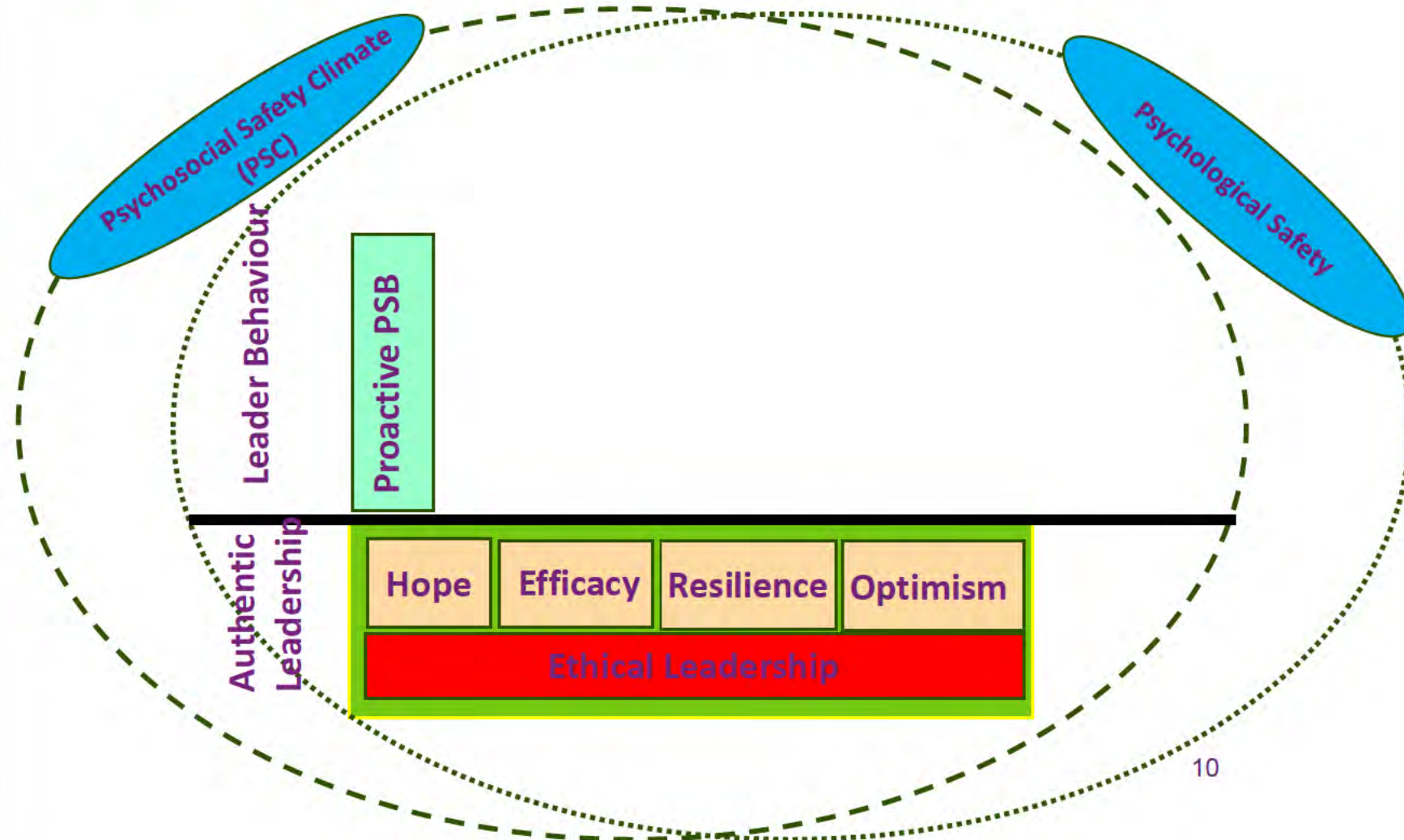


The Definition of Authentic Leadership

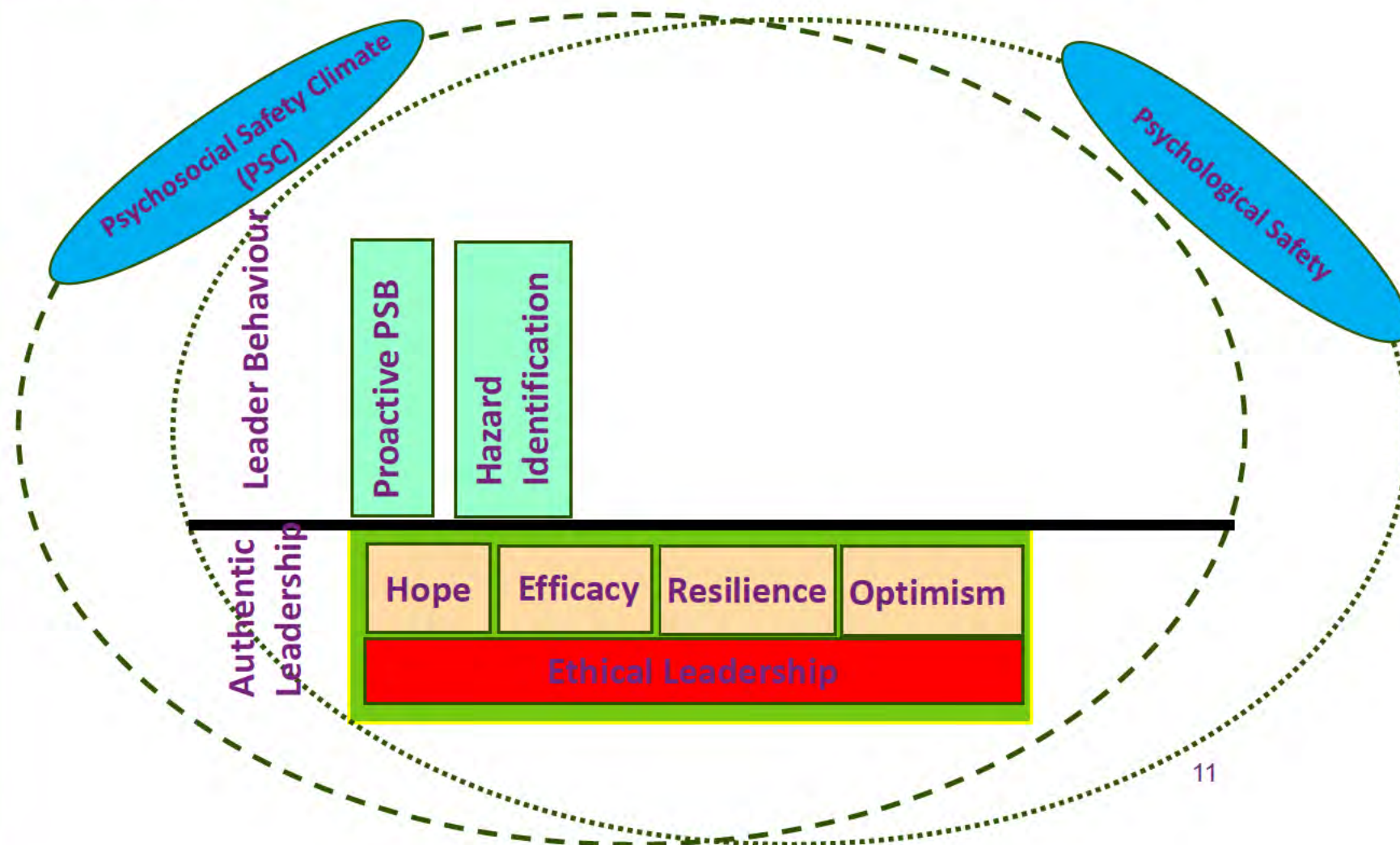
A pattern of leadership behaviour that draws upon, and promotes both a positive ethical climate and positive psychological capital to:

- foster greater self-awareness (honesty of self),
- an internalised moral perspective (in step with core values),
- balanced processing of information, (gain opinions & opposing views), and
- relational transparency (showing authentic self & share true feelings)

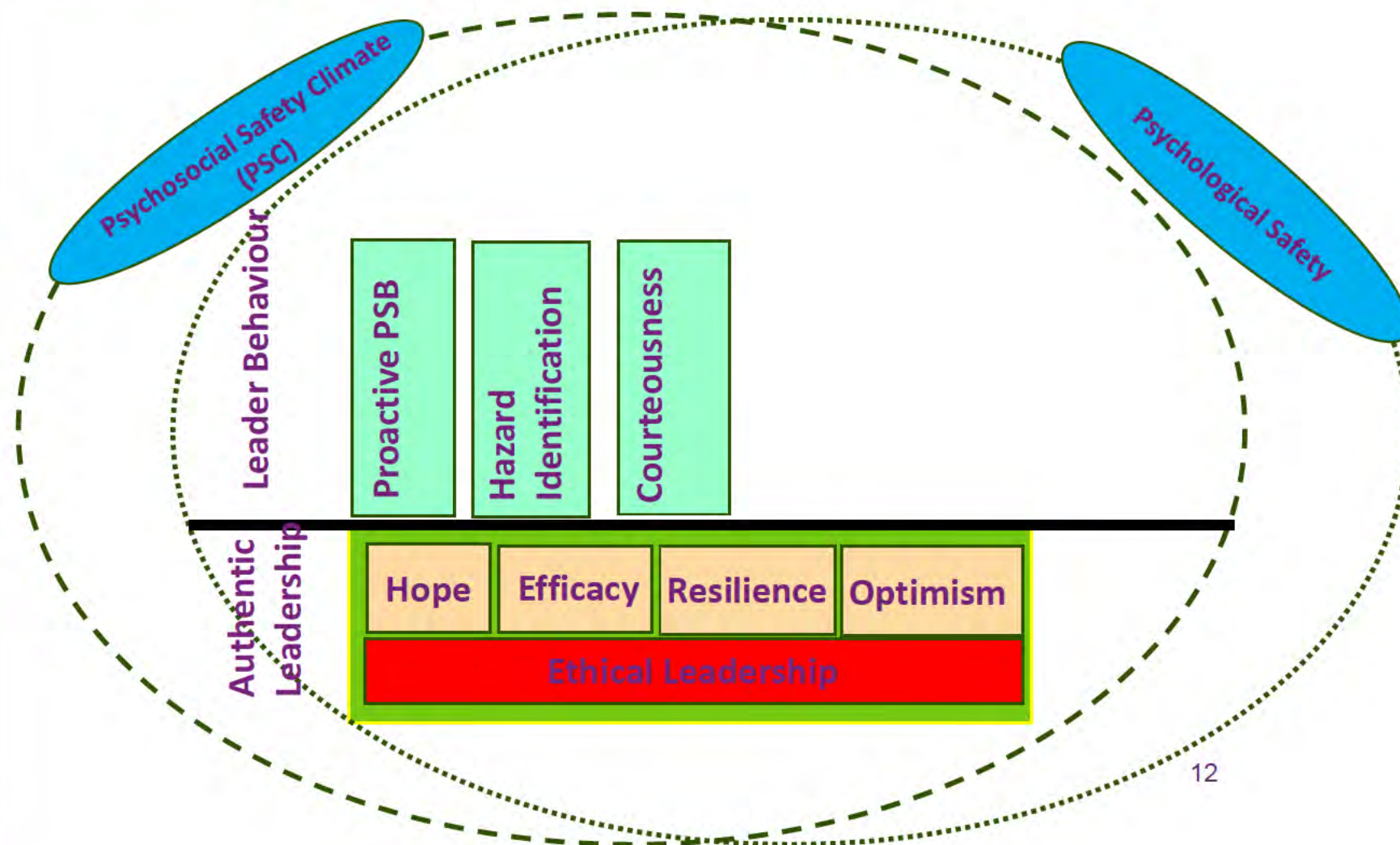
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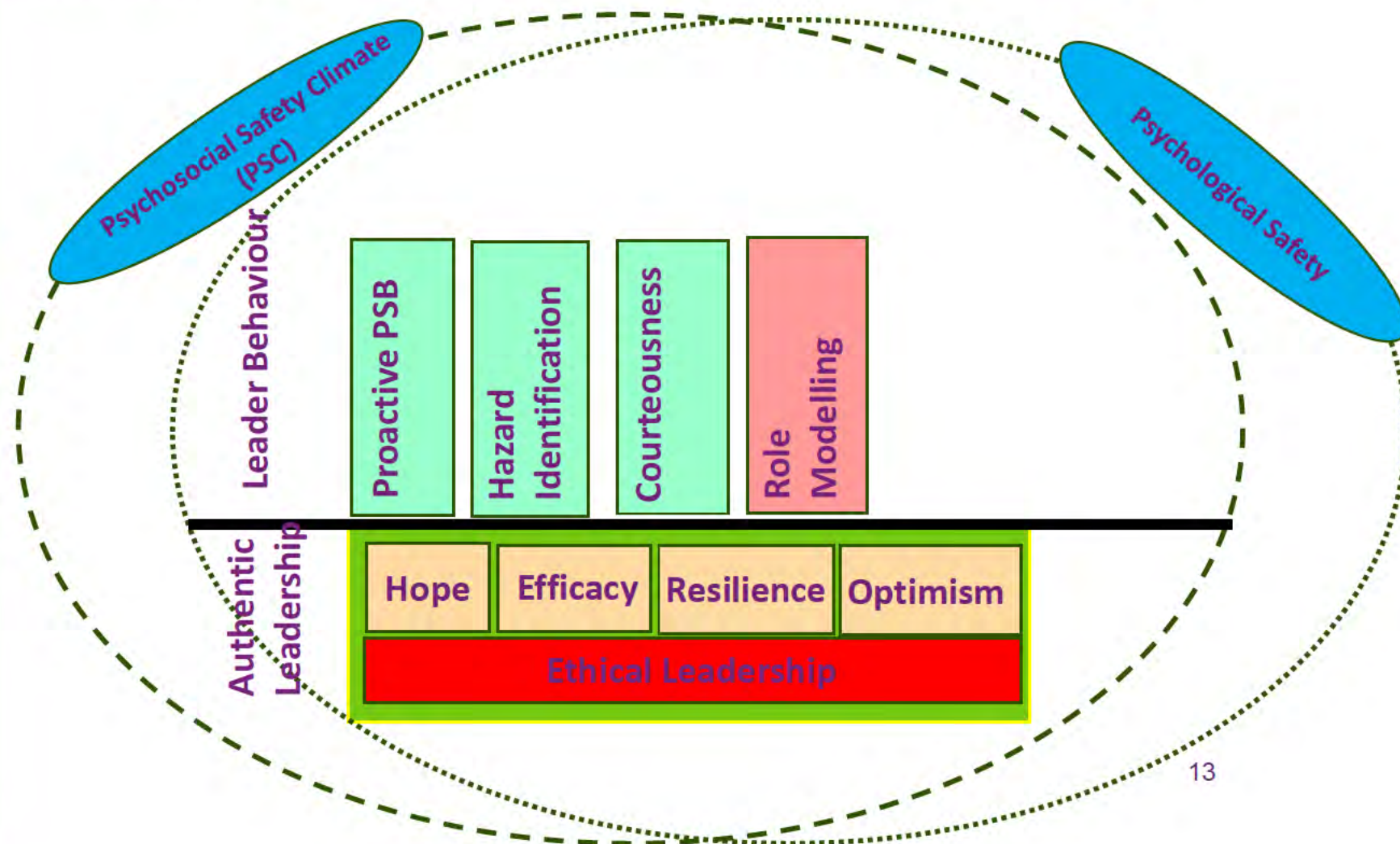
Making it safe for everybody



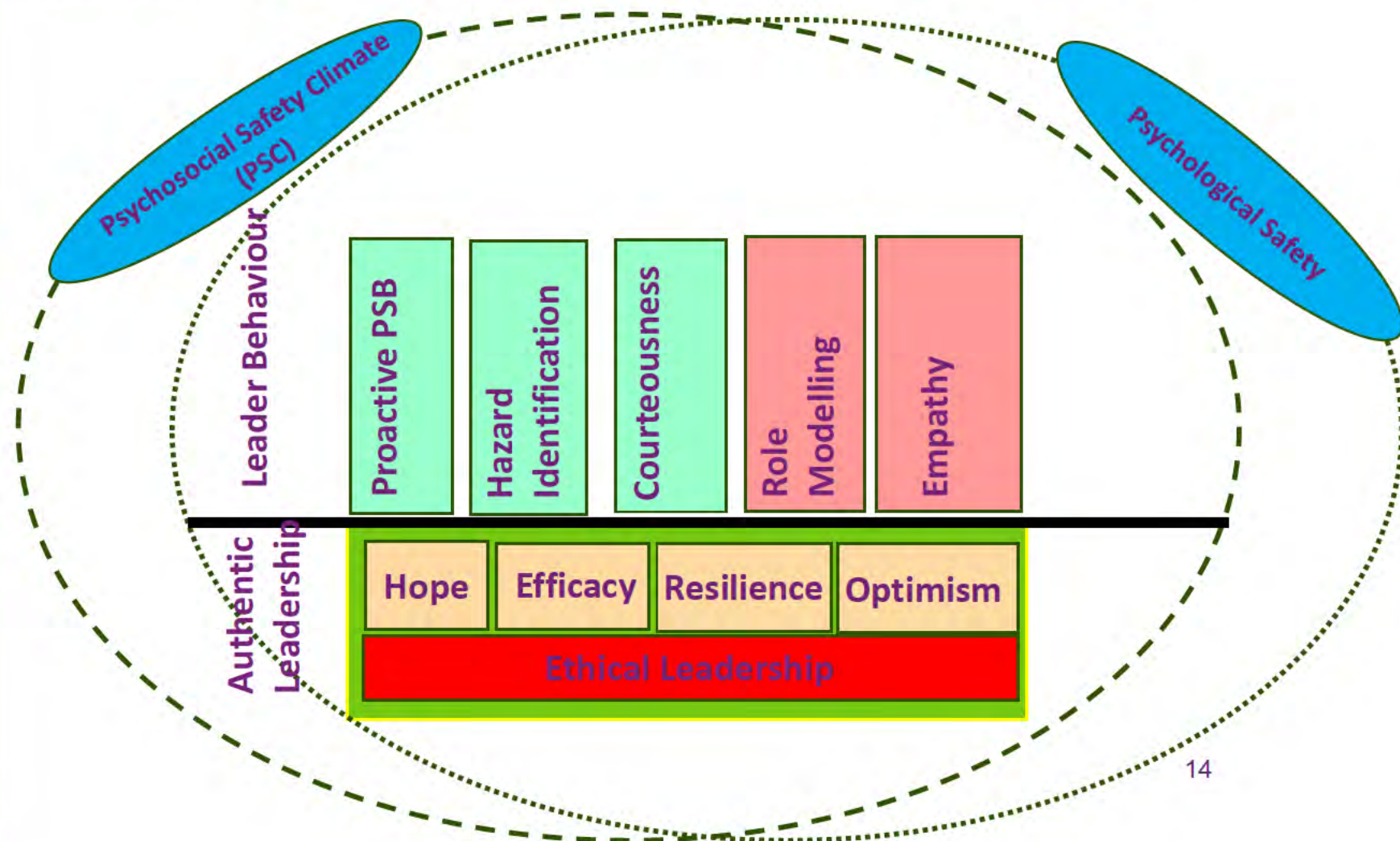
Making it safe for everybody



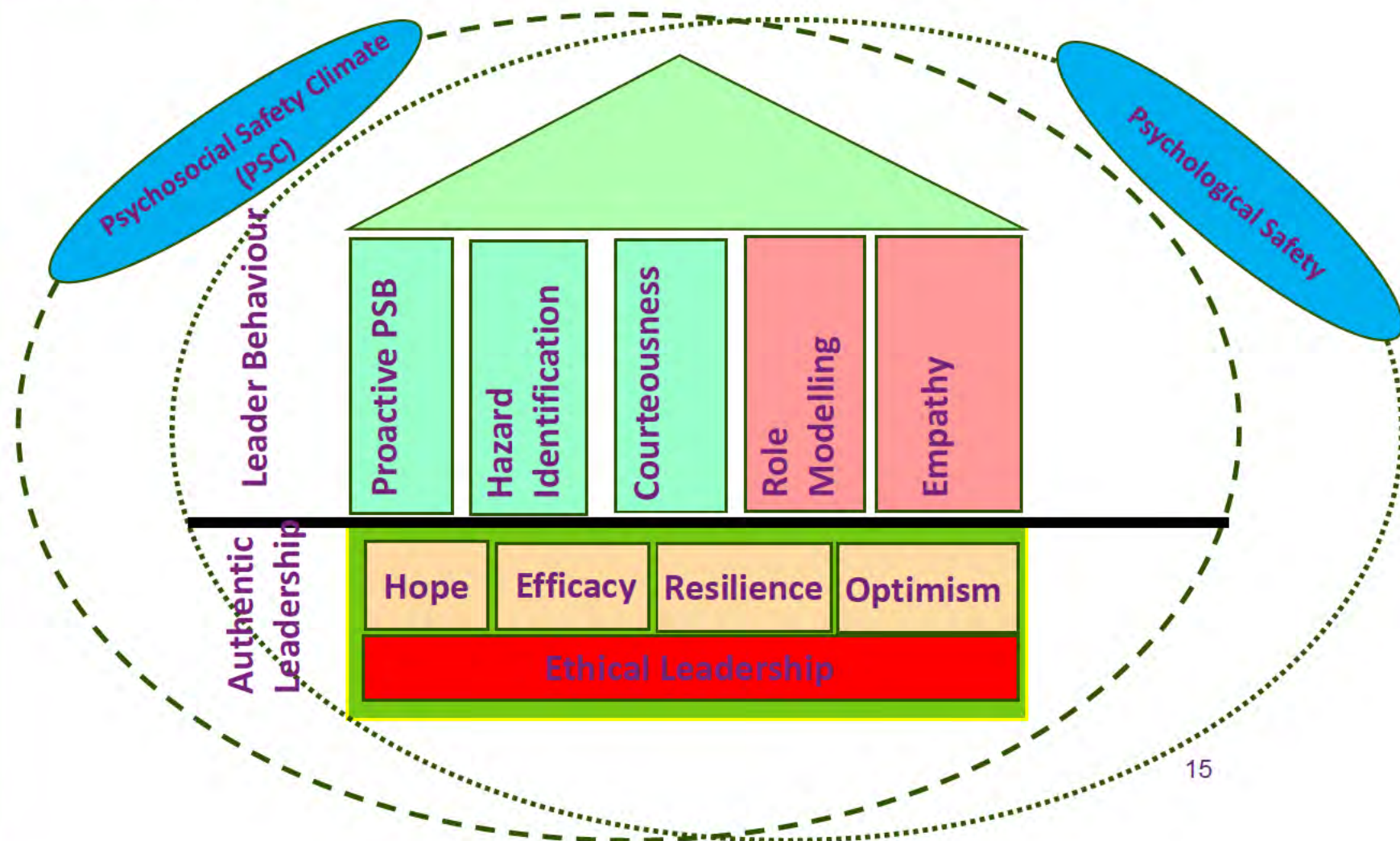
Making it safe for everybody



Making it safe for everybody



Making it safe for everybody





In Summary

1. Transactional and transformational – Improve physical safety, but not psychosocial safety.
2. Laissez-faire / passive-avoidant leadership has been found to worsen physical safety as well as psychosocial safety.
3. Ethical leadership impacts physical safety but only impacts psychosocial safety in a very small way.
4. Authentic leadership has a significant positive impact on physical safety as well as psychosocial safety (+/-40%) .

Thank You Questions?



Resources

- [Workplace Psychosocial Safety Guidelines](#)
- [Safe and Respectful Workplace Policy](#)
- [Procedure for Responding to Bullying, Harassment and discrimination](#)
- [NDIA Reporting Unacceptable Behaviour Fact Sheet](#)
- [Safe & Respectful Workplace FAQs \(Frequently Asked Questions\)](#)
- [Procedure for Responding to Sexual Harassment](#)

National Disability Insurance Agency

 1800 800 110

 [ndis.gov.au](https://www.ndis.gov.au)

 enquiries@ndis.gov.au

 Find us on Facebook/NDISAus

 Follow us on Twitter @NDIS

For people with hearing or speech loss

 TTY: 1800 555 677

 Voice Relay: 1800 555 727

For people who need help with English

 TIS: 131 450



Supporting Staff During Unsafe Or Aggressive Interactions

Staff Safety and Support Guidance

Service Delivery Skills Development Forum

[ndis.gov.au](https://www.ndis.gov.au) | May 2026

Acknowledgement of Country

Before we begin, I would like to acknowledge the Traditional Owners and Custodians of the Country on which we meet today, and their continuing connection to land, sea, and community. I pay my respects to their Elders, past present and emerging.

I would like to extend that acknowledgement and respect to any Aboriginal and Torres Strait Islander peoples here today.



