

Psychosocial hazards in work environments and effective approaches for managing them

APRIL 2019

The purpose of this report is to define psychosocial health in the workplace context, identify psychosocial health risks in the workplace and develop WorkSafe's approach to reducing psychosocial harm to New Zealand's workers.

The report is structured into three main sections that aim to:

- provide an overview of psychosocial health in the workplace
- provide an overview of how other jurisdictions have addressed psychosocial health and harm
- research-informed action, indicator development and risk management.

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EXECUTIVE SUMMARY

Part One: Psychosocial hazards at work

- Workplaces contain hazards, some of which may be psychosocial stressors.
- Definitions of psychosocial hazards tend to be broad, and this breadth accurately reflects the complex nature of the relationship between the social environment and health outcomes.
- An established definition of psychosocial hazards from occupational health is: When referring to work, the term 'psychosocial hazard' refers to the aspects of design and management of work and its social organisational contexts that may have the potential for causing psychological or physical harm.
- Psychosocial stressors are common in workplaces and take numerous forms.
- Exposure to psychosocial stressors, if sustained, is linked to psychiatric/psychological disorders, illness and/or physical injury.
- Decades of descriptive occupational health and safety research has reliably demonstrated that work-related stress stemming from psychosocial hazards is associated with various physiological pathologies, including hypertension, coronary heart disease, impaired wound healing, musculoskeletal disorders and impaired immune-competence. In addition, health deficits that are in part stress-related include: bronchitis, mental illness, thyroid disorders, skin diseases, certain types of rheumatoid arthritis, obesity, tuberculosis, headaches and migraine, peptic ulcers and ulcerative colitis, and diabetes.
- Work-related stress can be influenced by both organisational and individual factors.
- Factors that are known determinants of psychosocial stress and harmful to workers health are aspects of work design - how work is organised and managed.
- There are a range of models in this field. Two in particular have been reliably empirically supported:
 1. The job strain 'demand-control' model, which models job stress (or strain) as an interaction between workload demands and decision-making authority (or latitude). The job strain demand hypothesis argues that high decision latitude (ie freedom to make decisions) and low-to-moderate job demands are good for workers' health and that the combination of high job demands and low decision latitude results in high psychological strain and physical illness.
 2. The effort-reward imbalance paradigm, which accounts for worker-related factors such as motivation. The imbalance between high efforts and low rewards at work is central to the development of stress-related disorders.
- There are a range of upstream determinants on psychosocial health in the workplace including the state of the economy and the nature of contractual relationships governing workers' employment and the relationship between precarious employment and working conditions and health.
- Workplace bullying has been identified as a significant hazard in New Zealand. It is multi-causal and at an organisational level, it has been associated with ineffective leadership, low levels of resourcing, poor work organisation, poorly defined roles and role ambiguity, workplace cultures that stress 'get it done', workplace change and uncertainty, and poor human resources practices.
- Workplace bullying is a psychosocial stressor that at the time and afterwards can result in low self-esteem, anxiety, stress, fatigue, burnout, depression, sleep disruption, and post-traumatic stress disorder (PTSD) in extreme cases.

- Workplace bullying has an impact on effective organisational functioning: reduces worker productivity, leads to increased absenteeism, lowers morale, increases mistakes being made and accidents happening, damages the organisation's reputation, leads to increased employee turnover and difficulty recruiting employees, reduces customer service and/or product quality.
- Workplace violence is one of the leading forms of occupational fatality and injury. Women are disproportionately affected by workplace violence, as too are those in non-standard forms of employment, night workers and ethnic minority groups.
- Evidence demonstrates that being employed has mental health benefits. However, evidence also demonstrates that poor-quality work and working conditions are detrimental to mental health.
- Specific groups (eg women, Māori, migrants) have greater vulnerability to psychosocial stressors.
- The mental health of workers to a large degree depends on the absence of psychosocial stressors.
- There is little New Zealand data to guide policy makers.