Presentation Overview

- Work Health and Safety team:
Understanding psychological health and safety
- Protective Security team:
How to support staff through unsafe interactions
- Mental Health and Wellbeing team:
Supporting your wellbeing



Psychological Health and Safety

Work Health & Safety

[ndis.gov.au](https://www.ndis.gov.au) | May 2026



Some context

In the past, WHS was primarily about physical safety.

- In Australia, legislation was changed to acknowledge psychological health and safety in the workplace.
- Publication of the Model Code of Practice: Managing Psychosocial Hazards at Work



Psychological Health and Safety

Protecting workers and others in your workplace from psychological harm, in the same way that you protect them from physical harm.

It includes the management of aspects of work which may cause stress, known as psychosocial hazards.



Psychosocial Hazard

A psychosocial hazard is anything that could negatively impact psychological health.

It can be aspects of:

- work design,
- the work itself,
- and the interactions between employees,
- which can negatively influence their mental health and emotional wellbeing.



Examples of psychosocial hazards

1. High Job Demands
2. Low Job Control
3. Poor Organisational Change Management
4. Traumatic Events or Material
5. Poor Support
6. Lack of Role Clarity
7. Poor Organisational Justice
8. Poor Physical Environment



Psychosocial hazards (continue):

- | | |
|-----------------------------------|----------------------------|
| 9. Fatigue | 14. Bullying |
| 10. Inadequate Reward/Recognition | 15. Harassment |
| 11. Remote/Isolated work | 16. Job Insecurity |
| 12. Violence and Aggression | 17. Intrusive Surveillance |
| 13. Poor Workplace Relations | |



Psychosocial hazards can also:

- Compound
- Combine
- Interact

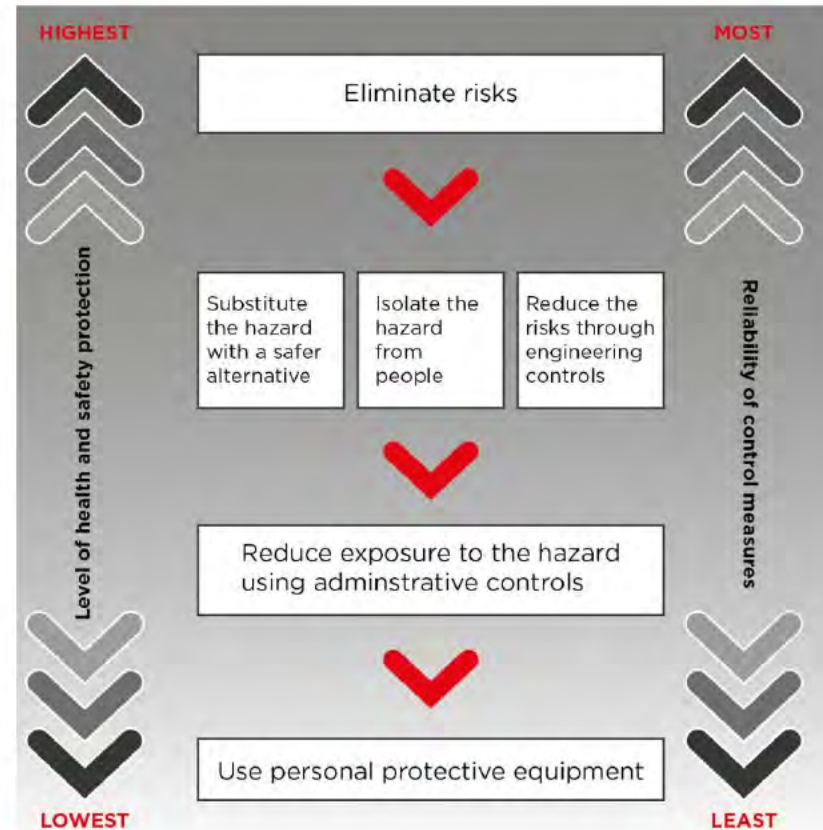


Psychosocial hazards can also:

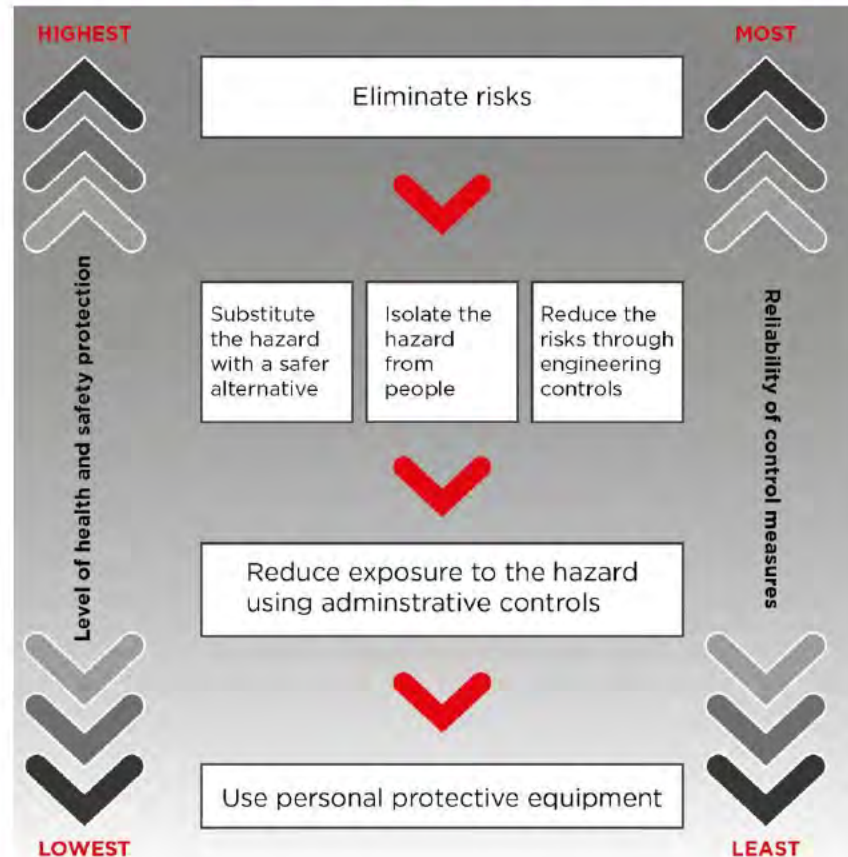
	Common terms we may use for this
• Compound • Combine • Interact	• Snowball effect • The straw that broke the camel's back • Different, but co-occurring hazards



The Hierarchy of Control



An Example: Violence & Aggression



Refusal of service to customers with higher risk of violence or abuse



Isolate: Transparent partitioning



Admin: Rostering



Speak ups

For a step-by-step guide on how to raise a speak up, click [here](#).

OFFICIAL

Quick Reference Guide: Speak Up

The contents of this document are OFFICIAL

Quick Reference Guide: Raise a Speak Up

All Staff

This Quick Reference Guide (QRG) provides staff with instructions on how to raise a Speak Up.

Select one of the hyperlinks below to find out more

- [Speak Up FAQs](#)
- [How to raise a Speak Up](#)
- [Speak Up Work Streams](#)

Speak Up is the all-staff doorway to raise incidents, issues or concerns.

October 2025 OFFICIAL

The NDIS logo, consisting of the lowercase letters 'ndis' in white on a purple background, with a small green dot above the 'i'.



Training

Consult LEAP for training on reporting specific psychosocial hazards

Course Catalogue

whs - ✕ 🔍

[Courses](#) [Sessions](#)

All Recommended All Categories

↑↓ 📊 ☰

16 courses



45m

Safety and Wellbeing

WHS - How to lodge a WHS Psychosocial Speak Up - Burn Out

📅 Sessions + Enrol



45m

Safety and Wellbeing

WHS - How to lodge a WHS Psychosocial Speak Up - Low Job Control

📅 Sessions + Enrol



45m

Safety and Wellbeing

WHS - How to lodge a WHS Psychosocial Speak Up - Workplace stress change management

📅 Sessions + Enrol



How to support staff through unsafe interactions

Protective Security

[ndis.gov.au](https://www.ndis.gov.au) | May 2026

16



First Things First

- Staff safety comes before service outcomes
- Team Lead responses shape staff confidence and reporting behaviour
- Failure to report limits organisational risk controls
- Unreasonable behaviour and aggression must be visible to support appropriate action
- Self-care following incidents is important, especially where there has been cumulative exposure.



Supporting Staff to End Unsafe Conversations

The core message: Safety comes first, not problem resolution at any cost

The 'Continue, Redirect, End' Model has been developed to provide guidance on language that can be used in these circumstances.



What Team Leads Must Reinforce

Our staff must clearly hear and see that:

- They do not have to continue conversations that are unsafe, abusive or threatening
- They are authorised to end calls or disengage from unreasonable behaviour
- They are not expected to solve problems while being abused



What Appropriate Staff Action Looks Like

Team leads should expect and support staff who:

- Trust their instincts and disengage if behaviour feels threatening
- Use calm, assertive boundary statements:

"I'm not able to continue this conversation if you speak to me in that way"

- Create physical distance or exit where required
- Seek immediate support when needed



Team Lead Responsibilities After Disengagement

- Support the decision to hang up a call or disengage
- Never question or undermine staff for prioritising their safety
- Reinforce that disengagement is a protective action, not poor customer service
- Check in with staff after incidents, both immediately and several days later
- Provide reassurance and practical support
- Ensure reporting processes are adhered to



Team Lead Safety Responsibilities

- Support staff to follow MUB policy, guidelines and the Aggression Response Plan
- Never expect staff to “push through” escalating behaviour
- Reinforce that immediate risk overrides service outcomes
- Ensure that security protocols are followed when required



Team Lead Expectations for Reporting

- All unreasonable or aggressive behaviour must be raised via Speak Up
- **Speak ups enable** informed risk assessments, behaviour management strategies and restriction or access control discussions
- Unreported incidents prevent the organisation from protecting staff



What Needs to be Documented in a Speak Up

Support staff to clearly and accurately record:

- Date, time and location
- What occurred
- Actions taken
- The name and other identifiable information of the person who was the source of the incident and any other witnesses involved

Even if an issue has been resolved, a Speak Up still needs to be submitted.



Post Reporting and Speak Up Culture

- Conduct supportive debriefs, check on well-being and refer to [EAP services](#) as required
- Ensure reports are completed and followed up in the line manager section of the report
- Consistently reinforce that “speaking up” is encouraged. Records are used to prevent future harm, and are a critical safety and risk control tool



Key Takeaways for Team Leads

- Staff are authorised to disengage from unsafe behaviour
- Your response determines whether staff feel safe to act and report
- Aggressive behaviour must always be reported
- Risk controls depend on Speak Ups
- Supporting staff is a leadership responsibility



Supporting Wellbeing

Mental Health & Wellbeing

[ndis.gov.au](https://www.ndis.gov.au) | May 2026



A further note on Psychological Safety

Leaders set psychological safety through everyday actions – especially in moments of pressure, error, or distress.

“Psychological safety isn’t what you say, it’s what you consistently model, allow and respond to.”

Encouraging people to submit speak ups, raise concerns and take time for their own wellbeing, demonstrates that their safety is paramount to you.



Modelling

“Put your own oxygen mask on first”

Your staff will learn from the behaviours you model. Leaders must manage their capacity, clarity and wellbeing to effectively lead others.

- Your emotional state sets the tone
- Staff look to you for safety, calm and direction
- How you respond shapes recovery and resilience, including, the way you manage your own wellbeing.



Self-Care

As a leader, you are not immune to the affects of unsafe or aggressive behaviour, especially when they're cumulative.

Know the signs that you may not be coping and build a plan to support your wellbeing.

- Beyond Blue – [Burnout Check-in Tool](#)
- Beyond Blue – [Wellbeing Action Tool](#)
- TELUS Health One – CareNow Programs and Wellbeing Assessments



TELUS Health One Portal

Coping

01

Reading time 8 minutes

Next: Tell us how you are doing

To start, please answer the following few questions. It will only take a couple of minutes.

[Continue](#)


Your Path

01 Next: Tell us how you are doing

Reading time 8 minutes

02 Challenging Times

Reading time 7 minutes

03 Challenging Your Perceptions

Reading time 2 minutes

Connect

Get Immediate Support

If you're in urgent need of support or in crisis, connect with us confidentially

[Get Help Now](#)


People leader toolkit: Resources for new and experienced managers

- Practical tips for new and experienced managers
- Promoting wellbeing in the workplace
- Supporting your team through workplace challenges
- Supporting employees through personal difficulties
- Burnout and overload prevention
- Navigating workplace change
- Fostering diversity in the workplace
- Transitioning into a new role as a manager

Make the most of our many resources to help you coach and motivate, handle performance issues, create a supportive work environment, and take care of yourself and your team.



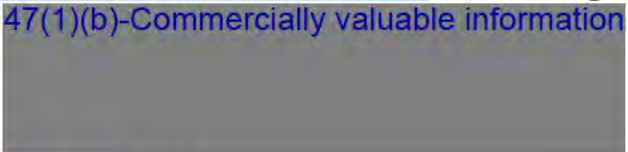
Leader Supports

[TELUS Health Manager Hotline](#)

Free and confidential access to a clinician who can coach you through workplaces challenges, or, used proactively.

[TELUS Health One Platform](#) – Manager Toolkit

47(1)(b)-Commercially valuable information

A large grey rectangular box redacts the content of the Manager Toolkit.

Leader learning

- [Resilient Leadership | Vimeo \(external\)](#)
- [Building Psychologically Safe Teams | Vimeo \(external\)](#)
- [Managing Hybrid Teams | Vimeo \(external\)](#)
- [Supporting Individual Mental Health in the Workplace as a Leader | Vimeo \(external\)](#)



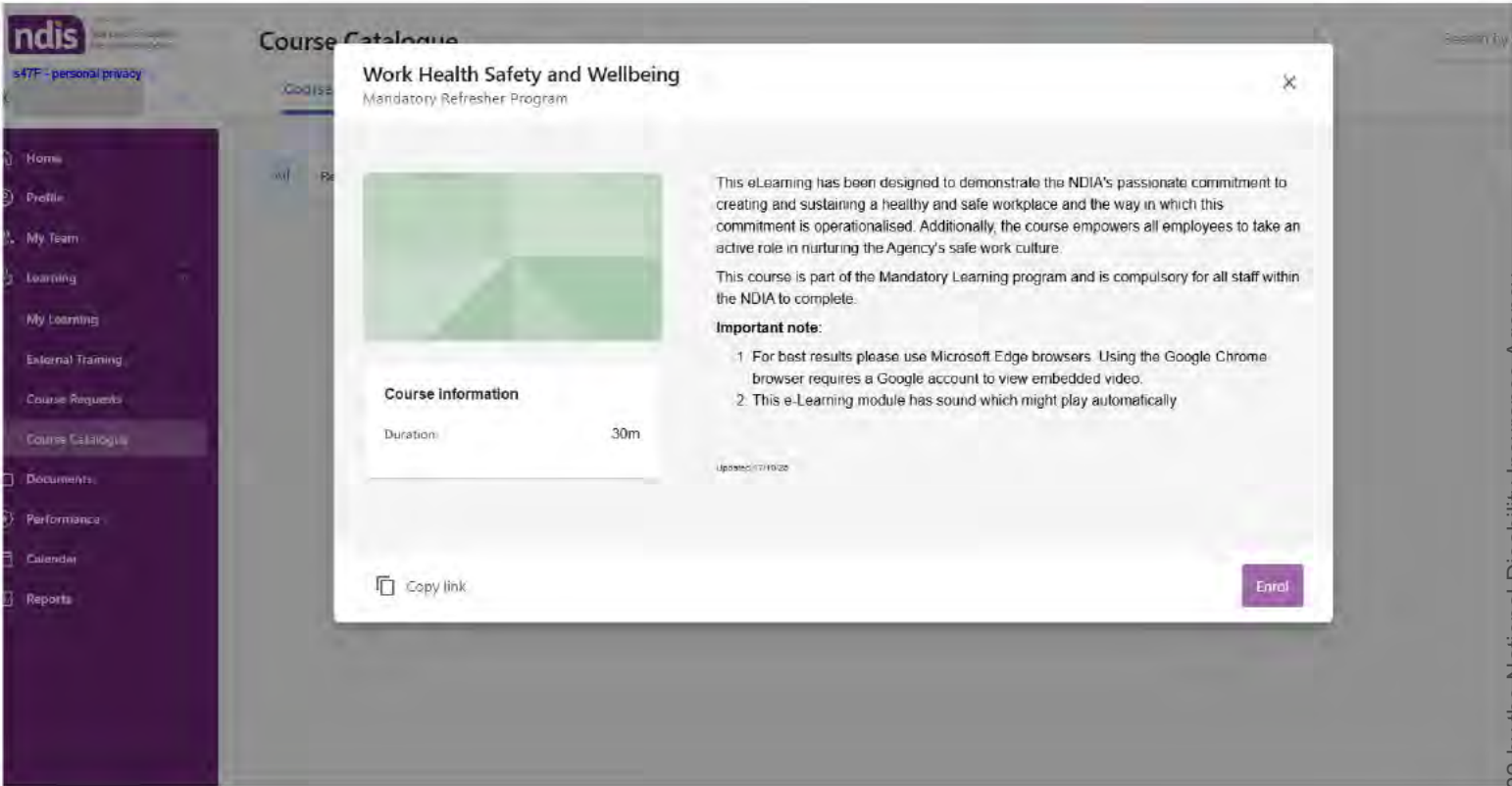
In Closing

- The safety of our staff always comes first.
- You can end a conversation with the 'Continue, Redirect, End' model.
- Psychological safety encourages people to report issues.
- Self-care is vital and helps minimise burnout and/or injury.

Contact the team via the People & Culture Service Desk.

[ndis.gov.au](https://www.ndis.gov.au) | May 2026

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Course Information		COMPLETED
Duration	45m	
Type	Required ⓘ	
Enrolment date	20 Jan 2026	
Start date	21 Jan 2026	
Complete date	21 Jan 2026	
Enrolment method	Rule ⓘ	

Overview

This is the third course in the Mandatory Induction Program and should take approximately 45 mins to complete.

Course description: This course introduces you to the rules we need to follow and actions we need to take to keep us secure and safe at work such as identifying hazards, safe and respectful framework, building pass access, working from home and off-site visits.

Target audience: All new staff.

Course completion: Completing this course is a requirement of your employment at the agency and ensures you are complying with the APS Code of Conduct and APS Values. By marking the course complete, you agree you have understood the content.

Please note: All links will open in a new browser tab. Please return to the course to continue.

Course contact: For any questions about this course, please contact the [People and Culture Service Desk](#).

Updated 12/09/25

1. Our safety and security

eLearning	COMPLETED
View	

Building Psychologically Safe Teams for Leaders | Well+ Webinar 2026

Safety and Wellbeing



DESCRIPTION

SESSIONS



Course information

Duration

1h

Course description: Leaders have both a responsibility and an opportunity to contribute to a psychologically safe workplace. Creating a psychologically safe environment can benefit individuals, teams and the wider organisation.

This session explores the key role leaders play in creating a psychologically safe team. The program explores the various domains of psychological safety including showing respect and unconditional positive regard, encouraging others to apply learning and building a feedback culture, providing autonomy and allowing others to voice constructive criticism and challenging the status quo.

With a focus on identifying specific behaviours that contribute to a psychologically safe team culture, this session encourages leaders to commit to specific strategies to enhance psychological safety in their teams.

Please note: To complete your enrolment and access the MS teams link you must:

- Enrol
- Select 'View course'
- Sign up for each 'Session' you wish to attend
- Copy the MS Teams link from the session details and create a calendar reminder for yourself.

Course Description: Today's leaders' effectiveness relies more on their ability to understand and influence other people. Creating a psychologically safe workplace is now mandated in the legislation and helps teams thrive. Success as a leader comes from developing oneself and developing others. This workshop will support leaders to recognise their leadership capability in an engaging and thought-

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Contributing to a Psychologically Safe Team Culture | Well+ Webinar 2026

Safety and Wellbeing

DESCRIPTIONSESSIONS



Course information

Duration	1h
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Course description:

Please note: To complete your enrolment and access the MS teams link you must:

- Enrol
- Select 'View course'
- Sign up for each 'Session' you wish to attend
- Copy the MS Teams link from the session details and create a calendar reminder for yourself.

Course Description: Typically, when we think about mental health in the workplace, we don't automatically consider our individual responsibility and opportunity in contributing to a psychologically safe workplace. This includes allowing others to share ideas and thoughts safely, to support our colleagues manage workplace environment, and to be a peer to speak to, if needed. The session focuses on strategies that individual employees can adopt to contribute to a safe team culture.

Target Audience: All staff

Course Contact: Safety and Wellbeing team via the [People and Culture Service Desk](#)

 Copy link

Enrol

Safety and Wellbeing

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2025

Safety and Wellbeing

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Webinar 2025



Safety, Wellbeing and Security Strategy

Discovery - Executive Summary

Background

The Safety, Wellbeing and Security Strategy (SWSS) is a commitment under the [Agency Action Plan \(PDF 303KB\)](#) and directly supports the **Chief Operating Officer Priority 3: keeping staff and visitors safe and well.**

The SWSS will complement the Agency's Security Improvement Program, developed following the 2024 Safety and Security Review conducted by Graham Ashton. The strategy will integrate psychosocial safety, wellbeing and physical security into one agency-wide, coherent framework. It will align and amplify key initiatives that strengthen the Agency's total safety, wellbeing and security

Discovery Overview

The NDIA has completed Phases 1 and 2 of a comprehensive discovery process to inform the development of the inaugural SWSS. The discovery process engaged a broad cross section of the workforce, incorporated independent clinician validated insights, and mapped staff experiences against [Safe Work Australia's 17 Psychosocial Hazards \(external\)](#).

Phase 3, schedule for early 2026.

The discovery process combines three distinct but complementary approaches:

Phase 1 - SME Focus Groups | Complete

1. Capture practical, cohort specific insights into psychosocial risks, control effectiveness, and system pressures.
- Validate the phase two discovery approach against real-world operational experience.

Phase 2 - Broad Workforce Discovery | Complete

- Capture agency-wide perspectives at scale, reflecting diverse roles, levels, locations, and work types.
- Validate SME insights and surfaced broader patterns, including protective factors and cultural strengths not evident in specialist groups.

Phase 3 –Explore & Understand, and Enterprise Psychosocial Risk Assessment | Early 2026



- **Phase 3 will extend discovery through targeted deep dives** into priority psychosocial risks to understand root causes, validate patterns, and test assumptions in high risk areas.

Phase three will include:

- Explore & Understand sessions with high risk areas
- Senior Executive Service (SES) interviews
- An enterprise wide psychosocial risk assessment

Insight and Data Collection Approach

Discovery insights were derived through a rigorous, independently assured approach designed to provide confidence in findings, support WHS compliance, and withstand regulatory and audit scrutiny.

- Applied a robust, defensible discovery methodology designed to maximise psychological safety, data integrity, and executive level assurance.
- Aligned all insights to the Safe Work Australia Psychosocial Hazards Framework, mapping staff feedback against the 17 nationally recognised hazards to support WHS compliance and a consistent, enterprise wide view of risk.
- Strengthened independence and analytical rigour through external, trauma-informed coding of all qualitative data by TELUS Health, reducing bias and meeting audit and regulatory expectations.
- Enabled open and candid staff input through independent facilitation, with an external organisational psychologist from Grow Together Now providing a neutral, psychologically safe environment that lifted insight quality and credibility.

Phase 1 Focus Groups with SMEs – Summary

18 targeted Focus Group sessions were conducted across key stakeholder groups, engaging 212 participants. The cohorts primarily operationalise safety, wellbeing, and security functions across the Agency, which means the findings are naturally skewed toward those perspectives., which thereby reinforced the need for broader, agency-wide Discovery Workshops designed to capture the full spectrum of roles and risks.

Primary hazards identified:

- Poor/Lack of support
- High job demands
- Poor organisational justice
- Lack of role clarity
- Poor organisational change management



- Fatigue
- Exposure to confronting information / events

Phase 2 Discovery Workshops – Summary

A total of 46 Discovery Workshops were delivered virtually and face to face, engaging 1,341 registrations (representing approximately 10–11% of the NDIA workforce) and 760 participants (7–8%). Dedicated sessions were delivered for 'All staff', all employee diversity groups and rural/remote and metro staff.

Note: The findings draw on two distinct data sources.

- **Coded:** derived from qualitative statements made during workshops. Through clinical coding, underlying patterns are identified even when participants do not directly reference a specific hazard, ensuring a deeper understanding of the concerns impacting staff wellbeing.
- **Voted:** results are based on staff selecting their top three psychosocial hazards using MS Forms. This method captures observed priorities from a large sample, providing a clear indication of which hazards staff believe most impact their roles.