Part Two: The development of standards and frameworks and international responses to psychosocial health risk management

- Part Two of this report catalogues international standards and outlines various frameworks that can potentially be applied in New Zealand.
- The World Health Organization (WHO) and the International Labor Office (ILO) have developed guidance on psychosocial hazards, work-related stress and psychological harassment.
- A review of these standards reveals divergence in terminology related to psychosocial hazards. Non-standardised lexicons can lead to confusion and misinterpretation. In Europe, the Psychosocial Risk Management Excellence Framework (PRIMA EF) addresses these inconsistencies and provides a unified terminology for basic concepts.

Part Three: Research-informed action, indicator development and risk management

- Mitigating psychosocial hazards is informed by some key concepts:
 1. Good psychosocial risk management is good for business.
 2. Managing risk in health and safety involves a systematic, evidence-based approach and the provision of quality information prior to the design of the intervention. Risk management actions need to be evaluated and evaluation should inform reassessment and adjustment of an intervention.
 3. Ownership - the management of psychosocial hazards is connected to how work activities are organised and carried out - both managers and workers performing the work must own the risk management process.
 4. A good understanding of workplace context is key to designing risk management strategies and for tailoring the intervention to the particular workplace.
 5. A participatory approach and social dialogue is key to successful intervention. Good risk management models include recognition of the importance of worker participation. This participation must be meaningful for the worker if the work-related stress intervention is to be effective.

6. Psychosocial hazards are multi-factorial, typically involving factors such as work organisation, work processes, workplace, work-life balance, team and organisational culture, occupational health provisions. Multi-causality requires in-depth analysis to identify the key factors. Addressing psychosocial hazards requires a continuous management process.
 7. Evidence should inform the psychosocial risk management process.
 8. Acceptance that protecting workers from psychosocial hazards is not simply a legal obligation, it is also an ethical obligation.
- Prevention is stratified in terms of primary prevention, secondary prevention, and tertiary prevention. Primary prevention is the most effective, focuses on the organisation as the source of risk and emphasises the need to identify the causes and practices within the organisation that are in need of change. Primary prevention promotes organisation healthiness through addressing key aspects of organisational culture and development, tailoring the intervention to different contexts and addressing risk systematically.
 - Psychosocial intervention effectiveness: organisationally focused high and moderate systems approaches (addressing working conditions) have favourable impacts at both individual and organisational levels. Individually focused interventions for work stress (low systems approaches) tend not to have favourable impacts at the organisational level.
 - There have been very few evaluations of work stress interventions.
 - Examples of best practice for addressing violence, bullying, harassment and mental health interventions are summarised in this part of the report.

Part 1

Psychosocial hazards at work

IN THIS SECTION:

- 1.1 The role of WorkSafe New Zealand
- 1.2 Psychosocial hazards
- 1.3 Stress and stressors
- 1.4 Psychosocial stressors in the workplace
- 1.5 Predictors of psychosocial stress in the workplace
- 1.6 Job characteristics and the nature of work
- 1.7 Social and organisational context of work
- 1.8 Individual risk factors
- 1.9 The relationship between workplace psychosocial stressors and worker mental health

Most occupations are associated with hazards of one sort or another to workers (Table 1), and these hazards differ across occupation type.

Across all occupations, however, there is widespread acknowledgement that psychosocial hazards are an important health risk for workers, yet in many workplaces, the focus remains on physical hazards. It is argued that the downplaying of workplace psychosocial hazards is primarily due to the perception that they present a more difficult and complex challenge when compared to other health and safety issues. Others, however, argue it is the lack of awareness about psychosocial hazards and their mitigation that explains their relative neglect. Following global trends, the New Zealand Government now recognises that psychosocial hazards must be minimised within our workplaces and, furthermore, that there is a requirement for workplace interventions to reduce psychological harm and promote mental health for all New Zealand workers.