CODED: Primary hazards identified (no diversity Groups).

- Poor/Lack of support
- High job demands
- Poor organisational justice
- Poor organisational change management
- Conflict or poor workplace behaviours
- Fatigue
- Bullying
- Lack of role clarity
- Violence and aggression
- Exposure to confronting information or events

CODED Primary hazards identified across Diversity groups, Rural/Remote and Metro coding.

Poor/Lack of support and Poor organisational justice have been colour coded below to show consistency across all groups.

Network or Location	#1 Psychosocial Hazards	#2 Psychosocial Hazards	#3 Psychosocial Hazards
---------------------	-------------------------	-------------------------	-------------------------



Employee Disability Network	Poor/Lack of Support (37)	Poor organisational justice (31)	Conflict or poor workplace relationships and interactions (27)
First Nations employee Network	Poor Organisational Justice (16)	Poor/Lack of Support (13)	Harassment including Sexual Harassment (8)
Neuroinclusion Network	Poor/Lack of Support (19)	High work demands (7)	Poor Organisational Justice (6)
HarmonyHub	Poor Organisational Justice (10)	Harassment including Sexual Harassment (5)	<i>Data too low to aggregate</i>
Pride@NDIA	Poor/Lack of Support (26)	Poor Organisational Justice and Harassment including Sexual Harassment (10)	Bullying (8)
Gender Equity Network	Poor/Lack of Support (7)	Harassment including Sexual Harassment (6)	<i>Data too low to aggregate</i>
Metro	Poor/Lack of Support and Bullying (8)	<i>Data too low to aggregate</i>	<i>Data too low to aggregate</i>
Rural Remote	Remote / Isolated Work and Conflict or Poor Workplace Relationships and Interactions (9)	Poor/Lack of Support (7)	<i>Data too low to aggregate</i>

VOTED: Primary Hazards (All staff including Diversity groups).

- High job demands
- Violence and aggression
- Exposure to confronting information or events
- Bullying
- Poor organisational change management
- Conflict or poor workplace behaviours
- Lack of role clarity
- Poor/Lack of support
- Fatigue
- Poor recognition and reward

Poor/Lack of Support emerged in references to poor leadership support, insufficient resources and systems, barriers to seeking assistance, and inconsistent post incident support.



High Job demands was identified through unrealistic KPIs, work-life balance erosion and fear of speaking up.

Poor Organisational Justice was identified through significant concerns and gaps between stated organisational values and observed practices, fair selection, fear of Speak Ups and inconsistent application of policies and procedures.

Poor organisational change management themes emerged such as consultation processes, the volume of organisational change and the impacts of change.

Conflict or Poor Workplace Behaviours themes that emerged were distrust (or psychological safety), microaggressions and workplace incivility, and a pattern of non-intervention.

Fatigue emerged as an important psychosocial hazard within the Agency, manifesting in the themes of exhaustion, inability to sustain demands and workload/performance pressures.

Bullying emerged as a psychosocial hazard within the Agency, with concentration in leadership and management tiers, fear of reporting, ineffective response systems and performance-related pressures.

Lack of role clarity was identified through themes such as role confusion, conflicting priorities and the lack of procedural guidance

Violence/ Aggression themes emerging with this hazard were normalisation and under-reporting, cumulative psychological impact, under-reporting, vulnerabilities created by physical environment and the concerns about the numerous sources of aggression

Exposure to confronting information or events themes raised included the levels of exposure to trauma materials, alert systems, impacts of trauma, staff capability and adequacy of training and debriefing supports

At a glance

- During workshops, attendees voted on the top three psychosocial hazards they felt most impacted their roles and were engaged in conversations where insights were captured by content analysts.
- While results might appear to represent staff perceptions alone, they are validated and reinforced by multiple data sources, confirming the accuracy and significance of the identified themes.
- Voting data mirrored themes seen in Work Health and Safety (WHS) incidents reported as referenced in the WHS Quarterly Report Q1 FY2025-26 and those identified through our WHS psychosocial hazard risk assessment.
- 'Organisational justice' and 'Poor/Lack of support' surfaced strongly in clinical coding which shows it as a consistently high theme across all groups, and consultation phases.



- Workplace relationships hazards (Harassment including Sexual Harassment, Conflict or poor workplace behaviours and bullying) were frequently coded in diversity networks, rural / remote and metro groups. Interestingly, these same hazards were high in the voting data for all staff implying that this is a consistent and persistent issue across all areas.
- 'High work demands' consistently ranked at the top in both voting and coded analysis, indicating it is not only highly visible but also deeply embedded in staff experiences. Its persistence suggests it is a pervasive organisational hazard requiring targeted intervention.
- Poor organisational change management showed up in both voting and coding showing it is a consistently high theme across all groups, and consultation phases
- Violence and aggression, along with exposure to confronting information or events, ranked highly in the voting results, this is reflected in the recent rise in unreasonable behaviour incident through Security Speak Up reports.
- Staff reported that positive participant outcomes, peer recognition, and professional growth opportunities are key drivers of engagement. Capability building was highlighted as particularly rewarding. Flexible and remote work arrangements were consistently cited as enablers of improved focus, work-life balance, and overall wellbeing
- The Grow Together Now report highlighted similar themes to the TELUS Health conclusions, particularly around the Speak Up process and leadership capability. The only notable difference was that lack of role clarity did not emerge as a major theme in their report, likely because it was developed from a facilitator perspective through conversation rather than data analysis.

Key themes

The consultation process revealed that poor support is the most frequently reported psychosocial hazard, accounting for 26% of coded items, while high work demands emerged as the primary concern, receiving 32% of first-choice votes. Diversity groups highlighted distinct experiences of these hazards, underscoring the need for tailored approaches.

Cultural analysis identified concerns around psychological safety and the effectiveness of the Speak Up process. At the same time, protective factors such as recognition, flexible work-life balance, supportive team cultures, and the sense of making a meaningful difference were noted as sustaining staff wellbeing. The review of safety, security, and physical environments highlighted issues impacting staff wellbeing and service delivery, particularly in co-located sites.

While staff demonstrated strong commitment to the Agency's mission and valued aspects of their work, significant psychosocial hazards require attention to safeguard workforce wellbeing, retention, and service quality.



The findings point to opportunities for NDIA to better align lived experiences with its espoused values through targeted interventions in leadership capability, organisational justice, workload management, and psychological safety. This comprehensive consultation provides a strong foundation for NDIA's future psychosocial risk management strategy.

Gaps identified for further consultation

Further recommendations call for deeper examination of specific areas, including non-ongoing staff, neuro-diverse cohorts, challenges in co-located offices, onboarding processes, and improvements to the Speak Up mechanism. In addition, there is an opportunity to strengthen leadership capability, enhance wellbeing supports beyond EAP, and address high-risk psychosocial hazards and poor workplace behaviours to ensure a safe and inclusive environment for all staff.

Phase 3 **of discovery** begins January 2026 with SSS interviews beginning end January.

What are we doing well?

Staff consistently highlighted the value of meaningful purpose, strong team culture, and supportive leadership as key protective factors across the agency. They reported feeling energised by positive participant outcomes, recognition from colleagues, opportunities for development, and the ability to build skills and uplift capability. Remote and flexible work arrangements were frequently noted as enhancers of focus, balance, and overall wellbeing.

Staff also emphasised the importance of mentoring, coaching, and constructive feedback in sustaining motivation, alongside the positive impact of working with engaged teams and leaders who prioritise wellbeing, provide direction, and support growth. While mechanisms such as Speak Up and PACE are appreciated, staff noted opportunities to simplify processes and improve consistency to better support safe, effective practice.

Agency staff praised resources such as the Safe and Respectful Team along with designated support roles including the wellbeing officers, Peer Support Contact Officers and Culture Champions.

Talking Points – Deep Dive Psychosocial hazards PPT

Slide		Talking Points
2	What is happening in the NDIA environment.	• Our psychosocial risk profile has grown in parallel with rapid workforce growth – a 12.1 % increase in workforce in 12 months to 30 Dec 2025. • This has coincided with a 19% increase in reported WHS incidents, indicating both higher exposure and improved reporting. • Psychosocial hazards continue to be the dominant incident category, making up 78% of all WHS incidents • This represents a shift, with psychosocial incidents now forming a greater proportion of total incidents than in previous years

OFFICIAL

		• The operating environment is becoming more challenging with the escalation of external aggression towards our staff, increasing exposure to objectionable material and ongoing organisational change and reform pressure • The August 2024 Workplace and work-related violence and aggression in Australia report we provided a view of the prevalence, causes and impacts of violence in Australian workplaces, highlighting an alarming trend in serious workers' compensation claims arising from workplace violence and assault. Having surged by 56% between 2017–18 and 2021–22. Reinforcing the alarming change in the nature of harm in Australian workplaces and the increased risk of aggression we face in environment that we operate in. • Emerging factors are compounding baseline psychosocial risks, particularly in frontline roles. This includes a perception of constant changes, reform programs, resourcing pressure, the industrial relations climate, and public scrutiny
3	What psychosocial incidents are being reported?	• The majority of reported incidents relate to three primary psychosocial hazards ○ Violence and aggression being Unreasonable behaviour from participants, carers, or the public ○ Traumatic events or material being Exposure to distressing or traumatic content, and ○ Conflict or poor workplace relationships and interactions. ○ The remaining portion of incidents relate to secondary risks covering workload, systems, physical environment, and organisational change.

		• This pattern aligns with the frontline service delivery exposure and high-volume decision environments • The Employee Assistance Program (TELUS Health) utilisation for the last 12 months (January to December 2025) was 22.50% which is 16.98% higher than the industry benchmark and 17.14% higher than the National benchmark. • High EAP utilisation is generally considered a positive indicator of organisational health as it demonstrates strong awareness of the service offer, high levels of mental health history and represents a culture where seeking support is normalised • The top 5 presenting issues were: ○ Stress- personal ○ Workplace Issues ○ Relationship- general ○ Anxiety ○ Mental Health
4	What are staff telling us?	• Our census results show strong recognition of the agency's efforts on health and wellbeing – with over 80% positive results across most measures, and consistently above APS averages. • Staff particularly value supervisor support (which is 89%) and visibility and communication of wellbeing supports (which is 83%) • The NDIA have completed 68 Discovery sessions, engaging over 750 staff, with 1,700 responses across the Agency to understand what safety, wellbeing and security mean to them, with a

		particular focus on identifying and addressing psychosocial hazards. The top 10 psychosocial hazards identified from analysing the coded data are: ○ Poor/lack of support 29% ○ High job demands 15% ○ Poor organisational justice 15% ○ Poor organisational change management 9% ○ Conflict or poor workplace behaviours 7% ○ Fatigue 5% ○ Bullying 4% ○ Lack of role clarity 3% ○ Violence/ aggression 3% ○ Exposure to confronting information or events 3% • These risks will be further explored and mitigation strategies developed as part of the Safety, wellbeing and security strategy. With interim measures in place. For example, establishing an internal clinical workforce and embedded workplace supports (a clinician from EAP placed in high-risk business areas). • Diversity Groups Discovery Workshops were also conducted. These results weren't dissimilar to those of the other Discovery Workshops. ○ Harassment and bullying were reported more frequently
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		○ High Job Demands were identified in fewer diversity groups overall but emerged strongly within the Neuroinclusion cohort. • However, it is important to highlight that Intersectionality significantly increases psychosocial risk because individuals with multiple marginalised identities experience, compounded and unique forms of workplace harm. • Regulators (SafeWork Australia/Australian Human Rights Commission) note that social-cultural factors- such as race, gender, and disability can interact to amplify the severity of hazards like discrimination and harassment, often creating greater barriers to reporting and safety.
5	What is the leading cause of injury for compensation claims?	Mental stress is the primary driver of claims • Most psychosocial claims stem from workload, work pressure, and interpersonal relationships. • These factors remain consistent year-on-year. Psychosocial injury is still the biggest cost risk • Even though incapacity periods are reducing, psychosocial claims dominate both frequency and cost. Aggression and objectionable material are not the main contributors • Early intervention strategies in these areas are working - risk is being managed effectively. Claim incidence and premium risk • NDIA's accepted claim rate is 3.8 per 1,000 FTE, below the Commonwealth average of 5.2.

	• However, psychological claims are 3.3 per 1,000 FTE, above the Commonwealth rate of 1.9 - this is the key premium driver. Proactive supports are helping • Adjustments and workplace supports have reduced incapacity periods. • Average return-to-work duration is now around 29 weeks down from 52 weeks, showing improvement. Points to reinforce: 1. Accepted claims = premium cost ○ Every accepted claim increases NDIA's Comcare premium. ○ Our focus is on prevention and early intervention - not just managing claims after they occur. ○ When a claim is accepted, our focus on return to work becomes the priority 2. Early intervention success ○ External aggression and objectionable material risks are being controlled through early intervention action. ○ These strategies are preventing claims and reducing exposure. 3. Next steps for improvement
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		- Continue targeting psychosocial risk factors: workload, interpersonal conflict, and work pressure. - Strengthen manager capability and early intervention responses to reduce psychological claim lodgements. 4. Benchmark context - NDIA is performing better than the Commonwealth overall on total claim rate. - But psychological claims remain higher than the benchmark - this is where we need to focus.
6	What is the cost of injury for compensation claims?	Premium impact is significant - This is largely driven by payroll growth (increased staff recruitment), but accepted claims also directly influence this cost. - NDIA's FY2025–26 Comcare premium is \$19.1 million (excluding GST). - Total cost impact of psychosocial claims is \$3,747,231 for the 2024-25 financial year. For 2025-26 YTD the cost of psychological claims is at 1,439,562 equating to 85.11% of all claim costs. Claim costs refer to all claims that have costs paid in each financial year, irrespective of the financial year the claim was determined Current claim activity shows ongoing exposure 80 open claims, 10 closed claims, and 15 re-opened claims (administrative or tribunal matters).

		- Re-opened claims add complexity and prolong liability. Direct cost of claims is substantial - From December 2024 to December 2025, total claim costs reached \$960,595.75. - Psychological claims are the dominant contributor to this figure. Link to premium risk - Every accepted claim increases NDIA's premium. - Reducing claim lodgements and preventing re-opened cases is critical to controlling costs.
7	What controls are in place now for our top psychosocial risks?	- The Agency has implemented a program of comprehensive risk controls to manage psychosocial risks, including regular inspections, risk assessments, training programs, and flexible work arrangements to support work-life balance. - Targeted Risk Assessments: High-risk branches undergo deep-dive psychosocial assessments aligned with the Commonwealth Code of Practice, incorporating staff surveys and wellbeing focus groups to inform tailored interventions. - Annual Hazard Review: 23 physical and psychological hazards are reviewed annually through the site risk register process in consultation with leadership and safety representatives. - Advanced Wellbeing Services: Over the past 18 months, the Agency has deployed embedded psychological support, leadership coaching, mindfulness sessions, and informal wellbeing check-ins to teams.

		• Specialist Programs: ○ Embedded Workplace Supports (EWS): Clinicians provide individual sessions, seminars, mindfulness activities, and team meeting support. ○ Role Supervision & Wellbeing Checks: Structured oversight for high-risk roles and formal wellbeing assessments with psychometric reporting. ○ Mental Health First Aid Training: Internal resources delivering tailored courses since early 2024. ○ Leadership Accountability: SES plans now include specific goals and actions to ensure psychosocial safety within their areas of control. ○ Early Intervention & Rehabilitation: Dedicated team supports employees' health and safe return to work following injury. Safety & Security Measures: ○ Comprehensive training suite for staff and leaders. ○ Peer Support Contact Officer network for confidential assistance. ○ Incident reporting system ("Speak Up") for WHS and security issues. ○ Security Officer Program deployed at service delivery sites for visible deterrence and respectful de-escalation. ○ The Agency's Safe and Respectful Workplace Program provides a structured framework to prevent, identify, and respond to bullying, harassment, discrimination and other unacceptable behaviours, supporting a zero-tolerance approach and ensuring all workers
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		uphold professional, respectful conduct to maintain a healthy, safe, and psychologically secure workplace. ○ Additional Safeguards: Objectionable material handling framework and PACE system alerts to manage participant-related risks
8	What are we doing next to lower the risk?	The Agency will continue to strengthen safety systems with the iterative implementation of measures focusing on: • Expansion of controls for unreasonable behaviour and threats through improved guidance and training and new programs of work- Establishing Social work model of care to support de-escalation of high-risk participants and upskill staff in effective communication. • Strengthening safety and security processes and the physical environment that we operate in, as an outcome of the Ashton Review recommendations, including a review of remote travel protocols. • Seeking expansion of the existing Employee Assistance Program (EAP) services to align with contemporary workforce needs and integration of proactive mental health support. • Enhancing wellbeing and early intervention supports through the development of a 3-year safety, wellbeing and security strategy focusing on psychosocial safety, early intervention and evidence based and safe return to work systems. • Complete the Enterprise psychosocial risk assessment to have a holistic view to identify, prioritise and manage risks.

9	How is psychosocial safety positioned within the NDIA's strategic and risk architecture?	• The insights from the enterprise and site-based risk assessment activities will be progressively embedded within the Agency's approach and framework for enterprise risk, led by the Risk, Audit and Resilience division. • At a strategic level, psychosocial safety directly supports the NDIA Corporate Plan by underpinning delivery capability and workforce sustainability • It also aligns to COO priority 3, which focusses on keeping staff and visitors safe and well. • Psychosocial risks are reflected within the strategic risk framework, particularly through strategic risk 4, which relates to workforce and culture, including our ability to maintain a safe, capable and high performing workforce. • There is also a connection to Strategic Risk 5 on integrity, recognising that a pro-integrity culture depends on a safe, respectful behaviours. • These risks are monitored through established strategic risk review processes, including reporting to the NDIA Board by the CRO • From an assurance perspective, psychosocial risks are managed through existing and planned mechanisms, including: ○ At the strategic level, risks are monitored through SR4 and SR5 and reported through to the Board for oversight ○ We are also partnering with the CRO to ensure insights from safety risk assessments and all safety/security initiatives can inform the future development of enterprise level risks by the CRO
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		• Oversight is provided through the National Health and Safety Committee and related governance committees, which monitor health, safety, security and wellbeing risks and controls. • This is supported by policy and procedures on roles and responsibilities in relation to safety. • We also rely on data driven insights from Census results, incident trends and deep dive analysis, to inform priority risks and assess whether controls are effective. • In Addition, internal audit and targeted assessment activities, such as site safety risk assessments, provide assurance over controls.
10	How can you create a psychologically safe workplace?	• We know from our own reviews and broader sector evidence that when psychological safety is strong, engagement, performance and risk management all improve; when it's weak, the impact of psychosocial hazards escalates quickly and visibly. • The actions we'll walk through are simple, observable and immediately implementable. They are about how we show up every day- how we role-model safety, remove friction for our teams, and intervene early when risks emerge. Our goal is to ensure the NDIA continues to mature into an environment where people feel confident to speak up, supported in periods of change, and safe to do their best work. Role-Model Safety & Wellbeing Behaviours • Demonstrate respectful, inclusive and calm communication- especially under pressure. • Show healthy workload habits (take breaks, set boundaries, avoid glorifying overwork). • Respond constructively to concerns; reinforce that raising issues is valued, not penalised.

		Accelerate APP Actions • Prioritise and unblock APP-related tasks inside your remit, actively remove delays for your teams. Champion Staff Engagement • Be visible: spend time with frontline teams in high-risk or high-pressure areas. • Act on staff feedback quickly and transparently, close the loop so people see their input matters. Sponsor Safety, Wellbeing & Security • Personally sponsor at least one initiative and speak to it consistently in leadership forums. • Reinforce the messaging in your decisions, ensure safety and wellbeing are integrated into priorities, not added on later. Set the Standard Through Leadership • Participate in WHS and due diligence training model that learning in everyday decisions. • Ask the psychosocial impact question in briefs and decision papers: “What is the psychosocial impact of this decision or change?” • Use leadership influence to normalise open conversations about risk, pressure, and workload. Lead Change Safely • Build safety and wellbeing considerations in from the earliest stages of any change program and involve People Culture & Wellbeing early.
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	• Require clear evidence of consultation, risk identification and mitigations before approving change. • Monitor impacts throughout implementation, not just at the end. Intervene Early and Engage Early • Act immediately when early signs of stress, conflict, or escalating risk surface. • Bring Safety, Wellbeing and Security teams in early to prevent small issues becoming major ones. • Encourage proactive reporting and reward early escalation rather than crisis management.
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Deep Dive: Psychosocial Hazards and Risk Management

What is happening in the NDIA environment?

Workforce growth

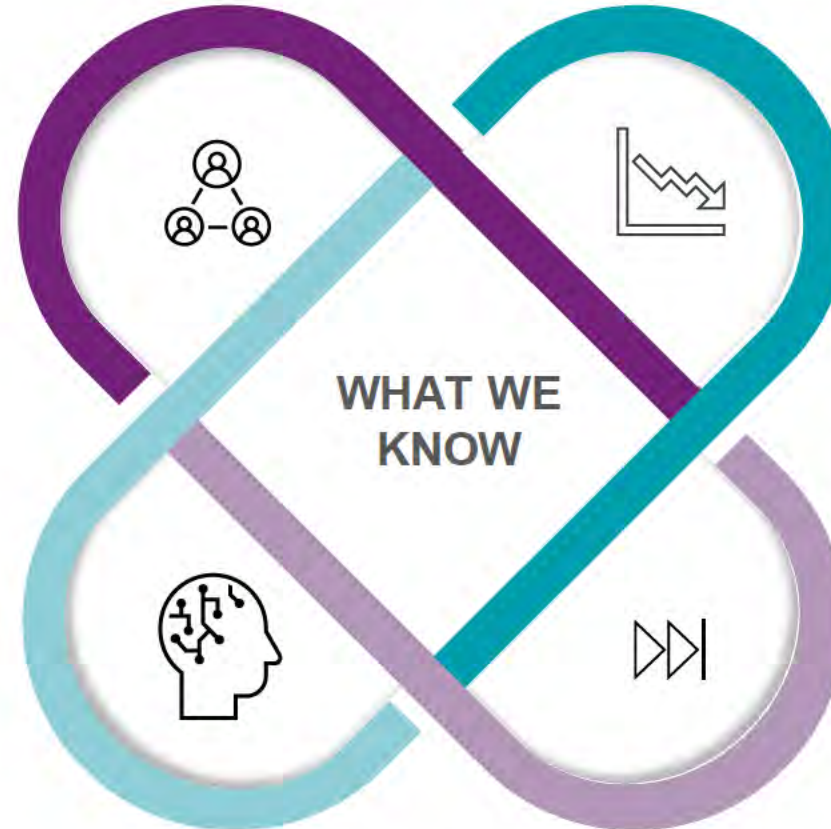
Our psychosocial risk has grown alongside our workforce.

Workforce has grown by 12.1% (1,328) in the 12-month period to 30 December 2025, with a 19% increase in the total reported Work Health and Safety (WHS) incidents.

Psychosocial incidents

Psychosocial hazards are dominant incident category.

78%, (1,065 of 1,364) of reported WHS incidents relate to psychosocial behaviour or injury. This represents a 10% increase over 2025, (78% in 2025 compared to 68% in 2024) in psychosocial-related incidents as a proportion of total incidents.



Environment

The operating environment is becoming more challenging. Key drivers of reported psychosocial-related incidents include external aggression escalation, exposure to confronting or objectionable material, interpersonal conflict between staff and continuous organisational change.

Over the last 5 years, Safe Work Australia have reported a **56% increase** in client and customer work-related violence in workplaces across Australia.

Emerging factors

Significant change and transformation initiatives introducing new pressures and uncertainty.

- New Framework & Thriving Kids rollout
- Leadership and organisational changes
- Budget and resourcing pressures
- Industrial relations focus on safety and bargaining
- Reputation and public sentiment
- Workforce resilience under high job demands
- Fraud taskforce actions increasing tension and risk

What psychosocial incidents are being reported?

89% of reports relate to three primary psychosocial hazards

Unreasonable Behavior

Behaviour from participants, carers or members of the public that is abusive, aggressive or inappropriate.

Exposure to Distressing Content

Viewing, hearing or handling confronting, explicit or traumatic material.

Workplace Interactions

Interpersonal conflict between staff.

The remaining 11% of reports relate to five psychosocial hazards

Lack of Contact officers on site

Systems and Process

Physical Environment challenges

Poor Organisational Change

High Workload Issues

Employee Assistance Program (TELUS Health) - top 5 presenting issues

1

Stress-Personal

2

Workplace Issues

3

Relationship-General

4

Anxiety

5

Mental Health

What are staff telling us?

2025 NDIA APS Census insights

Staff strongly recognise the Agency's efforts to support health and wellbeing, with over 80% positive responses across most measures, which are above APS averages. This includes supervisor support (89%), promotion of health and wellbeing and communication of wellbeing supports (83%)

Safety, Wellbeing and Security Strategy all staff Discovery Workshops top 10 psychosocial hazards



Diversity Groups* Discovery Workshops

Poor/Lack of Support and Poor Organisational Justice were the most consistently identified hazards across all groups.

Harassment and Bullying were reported more frequently within diversity groups.

Rural/Remote cohorts experienced risks associated with **Isolation** and **Workplace Conflicts**.

High Job Demands were identified in fewer diversity groups overall but emerged strongly within the Neuroinclusion cohort.

Diversity Groups*

Employee Disability Network
First Nations Employee Network
Neuroinclusion Network
HarmonyHub (CALD)
Pride@NDIA
Gender Equity Network
Metro
Rural and Remote

What is the leading cause of injury for compensation claims?

FOI 25/26-2921



Mental stress is the leading injury mechanism of Comcare claims. External aggression and exposure to distressing content are not the leading cause of Comcare claims.



Proactive workplace supports and adjustments are reducing incapacity periods and improving return-to-work outcomes **from an average of 52 weeks to 29 weeks.**



Psychosocial claims continue to mostly stem from workload, work pressure and interpersonal relationships. Early Intervention in instances of external aggression and distressing content **has reduced risk and prevented claims.**



Psychosocial injury remains the leading cause of injury, accounting for 68% of costs associated with NDIA compensation claims.



The NDIA's incidence of all accepted claims (per 1000 FTE) is currently 3.8 for the 25-26 Financial Year, below the Commonwealth rate of 5.2.



The NDIA's incidence of accepted psychological claims (per 1000 FTE) is currently 3.3 for the 25-26 Financial Year, above the Commonwealth rate of 1.9.

What is the cost of injury for compensation claims?



The increase in our Comcare premium is significantly driven by the agency's payroll growth of 12.1% in the 12-month period up until 30 December 2025.



The Agency's FY 2025-26 Comcare premium is \$19.1m (excluding GST)



For 2025-26 YTD the cost of psychological claims is at \$1,439,562 equating to 85.11% of all claim costs. Claim costs refer to all claims that have costs paid in each financial year, irrespective of the financial year the claim was determined.



Current claim activity:

- 80 open claims
- 10 closed claims
- 15 re-opened claims (administrative or tribunal matters)



The total cost of all claims from December 2024 to December 2025 is \$960,595.75

What controls are in place now for our top psychosocial risks?

FOI 25/26-2921



Site inspection and Risk Register program

A structured program to identify, assess, and manage site-specific risks through regular inspections and annual risk workshop.



Psychosocial and physical Risk assessments

Evaluating workplace hazards that may impact staff wellbeing and physical safety to identify and mitigate risks.



Psychosocial Workplace Training

Building awareness and skills to manage psychosocial risks, build resilience, and promote a psychosocial safe workplace.



EAP, Advanced Wellbeing Supports, Well+ program

Providing confidential counselling, advanced wellbeing resources, and proactive programs to enhance mental health and resilience.



PACE System content alerts

System alerts that notify a user to distressing or triggering content that may be contained on a file.



Objectionable material and managing unreasonable behaviour framework

Processes, guidelines and training to identify objectionable content and effectively manage unreasonable behaviours.



Security Officer Program

Deployed at service delivery sites for visible deterrence and respectful de-escalation.



Security and Managing Unreasonable Behaviour Training

Training to strengthen security awareness and equip staff with strategies to safely manage and respond to unreasonable behaviours.



Safe and respectful workplace

Framework, training and awareness program to create proactive and positive behaviour in the workplace to create and maintain a safe and healthy workplace.

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What are we doing next to lower the risk?

FOI 25/26,2921

To address unreasonable behaviour and external aggression

- **Develop Agency Site Security Plans – July 2026**
Implement Site Security Plans to regularly review physical security and mitigate security risks.
- **Commonwealth Protection Orders – May 2026**
Strengthen protections for staff through authorised legal controls.
- **Establish the Social Worker Model of Care (Participant) - August 2026**
Embed APS allied health professionals to provide crisis de-escalation for at-risk participants and strengthen referral pathways.

To reduce mental stress, workload pressure and psychological injury

- **Update the EAP and Wellbeing model - April 2026**
Expansion of service offering and improving early intervention capability to better support staff.
- **Establish the Internal Clinical Workforce (Workforce) - August 2026**
Embed APS allied health professionals to support staff wellbeing, build psychosocial capability, and enable early intervention for risk.

To better identify and manage psychosocial risks across the agency

- **Deliver the Enterprise Psychosocial Risk Assessment / Register - June 2026**
Delivers enterprise-wide visibility of psychosocial hazards and embeds a consistent model to identify, prioritise, and manage risks.
- **Deliver the Enterprise-wide Security Risk Assessment/Register - June 2026**
Provides a holistic view of the Agency's security posture, enabling informed decisions and targeted actions to safeguard our people, information, and resources.
- **Launch inaugural Safety, Wellbeing and Security Strategy - October 2026**
Create a framework that promotes a safer, inclusive NDIA by integrating wellbeing, security, and psychosocial safety.

How is psychosocial safety embedded at an agency level?

Alternative: How is psychosocial safety positioned within the NDIA's strategic and risk architecture?

Psychosocial risks are reflected and managed through the NDIA's strategic planning, risk and assurance frameworks

The insights from the enterprise and site-based risk assessment activities will be progressively embedded within the Agency's approach and framework for enterprise risk, led by the Risk, Audit and Resilience division.



Strategic planning

- **NDIA Corporate Plan** - Psychological safety underpins delivery capability and workforce sustainability.
- **COO Priority 3** - Keep staff and visitors safe and well.



Strategic Risk Framework

- **Strategic Risk 4 (SR4) Workforce and Culture** - Ability to build and maintain a safe, capable and high performing workforce.
- **Strategic Risk 5 (SR5) Integrity** - Ability to protect the NDIS and participants against fraud and non-compliance, through a pro-integrity culture and in accordance with integrity frameworks and guidelines.



Risk and assurance mechanisms

- Strategic risk framework - psychosocial risks are monitored through SR4 and SR5 and reported to the NDIA Board
- Enterprise risk – partnering with the Chief Risk Officer / Audit and Resilience Division to ensure strategic risk insights and safety risk assessment outcomes inform the future development of enterprise-level risks
- National Health and Safety and governance committees - oversight of health, safety, security and wellbeing risks and controls
- Policy and procedural controls – clear role accountabilities for staff, managers and executives
- Data and insights – Census, incident trends and deep dive analysis inform priority risks and controls
- Audit and assurance activities - internal audit and targeted reviews (e.g., site safety risk assessments)

How can you create a psychologically safe workplace?



Role Model Safety & Wellbeing Behaviours

- Demonstrate **respectful, inclusive and psychologically safe behaviours**
- Model **healthy workload practices** and constructive conversations and responses to concerns



Accelerate APP Actions

- **Prioritise and unblock APP actions** within your remit, including resources and decision bottlenecks
- Hold accountable officers to **clear milestones**, escalating where progress stalls



Champion Staff Engagement

- Sponsor **targeted frontline engagement** in identified high-risk areas
- Enable access to teams and time, and **support action on staff feedback**



Sponsor Safety, Wellbeing & Security

- Actively sponsor at least **one Safety, Wellbeing or Security initiative**
- **Participate in consultative forums** and visibly reinforce priorities through leadership decisions and messaging



Set the Standard Through Leadership

- Participate in **executive workshops and WHS due diligence training**
- Apply learning by asking the right questions in briefs and decisions (e.g. **"What is the psychosocial impact?"**)



Lead Change Safely

- Embed safety and wellbeing **from the outset** of all change initiatives
- Require evidence of **risk identification, consultation and controls** before approval



Intervene Early and Engage Early

- **Identify and act early** when psychosocial risks, issues, or pressures emerge
- **Engage Safety, Wellbeing and Security early** to prevent escalation and enable timely support

When we invest in psychosocial safety, we prevent injuries and unlock higher engagement, productivity and retention

Psychologically safe teams perform better, stay longer, and deliver more

Findings Diversity Groups and All of Staff Psychosocial Hazard Workshops

Report prepared for National Disability and Insurance Agency,
Safety & Wellbeing Team

19th November 2025



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1. Executive Summary

NDIA retained TELUS Health to support a comprehensive psychosocial hazard staff consultation program across the Agency in September, engaging staff through 46 structured workshop sessions. TELUS Health content analysts and trained clinicians observed all sessions with diverse employee cohorts, comprising eight diversity groups and 25 "All staff" groups, ensuring broad representation across the workforce. Over 1,700 responses were received via anonymous surveys and professionally facilitated discussions. All data was systematically mapped against the Commonwealth Psychosocial Risks and Hazards framework.

Staff responses and commentary to four anonymous targeted questions explored perceived psychosocial hazards, as well as sources of professional satisfaction. The methodology prioritised psychological safety and confidentiality. This report outlines the findings from the diversity groups and the staff focus groups. In addition, it synthesizes findings on NDIA culture, safety, security, physical environment and protective factors.

This report presents findings across five key areas:

- Section 2: Approach and methodology for the Focus Groups.
- Section 3: Quantitative analysis identifying the top psychosocial hazards through voting and coding data, for each Diversity Group and aggregated All Staff data.
- Section 4: Qualitative data for the 25 All Staff workshops for the top ten psychosocial hazards.
- Section 5: Qualitative data for the eight diversity groups.
- Section 6: Cultural analysis exploring gaps between the Agency's espoused values and staff experiences.
- Section 7: Safety, security and physical environment concerns impacting staff wellbeing.
- Section 8: Protective factors sustaining staff and suggested amplification strategies.
- Section 9: Recommendations for areas which merit further review.

The key findings were that Poor support emerges as the most frequently coded psychosocial hazard, representing 26 percent of coded items. High work demands also ranked as primary concern, awarded 32 percent of first-choice votes. Diversity groups reported distinct experiences of psychosocial hazards.

The cultural analysis, informed by an organisational culture framework, outlines concerns for perceived psychological safety and the Speak Up process. Protective factors are described which sustain staff wellbeing, such as recognition, work-life balance, supportive team cultures and the satisfaction of making a genuine difference in participants' lives. The review of Safety, security and physical environment identified important issues affecting staff wellbeing and service delivery and lists issues raised, including those for co-located sites. Additional recommendations have been made about areas warranting deeper examination, namely non-ongoing staff, neuro-diverse cohorts, NDIA co-located offices and their challenges, new employee onboarding, and the Speak Up process.

The consultation findings indicated that while staff demonstrated strong commitment to the Agency's mission and valued aspects of their work, significant psychosocial hazards required attention to ensure workforce wellbeing, retention, and the Agency's capacity to deliver quality services to participants. The data suggested opportunities for the Agency to align lived experiences more closely with espoused values through targeted interventions addressing leadership capability, organisational justice, workload management, and

psychological safety. The Agency has now accomplished a significant consultation process, from which to build solid foundations for its future psychosocial risk management strategy. TELUS Health has welcomed the opportunity to partner with NDIA on this project.

2. Approach

Clinical content analysts attended 46 consultation sessions across September and October 2024, with each session engaging a different employee cohort. This approach ensured broad representation across the Agency's workforce and provided diverse perspectives on psychosocial safety and wellbeing.

Each session followed a structured two-part format designed to maximize participant engagement and data quality. In the first 30 minutes, participants received an introduction to psychosocial hazards and workplace wellbeing via PowerPoint presentations. Following this briefing, participants responded anonymously to four targeted questions via Microsoft Forms, ensuring confidentiality and encouraging candid responses. The second 30-minute segment shifted to open dialogue, where participants shared perspectives either through the chat function or verbal contributions to the group discussion. This dual-mode approach accommodated different communication preferences and comfort levels of participants.

The conveners implemented deliberate strategies to establish a psychologically safe environment conducive to honest and reflective responses. The session design prioritized accessibility and anonymity at all interaction points, enabling participants to share experiences without fear of identification or reprisal. This careful approach yielded rich, substantive data that would likely not have emerged in a less secure setting, providing genuine insights into staff experiences of psychosocial hazards.

Throughout all 46 sessions, clinical content analysts systematically recorded verbatim statements from participants, key words and phrases, recurrent themes and salient commentary, and group dynamics. Analysts subsequently received two complementary data sets: anonymous written responses to the four survey questions and complete raw transcript data from each session. This multi-layered approach enabled triangulation of findings across different data sources, strengthening the validity and reliability of the analysis.

Participants responded anonymously, via google-presented forms, to four questions that formed the foundation of the consultation. The first question asked what part of their work at the NDIA brings them the most joy or satisfaction. The second question required participants to vote on which three psychosocial hazards have the greatest impact on their safety, wellbeing and security. The third question used a fill-in-the-blank format: "We know [blank] is a problem when we see/hear/feel [blank]." The fourth question invited participants to share what people think, feel or hear, but rarely say out loud. These questions captured both positive workplace factors (protective factors) and challenges (psychosocial hazards), while the final two questions encouraged participants to articulate tacit knowledge and unspoken concerns that might not emerge through conventional survey methods.

Data analysis relied on a coding process whereby content analysts reviewed all statements submitted via the forms and phrases, coding each to emerging themes and subthemes. All statements and phrases were mapped against the Commonwealth Psychosocial Risks and Hazards framework, ensuring alignment with established psychosocial safety standards and enabling consistent categorization across all data sources

The analysis proceeded through five distinct stages. The first stage focused on aggregate hazard identification through analysis of Microsoft Forms data from the second question, which yielded over 1700 responses identifying psychosocial hazards. This quantitative analysis of the voting identified the top three psychosocial hazards across all participant groups, including eight diversity groups and 25 general staff cohorts, providing both depth and breadth to priority psychosocial concerns.

The second stage involved separate analysis of each of the eight diversity groups to identify top psychosocial hazards specific to them, observable indicators of these hazards, direct quotes from staff members, and summary findings highlighting group-specific concerns. This analysis revealed important variations in how different employee groups experience psychosocial hazards and ensured that the voices of potentially marginalized or minority groups were distinctly heard and understood.

The third stage examined data from general staff focus groups to identify and discuss the top 10 psychosocial hazards affecting the broader workforce. This analysis provided depth to the quantitative findings from stage one, offering contextual understanding of how these hazards manifest in daily work experiences and their cumulative impact on employee wellbeing.

The fourth stage, presented in Section 6 of this report, synthesizes cultural findings and insights derived from comprehensive data analysis, identifying systemic and organizational factors influencing psychosocial safety. This analysis covers underlying cultural dynamics, leadership practices, and structural issues that either exacerbate or mitigate psychosocial risks.

The fifth and final stage, explored in Section 7, analyzes protective factors identified through responses to the first question regarding sources of workplace satisfaction and joy. This analysis identified existing protective factors that support employee wellbeing, highlighted gaps where protective factors are absent or insufficient, and recommended amplification strategies to strengthen workplace wellbeing. By examining both hazards and protective factors, this approach provides a balanced foundation for developing evidence-based interventions that both reduce risks and enhance positive workplace experiences, notwithstanding the intention of the Agency to proceed to Strategy development.

3. Quantitative Data Findings

Hazards identified by Voting (MS forms)

The following data shows the outcome of the 'voting' on the top three psychosocial hazards by all Agency staff (including Diversity Groups). Over 1700 responses were received in total across the 46 workshops.

The coloured banding shows that the ranking of the top three hazards across the three voting positions.

Voting- first out of three choices

High work demands	187	32.1%
Violence or aggression	67	11.5%
Exposure to confronting information or events	45	7.7%
Bullying and Conflict	44	7.5%

Poor Organisational Change Management	39	6.7%
Workplace Behaviours,	32	5.5%
Lack of Role Clarity	31	5.3%
Lack of Support	29	5.0%
Fatigue	25	4.3%
Poor Recognition and Reward	24	4.1%
Low job control	24	4.1%
Poor Office Environment	8	1.4%
Remote or Isolated Work	7	1.2%
Poor Organisational Justice	7	1.2%
Insecure Employment	4	0.7%
Harassment including Sexual Harassment	4	0.7%
Intrusive Surveillance	4	0.7%
Workplace Behaviours	2	0.3%
Grand Total	583	

Voting - second out of three choices

Poor Organisational Change Management	65	11.3%
Exposure to confronting information or events	57	9.9%
High work demands	54	9.4%
Bullying and Conflict	52	9.0%
Violence or aggression	48	8.3%
Workplace Behaviours,	43	7.5%
Fatigue	42	7.3%
Lack of Support	37	6.4%
Lack of Role Clarity	34	5.9%
Poor Recognition and Reward	29	5.0%
Low job control	27	4.7%
Poor Organisational Justice	23	4.0%
Poor Office Environment	13	2.3%
Remote or Isolated Work	13	2.3%
Intrusive Surveillance	12	2.1%
Insecure Employment	11	1.9%
Harassment including Sexual Harassment	7	1.2%
Workplace Behaviours	6	1.0%
Fatigue	2	0.3%
(blank)		0.0%
Grand Total	575	

Voting – third out of three choices

Fatigue	73	13.1%
Poor Organisational Change Management	62	11.1%
Exposure to confronting information or events	56	10.0%
Workplace Behaviours, Lack of Support	51	9.1%
High work demands	42	7.5%
Bullying and Conflict	38	6.8%
Poor Organisational Justice	38	6.8%
Poor Recognition and Reward	27	4.8%
Violence or aggression	27	4.8%
Poor Office Environment	26	4.7%
Lack of Role Clarity	25	4.5%
Low job control	22	3.9%
Harassment including Sexual Harassment	21	3.8%
Remote or Isolated Work	13	2.3%
Intrusive Surveillance	13	2.3%
Insecure Employment	11	2.0%
Workplace Behaviours	9	1.6%
Grand Total	4	0.7%
	558	

Key Observations

- High work demands is the top 1st choice (187 responses - 32% of all 1st choices), but drops significantly as a second and third ranking. This suggests it is an acutely felt issue, but once identified, other concerns emerge.
- Consistently high rated hazards are organisational change management, exposure to confronting information, and bullying/conflict. An acute hazard is also Violence and aggression, which was also a prevalent first choice.
- The “cumulative impact” hazards of fatigue and lack of support emerge more prominently in the second and third choices, so potentially once staff felt they had identified the priority hazards, they could then turn their vote choice to other concerning hazards.
- This data suggests that while immediate workload pressures predominate as the biggest concern, they are overlaid with the important systemic issues such as change management, workplace culture, fatigue) emerge as significant contributing factors.

Hazards identified by Coding

Psychosocial hazard frequencies were elicited through the completion of the Forms data, completed anonymously during the workshops. Coding was done on statements verbally made by staff during the workshop sessions. Over 1500 items referencing hazards were individually coded and are presented below. Coded All Staff items (e.g. from the 25 All Staff workshops) account for 70% of all items.

All Staff groups (no Diversity Groups)

Psychosocial Hazard		%
Bullying	43	4%
Conflict or poor workplace relationships and interactions	80	7%
Exposure to confronting/traumatic information/material/events	28	3%
Fatigue	51	5%
Harassment including sexual harassment	22	2%
High work demands	164	15%
Insecure Employment	11	1%
Intrusive Surveillance	1	0%
Lack of Role Clarity	36	3%
Low job control	14	1%
Poor Organisational Change Management	100	9%
Poor Organisational Justice	163	15%
Poor Physical Environment	21	2%
Poor/Inadequate Recognition and Reward	18	2%
Poor/Lack of Support	284	26%
Remote/Isolated Work	11	1%
Violence or aggression	29	3%
TOTAL	1076	

EDN, First Nations, Gender Equality and Harmony Diversity Groups

Psychosocial Hazard	EDN		First Nations		Gender Equality		Harmony	
Bullying	6	4%	0	0%	0	0%	1	3%
Conflict or poor workplace relationships and interactions	27	18%	4	8%	4	14%	2	6%
Exposure to confronting/traumatic information/material/events	1	1%	0	0%	0	0%	1	3%
Fatigue	10	7%	1	2%	1	4%	0	0%
Harassment including sexual harassment	5	3%	8	16%	6	21%	5	16%
High work demands	11	7%	2	4%	2	7%	3	9%

Insecure Employment	0	0%	0	0%	1	4%	0	0%
Intrusive Surveillance	1	1%	0	0%	0	0%	0	0%
Lack of Role Clarity	2	1%	0	0%	1	4%	0	0%
Low job control	0	0%	1	2%	0	0%	1	3%
Poor Organisational Change Management	6	4%	0	0%	0	0%	2	6%
Poor Organisational Justice	31	21%	16	33%	4	14%	10	31%
Poor Physical Environment	5	3%	0	0%	0	0%	0	0%
Poor/Inadequate Recognition and Reward	7	5%	4	8%	1	4%	2	6%
Poor/Lack of Support	37	25%	13	27%	7	25%	4	13%
Remote/Isolated Work	0	0%	0	0%	1	4%	1	3%
Violence or aggression	2	1%	0	0%	0	0%	0	0%

Metro, Neuroinclusion, Pride and Rural Remote Diversity Groups

Psychosocial Hazard	Metro		Neuro inclusion		Pride		Rural Remote	
Bullying	8	32%	4	8%	8	11%	2	5%
Conflict or poor workplace relationships and interactions	1	4%	4	8%	4	5%	9	23%
Exposure to confronting/traumatic information/material/events	1	4%	1	2%	0	0%	0	0%
Fatigue	0	0%	2	4%	1	1%	3	8%
Harassment including sexual harassment	0	0%	1	2%	10	13%	0	0%
High work demands	2	8%	7	13%	7	9%	0	0%
Insecure Employment	0	0%	0	0%	5	7%	0	0%
Intrusive Surveillance	1	4%	1	2%	0	0%	0	0%
Lack of Role Clarity	0	0%	1	2%	0	0%	0	0%
Low job control	0	0%	0	0%	0	0%	0	0%
Poor Organisational Change Management	1	4%	1	2%	3	4%	3	8%
Poor Organisational Justice	2	8%	6	12%	10	13%	4	10%
Poor Physical Environment	1	4%	1	2%	0	0%	0	0%
Poor/Inadequate Recognition and Reward	0	0%	3	6%	1	1%	1	3%
Poor/Lack of Support	8	32%	19	37%	26	34%	7	18%
Remote/Isolated Work	0	0%		0%	0	0%	9	23%

Violence or aggression	0	0%	1	2%	1	1%	1	3%
Total All Diversity Groups	452							

Key Observations

- The top three hazards revealed in this data are: poor/lack of support; Organisational justice and high work demands.
- For the All Staff work groups, high work demands and Organisational justice both showed quite high variability between workshop groups, suggesting quite different experiences (nb: the data here has aggregated all workshops so is not visible on the table above)
- For the All Staff groups, Conflict/Workplace relationships had variability of occurrence, with several workshops coding this hazard with high frequency. Note, that this could reflect the way the discussion arose in the workshop and is not necessarily indicative of all experience.
- Lack of support (All Staff) alongside its high frequency also showed a reasonable degree of variability across the workshops from very high to moderately high. It appears to be a pervasive issue.
- Fatigue and bullying hazards were rated consistently moderately (All Staff) from the workshop Coding but in the voting table, Bullying was rated relatively high, #4 in priority (7.5%). Differences in ranking between the two sources of data could reflect the workshop facilitator's encouragement to mention risks not known about by the Agency. Coding and Voting data may therefore be based on different reference points for individuals.
- Intrusive surveillance, insecure employment, low job control and remote/isolated work emerge as universally low hazards (All Staff).

4. Qualitative Data: Specialist Diversity Group Findings

The following pages outline the points raised by the Diversity groups as a whole. Different individual workshops for the same Diversity group often had different 'flavours' and levels of contribution. The ranking of hazards is derived from the Coding Analysis. The top nine hazards were the same across both Coding data and Voting data, although with different positional ranking. One hazard, Organisational justice, was highly rated by the Coding Analysts but barely rated in the Voting data. The difference is attributed to the difficulty staff may have to make sense of the term easily and quickly in the workshop environment.