WORKPLACE HAZARDS	EXAMPLES	HEALTH OUTCOMES
Physical hazards Exposure of organs to harmful physical forces	Force to the torso or head, materials entering the eye, high intensity sound	Lacerations, burns, fractures, disembowelment, brain injury, blindness, hearing loss
Chemical hazards Exposure of the organs to harmful inorganic substances	Exposure to asbestos, acid, chemical weapons	Fibrotic lung disease, asphyxiation, chemical burns
Biological hazards Exposure of the organs to harmful organic substances	Exposure to pathogenic bacteria, fungi, viruses	Infection leading to somatic illness
Ergonomic hazards A physical factor that harms the musculoskeletal system	Repetitive strain injury, vibration, heavy lifting	Musculoskeletal disorders
Psychosocial hazards Occupational hazards degrading psychological well-being	Bullying, harassment, violence, deadlines	Stress, depression, anxiety, sleep disorders, suicidal ideation
Financial hazards Risks associated with worker remuneration	Non-payment, under-payment, redundancy	Stress, postponed or suspended medical treatment

TABLE 1:
Categories of workplace hazards, with examples and health outcomes

Since the 1990s, New Zealand employers have had a duty to safeguard workers against the risk of psychiatric injury. This development was in part driven by international research in occupational health that focused on the harmful outcomes and financial burden of occupational stress! In New Zealand, cases appearing in the Employment Court, under the Employment Contracts Act 1991, provided an impetus to examine employer obligations towards employees when psychiatric injury resulted from doing the work required of the employee. At this time, a distinction was made between psychological pressures, a constituent of most jobs, and types of psychological harm that employers were held responsible to minimise.² During the 1990's, numerous legislative Bills concerning health and safety at work were passed into acts, for example, the Health and Safety in Employment Act 1992. In addition, the Employment Relations Act 2000 overtly stipulated that employers have an obligation to take reasonable steps to ensure the safety and health of employees at work, including their mental health.³

This review aims to provide insight into psychosocial hazards at work, how international jurisdictions have developed policy and workplace interventions to reduce psychosocial risk and what might be done in New Zealand to develop preventive interventions to reduce psychosocial hazards for New Zealand workers. Psychosocial hazards outside of paid employment are beyond the scope of this review. The review has been structured to provide WorkSafe with the evidence it needs to move forward in this priority area and to ensure that quality health advice for New Zealand workers and employers can be provided.

Because of the vast amount of material relevant to psychosocial hazards, this review is a 'horizon scan' and as such does not constitute a systematic review of all available evidence on psychosocial hazards and workplace health and harm. Nor is it a systematic review of workplace interventions and their evaluations. Rather it provides an overview of the state of play in research, policy and legislative shifts, and how various governing bodies have determined the nature of interventions in this very complex and challenging field. This scan was achieved using a desktop review of published peer-reviewed literature and institutional reports.

1.1 The role of WorkSafe New Zealand



FIGURE 1:
WorkSafe's core roles

Harm prevention is one of WorkSafe's three core roles (Figure 1), and workers are at the heart of New Zealand's health and safety policies. Historically, health and safety has tended to involve a strong focus on safety and the mitigation of physical injuries. Comparatively, much less attention has been paid to the relationship between psychological well-being and the workplace context.

This physical focus is also evident in the ACC compensation regime where 'mental injury' will only be considered for compensation if it results from a physical injury, sexual abuse, or exposure to a single traumatic event at work.⁴ Another significant gap in the ACC scheme is the gradual deterioration of mental health due to work stress related illness.^{5,6} Additionally, in the public health arena, there is little attention paid to the prevention of poor occupational health outcomes beyond physical injuries. This focus on physical hazards in the New Zealand workplace has, in recent times, become increasingly challenged, and there is an emerging interest in work-related health in the broader sense (ie disease, absence of disease, psychological well-being and mental health) as is evident in a range of communications, policy developments and organisational strategies.⁷ For example, New Zealand's Health and Safety at Work Act 2015 (HSWA) requires businesses to ensure the safety of their workers' mental health as well as physical health and to manage risks arising from exposures to hazards at work which may cause more than just physical harm.