First Nations Employee Network (FNEN)

Definition	NDIA's FNEN enables Aboriginal and Torres Strait Islander employees to connect with each other on a national basis and provide a forum to build our 'community' within the Agency.
Top Psychosocial Hazards	• Poor Organisational Justice 33% • Poor/Lack of Support 27% • Harassment including Sexual Harassment 16%
Indicators	Poor Organisational Justice • Unfair, biased or inconsistent policies or procedures

	• Failing to appropriately address (actual or alleged) underperformance, inappropriate or harmful behaviour or misconduct • Discriminating against particular groups or not applying policies fairly to some groups Poor/Lack of Support • Inadequate guidance from supervisors or assistance from other workers • Workers cannot ask for help when needed • Limited emotional support or unempathetic leadership • Supervisors do not notice when workers are struggling, do not take issues seriously or provide a safe space to raise issues Harassment including Sexual Harassment • Harassment based on personal characteristics: age, disability, race, nationality, religion, political affiliation, sex, relationship status, family or carer responsibilities, sexual orientation, gender identity or intersex status. • Sex or gender-based harassment and discrimination
Quotes	<i>"Nothing has happened after reports made of racism on site"</i> <i>"Cultural safety is a problem when I hear derogatory comments still being made in the work place about First Nations staff being employment to tick a box and not on their own merits"</i> <i>"When we speak out our leaders do not know how to handle it eg: vicarious trauma, cultural fatigue"</i> <i>"We know lack of cultural safety is a problem when we see low retention rates of First Nation employees"</i> <i>"When made to feel like you're an issue after speaking out against casual racism in the workplace rather than leadership addressing. Fear of being targeted in the future"</i>
Summary:	First Nations staff identified Organisational injustice in a number of ways. Staff reported hearing derogatory comments about First Nations employees being hired to "tick a box" rather than on merit, which undermined their professional credibility and confidence. Leadership required First Nations staff to justify their behaviour at conferences in ways not expected of other employees, demonstrating potential discriminatory treatment. Some managers questioned family connections before approving cultural leave for funerals, showing a lack of cultural understanding. Staff identify facing barriers to career progression, particularly when required to provide evidence of First Nations status, and this can be problematic especially for staff that do not have access to documentation (for example, stolen generation). Career advancement opportunities were given to non-merit-listed candidates while First Nations staff appeared to be overlooked. One or two references were made to Team leaders on occasion who failed to support or model cultural inclusive practices such as an Acknowledgement of Country. Reports of racism were stated to have received no action, and when staff raised concerns, some assertions were made about the person being removed from the Agency rather than the issues being addressed. First Nations planners received pushback from within the Agency when attempting to provide culturally safe services to participants.

First Nations staff also reported lack of support at multiple levels. Low retention rates and high staff turnover indicated potential systemic support failures. Remote areas had no First Nations planners despite multiple recruitment rounds, leaving existing staff to travel extensively without adequate team leader support or recognition. Some leaders demonstrated limited understanding of the Agency's need to match First Nations participants with First Nations planners. Some leaders lacked training in vicarious trauma as it related to First Nations experiences, leaving staff unsupported when dealing with cultural fatigue and trauma. Staff reported feeling burnout, with visible declines in staff morale and "absent spirit." Remote workers received inadequate support from leadership, particularly when leaders were in different locations or lacked personal relationships with staff. Staff feared speaking up about issues due to concerns about being targeted or having their voices dismissed. First Nations staff reported regular racial harassment and microaggressions in the workplace. Some staff encountered micro-racist comments that were dismissed or gaslit when challenged, with perpetrators claiming comments were not meant to be racist. Knowledge articles about supporting First Nations people may be viewed as containing racist content. Non-Indigenous colleagues made inappropriate comments and displayed "benevolent racism," dropping their guard and sharing inappropriate views with First Nations staff as if they were complicit. Staff were treated as a homogenous group rather than as individuals. When staff reported casual racism, leadership failed to address the behaviour, instead making the reporting staff member feel like they were the problem, creating fear of future targeting. Staff who experienced racism on site with no action taken after reports were made.

Source Data: 49 coded items, 3 workshops.

Harmony Group

Definition	Harmony Hub – this is the Agency's culturally and linguistically diverse (CALD) staff network.
Top Psychosocial Hazards	• Poor Organisational Justice 31% • Harassment including Sexual Harassment 16% • Poor Lack of Support 13%
Indicators	Poor Organisational Justice: • Policies or procedures that are unfair, biased or applied inconsistently • Discriminating against particular groups or not applying policies fairly to some groups • Allocating work, shifts and opportunities in a discriminatory or unfair way Harassment including Sexual Harassment • Insulting comments related to protected characteristics • Discrimination based on personal characteristics Poor Lack of Support: • Inadequate Resources & Information • Not enough supervisor support (Limited emotional support or unempathetic leadership) • Inadequate training for the task
Quotes	<i>"CALD staff are not promoted accordingly based on merits and also faced issues with favouritism and nepotism with existing staff promoting one another to higher level"</i>

	<i>"I do not see CALD being given opportunities the same as others"</i> <i>"We know CALD is a problem when we don't see groups / culture been celebrated. or not group get together"</i> <i>"Indirect racist comments from colleagues"</i> <i>"Many managers don't understand how to find affinity with CALD staff and demoralise them or ask them to explain everything about every culture, burning them out"</i> <i>"English is not everyone's first language. Many of us English is second language."</i>
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Summary

Poor Organisational Justice emerged as the predominant psychosocial hazard for this cohort. Some staff expressed concerns about fairness in workplace processes, particularly regarding career progression and recruitment. Multiple respondents indicated that they felt CALD staff were not being promoted based on merit and given the opportunities others might, with career advancements described as rare. Concerns were raised that staff were being passed over in expression of interest processes while others were promoted through private channels. One staff member indicated that their accent affected project work allocation, suggesting bias in work distribution. The perception existed that culturally diverse staff felt unseen, unheard and not included in workplace culture. The absence of cultural celebration and recognition of diverse groups was mentioned as contributing to feelings of exclusion.

Harassment including Sexual Harassment represented the second major hazard for this cohort. A staff member described experiencing indirect racist comments from colleagues and another noted that colleagues held "ideas about a certain race." The experience of being the only CALD person in a team, or part of a very small number, was identified as a concern that was not adequately recognised or understood by the broader workforce. Some staff indicated they felt uncomfortable expressing their actual feelings and engaged in self-censoring. The fear of consequences was noted, with some staff describing situations where individuals were afraid to voice concerns even when leaving the Agency.

Inadequate support emerged as the third most common hazard for this cohort, particularly regarding cultural understanding and inclusion. It was shared that many managers did not understand how to find affinity with CALD staff, a circumstance that required staff to explain everything about their culture and contributed to symptoms of burnout. The lack of support and mentoring opportunities for staff from CALD backgrounds was specifically identified. Language barriers were acknowledged, with staff noting that English was not everyone's first language, yet plain English was not consistently used when referring to mental health concepts, and in Agency communications. In addition, it was shared that mental health initiatives were heavily westernised, with the nuances and stigma of mental health for CALD staff not adequately considered. It was also indicated that staff felt less safe to speak up about concerns or make suggestions, contributing to a culture of silence.

Other hazards (of lower frequency) included higher work demands, with staff describing unrealistic key performance indicators that created mental and physical pressure. KPIs were apparently implemented without consulting employees, and leadership needed to understand that targets could not always be achieved. The combination of high workload and exposure to aggressive or abusive participants was identified as particularly challenging, as was exposure to confronting and traumatic material was noted, with one staff member requesting more effective alert systems when reviewing participant evidence and assessment documents. Poor Organisational change management was referenced, with

feedback indicating this was reflected in census results and contributed to low job control in newer branches experiencing frequent structural changes.

Source Data: 32 coded items, 2 Focus Groups

Neuroinclusion Network

Definition	The Neuroinclusion Network invites membership from neurodivergent employees, allies and interested staff and provides a space where both neurodivergent and non-neurodivergent staff can learn about neurodiversity.
Top Psychosocial Hazards	• Poor/Lack of Support 37% • High work demands 13% • Organisational justice 12%
Indicators	Poor/Lack of Support • Lack of neurodiverse-friendly workspaces • Managing relationships with uninformed neurotypical colleagues and leaders • Burden of self-advocacy High Work Demands • Meeting high work loads • Difficulties adapting to changes and processes without appropriate support and understanding Organisational Justice • Pressures to conform to neurotypical norms • Unacceptable resolutions or recognition of bullying and Speak Up complaints
Quotes	<i>"Pretending you are NT is like living with hand cuffs on"</i> <i>"Autistic participants make up our biggest cohort, but there is limited understanding and experience of autism in the workplace, with staff. The workplace is designed for neurotypicals, and neurodivergent staff need to accommodate."</i> <i>"Once I did the Speak Up, I was pretty much forced to take leave because the bullying increased"</i>
Summary	This group expressed a need for neurodiversity education and training for leadership, delivered by people with lived experience who share both challenges and strengths, not just limitations. Neurodivergent staff described how exhausting self-advocacy was in the workplace, explaining that navigating requests for workplace arrangements or workload adjustments was unnecessarily difficult, and that masking to fit in required working twice as hard just to be understood. Many felt misunderstood, noting that broader lack of knowledge about neurodivergence was evident in comments, online chats, and instances where staff were reprimanded for displaying aspects of their disability. Staff identified systemic barriers including lack of flexible workplace arrangements, absence of sensory and quiet spaces despite demanding KPIs, and wellbeing initiatives that didn't reflect neurodiverse needs. They reported that feedback from neurodivergent

staff was collected but not acted upon, and that there was insufficient value placed on neurodivergent lived experience or clear career paths. Staff wished managers would ask about individual working styles and expressed frustration that while some managers were exceptional, they appeared to be in the minority. A recurrent theme is the 'burden' of self-advocacy.

High work demands were reported by this group. They referenced how unrealistic demands and constant organizational changes without appropriate support created significant workload pressures. Learning new processes led to feelings of overwhelm, reduced ability to focus, and drops in productivity, leaving staff feeling unable to support participants appropriately. The poor work environment resulting from these conditions contributed to increases in unplanned leave.

The workload burden was compounded by the need to conform to neurotypical patterns, which staff described as living with handcuffs on, while simultaneously managing imposter syndrome. Staff expressed frustration at having to explain things multiple times when colleagues couldn't understand their perspective, as they approached situations from a different viewpoint. Masking and adopting neurotypical behaviours to meet social expectations created invisible work that drained their capacity.

Organizational justice emerged as the third major hazard. Staff commented about recurrent bullying experiences and the Agency's response to complaints. One staff member described taking several months off with nobody to support them despite going through every tier of the Speak Up process more than once, another that the bullying actually increased after speaking up, forcing them to take leave. Staff observed that bullying behaviours from team leaders through to branch managers was hidden and not addressed, creating an environment where fear of being misunderstood or penalised kept people silent.

The lack of psychological safety compounded pressure to conform to neurotypical norms requiring neurodivergent staff to continuously accommodate and mask their authentic selves to avoid judgment or exclusion.

Source Data: 52 coded items, 1 Focus Group

Rural & Remote Group

Definition	The rural and remote network provides essential services to support people with disabilities living in remote communities across Australia. This group consists of specialised teams which work together to deliver quality, culturally appropriate services and programs.
Top Psychosocial Hazards	• Remote / Isolated Work 23% • Conflict or Poor Workplace Relationships and Interactions 23% • Poor/Lack of Support 18%
Indicators	Remote / Isolated Work • Challenges of being a sole worker with no one around • Lack of connection with others doing the same work • Limited access to support services in regional areas Conflict or Poor Workplace Relationship and Interactions • Lack of leadership presence in rural/remote offices • Low morale and negative feedback tendencies in teams

	• Limited engagement with upper-level management on site Poor/Lack of Support • Difficulty reaching out for support when underperforming • Delayed responses from leadership (up to a week) • Feedback being used against staff rather than for development
Quotes	<i>"We know rural and remote staff don't matter when they have no leadership on site, concerns are raised via Speak Up and these are closed off without further action or consultation with staff onsite"</i> <i>"Accessing support within regional areas can sometimes be limited. NDIA have a metro-centric view of supports available in the community"</i> <i>"Watching a team leader have a meeting with staff in the office and the engagement compared to staff that are virtual"</i> <i>"Driving long distances – takes on more cognitive load – higher level of concentration with navigating long distances and unfamiliar roads. High levels of fatigue after a trip"</i> <i>"Moving to a remote/rural office is a career killer"</i>
Summary	Remote/Isolated Work emerged as the predominant psychosocial hazard. Staff working in rural and remote areas face significant isolation, with workers reporting they have no team members in their physical office and must work virtually. The geographic separation creates challenges for sole workers who lack colleagues to bounce ideas off and feel disconnected from others doing the same work. This isolation is compounded by extensive travel requirements that disrupt normal routines, cause sleep disturbances, and lead to increased unplanned leave upon return. Workers report that driving long distances requires higher cognitive load and concentration, resulting in significant fatigue. The career implications are stark, with staff perceiving that moving to a remote or rural office is a "career killer" and that metro staff have greater opportunities for development and advancement. Rural and remote workers regularly miss out on higher duties and promotions compared to their city-based colleagues. Conflict or Poor Workplace Relationships and Interactions represented the second major hazard. Staff express deep unhappiness with leadership and upper management, feeling excluded, targeted, and subjected to bullying behaviour. There is limited engagement with upper-level management on site, with senior leadership only appearing after natural disasters or significant incidents, demonstrating a lack of respect for rural remote workers. Workers report that concerns raised through Speak Up mechanisms are closed off without further action or consultation with onsite staff, creating a sense that rural and remote staff don't matter. Senior leadership is perceived as disconnected from junior staff, unaware of their true skill sets, and disrespectful of those below them. The morale issues are evident through low interaction levels and tendencies for negative feedback within teams. Staff feel that decisions are made at senior levels without proper consultation and with little knowledge about the subject or consequences. Poor/Lack of Support constituted the third critical hazard. Workers experienced significant delays in receiving responses from leadership, sometimes waiting up to a week for email replies compared to onsite team members. There was stigmatization around reaching out for help, with an expectation that staff will manage issues themselves. Staff felt uncomfortable raising performance concerns or reporting problematic behaviours of team members. When feedback is requested, it is used as a mechanism against staff rather

than for development. Recurring issues cannot be effectively raised above team leaders due to a perceived "club" mentality where issues don't get addressed. The lack of support extends to practical matters, with limited access to support services in regional areas and a metro-centric view of available community supports. Workers report feeling unheard, with observable differences in team leader engagement between office-based staff and virtual workers.

Source Data: 39 coded items

Pride@NDIA Network

Definition	Pride@NDIA is the Agency's LGBTIQASB+ Staff and Allies Network.
Top Psychosocial Hazards	• Poor Lack of Support: 34% • Poor Organisational Justice 13% • Harassment including sexual harassment 13% • Bullying 11%
Indicators	Poor Lack of Support • Inadequate training, tools, and resources • Insufficient practical assistance and emotional support from managers and colleagues • Poorly maintained or inadequate tools and systems Poor Organisational Justice • Failing to appropriately address (actual or alleged) underperformance, inappropriate or harmful behaviour, or misconduct • Policies or procedures that are unfair, biased or applied inconsistently • No or inadequate processes for making decisions affecting workers. Harassment • Harassment or Discrimination based on personal characteristics
Quotes	<i>"I think maybe some required training on the different minority groups for leadership, especially if they don't have lived experience, would be really helpful."</i> <i>"Staff at higher classifications are performative in their allyship/engagement with culture more generally."</i> <i>"When they (leaders) are causing the discrimination or targeted behavior it is hard to speak up especially in smaller sites where everyone knows everyone"</i> <i>"We know the leadership is a problem when we hear inappropriate comments and feel like nothing is going to happen as a consequence"</i> <i>"I think it is really important that the mainstream areas of health, wellbeing and safety are prioritizing cultural safety so it becomes a safe place for everyone"</i>

Summary

Poor support in the forms of insufficient leadership support and organizational resources emerged as the top hazard for this cohort. Staff noted that leaders were often ill-equipped when providing them with support about how to assist trans participants. Staff felt that they were actively discouraged from going into the community as non-binary. LGBTQIA+ Allyship was described by one staff member as lacking authenticity at higher levels, and some leaders were un-enthusiastic when celebrating diversity or days of significance. Staff noted that valuable LGBTQIA+ support materials, such as the allyship guide, had limited visibility across the organization. Additionally, administrative challenges were reported, including difficulties experienced by a transitioning staff member when attempting to update their name in the HR system. To address these gaps, participants recommended mandated and targeted LGBTQIA+ training for both leadership and staff, particularly for those without lived experience in these areas. It was also suggested that promoting existing LGBTQIA+ resources, particularly in the onboarding process, improving HR systems and encouraging the celebration of diversity would enhance organizational understanding of this cohort and strengthen their sense of inclusion and support.

Organisational Justice ranked as the second major concern. Staff referenced the Speak Up process as presenting substantial barriers to effective reporting. They stated that previous reports had not resulted in visible action, creating reluctance to report subsequent incidents. The process was perceived by some staff as procedural rather than substantive, with some cases being described as closed off without meaningful feedback regarding outcomes or consequences. Staff also expressed discomfort utilising the Speak Up mechanism or approaching the wellbeing and safety team when concerns related to leadership, particularly given potential escalation pathways. For example, some LGBTQIA+ staff expressed concerns about reporting discrimination or bullying by leaders due to the potential for complaints to be directed to the individual being reported. Staff perceived that this exposure could negatively impact their job security and career progression, with these concerns heightened in smaller sites where professional relationships are closely interconnected. This perceived lack of accountability for inappropriate conduct appeared to undermine staff's confidence in reporting mechanisms and the Agency's commitment to addressing discriminatory behavior. Another comment made in the group was staff were not necessarily encouraged or supported to speak up, a belief that further increased their hesitation to be brave and share their concerns as vulnerable staff.

Harassment constituted another important hazard. Staff across multiple sites reported witnessing and experiencing discrimination or inappropriate behavior, with some instances originating from individuals in leadership positions. Day-to-day interactions with colleagues also highlighted challenges to staff feeling able to experience a sense of belonging. One piece of feedback highlighted the need for staff to be more mindful of their reactions when pronouns are used, to ensure colleagues feel safe expressing their authentic identities. Other comments highlighted that staff's cultural attitudes or bullying behaviour can lead to reduced office attendance where discriminatory attitudes could emerge through inappropriate jokes and comments.

Bullying emerged as another less frequent psychosocial hazard, with leaders implicated in incidents and staff fearing repercussions from disclosing experiences. A further barrier is the lack of confidence in the processes to address unacceptable workplace behaviours.

Source Data: 76 coded items

Gender Equity Group

Definition	The Gender Equity staff network exists to create an open and inclusive workplace culture, where staff of all gender identities have equitable opportunities to achieve their full potential.
Top Psychosocial Hazards	• Lack of support 25% • Harassment 21% • Organisational justice 14% • Conflict or Poor Workplace Relationships 14%
Indicators	Poor Lack of Support • Inadequate training, tools, and resources • Insufficient practical assistance and emotional support from managers and colleagues • Poorly maintained or inadequate tools and systems Harassment • Harassment or Discrimination Poor Organisational Justice • Inadequate processes for making decisions affecting workers. • Promotion and career progression opportunities • Poor workplace relationships • Lack of usage and recognition of appropriate gender diversity communication • Feeling unheard or unsafe
Quotes	<i>"Male names that colleagues tell me to avoid for that reason. There's just a little bit of that around here and there, which is the case for all workplaces"</i> <i>"We experience gender inequality both at an individual and systemic level"</i> <i>"Often support is about doing, being able to do your job like functionally rather than sort of this orientation towards thriving and actually achieving your own goals' (in relation to supporting people with a disability at work excel and move into leadership roles)"</i> <i>"We feel bad for expressing or correcting incorrect pronoun usage"</i> <i>"There are so many rooms where decisions and choices are being made, and there is no visibility of the input of lived experience."</i>
Summary	Poor or inadequate support emerged as a primary concern for this cohort. Several staff members shared that the assistance given to people with a disability was inadequate, with workplace supports focusing solely on functional job performance rather than helping staff with a disability thrive and achieve their career goals or leadership positions: this could result in Agency leaders with little lived experience as they exercise their responsibilities. As a result, some staff felt that there was a lack of support and training for people with disabilities to excel and move into leadership roles. Furthermore, at time the group were disappointed by managers not honoring significant days of LGBT+. The Agency's claim to be data and research-informed was also challenged, with a few staff reporting having limited access to academic research and useful internal data. Staff members experienced their chosen

pronouns not being used. One staff member highlighted that the Agency needs better support for staff going through grief.

Harassment and identified gender-based discrimination, inequality were all identified as concerns. Staff reported experiencing gender inequality at both individual and systemic levels. Examples of workplace inequality included the perception that males were preferred in promotional reviews, senior male colleagues making dismissive comments that undermined women's professional qualifications and the experience of being silenced in a meeting after a comment by an older man which 'cut the room down'. Another example referenced was how staff shared information informally on specific sexist males to avoid. One staff member described women as facing structural disadvantages including the gender pay gap, greater care obligations, and higher likelihood of experiencing domestic and family violence.

Poor Organisational Justice was exhibited in Agency decision-making processes which are seen as lacking procedural fairness. Lower promotion rates were seen to have created a flow-on effect of underrepresentation among leadership positions and board memberships. In addition, a lack of safety to speak up amongst peers was shared by some staff. Examples included discomfort correcting pronoun misuse and expressing non-binary gender identify, as well as staff feeling unable to challenge leaders who didn't uphold Agency values.

Workplace relationships, the equal third hazard, encompassed perceived disempowerment to call out poor leader behaviours. This hazard also referenced underpinning psychological safety in feel safe in the staff members' chosen gender expression.

Source Data: 27 coded items

Employee Disability Network (EDN)

Definition	EDN: this forum is for Agency staff with disability to connect, collaborate and contribute to the NDIA's aim to be a leading Agency for accessibility and inclusion, and an employer of choice for people with disability.
Top Psychosocial Hazards	• Poor/Lack of Support 25% • Organisational Justice 21% • Conflict or poor workplace relationships and interactions 18%
Indicators	Poor lack of support • Insufficient disability awareness training for managers and staff including - Lack understanding how disability impacts on work performance • Inconsistent application of workplace support requests Organisational justice • Unfair promotion practices or opportunities • Discomfort or fear of reporting discrimination practices or experiences Conflict or poor workplace interactions • Acceptance of poor behaviours including bullying • Disclosure of experiences of exclusion and ableist communication/attitudes

Quotes	<i>“Adjustment is based on what the line manager or branch is willing to accept, not on what a person can reasonably achieve given their disability”</i> <i>“I am frightened to ask for adjustment”</i> <i>“No able bodied person will ask me for help”</i> <i>“Career progression doesn’t seem to happen for the staff genuinely wanting to excel in their career”.</i> <i>“Team leaders/EL1s and SESs need more training on how to manage staff with disabilities, about EDN, disability passports and workplace adjustments and the law and so on.”</i>
Summary	Lack of support was identified as the greatest psychosocial hazard. Staff described a lack of disability awareness and competence among managers and staff without a disability. They expressed frustration that a disability Agency demonstrated insufficient understanding of how disability impacts on work performance. They expressed concern that they might be perceived as slower to do certain tasks, and experience a lack of understanding from their managers. The requirement to repeatedly disclose disability when changing teams was identified as stressful and unnecessary; this process is seen as an inconsistent ‘grey area’, influenced by the mindset and interpretation of a staff member’s individual manager. To add to this, with each new manager or role, repeated disclosure is required. Mention was made of a “passport”, which is oriented towards labelling rather than support being allocated on the basis of functional support. One staff member stated the hiring process may not adequately consider how workplace supports will be available. Numerous statements throughout the workshops were expressed in which staff reported that existing support mechanisms, including Speak Up and EAP, were ineffective in addressing their concerns and not trusted processes. Poor Organisational justice emerged as the second most frequent concern. Staff perceived unfairness in promotion and career progression, with some believing they had no chance of advancement due to reduced work schedules or perceived lack of capability. In several cases, they referenced making multiple applications to be placed (again) on merit lists. Many strive to meet the ‘standard’ performance expectations upon them, but experience inevitably the fatigue and load associated with developing compensatory strategies. Some staff felt stigmatised by perceptions that they were hired to meet quotas rather than on merit. The fear of consequences for calling out discrimination appears to have created a climate where staff felt unable to address harmful behaviours. Many staff referenced disrespectful interactions where their concerns were disregarded, or that if they did speak up, no change would occur. These perceptions of unfairness in processes, outcomes and support create a challenging working environment. Conflict or poor workplace relationships represents the third most frequent hazard. Difficulties with support has been described in the first paragraph. Lateral relationships are challenged too, with staff referring to difficulties in their relationships with colleagues around disability disclosure and even lateral ableism from participants. Several comments reflect experiences of not being believed when speaking about discrimination or feeling that colleagues do not understand the impact of their disability or that they believe preferential treatment exists. The relational challenges around accessibility and inclusion create ongoing interpersonal friction. Employees report having to repeatedly advocate for accessibility needs, describing this as a constant struggle when inaccessible practices

occur daily. Some describe having to "fight" for what they need to feel safe at work and a sense of isolation.

Source Data: 151 coded items

Metro Staff

Definition	NDIA staff living and working in metro areas
Top Psychosocial Hazards	- Poor/Lack of Support 32% - Bullying 32%
Indicators	Poor Lack of Support - Inconsistent support from Management - Feedback processes being performative rather than genuine - Staff feeling unsupported by senior leaders Bullying - Bullying and harassment from senior leaders - Peer-to-peer bullying
Quotes	<i>"We know bullying is a problem when we see our team members withdrawing communication"</i> <i>"Bullying and harassment is a problem when we see it on display from our senior leaders"</i> <i>"Limited support and processes to support changes within the Agency"</i> <i>"Many people feel used or undervalued, especially when they're expected to support managers without receiving adequate support themselves"</i> <i>"Support from senior leaders sways – it's inconsistent and often, unsafe when there is an issue. It's not discussed – people are accused of doing the wrong thing rather than being asked what happened"</i>
Summary	The content analysis of Metro workshops identified two primary psychosocial hazards that posed potential risks to staff wellbeing and workplace culture. Poor/Lack of Support emerged as the most frequently cited concern, followed by Bullying. Staff reported issues with leadership support and Agency responsiveness throughout the workshops. They observed high turnover rates and expressed frustration that concerns were consistently redirected without resolution. Feedback processes were perceived as being more focused on compliance than genuine improvement, creating a sense of futility among staff members. Many employees felt used or undervalued, particularly when they were expected to support managers without adequate support themselves. There was a belief that feedback processes were performative and that leadership was already aware of the issues but chose not to act on them.

The reporting mechanisms within the Agency were viewed as ineffective. Staff indicated that reporting issues through systems like Speak Up was perceived as a waste of time, with nothing being actioned and no follow-up contact from management. This lack of response further eroded trust and discouraged staff from raising concerns.

Staff reported that some senior leaders shut down topics or thoughts and ridiculed staff members, creating an environment where it was not safe for others to speak up. Support from senior leaders was described as inconsistent and often unsafe when issues arose. Rather than being asked what happened, staff reported being accused of doing the wrong thing. Performance pressures compounded these issues, with staff struggling to meet weekly KPI expectations. This created fear about not meeting expectations and contributed to declining staff morale. Meetings focused predominately on KPIs and turnaround times rather than positive themes, further diminishing morale.

Bullying was identified as a significant and widespread problem at multiple levels of the Agency. Staff reported witnessing bullying and harassment on display from senior leaders, which set a concerning tone for workplace culture. The impact of bullying was visible in observable behavioural changes, with team members withdrawing communication as a protective response. One incident was reported where the same person was bullying multiple people, yet no one reported it, due to fear of retaliation and the non-renewal of contracts. The fear of consequences for speaking up created a culture of silence that allowed bullying behaviours to continue unchecked.

Peer-to-peer bullying was also identified. Staff attributed this to factors related to the role, such as excessive workload and lack of adequate training. Bullying occurred within teams, creating toxic environments. Additionally, staff experienced abuse from participants, adding another layer of stress to their roles.

While not classed as bullying, reference was made by non-ongoing employees to fear of speaking up about workplace issues because their contract renewal depends on manager discretion, creating a powerful silencing mechanism. Metro staff explicitly identified this: "Fear to speak out for fear of retaliation. For example, non-ongoing contracts are not renewed." This power imbalance enables bullying and harassment to continue unreported ("the same person is bullying multiple people, but no one is reporting it"), undermines feedback systems, and creates two-tier psychological safety where temporary staff must choose between job security and workplace justice.

The two psychosocial hazards of bullying and lack of support raise concerns about a negative workplace culture. The combination of inadequate support and bullying behaviours fostered an environment where staff felt unsafe, undervalued, and unable to speak up about their concerns without fear of negative consequences.

Source Data: 25 coded items.

5. Qualitative Data: All Staff Focus Group Findings

The following pages provide an outline of the top ten psychosocial hazards from the workshops. The top nine were common across both Voting data and Coding data, but ranked in different orders. The order of the hazards outlined below preferences the ranking attributed through the coding results, as opposed to the voting results. The only psychosocial hazard which did not appear in the voting, but did appear in the coding results, is Organisational Justice.

5.1. Hazard #1: Poor/Lack of Support

Prevalence	26% in Coding (#1) 5% in Voting (#8).
Definition	Lack of emotional and practical support from colleagues and management. Or training, tools, resources.
Indicators	• Reluctance to seek help or guidance from managers • High staff turnover with team members actively seeking to exit teams • Perceptions of lack of understanding and support by managers, both general and based on diversity. • Lack of psychological safety to raise concerns or lodge Speak Ups • Expressions of confusion, stress, distress, fatigue and burnout • Lack of support following incidents or trauma exposure • Disengagement from team conversations and meetings
Quotes	<i>"My managers don't walk the talk with Wellbeing, Security and safety; do not have the skills to do the job".</i> <i>"We know staff training and lack of guidance to perform their job role is a problem when we see poor performance, poor quality and poor achievements"</i> <i>"Leadership is a problem when leaders do not schedule regular 1:1s with direct reports."</i> <i>"The culture is one-way communication"</i>
Summary	Analysis of the data revealed poor/lack of support as a key psychosocial hazard within the Agency in multiple ways. This hazard emerged in references to poor leadership support, insufficient resources and systems, barriers to seeking assistance, and inconsistent post-incident support. Leadership support emerged as a critical concern, with staff reporting that some team leaders lacked the competence, training (people skills, disability, diversity group needs), motivation or capacity to provide effective guidance and assistance. Communication from leaders was described as limited or ineffective, with managers often unavailable for consultation, unable to address staff needs appropriately, and not communicating sufficiently or acting as uncaring about their team ("staff do not feel valued"). Numerous staff made statements about feeling unsupported. Staff noted deficits in leadership understanding of neurodiversity, accessibility, mental health, and cultural requirements. The quality of support received appeared highly variable, dependent on which manager staff were assigned to, creating what was termed a "leadership lottery". The amount of role turnover was referenced by some as this meant team members have to adjust again and again to a new leader, and in some cases, view distressing content such as domestic violence. Some managers were reported to focus predominately on performance outcomes and KPIs rather than staff wellbeing, with staff reporting concerns were dismissed or met with response suggesting acceptance of problematic situations rather than resolution. One staff member yearned for leadership presence, stating "I would love to see our senior leadership more often at meetings to speak with us and provide direction (without all the death-by-PowerPoint-presentations), while others stated that their manager did not set regular catch-ups.

Staff noted that managers and leaders themselves struggled and were sometimes overwhelmed, and that they too needed support and guidance and had “minimal Agency training”. When managing staff with complex needs, lack of a “holistic direction from P&C” was cited.

The provision of adequate resources, tools, and training represented another support deficit. Staff experienced considerable difficulty accessing necessary information to perform their roles, with the primary database system (PACE) identified as particularly problematic. Locating required information was reported to take excessive time, with knowledge articles or SOPs described as overly wordy, lacking clear instructions, and failing to cover all necessary procedural steps or requiring a significant amount of time to retrieve (45 minutes). This forced staff to rely on multiple offline processes and created frustration and inefficiency. Information appeared to be located in several places and was sometimes out of date.

Training was regularly reported as inadequate for the complexity of roles, particularly regarding disabilities, the continuous NDIS changes, JIRA, LEAP, safety and conflict resolution. Staff described situations where they were expected to perform complex functions without adequate preparation or were required to use new systems without appropriate training. One Fraud Investigation staff members stated they had not seen any Safety training despite needing to execute search warrants. Some staff reported remaining uncertain about how to complete core tasks properly despite extended tenure in their roles. One Early Childhood Branch planner objected that he was told off for asking too many questions and should just “get on with it”.

Psychological safety concerns created significant barriers to staff seeking the support they required (note, this is not described further here as it is covered in other areas of this report – Section 6.3). Some staff indicated they required support from their team leader even to determine whether a concern was appropriate to raise, suggesting a lack of clarity about when and how to access support. Management responses that conveyed expectations that staff should already possess certain knowledge deterred staff from seeking clarification or assistance.

Support following difficult incidents or interactions was reported as inadequate and inconsistent. Debriefing processes and check-ins post-incident were inconsistent, creating difficulties for staff with lived experience who were exposed to traumatic content. Complaint process investigation felt one-sided with interactions not consistently recorded. Staff in certain roles reported receiving no training in conflict resolution, despite regularly managing difficult conversations with angry or frustrated stakeholders. Confusion existed about when and how to access NDIA internal support services, with some staff uncertain about available resources.

Support for the issue of Domestic Violence was stated as difficult for several reasons: broken links, outdated information, and feelings of “not getting anywhere” when applications for support are actioned.

The impacts of inadequate support were substantial and multifaceted. Staff reported feeling overwhelmed, stressed, confused, and inadequate to perform required tasks. High staff turnover was referenced in multiple staff comments in the workshops, with team members actively seeking to leave teams or exit the organization. Unplanned leave and absenteeism were referenced by many, as staff struggled without adequate support. Statements were made about morale deterioration and staff crying in the office, experiencing burnout, and suffering declining mental health. Work quality and performance suffered when staff lacked necessary guidance and resources, creating a cycle where poor support led to poor outcomes, which in turn created additional stress for staff.

The hazard demonstrated strong interconnections with other psychosocial risks. Poor support exacerbated the impact of high work demands, as staff lacked the resources and assistance needed to manage demanding workloads and performance expectations. The absence of support contributed directly to Fatigue and burnout, with staff exhausted from attempting to navigate complex systems and manage difficult situations without adequate guidance. Staff also appear to have been left vulnerable when dealing with aggressive or confronting situations due to inadequate training and post-incident support (Violence and Aggression hazard).

Data: 284 coded items

5.2. Hazard #2: High Work Demands

Prevalence	15% in Coding (#1) 32% in Voting (#2).
Definition	High workloads or time pressures that can lead to stress and burnout. Or low demands e.g. repetition.
Indicators	- Physical indicators such as not taking breaks, lunch or weekend work - HR indicators such as absenteeism, resignations and leave levels - Difficulty meeting KPIs - Individual indicators such as behaviour changes, decline in work quality or expressions of fatigue and overwhelm.
Quotes	<i>"Giving everything to a job that keeps asking for more."</i> <i>"We know the workload is a problem when we see high staff turnover and staff burnout."</i> <i>"I struggle to balance outside work commitments with work demands."</i> <i>"We know it's a problem when volume of work is more important than the quality of work completed."</i>
Summary:	The following themes emerged: unrealistic KPIs, work-life balance erosion and fear of speaking up. Work-life Balance erosion: Staff reported frequently working during personal time, including nights and weekends, to manage workload demands. This pattern extended beyond occasional overtime to become a regular coping mechanism to cope with the work demand. Staff described being unable to mentally disconnect from work, with work-related anxiety intruding into personal time and sleep. The psychological burden of unfinished work led to anxiety and preoccupation with work matters during what should have been recovery time and thus hampering the opportunity for rest and recuperation between work periods. The inability to balance work with family and personal commitments was explicitly identified as problematic, with some staff suggesting that a four-day work week would better support work-life balance. Unrealistic KPIs were referenced by many staff who reported the pressure as relentless and unrealistic given the complexity of their work. Many staff felt their value was measured

solely by plan numbers rather than quality of service. These pressures manifested in staff logging on after hours specifically to meet KPI requirements and feeling the need to justify output repeatedly. Staff felt prioritizing volume over quality conflicted with staff training in service standards. This, combined with heavy administrative burden, generate baseline stress.

Fear of speaking up and feeling silenced emerged with this psychosocial hazard, as it does with many others. Staff reported self-censoring concerns about workload for fear of being perceived as incompetent, not coping or being required to undergo performance management. Some staff reported that management responses to workload complaints had been dismissive, so staff suffered in silence rather than risk negative perceptions or career consequences. This suppression creates a double burden of workload pressure and the additional stress of being unable to safely discuss it. It appears likely that there is an unrealistic awareness of the extent of the problem.

Numerous contributors were cited to the assessments of extremely high workloads: inefficient processes, whereby the same documentation is completed multiple times; the need for numerous manual workarounds; the stresses of dealing with constant Agency change with a reduction in existing demands and insufficient support from leaders and managers.

The impacts of high work demands on an individual level are burnout, fatigue, anxiety, and stress-related illness. The data indicated both acute stress responses (crying, fatigue, anxiety, feelings of overwhelm) alongside more serious conditions such as sustained burnout and exhaustion. The inability to recover between work periods is likely to lead to cumulative psychological harm. Increased unplanned leave was identified as an indicator of unsustainable work demands, as was staff movement away from frontline service delivery roles. The pattern included both actual resignations and staff seeking internal transfers to escape high-demand areas. High turnover created additional pressure on remaining staff, compounding the workload problem.

At the Agency level, this hazard appeared to manifest also as reduced work quality, increased errors, staff turnover and elevated absenteeism. This hazard's linkages to other psychosocial hazards such as fatigue and lack of support have been referenced above.

Data: 164 coded items

5.3. Hazard #3: Poor Organisational Justice

Prevalence	15% in Coding (#3) 1.2% in Voting (#13).
Definition	Lack of fairness (or perception) in workplace e.g. procedural fairness, information, relational fairness, interpersonal, distributive justice (rewards or resource allocation)
Indicators	• Performance issues not addressed • Fear of speaking up and potential repercussions • Breakdown in trust about complaint and reporting mechanisms • Perception of unfair recruitment and promotion
Quotes	<i>"Only certain people will be selected for promotion – favourites – even if you are more qualified and experienced."</i>

	<i>"Team culture is a problem when managers/leaders do not address poor performance or below par behaviours."</i> <i>"Speaking up will not change the outcome anyway and it is pointless to speak up – a feeling of hopelessness."</i>
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Summary

It was noted that this psychosocial hazard was rated differently in the Coding as opposed to the Voting data. This trend was also observed in the first set of workshops and may reflect a lack of familiarity with the term at the time of voting.

Staff at the Disability Agency identified significant concerns across multiple dimensions of workplace fairness. Staff perceived substantial gaps between stated organizational values and observed practices, particularly in relation to accountability, fair selection, fear of Speak Ups and inconsistent application of policies and procedures.

Accountability was identified in the form of lack of consequences for poor performance or inappropriate behaviour. Staff reported that performance issues and leadership concerns appeared to be addressed inconsistently, with some staff perceiving that consequences were rarely applied to individuals in senior positions and that nothing gets done about lower performers. One staff member described the perception that "there are rarely consequences for poor leadership," which appeared to influence decisions about whether to raise concerns or that were they to speak up, this could alienate the person who might act as a referee for them at another moment. Staff also reported observing different accountability standards, with some describing experiences where their own errors received substantial scrutiny while a mistake made by the leader was not accompanied by the leader taking accountability. These perceptions appeared to contribute to reduced confidence in performance management systems and concerns about the fairness of workplace processes.

Unfair selection and career progression was raised by many. Staff cited the career advancement structures such as EOIs, TPAs, IMRs; job offers were being allocated based on relationships rather than demonstrated capability or merit. Multiple staff members used terms such as "nepotism," "favouritism," and references to "cliques" when describing promotion processes. Staff reported perceptions that some individuals were "tapped on the shoulder" for opportunities while others with relevant qualifications were not considered. Some staff described the emotional impact of these perceptions, with one noting that this was a source of "genuine emotional distress and alienation." Some staff reported concerns about recruitment processes lacking transparency, with particular concerns raised about situations where a staff member's (Acting) direct supervisor was also involved in assessing their application for advancement.

Fear of speaking up, the effectiveness and fairness of complaint, feedback and reporting mechanisms all emerged as substantial concerns, affecting staff willingness to raise issues or provide feedback: this was extensively documented in the September TELUS Health report provided to NDIA. The concerns described have led to a reduced confidence in internal reporting mechanisms, reluctance to utilize formal complaint processes and several outright criticisms of the Safe & Respectful team. Perceptions that senior leaders formed cohesive groups that protected one another appeared to affect confidence in complaint resolution processes. Lack of safety was also referenced in terms of willingness to provide feedback during a Branch re-structure as "in the past there had been repercussions."

Inconsistent application of policies and procedures across the Agency were described. Reports suggested that policies related to leave approval, acting arrangements, and performance management were applied differently, depending on the individuals involved or their relationships with decision-makers. Staff described variability in how similar situations were handled across different teams or regions. Some staff described perceptions of hierarchy, where individuals at lower classification levels were dismissed or disrespected by more senior staff, or that junior staff ((APS) were not "meant" to speak to those higher up (SES).

Organisational Justice concerns appeared to have a common thread of a perceived lack of psychological safety, crucially impacting the willingness to voice experiences of unfairness and thereby arguably perpetuating issues. The implications extend beyond individual experiences of unfairness. The cumulative effect of these perceptions are to reduce trust in organizational systems and leadership and impact staff engagement, retention, team dynamics and a willingness to contribute discretionary effort.

Data	163 items coded
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5.4. Hazard #4: Poor Organisational Change Management

Prevalence	9% in Coding (#4) 6.7% in Voting (#5)
Definition	Poorly managed organizational change can lead to uncertainty and anxiety among employees e.g. consultation, insufficient support or consideration of new HZ or impacts.
Indicators	- Decisions communicated after finalisation, with minimal genuine consultation - High numbers of reference to change fatigue - Insufficient notice and rationale for change - Ambiguous interpretations of change (status, consistent understanding)
Quotes	<i>"We are asked to do a risk assessment in relation to change but the decision for the change has already been taken. Ideally you would want to have that the risk assessment to be done before the decision had been taken"</i> <i>"I can speak from a planner's perspective, I think it really disempowers us and feels it really affects our ability to make decisions because it is often unclear when a change has come in and when it has not, and it just contributes to that need to second-guess ourselves to be unsure."</i> - in regards to how unclear change management effects planners" <i>"The emotional impact of constant change.... Staff often might feel unsettled by shifting priorities, restructures or unclear direction. This may affect trust, stability and wellbeing, but it's rarely acknowledged directly."</i> <i>"The slowness of things to get rectified for example if there is a new process that is going to create efficiencies, less admin and better outcomes for participants and so forth, you hear about this 2-3 months ago however, you're sort of still waiting for this particular change to</i>

	happen.'
Summary The key themes emerging were consultation processes, the volume of organizational change and the impacts of change. Absence of consultation: a number of instances were reported about Agency changes being implemented with insufficient consultation, inadequate transparency, and limited advance notice. Consultation processes were sometimes cited as tokenistic, with decisions communicated after they had been finalised rather than genuinely incorporating staff input. Overwhelming pace and volume of Agency change: both pace and volume of change seemed to regularly exceed staff capacity to adapt effectively. Staff described change fatigue and exhaustion from constant reform, with frequent leadership rotation compounding the challenge. The rapidity of change meant that staff struggled to distinguish between current and outdated processes, leading to uncertainty and second-guessing in decision-making, as sometimes changes were apparently outdated within a day or week. Specific references were made to the PACE system. One staff member noted that changes occurred so quickly that "your brain starts to get so tired from it that you're not understanding which path you are following." One staff member voiced an opportunity for different planning during any implementation stage of change, so as to avoid wasted time and enable staff to "continue to get on with value adding work and not be told to park that project because we're waiting for things because weeks go by." An Enabling Services staff member commented about the amount of support for changes done on behalf of the front-line and yet it "changes again in 5 minutes". Other comments referred to how a process improvement could take a lengthy amount of time to implement. An opportunity to improve process changes was made by one staff member who suggested "Practice Leads" should be consulted during change as they have much more context about the impacts or details of what can occur. Another opportunity was suggested to allow the "Daily Media" reports to include the internal stance of the Agency. Emotional impact of constant change: this is substantial, though staff indicated this was rarely acknowledged directly by the Agency. Staff reported feeling unsettled by shifting priorities, restructures, and unclear direction, which affected trust, stability, physical energy and wellbeing in the short-term and increases propensity to burnout, anxiety, stress, and lack of motivation in the medium-term. Multiple explicit references were made to change fatigue by staff. Communication and Support: Communication during change processes was identified as inadequate. Changes were rolled out with short notice and insufficient explanation of rationale. Staff reported being told what was happening without understanding why, creating confusion and frustration. The impact was particularly pronounced for frontline staff such as planners, who described feeling disoriented when it remained unclear whether changes had been implemented, contributing to self-doubt and hesitation. Training and support during transitions were reported as insufficient, with staff expected to maintain performance levels while learning new systems and processes. Lack of understanding was also cited with some staff expressing that they were made to feel that the problem was theirs. A couple of statements implied that the status of the change itself was sometimes unclear "we feel like we don't know when one change is starting or finished." A couple of opportunities were raised by staff: an observation was made on more than one occasion about the opportunity to harness the wisdom and experience from outside the Agency. "We have so many people from other agencies but you hear 'we are doing things	

our own way.” A second is the opportunity to communicate more effectively to parties outside the Agency, including community, the participants and their nominees and stakeholders, “whom we see as part of the planning process.”

This hazard demonstrated strong interconnections with other psychosocial risks, such as fatigue and burnout and the impact on perceived job demands as staff managed transitions alongside existing responsibilities. Comments about lack of transparency and inauthentic consultation raises concerns about Agency justice and fairness. This hazard appeared to erode psychological safety, with some staff indicating reluctance to speak up about changes due to concerns about career consequences and the recurring reticence to speak up.

Data	100 items coded.
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5.5. Hazard #5: Conflict or Poor Workplace Behaviours

Prevalence	7% in Coding (#5) 5.5% in Voting (#6).
Definition	Disparaging comments, unresolved conflict about work tasks, disagreements from clients or customers.
Indicators	• Indirect data such as absenteeism, turnover etc. • Disrespectful interactions occurring without intervention • Statements of reluctance to speak up and fear-based silence • Accounts of staff who have actively avoided areas or the office altogether • Negative conversations about others and workload
Quotes	<i>"We are not a cohesive workforce. We fail to remember we are on the same team. If you reach out to another section (for example access) they do not answer your question. They seem quite defensive."</i> <i>"They do not call out disrespectful interactions in virtual Teams and onsite, as they do not believe they will be heard by leadership."</i> <i>"We see our colleagues not talking to each other."</i>
Summary	Conflict or poor workplace relationships emerged as an important psychosocial hazard within the Disability Agency. The reporting of information from the workshops excludes the theme of bullying, which is covered as its own Hazard (see Section 5.7). The themes which emerged for this hazard were distrust (or psychological safety), microaggressions and workplace incivility, and a pattern of non-intervention. Distrust and psychological safety was referenced by all levels of staff and are addressed in another area of this report (Section 6.4). A fear about speaking up exists, and a reluctance to raise concerns about interpersonal issues due to anticipated judgment, repercussions, or dismissal by leadership or even peers. Staff reported feeling unable to call out disrespectful interactions as they did not believe they would be heard by leadership. One staff member stated, "Safety and wellbeing are often discussed in terms of physical and mental health, but not enough is said about psychological safety. Perhaps staff might not feel safe to speak up, ask questions this silence affects trust, learning and team performance." Distrust between teams and 'silo' mentality (between Branches) was referenced on several occasions.

Micro-aggressions and workplace incivility were described by many, including staff withdrawing from team meeting conversations, colleagues choosing not to work with one another, rude colleagues, “passive aggression”, negative discussion about colleagues, whispering, communication channels containing unprofessional posting behaviour, micro-management, colleagues’ judgement about a staff member’s adjusted allocations based on disability, gossiping and colleagues not speaking to one another. Several experiences of exclusion and social isolation were described, with some staff feeling invisible to others, disconnected from teams, inappropriately excluded from workplace activities/office celebrations and left unsupported if reaching out to another workplace team. Some staff felt that not being made aware that SES staff were at their office was disappointing and experienced this as a form of poor workplace etiquette or behaviour.

Several comments were made about some leaders or managers themselves being the cause of conflict or exhibiting poor behaviours, such as shutting down a team member’s voice, minimising staff opinions and contributions or being uncivil. Managers or Team Leaders who did not actively intervene appeared as an important pattern. Some staff noted that disrespectful interactions in both virtual and onsite settings were not being called out, reportedly because they would not be heard by leadership. The absence of what some staff perceived as a culture supporting respectful conversation was also highlighted, with reports that individuals felt unable to discuss experiences of mistreatment or differential treatment without jeopardising their job security or future opportunities.

The implications of this hazard are important, with staff reporting that poor workplace relationships impacted mental health, including anxiety, stress, diminished self-confidence, and feelings of being undervalued. The organisational impacts include role changes to escape negative relationship dynamics, increased unplanned leave, reduced engagement with office culture, and a preference for remote work to avoid office-based interactions. Performance is also arguably affected, as the breakdown in collegial relationships appeared to impair collaboration across sections and potentially the quality of service delivery to participants.

This hazard appeared to link with *Poor organisational justice* with its references to favouritism and inconsistent application of policies regarding behaviour. It also relates to the hazard of *Poor support*, primarily from leadership.

Data	80 items coded.
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5.6. Hazard #6: Fatigue

Prevalence	5% in Coding (#6) 4.3% in Voting (#9).
Definition	Chronic tiredness due to excessive workloads or lack of rest can impair mental health.
Indicators	- Increased levels of unplanned leave and personal leave - High staff turnover rates - Staff actively seeking roles outside their current workplace - Staff appearing unmotivated, tired, unwell, and less present - Expressions of disengagement, apathy and loss of initiative
Quotes	“We know KPI demand is a problem when we see people calling in sick due to fatigue/burnout.”

	<i>"We know workplace burnout is a problem when we see workplace expectations are too high and not supported by enough time and resources."</i> <i>"We have a full team feeling fatigued, burnt out and having 'misses'."</i>
Summary Fatigue emerged as an important psychosocial hazard within the Agency, manifesting in the themes of exhaustion, inability to sustain demands and workload/performance pressures. Exhaustion, both emotional and mental exhaustion, was cited by many staff. One staff member stated: "I'm feeling intimidated, I'm feeling fatigued and overwhelmed but when I try to address these with management, it impacts perceptions of capability". The cumulative effect was described in the question: "How am I meant to keep doing this day after day when every day staff report work is making them not want to get up every day." Staff described experiences where work became a source of sadness and stress rather than satisfaction, and where individuals felt overwhelmed and unsupported but continued working to avoid letting their team down. The severity of the situation was emphasized in comments that "many staff are at breaking point" and expressions such as "I don't think I can keep up" and "I'm not coping, and I don't know what to do." Several staff reported experiencing burnout as a consequence of excessive workload combined with unrealistic key performance indicators. One staff member stated they had "never had such a job that has landed me in a state of burnout" noting the expectation of KPI's was unrealistic and overwhelming. Staff noted how fatigue impacts the quality of work, with staff making errors and becoming less accurate in their work. An inability to sustain current demands emerged as staff expressed concerns about their capacity to maintain current levels of performance and workload. Comments included: "I don't think I can keep up," and that one comments was made that "many staff are at breaking point." Workloads and performance pressures were reported by several staff members referencing the high workplace expectations, KPIs and "misses". The impacts of fatigue were recognized across multiple domains. They include increased staff turnover as individuals sought roles elsewhere when fatigue became unsustainable; absenteeism, anxiety, stress and emotional distress. Physical health was also affected, with staff reporting illness and stress-related physical symptoms. The psychosocial hazard of Fatigue linked with multiple other psychosocial hazards. The most frequent secondary hazard was high work demands, with staff reporting that excessive workload and unrealistic performance expectations were primary contributors to fatigue. Poor/lack of support was also frequently linked, as staff reported that management responses to expressions of fatigue were inadequate or dismissive. Poor organisational change management was identified as a contributing factor, with staff experiencing exhaustion from the volume and pace of Agency change. Finally, connections were evident with poor Agency justice, as staff reported fear of performance management if they spoke up about unsustainable workloads. Data: 51 items coded.	

5.7 Hazard #7: Bullying

Prevalence	4% in Coding (#7) 7.5% in Voting (#4).
Definition	Bullying is repeated, unreasonable behaviour directed towards a worker or group of workers, that creates a risk to health and safety e.g. intimidating behaviour, practical jokes, offensive language.
Indicators	• Increased absenteeism • Staff expressing reluctance to attend the workplace due to fear • Cessation of help-seeking behaviours from managers • Observable changes in staff performance and attitude
Quotes	<i>"We know leadership is a problem when we see and hear from staff they are being abused, micromanaged, harassed and bullied with nil or limited action being taken by the Agency"</i> <i>"When you being bullied by a team leader and tell someone but it is not being taken seriously."</i> <i>"It's hard to speak up sometimes as there is concern it will get back to the person and there will be repercussions"</i>
Summary	Analysis of the data revealed that bullying emerged as a psychosocial hazard within the Agency, with concentration in leadership and management tiers, fear of reporting, ineffective response systems and performance-related pressures. Bullying behaviours were described as mainly originating from management and supervisory levels. One staff member noted "It's hard to speak up and report bullying when it's coming from the top down in the org structure." Staff reported bullying primarily from supervisors and managers, including micromanagement, abuse, and harassment tied to performance targets. A barrier to addressing bullying was identified as staff reluctance to report incidents. Staff consistently expressed concern that reporting would result in negative repercussions, including impacts to job security and career progression. The hierarchical nature of the bullying referenced above compounded this issue, as staff felt unable to report behaviors originating from senior levels of the Agency. Staff reported witnessing colleagues being targeted by leadership but remained silent due to fear of becoming subsequent victims. This created an environment where bullying behaviours were observed but not formally reported through available mechanisms. Ineffective reporting and response systems were also seen as part of perpetuating this hazard. Staff believed that formal reporting mechanisms did not result in meaningful action. One staff member stated: "Why would I bother raising a Speak Up when, as part of a minority, my opinion is completely ignored every time, despite multiple people reporting the same bullying and aggressive behaviours by the same person". Performance-related pressures created a concerning context for bullying behaviours: one individual stated: "Feeling bullied to perform job tasks which you are not comfortable with and feeling helpless in this situation as to what you can do about it." Staff expressed that leadership prioritized KPI outcomes over quality outcomes, and that this pressure manifested as bullying behaviour.

The impacts of bullying were evident. Staff reported increased absenteeism, with individuals choosing to take leave rather than confront bullying situations. Fear was a prominent consequence, with staff expressing reluctance to attend work or speak up about their experiences. The hazard appeared to create a cycle of silence, where staff who witnessed bullying were reluctant to report it due to fear of becoming the next target. Career progression appeared to be affected, with staff reporting that those who submitted complaints subsequently experienced difficulty in securing internal positions.

Bullying demonstrated interconnections with multiple other psychosocial hazards, including poor Organisational justice. Staff reflected on perceptions that bullying complaints were not addressed fairly or consistently. Bullying was also linked to poor/lack of support, as staff reported that managers and HR staff did not adequately respond to complaints. Connections were identified with low job control and high work demands, as staff felt pressured to perform tasks they were uncomfortable with.

Data: 43 coded items.

5.8. Hazard #8: Lack of Role Clarity

Prevalence	#8 in Coding (3%) #7 in Voting (5%)
Definition	Unclear job responsibilities and expectations that can create confusion and stress e.g. unclear reporting lines, changing standards and expectations, missing information and unclear work priorities.
Indicators	• Confusion about roles and responsibilities • Inconsistency across similar functions or branches • Conflicting expectations from different levels of leadership • Reporting lines unclear or frequently changing • Task information missing or incomplete • Competing demands and unclear priorities
Quotes	<i>"Job clarity is a problem when we hear conflicting priorities and consistent changes in scope of work tasks."</i> <i>"Communication is a problem when it impacts understanding and change in work roles/expectations."</i> <i>"Team leaders with inconsistent expectations for our work and work output."</i>
Summary	Role conflict, manifested primarily as lack of role clarity, emerged as a key psychosocial hazard affecting staff across the Agency. The arising themes were role confusion, conflicting priorities and the lack of procedural guidance. Role confusion was evident in the descriptions by staff of feelings of confusion about their roles, responsibilities, the expectations placed upon them or even a base-line clarity ("no clarity on our role or tasks"). This confusion was characterized by unclear, inconsistent, or frequently changing role definitions, overlapping responsibilities between workers, and conflicting expectations from different levels of leadership. The roles of Team Leader and Planners were singled out as an example of where this occurred.

A predominant theme was the tension between competing demands, particularly the conflict between delivering quality customer service and meeting quantitative performance targets. Staff reported that they were required to choose between these priorities without clear Agency guidance about which targets should take precedence. This created a form of role conflict where staff felt uncertain about how to appropriately allocate their time and effort, worrying as to whether they were meeting expectations. One staff member pointed out the unfairness associated with all the extra work being done which is “just called ‘Admin’ work.”

The absence of clear, consistent procedures across the Agency compounded these difficulties. Staff noted significant inconsistency across branches and described the Agency approach as lacking concrete guidance, with references to an unclear articulation of the top three priorities of Branch goals, information being conveyed with no resources or official guidance. This procedural ambiguity extended to legislative interpretation, where staff reported that similar situations could yield different outcomes depending on individual interpretation. Examples were also given of staff continually asking the same question of many team members as they strived to create understanding about their role.

The psychological impact of the role clarity psychosocial hazard was evident in staff reports of stress, anxiety and sleep disturbance. Staff described worrying about whether they had fulfilled their responsibilities correctly, with concerns persisting beyond work hours. The data indicated that this uncertainty contributed to increased error rates, declining team morale, and reduced staff confidence. Some staff reported seeking roles outside their current areas or leaving the Agency entirely due to the stress associated with unclear role expectations. The impact of this hazard includes reduced productivity and undermined psychological safety,

Role conflict is linked with other psychosocial hazards, notably workload, as it can create additional cognitive load as staff attempt to navigate unclear expectations. It may also lead to interpersonal conflict as staff experience duplication of effort or gaps in service delivery. Leaders who focus primarily on key performance indicators without understanding role complexity can unwittingly compound these challenges.

Data	36 items coded.
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5.9 Hazard #9: Violence or Aggression

Prevalence	#9 (3%) in Coding, #2 in Voting (11.5%)
Definition	Exposure to aggressive behaviour from colleagues or clients which can lead to psychological harm.
Indicators	• Fear-driven and avoidance behaviours • Under-reporting of incidents and “culture of acceptance” for aggression • Multiple sources of aggression
Quotes	<i>“It is not okay when it's expected sometimes for planners or PSO or front of house staff to put up with emotional and verbal abuse even on the phone or video, and there is a culture of silence around when we do speak up”.</i>

	<i>"We know that aggression or unreasonable behaviour from participants and child representatives is a problem when we hear from planners re: their experiences in planning meetings."</i>
Summary	This psychosocial hazard is known already by the Agency to be a risk in many of the front-line staff roles ¹. Workshops in phase two, confirmed this. Of note is the discrepancy in ranking between the Voting and Coding data: this may represent staff noting the facilitator's encouragement to mention psychosocial hazards not already known about. It is important to review this qualitative data alongside the other Agency data available. The key themes emerging with this hazard were normalization and under-reporting, cumulative psychological impact, under-reporting, vulnerabilities created by physical environment and the concerns about the numerous sources of aggression. Normalisation of aggression was raised multiple times in the workshops and likely indicates that the true extent of staff exposure to aggressive behaviour may be substantially greater than formally documented incidents would suggest. Planning staff indicated they often did not report aggressive, abusive, or persistent unreasonable behaviours and voiced that they were expected to manage such interactions as an inherent component of their role, and that they should possess sufficient experience to handle such situations independently, or presumed that reporting would make no difference. Under-reporting of aggression and violent incidents was reported, and is potentially linked to the phenomenon of 'normalisation' and the perspective that even if reporting occurs, nothing will change. One staff member noted a "lack of appetite to go out with strong lines" and issue clear communications to the community about the non-acceptance of unreasonable behaviour. Even the definition of what is a reportable harassment appears unclear. Cumulative trauma was evident, with staff observing on multiple occasions in workshops that their colleagues in frontline roles developed anxiety disorders following prolonged exposure to aggressive interactions ("we can't downplay the impact aggressive behaviour can have on an employee over time."). The Agency's physical environment appeared to contribute to violent and aggressive episodes with reports of staff reported modifying their behaviour outside work hours, including avoiding identifying themselves as Agency employees, expressing fear when accessing public spaces near the workplace or even collecting mail, and being reticent to leave the building during lunch breaks. These descriptions and others, are discussed further in the section in this report titled "Security & Physical Environment". The numerous sources of aggression, spanning participants, service providers, applicants and child representatives, elevates the likelihood and frequency of violent and aggressive incidents. Providers sometimes directed angry participants to the Agency rather than managing concerns directly. Prospective applicants sometimes exhibited unreasonable behaviour, including swearing during telephone interactions, with staff noting these individuals often viewed the Agency as a last resort. Participants were also regularly aggressive, frustrated by service limitations or delays. The newly formed Access team felt under-equipped for their role and lacked adequate preparation for handling conflict and aggression, particularly when dealing with providers, plan managers, and participants. Data markers which alert staff to participants with histories of aggressive behaviour were missing.

¹ Agency Data 2024-2025 cites Customer Aggression as the most frequently reported security incident. Source: Focus Group Workshop slides September 2025.

not visible enough “you need to click into them to read them” or not operating on occasion. Even back-of-house staff deal with aggression but one comment was made that these teams do not receive training. These hazards occurred across multiple settings: phone calls, face-to-face meetings, and even outside the workplace – creating a complex and stressful environment.

An additional consideration was also raised about how co-located sites experience a greater risk of violence and lack of safety.

Another noteworthy observation is that the data did not code for the duration, frequency and severity of risks, and based on broader Agency data and input, the risk ‘profile’ for this hazard could be even more elevated than it appears.

Data	29 items coded.
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5.10 Hazard #10: Traumatic information, material or events

Prevalence	3% in Coding (#10) 7.7% in Voting (#3).
Definition	Serious injury, abuse, fear, natural disasters, war, victims, descriptions or crime evidence.
Indicators	• Early departure from work following distressing interactions • Reduced enthusiasm for work and decreased engagement • Staff departing from planning roles • Increased use of leave • Development of anxiety symptoms • Reports of suicidal ideation among staff members
Quotes	<i>“We know vicarious trauma is a problem when staff are exposed to too much traumatic information e.g. participant files”</i> <i>“We know workplace trauma is a problem when we hear that multiple staff have suicidal feelings”</i> <i>“Vicarious trauma is very real in the planning space”</i> <i>‘I’ve been with the Agency just over two years. I was pretty much not told that I could disconnect from unreasonable behaviour phone call until August this year. So I’ve had like a lot of phone calls (previously that I could have just walked out of) that did cause me a lot of like stress and angst afterwards.’</i>

Summary

Analysis of data revealed that exposure to confronting, and traumatic information, material, and events represented a psychosocial hazard within the Agency. Themes raised included the levels of exposure to trauma materials, alert systems, impacts of trauma, staff capability and adequacy of training and debriefing supports. The data indicated that staff across multiple roles experienced regular exposure to distressing content through written documentation, direct participant interactions, and the nature of decision-making responsibilities inherent in disability support work.

A primary concern identified in the data related to descriptions of exposure to participant files and documentation. Staff reported opening cases containing detailed accounts of child abuse without adequate warning or preparation. One staff member reported starting three cases in succession that dealt with child abuse, none of which had content warnings applied despite the existence of a process intended to flag such material. Staff in the justice planning team specifically noted that they read horrific things as part of their regular work.

The pattern of responses suggested that content warning and alert systems, while theoretically in place, were applied inconsistently and lacked sufficient specificity to enable staff to prepare for or manage their exposure to traumatic material. An example was given of planners receiving phone calls with no awareness of a prior history of verbal abuse or that the expected "content warning" is missing or doesn't indicate which document contains distressing content, thus leaving the staff member exposed to traumatic material.

The emotional and psychological impact of direct participant interactions emerged as a second major theme. Staff described experiencing significant distress from planning meetings and telephone conversations that, while not involving overt aggression such as shouting or swearing, were nonetheless emotionally harmful. One staff member recounted conducting a planning meeting where the participant was not physically or verbally aggressive in obvious ways, but by the conclusion of the meeting, the staff member was so emotionally impacted that they left work early and experienced a terrible night's sleep. The same staff member reported not knowing how to manage or terminate such interactions, feeling unable to bring the meeting to an end despite the psychological distress being experienced. Staff at front-of-house positions reported experiencing "trauma dumping" where participants overshared distressing information not only with staff but also within earshot of other people in reception areas. The data indicated that staff felt *expected* to tolerate unacceptable behaviours from participants, suggesting a normalisation of exposure to distressing interactions without adequate boundaries or support.

Staff reported that ongoing exposure without adequate recovery time or rotation led to progressive deterioration in psychological wellbeing. The impacts of this psychosocial hazard appeared substantial, including staff turnover in planning roles, the development of anxiety disorders among front-facing staff, loss of enthusiasm, declined engagement, and reduced effectiveness.

The capability of staff to deal with the complexity of individuals and situations presented was referenced and the suggestion voiced that the capacity to have the option to refer difficult clients to a more qualified staff member would be valuable, or even that "repeat offenders" are routed only to specific supervisors to reduce risk to all team members. Another staff member noted that another government Agency, Veteran's Affairs, had dedicated teams for particular cases.

Gaps in training were also referenced ("not being aware of the impact of vicarious trauma or burnout and so not addressing it early") including the desire for longer training and the need to target training for new starters as well as ongoing training like nurses and paramedics undergo.

The data suggested strong interconnections with multiple other psychosocial hazards such as high work demands e.g. workload pressures prevented adequate time to process traumatic content. The absence of adequate debriefing and training interconnected with poor support. Low job control is linked as staff reported feeling unable to end distressing interactions or control their exposure to traumatic content.

The pattern of response suggested that exposure to traumatic material was not experienced as isolated incidents but as a chronic stressor that accumulated over time, progressively impacting staff psychological wellbeing.
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Data	28 items coded.
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6. Agency Culture Findings

6.1. Prefacing Remarks

The following reflections on Agency culture have been derived from the CA Analyst coding, a set of over 1000 observations shared by the NDIA staff during the September/October workshops.

Edgar Schein's organizational culture framework has been selected to provide an underpinning reference point but note that the derivation of the findings does not reflect best practice in determining conclusions about culture, as Schein's methodology assembles numerous documents, processes and observations as well as specific and structured interviews about culture when creating the analysis. Edgar Schein's Organisational culture model² identifies three interconnected levels of visibility and accessibility: Artefacts, Espoused Values and Tacit Assumptions. This widely-used framework helps identify cultural dysfunction by examining inconsistencies between layers—when espoused values don't match observable artifacts or when underlying assumptions contradict stated values. These gaps can reveal the difference between "real" and "desired" culture, showing leaders where to focus improvement efforts.

This review focuses on themes aligned with the Agency's strategy—psychological safety, wellbeing and prominent psychosocial hazards—rather than exploring all elements of Organisational culture. The themes elicited are likely to provide a first lens for reviewing cultural implications of the workshop content raised in these areas.

6.2. NDIA Artefacts

Visible, tangible elements of culture including physical structures, observable behaviors, rituals, language, policies, and procedures.

Physical Environment and Workspace Design

The physical workspace serves as a visible reflection of Agency culture and priorities. Staff observations include challenges with hot desking arrangements, air conditioning adequacy, and office layouts at co-located sites. Employees note that office conditions (e.g. high temperature, hot desking) impact individuals that may not "fit the mould" and share concerns about public accessibility to certain work areas, which raises questions about security arrangements. Feedback regarding ergonomic workstations and meeting room accessibility suggests opportunities to better align the physical environment with employee wellbeing, safety and productivity needs.

² Schein, E. H. (1990). Organizational culture. *American Psychologist*, 45(2), 109–119. <https://doi.org/10.1037/0003-066X.45.2.109>

Communication Patterns and Meeting Behaviours

Communication practices reveal important cultural dynamics within the organization. It was raised that "people in meetings just shut down and say nothing or stay on mute," which may indicate opportunities to strengthen psychological safety. Leadership meetings where "the same few people speak up" could reflect current participation patterns that could benefit from broader engagement. Encouraging and supporting staff to feel safe to speak up represents an area for potential development.

Wellbeing Artefacts

The data revealed several visible artefacts related to staff wellbeing. Staff appreciated the availability of Speak Up forms as a mechanism for raising concerns, though some feedback indicated the process was experienced as unclear and clunky, with forms described as "not well laid out". Staff also acknowledged positively the Safe and Respectful Team (a formal reporting mechanism), and designated support roles including Wellbeing Officers, Peer Support Officers and Cultural Champions. The PACE system was described as a mechanism to provide safety alerts, though some staff noted it lacked visibility compared to previous systems. Staff referenced check-ins and debriefs following incidents, though some shared that they are inconsistently applied. While staff expressed appreciation for available wellbeing supports, feedback indicated that some available structures faced practical challenges and lower utilisation rates. This presents an opportunity to strengthen the accessibility and effectiveness of these resources to better meet staff needs and organizational goals.

6.3. Espoused Values

Explicitly stated beliefs, philosophies, strategies, and goals reflected in mission statements, strategic plans, and official communications.

In the context of this review, we have considered the espoused values to be the Australian Public Service (APS) six core values, Impartial, Committed to Service, Accountable, Respectful, Ethical and Stewardship. We also acknowledge the values of the Agency, including the Value of People, Growing Together, Aiming Higher and Taking Care and the commitments associated with each of these values.

Numerous disconnections between lived experience and these values surfaced in the workshops. This would be somewhat expected, given that the explicit questioning is designed to elicit experiences and descriptions of psychosocial risks, hazards, all of which reflect difficulties. The reader should also note that analysis of the answers to the question "What energises and inspires you at NDIA" will reveal a significant alignment with this particular value.

In terms of Impartiality, staff consistently reported recruitment processes that prioritised personal relationships over merit and a culture where career progression depended on being "mates with leadership" or part of "the clique," with opportunities going to those who were "cherry picked" rather than being transparently available to all qualified staff. This represented a fundamental misalignment with impartiality principles. Similarly, Accountability appeared compromised, as staff reported that poor leadership behaviours were "ignored and therefore accepted," with "zero consequences for the perpetrator" even when issues were formally raised. Staff expressed that leaders did not take accountability for mistakes.

The values of Respect and the NDIA commitment to Value of People showed substantial disconnection from staff experiences. Many staff reported feeling not valued. Multiple staff described bullying, micromanagement, and leaders who did not understand people or the importance of team culture. Reports of managers lacking understanding of cultural requirements and diversity group needs is covered extensively elsewhere Section 4 of this report, and illustrates contradictions to these the stated commitment to valuing people. In terms of Growing Together and Taking Care, staff described a workplace culture characterized by fear rather than psychological safety. The reader is referred to the Tacit Assumptions section on psychological safety. As well as feeling fearful, staff sometimes viewed wellbeing initiatives as "lip service" or "toxic positivity" amid a culture of distrust and micromanagement.

Despite these significant disconnections, some alignment existed around Committed to Service for participants. Staff demonstrated ongoing dedication to participant outcomes even amid challenging circumstances, with some feedback indicating frustration when they felt unable to provide quality service due to systemic barriers. While inadequate processes may be compromising their ability to deliver the service they wanted to provide, individual staff remained committed to service values.

6.4. Tacit Assumptions

The deepest layer of organizational culture—unconscious, taken-for-granted beliefs that operate below conscious awareness and fundamentally shape how staff perceive reality, interpret events, and respond to workplace situations.

Psychological Safety assumptions

"Scared to speak out against leadership to prevent repercussions"

A fundamental assumption associated with a lack of psychological safety emerged, where staff consistently expressed fear of "retribution," "repercussions," and believed that "speak ups lead to issues for the person submitting them." Staff believed that reporting concerns, particularly about leaders, would negatively impact their career progression, credibility, and relationships with leadership. This assumption suggested a gap between the Agency value of "Growing Together"—which emphasises honest, clear, proactive, and consistent communication—and some staff's experiences about speaking up. The implications of this assumption highlights opportunities to enhance psychological safety by addressing staff concerns about the consequences of speaking up.

Wellbeing assumptions

"It is hard to do a speak up as you feel management will think you are weak or a whinger"

A pervasive tacit assumption emerged that vulnerability could be interpreted as professional inadequacy. Many staff shared an unconscious belief that admitting struggles, requesting help, or discussing mental health would result in being labelled as incapable of managing workplace demands. This assumption revealed a gap between some staff and the espoused NDIA value of We Take Care- which emphasises looking after the safety, health and wellbeing of ourselves and others. This discrepancy highlights an opportunity to strengthen wellbeing support systems and foster a culture where discussing mental health challenges is viewed as appropriate rather than as a professional liability.

Organizational Justice assumptions

"Think reports will be ignored, or not handled respectfully and confidentially"

Staff frequently reported a fundamental assumption that raising concerns was futile because "nothing will be done," feedback was "heard but not considered," and "the loop is never closed." Multiple staff members described experiences where they weren't believed, were questioned repeatedly, or had their concerns dismissed or redirected. This suggests a gap between the APS value of Accountability and the AGENCY value of 'We Aim Higher' - which emphasises proactively seeking, reflecting and acting on feedback - and staff's actual experiences when giving feedback. This gap identifies opportunities to strengthen trust through fair, clear, and transparent processes that meaningfully address staff feedback.

Poor Support assumptions

"They don't know how to support us - for example lack of knowledge in neurodiversity"

A tacit assumption that emerged, particularly amongst staff from diverse backgrounds, was that some leaders lacked the training and knowledge to understand, support, and effectively manage staff with disability, neurodivergent staff, LGBTQIA+ staff, and staff from other underrepresented groups. This may suggest differences between the Agency value of 'We Grow Together' - which emphasises a commitment to building inclusive and respectful relationships - and staff's experiences in being understood. This insight highlights opportunities to strengthen leadership capabilities in supporting diverse teams.

Workload assumptions

"Volume of work is more important than the quality of work completed"

An assumption frequently shared in the data was that staff believed productivity was measured solely by quantitative outputs rather than quality or the complexity of work, creating pressure for some staff to prioritise volume at the expense of the meaningful, quality work they valued. This may suggest some variance between the NDIA value of 'We Take Care' - which emphasises ensuring our work is delivered to a high standard - and some staff's experience in how they should be approaching their work.

Concluding Note

This review, guided by Edgar Schein's cultural model, revealed opportunities for greater alignment between the NDIA's espoused values and staff experiences. While the Agency may demonstrate a commitment to APS and NDIA values, the analysis identified gaps where these values were not consistently experienced in daily practice. Observable artifacts—including communication patterns, physical environments, technological systems, and Agency processes—sometimes reflected cultural dynamics that diverged from stated commitments. Most significantly, deeply held tacit assumptions revealed staff's concerns about psychological safety, support, Organisational justice and wellbeing, shaping how staff perceived speaking up and seeking support in ways that sometimes-contradicted espoused values. By addressing these gaps between stated values and lived experiences, the organization has opportunities to develop a culture where espoused values are authentically experienced and enacted at all levels.

7. Safety, Security and Physical Environment Findings

7.1. Prefacing Remarks

The following pages provides a readable listing of the Safety, Security and Physical Environments issues raised in the All Staff workshops. Findings were very consistent with those from the first TELUS Health report.

7.2. Safety

Specific Issue	Quotations from Workshops
Fears in or around workplace	
Staff afraid in office and when leaving/arriving	"We feel afraid in the office and leaving/arriving at the office because our floor is the same as front facing reception and aggressive behaviour has been a problem"
Fear of being approached outside office	"Safety is a problem when staff are being approached outside the office"
PSOs afraid to leave building	"PSOs being too afraid to go out in the street for lunch/walk to/from work in case an aggressive participant, who they have interacted with, sees them"
Reticent to wear NDIS identification	"You had to make sure you didn't wear anything that identified you as working for the NDIS or for Services Australia"
Unable to access car park safely	"We were unable to access the car park. You had to be really mindful that you didn't go out unnecessarily"
Aggressive/Violent Behaviour (please see Section 5.9. for further detail)	
Aggression from participants, provider or nominees	"Unreasonable behaviours from providers - difficult conversations, verbal and physical aggression. Feeling bullied by providers"
	"Unreasonable behaviour/swearing on the phone with prospective applicants"
	"We know that aggression or unreasonable behaviour from participants and child representatives is a problem when we hear from planners re: their experiences in planning meetings"
	"Staff are fearful of abuse from participants/providers/nominees in meetings so avoid conversations or decision making" (<i>impact of creating avoidance</i>)
	"Customer aggression is a problem when staff avoid communication with participants" (<i>impact of creating avoidance</i>)
Staff avoiding front of house	"We know aggression towards staff is a problem when we see staff not wanting to work at front of house"

Mental health references	"I've seen a number of staff members develop anxiety disorders post long periods of time working in front facing roles"
Lack of clarity on Speak Up process	"Staff are unsure when to raise a speak up when we hear questions about who to go to regarding aggression from participants, partners or providers"
Noise, mail	
Unsafe mail collection procedures	"Mail just comes through the door and then the delivery people or whoever is coming is just knocking on the door...that's unsafe for us because you don't know what's being delivered"
Loud noise as safety indicator	"We know safety is a problem when we see/hear/feel loud noise" (<i>nervous system activation for individuals when hearing noises</i>)
Other	
"Access team"	"I'm part of the Access team and aggression over the phone plays a big role...every single person in our team is new and we just feel that the training needs to be expanded"

7.3. Security

Specific Issue	Quotations from Workshops
Co-located Sites	
Public access to back of house	"Staff feel unsafe due to public being able to access the back of house area of a co-located site, therefore are too scared to work in the office"
Interview rooms with direct access to staff areas	"The room that we have interviews with our participants in is readily accessible for them to get into the back of house area of the office. So that means if there's an aggressive incident then the participant will be able to follow the staff member into the back of the house area"
Staff blocked in by desk configuration	"Something that's looking to be rolled out to all Co-located sites, which is a huge security risk in the way that our desks are set up in the back of house area where they've got the rows. So if the angry participant comes out of that office, then if any staff is sitting in those rows, they're blocked in, they can't get out"

Front of house desk/protection	"They literally walk out into that open foyer area to have a discussion...If something flares up they have no protection. Like there's nothing, there's no desk"
General risks	"Many security and safety risks that need to continually be considered and addressed" "I know some of the team who are remote share office spaces with other services and it's not a great environment for them. So they avoid going into the office for many reasons... meeting room location, noise, lack of privacy, sharing across agencies , parking, physically getting in and out of the office feels unsafe due to location."
Privacy	"Lack of privacy, sharing across agencies"
Different security policies between agencies	"The lines are blurred as to what the obligation of the Aggression Response team is in the co-located site' - someone exploring the duty of care to Centrelink customers, the participants and staff at co-located sites."
General risks	"Many security and safety risks that need to continually be considered and addressed" "I know some of the team who are remote share office spaces with other services and it's not a great environment for them. So they avoid going into the office for many reasons... meeting room location, noise, lack of privacy, sharing across agencies , parking, physically getting in and out of the office feels unsafe due to location."
Pod Meeting Rooms	
Staff trapped with no safe exit	"If there is a violent or aggressive participant, the staff member is essentially trapped in that space and there's no safe exit"
Not wheelchair accessible	"It's also not really suitable for participants in wheelchairs. They can't actually access it, so it's not accessible"
Public Access	
Public access to toilets	"Potential security risk in office. The public has access to the public toilets"
Heightened people from shopping centre	"Because of where our site is located, the parking is a big issue. We get heightened people who come from the nearby shopping centre and the security issues are really high"
Parking	
Parking location creates security issues	"The parking is a big issue...security issues are really high"
Unsafe location for entering/exiting	"Parking, physically getting in and out of the office feels unsafe due to location"
Unable to access car park	"We were unable to access the car park"
Security Protocols	

Check-in process for face-to-face meetings	"The NDIS doesn't have currently in place any processes for planners to walk through to check someone coming in for a face-to-face office meeting"
Lack of security checklist	No checklist for assessing visitor wellness/risk before meetings

7.4. Physical Environment

Specific Issue	Quotations from Workshops
Building Structural/Maintenance	
Unsuitable office accommodation pending refurbishment or no accommodation	"Today I work at a stand-alone office which is apparently going to be refurbished and it really impacts morale of staff to see that over the previous years there that structurally the building we are in is dangerous. It's missing huge number of ceiling panels, there's leaks frequently, there are work hazards. We have witches' hats all over the place" "We have not had a office for two years and are required to work from home 100%."
Poor maintenance of amenities	"Poorly maintained amenities" "The delay in agency response to rectify is quite a concern. We have a few ongoing issues at the site that I attend. One of those issues has been going on for at least 23 months and we still haven't had it rectified." (air conditioning).
Office etiquette	"There tends to be a lack of accountability...the rubbish is overflowing and the dishes are left in odd places"
Air Conditioning Failures	
Extreme temperatures in office	"The air conditioning is atrocious at the site and on those hot days it can be between 30 and 38 [degrees] inside and we've got participants attending"
Staff wellbeing	"It's for a small handful of staff, but their well-being in relation to not getting the right support is being heavily affected" (regarding air con)
Staff avoiding office in summer	"I won't attend the office in summer because of it, which then puts me in a well-being situation because I'm not having that social interaction, which I enjoy immensely"
Widespread AC issues at co-located sites	"I hear you on the AC in collocated sites" (2 thumbs up)
Office Design/Workspace	
Hot desking impact	"Office conditions (e.g. high temperature, hot desking) and the impact that has on individuals that may not fit the mould"
Noise problems	"Meeting room location, noise, lack of privacy"
Lack of privacy	"Lack of privacy, sharing across agencies"
Shared office spaces	"Some of the team who are remote, share office spaces with other services and it's not a great environment for them. So they avoid going into the office"

Furniture	
Difficulty obtaining appropriate chairs	"I needed a new chair for the office, and was sent consent forms which were really confronting and based on a medical issue - I simply wanted a comfortable chair"
Ergonomic workstations	"Sit to stand desk availability is a problem when we hear staff voicing a need for better ergonomic workstations."

7.5. Concluding Remarks

The following paragraphs summarise the impacts of the Safety, Security and Physical Environment issues highlighted throughout the workshops.

Individual wellbeing impacts: Agency staff reported impacts on psychological wellbeing, with staff experiencing heightened anxiety, fear responses, and in at least one case, the development of diagnosable anxiety disorders. These psychological impacts translated into adapted behaviours, including avoidance of certain work locations, reluctance to engage in routine work activities, and a reduced willingness to participate in face-to-face service delivery. Staff wellbeing was further compromised by physical discomfort in the work environment and diminished opportunities for restorative social interaction with colleagues. The cumulative effect of these stressors is likely to affect individual capacity to perform core duties with confidence and consistency.

Team impact: At the team level, the reported concerns had implications for workforce stability, operations, and morale. Teams experienced challenges in maintaining adequate coverage for front-facing roles, with staff actively avoiding certain duties or work locations. The absence of clear protocols and the presence of unresolved environmental hazards eroded team confidence in Agency support. The impact of these hazards is likely to be on team cohesion and a collective sense of safety.

Agency-wide: At the Agency level, the impacts extended to service delivery quality, duty of care obligations, and reputation. Staff avoidance of participant communications and decision-making conversations can represent a direct compromise to service accessibility and responsiveness. The Agency's capacity to provide equitable service sometimes is potentially constrained by physical accessibility limitations and staff reluctance to utilize available facilities. Delays in addressing known hazards and the absence of consistent security frameworks across co-located sites raised questions about the effectiveness of risk management.

8. Setting NDIA up for Success

8.1. Protective Factors

Prefacing Remarks

The following reflections on Agency protective factors have been derived from both the form question, "What energises and inspires you" and CA Analyst coding, a set of over 1000 observations shared by the NDIA staff during the September/October workshops.

The Job Demands-Resources (JD-R) framework³ delineates between job resources which foster employee engagement and chronic job demands depleted wellbeing. A distinguishing feature of the contemporary JD-R model is its recognition that demands and resources operate at three interconnected levels:

Protective Factors Present

The focus group analysis identified seven primary protective factors that energized and sustained staff wellbeing. These protective factors have been organised across the three levels of the JD-R framework: Organisational, team and individual.

Organisational Level

Organization-wide demands and resources include organizational (or Agency) culture, strategic HR practices, organizational support systems and company-wide change initiatives.

Recognition and feeling valued constituted a protective factor at an Agency level. Some staff reported feeling energized when receiving "recognition of high-quality work" and "constructive feedback" from colleagues and stakeholders. One staff member noted that "when your leadership is genuinely interested in you and recognises your strengths and assist with guidance for future possibilities," it significantly enhanced their workplace experience.

Work life balance and flexibility, particularly remote work arrangements, also represented a protective factor. Multiple staff members cited "work/life balance, flexible work hours" and "the work/life flexibility" as energizing aspects of their roles. One participant specifically mentioned that "working from home is huge, focused work, being productive (without pressure!) and learning and team cohesion" contributed positively to their wellbeing. The ability to manage caring responsibilities through flexible arrangements was valued, though some noted this flexibility was not consistently supported by all managers.

Professional growth and development opportunities served as another protective factor. Staff reported feeling energised by "skill building" and "the ability to uplift people's capability." Some planners expressed satisfaction in "supporting my staff in their learning journey and watching them grow," while others valued "opportunities for development" and "exploring new areas as a graduate." The provision of "mentoring and coaching" was identified as particularly energising for both those receiving and providing such support.

Team/Group Level

Team-level resources include team climate, collective efficacy, and collaborative practices, while team demands might include team conflict or coordination challenges.

Supportive team culture and collaboration emerged as another protective factor that appeared to buffer against workplace stress. Staff members described being energised by "working with amazing colleagues" and valued "the team culture - encouraged to share and build professional relationships." One participant expressed that "my colleagues and flexibility

³ An occupational stress and motivation model developed by Demerouti, Bakker, Nachreiner, and Schaufeli (2001)

of the workplace" were what sustained them, while another noted feeling most fulfilled when "my team collaborate and support each other's growth." Several staff emphasised that "working within a team that is collegiate and has a common goal" provided essential support, with team leaders particularly valuing watching their staff grow and succeed in their roles.

Positive leadership and support emerged as a protective factor, though its presence varied considerably across teams, and it's acknowledged that Poor Support is identified as the most prominent psychosocial hazard. The apparent contradiction illustrates that variability exists and that positive leaders are indeed present. Some staff reported that "my team leader is very positive and inspiring" and appreciated "my amazing leadership team from EL2 to APS6 TL." Others valued leaders who demonstrated "genuine focus on employee health and wellbeing" and provided "support and direction." Overall, the experience of positive leadership appeared inconsistent.

Individual Level

Individual resources are psychological characteristics such as self-efficacy, optimism and resilience. These can drive personal work engagement, burnout, job satisfaction and performance.

Staff reported that *meaningful purpose and impact* served as a powerful protective factor, with one planner noting they felt "inspired and energised when I see my team collaborate and support each other's growth." Multiple participants described feeling rewarded through making a genuine difference in participant's lives and experiencing satisfaction when "communicating a decision as a planner that is going to positively change a participant's life, and they are grateful for my help." Some planners specifically mentioned the privilege of "hearing participants and their families' personal journeys and the immense trust that comes with those conversations."

Positive participant outcomes constituted another protective factor. Staff consistently reported being energised by positive outcomes for participants, whether this was in the form of a participant expressing satisfaction of their plan, helping them achieve their goals and seeing positive outcomes. For those working with parents and their children, meaningful reinforcement of their work's value was elicited through their ability to witness the relief and gratitude expressed by parents when they receive their child's NDIS package.

Missing Protective Factors

Despite these protective factors, the analysis revealed seven notable gaps predominantly at the Agency level that appeared to impact on staff wellbeing. These gaps are presented below:

Psychological safety

Staff consistently reported a fear of speaking up and a culture of silence. One participant observed that "safety and wellbeing are often discussed in terms of physical and mental health, but not enough is said about psychological safety. If staff do not feel safe to speak up, ask questions, this silence affects trust, learning and team performance." Multiple staff members indicated they were "scared to speak up" due to fear of retribution, with one noting "when you are scared to say things which could go against you in the eyes of the leadership, even though you are correct in what you feel and say." Some planners specifically described situations where "we know psychosocial safety is a problem when we see that people in a

meeting just shut down and say nothing or stay on mute." The fear was particularly acute when concerns involved senior leaders, with staff reporting "it's hard to speak up about senior leaders' negative behaviours (culture) for fear of repercussions."

Ineffective reporting systems

Limited follow-through and accountability represented a second major gap in an ideal listing of protective factors which should ideally be present. Staff expressed significant concerns about the Speak Up process, with one participant noting "there's a speak up processes, but because of the fact that people are speaking up about something that's made them feel unsafe, the uncertainty of what happens next in the process, where does it go? What happens?" Multiple staff reported that the outcome of the report doesn't always equate to something that is felt by the staff members" and complained that "the person who reported it doesn't get any sort of follow up and there is no support in what they were experiencing." Some felt the process itself was problematic, describing it as "such a clunky process" where "if you make the wrong selection your report will go to your manager and if you are actually reporting them then I feel like that is really bad." Others indicated they would not use the system because "to report an issue when you know you will get a cut and paste response" felt futile. The perception that "it's hard to share feedback when it feels that change doesn't happen when you do report something", further discouraged staff from raising concerns.

Management support and capability

Staff reported that "team leaders don't have the support to support their staff. They don't know how to support us," particularly regarding neurodiversity and disability support. Some participants observed that "managers seek support and guidance on how to undertake their roles", suggesting inadequate preparation for leadership responsibilities. Multiple staff noted that "ill equipped managers with no people skills are causing a lot of psychological harm to their staff" and called for "mandatory training should occur for all people leaders." The problem extended beyond individual capability, with some staff reporting that "there are not enough support for managers who experience psychosocial hazards from staff", indicating a systemic concern to support leaders adequately.

Lack of transparent communication

Lack of transparent communication was noted in terms of effective Agency change management. Staff expressed frustration that "the issue of change management... there is still a lack of transparency, and it was made very clear at the beginning that the consultation was not about the decision, the decision has been made so staff feel that we are not involved in the decision making process at all. This issue, and others such as understanding the purpose of changes, are described in more detail, in the Change Management Hazard summary in Section 5.4.

Perceived gaps in accountability and organizational justice

This factor speaks to perceptions of favouritism, with participants noting "we know there is favouritism among staff when the same staff are always offered opportunities that others do not" and "nepotism is rife in some areas of the Agency." Some staff observed that "people are being given opportunities on who they know not what they know" and complained about "favouritism of certain staff by Leaders." The perception that "there is often no point speaking up because there are rarely consequences for poor leadership" contributed to cynicism about Agency fairness. Multiple participants described situations where "we know team culture is a problem when we see managers/leaders not address poor performance or below par

behaviours," suggesting selective application of accountability. Some staff specifically noted that "the person doing the investigation is of the same category of the person perpetuating the problem and there are zero consequences for the perpetrator," undermining confidence in organizational justice processes. The reader is referred to Section 5.3 for further information.

Inadequate trauma-informed support

Staff reported "inconsistent debriefing processes with staff with lived experience being exposed to client's trauma" and noted that "we know staff not being supported is a problem when they frequently read or hear about triggering events (suicidal ideations, sexual abuse, emotional abuse)." Some planners described experiencing vicarious trauma, with one noting "vicarious trauma through reading the documents submitted especially when things are included when they are not relevant... other colleagues have been really effected and even see graphic images shared that people think are really helpful but they are not." Multiple staff indicated that "content warnings are not always useful as they do not indicate which documents have the content." The lack of systematic support was evident in reports that "staff safety - when there is no debrief after a community trip" and observations that "operationally, people focus more on wait times, KPIs and ticking boxes rather than, you know, we've had an incident right now, that's my focus and making sure that people are feeling safe, supported."

Approach to risk management

Staff consistently described an Agency culture that responded to problems after they occurred rather than preventing them. One participant specifically noted "how reactive the Agency is to problems rather than being proactive," while others complained about "the slowness of things to get rectified." Some staff expressed frustration that safety concerns were not addressed until incidents occurred, with one noting "some question whether safety is truly a priority, because the follow-through just isn't there." The reactive approach extended to change management, with multiple participants echoing the comment "why do some areas make change without lead times for staff training to understand" and "the rate of change in the Agency is difficult to keep pace with, witnessing bad decisions being made as leadership rotates like a musical chair."

8.2. Amplification Strategies for Protective Factors

The following amplification strategies are suggested, based on the reported protective factors from the data and the framework described:

Agency Level

Recognition and Feeling Valued, Work-Life Balance and Professional Growth Opportunities

1. Implement fair and transparent recognition: Amplification strategies include enabling staff to receive timely, meaningful feedback that reflects their efforts in supporting participants, with particular attention to work that may not be highly visible but contributes significantly to participant outcomes and scheme sustainability. This could be done through Agency communications or initiatives which reference this.
2. Reinforce, promote or identify additional flexible work practices: Amplification strategies might include very clear communication of the existing flexibility allowed, how this is

accessed and the benefits which individuals experience as a result of having flexible work arrangements. A second strategy would be to further enhance the current specified parameters around work hours, location, and scheduling. Team Leaders or managers could proactively ask if team members might wish to avail themselves of these practices. Finally, rostering practices could lift coverage during leave periods to prevent excessive workloads and allow staff sufficient time for rest and recovery between demanding work periods, particularly for staff exposed to traumatic content or aggressive behaviours.

3. Develop professional development pathways & skill uplift: defining structured career development pathways with designated training programs, mentoring arrangements, and transparency about the progression pathways could constitute an amplification strategy for the Agency. This might include robust induction programs for new staff. Additionally, setting up ongoing learning opportunities to build role specific competencies or support to staff to in managing complex participant interactions could significantly lift self-efficacy in these demanding moments.

Team/Group Level

Supportive Team Culture and Collaboration and Positive Leadership and Support suggestions.

4. Strengthen Team Collaboration Infrastructure: The Agency could enhance physical and virtual work environments to facilitate peer support and cooperation. This could include both formal team building activities which could strengthen interpersonal relationships and create psychologically safe spaces for sharing, as well as the set-up of regular points where staff could simply debrief and share with one another, thereby receiving some valuable peer support.
5. Review leadership development: leaders equipped with skills to provide constructive feedback, recognise early warning signs or staff distress, and create environments where workers feel safe to raise concerns would improve the probability of addressing cultural concerns around psychological safety. The Agency might consider “highly encouraging” or mandating Mental Health First Aid courses or ‘psychological safety for leaders’.

Individual Level

Meaningful Purpose and Impact and Participant Engagement and Positive Outcomes Suggestions

6. Any system, process or feedback mechanism whereby staff can regularly receive information about positive participant outcomes results from their work should reap rich rewards in terms of lifting the prevalent connection for many staff with purpose even further. Whether this is indirect feedback about participant outcomes or even creating opportunities for staff to hear directly from participants about how NDIS support has enhanced their independence and quality of life merits consideration.

9. Deep Dive Recommendations:

9.1. Ongoing Vs Non-Ongoing Staff

Exploring employment status differences will strengthen workforce stability and enable the Agency to create equitable support systems that recognise the unique psychosocial needs of both permanent and contract staff. Understanding how insecure employment affects wellbeing allows the Agency to develop targeted retention strategies and ensure all staff feel valued regardless of their employment type. This exploration supports the Agency's commitment to being an employer of choice by addressing job security concerns that currently impact staff engagement and psychological safety.

9.2. Neuro-Inclusive Practices

Deepening neuro-inclusive practices will position the Agency as a leader in creating workplaces that celebrate cognitive diversity and harness the unique strengths neurodivergent staff bring to disability services. The establishment of the Neuro-inclusion Network demonstrates an existing commitment, and further exploration and investment will ensure managers and teams have the knowledge and tools to provide meaningful accommodations and support. This work directly enhances the Agency's capability to serve participants authentically, as neurodivergent staff with lived experience bring invaluable insights to improving participant experiences.

9.3 Co-Located Offices

Examining co-located office arrangements will optimise the balance between collaboration opportunities and the unique safety, security, and operational challenges these shared spaces present. Understanding staff experiences across different office configurations enables the Agency to design environments that promote connection while maintaining appropriate boundaries and safety protocols. This exploration supports both staff wellbeing and participant experience by ensuring physical spaces facilitate quality interactions while protecting staff from psychosocial risks.

9.4. New Employees

Investing thoughtfully and actively in the Agency's onboarding systems will ensure staff feel supported, competent, and connected from day one. Early career experiences significantly influence retention and engagement. Enhanced focus on new employees creates opportunities to embed psychological safety, role clarity, and trauma-informed practices from the outset, building capability that directly benefits employee psychological health and participant outcomes.

9.5 Speak Up Process

Strengthening the Speak Up process will enhance psychological safety, demonstrate genuine commitment to staff voice, and create transparent pathways for continuous improvement across the Agency. Current data indicates staff uncertainty about when and how to use Speak Up, concerns about confidentiality, and fears of repercussions – addressing these barriers will unlock valuable insights for risk management and cultural development. A robust, trusted Speak Up system enables early identification of psychosocial

hazards, supports trauma-informed responses, and demonstrates that staff wellbeing is genuinely valued.

10. Final Note

This consultation has represented a significant undertaking in enabling staff across the Agency to share their experiences of psychosocial hazards in a confidential and psychologically safe environment. The breadth and depth of participation demonstrated staff commitment to contributing to workplace improvement.

The findings presented in this report reflected the lived experiences of Agency staff at a particular point in time and provide a foundation for the next phase of design, where evidence-based interventions will be developed to enhance psychosocial safety, support workforce wellbeing and strengthen the Agency's capacity to deliver quality services to participants.

TELUS Health project team acknowledge the trust placed in this process by participating staff, the co-operative cross-Agency project management between the NDIA and TELUS Health project teams, and the openness demonstrated by NDIA to share candid perspectives on difficult workplace matters.

Kate s47F - personal privacy

Team Manager – Clinical Operations, Assessments & Advisory Services, Psychologist
Workplace Support Programs

Tania s47F - personal privacy

Consulting psychologist and Clinician – Assessments and Advisory Services
Workplace Support Programs

Alex s47F - personal privacy

Consulting psychologist and Clinician – Assessments and Advisory Services
Workplace Support Programs