As a first step to addressing psychosocial hazards in the workplace, WorkSafe is currently in the process of establishing baseline data describing the types and prevalence of psychosocial hazards in the workplace. This is being undertaken using a worker exposure survey, which includes pre-validated psychosocial measures that afford comparisons with international studies. Preliminary results will be available in March 2019. This survey is the first step to ensuring that psychosocial risk factors are part of the occupational health monitoring system in New Zealand, is evidentially based and will enable WorkSafe to track risk exposure over time.

1.2 Psychosocial hazards

Internationally, psychosocial hazards in the workplace have been referenced in research, policy, legislation and intervention design for many years. In New Zealand, HSWA asserts that a person conducting a business or undertaking is required to ensure the safety of their employees, protect both their physical and **mental health** and manage risks arising from exposure to hazards at work. While the term 'psychosocial' is not explicitly referred to in this legislation, it has been included as a key focus area in the Healthy Work Strategic Plan 2016–2026 and in the Harm Reduction Plan 2016–2019 (currently being revised) and is addressed by the Minister for Workplace Relations and Safety's Letter of Expectations 2018/2019. The shift to referring directly to 'psychosocial' hazards or risks is an outcome of greater familiarisation with international research, policy and legislation, and more generally the challenges provoked by societal shifts and changes in working life in post-industrial societies.

Early international research on work-related psychosocial hazards emphasised stress-related harm and sought to identify typical triggers of psychological harm and their impact upon mental health. In New Zealand, the research record follows the same pattern, but the quantity of research is smaller and less balanced than the studies undertaken in Western Europe and North America. As a consequence of poor support for occupational health research, the development of interventions targeting psychosocial hazards in New Zealand has been slow, fragmented and only recently embraced. New Zealand-based researchers have tended to focus on explicit psychological issues such as workplace stress and fatigue, depression, anxiety and suicide, and the methods are usually self-report surveys of individuals in specific occupational groups.

The research record in New Zealand is weak in terms of workplace context and the social and cultural dimensions within which psychosocial harm arises. The aforementioned swing toward 'psychosocial' is important and not simply a change of terminology. Instead, it constitutes a shift from a mental health perspective (ie diagnosable psychological disorders) to a less medicalised

‘psychosocial’ perspective. Consequently, attention is explicitly directed away from the individual and a psychiatric diagnosis and instead steered towards recognising that individuals are social beings and that social context shapes health outcomes. This shift is also an outcome of contemporary challenges to both biomedical definitions of health and the traditional application of deficit models of health, both of which focus primarily on the presence or absence of disability and disease.

Deficit models of health have been challenged by developments in the biological, medical and social sciences, where a substantial body of evidence demonstrates that the social environment and subjective experiences of this environment play a pivotal role in shaping health outcomes. Subsequently, there is international recognition that holistic models of health more accurately depict the complexity of factors that contribute to health outcomes and, furthermore, that such models have more utility when developing preventive interventions. In fact, the international trend away from deficit models of health began in 1948 with the World Health Organization’s seminal definition of health: **a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.**⁸

The Government’s draft *Health and Safety at Work Strategy 2018–2028*⁹ also signals this shift away from the deficit model, making four direct references to ‘psychosocial’:

“The health and safety system needs to strongly address the **causes of occupational disease** more and this **includes psychosocial risks** like stress, fatigue and all types of violence at work” (Minister’s foreword p.3)

“We want to ensure that we are reducing all significant harm, **broadening our focus** from just acute harms **to include wider health and psychosocial risks**. To achieve this focus, the Government will develop broader measures and targets, including work-related health, to replace the current injury focused targets when they expire in 2021.” (p.6)

“Good risk management means having **clarity about all the risks** in the business, and **managing** them in a systematic way. This **includes poorly managed risks, such as work-related health and psychosocial risks.**” (p.10)

“Valuing and supporting diversity in the workplace is also a contributor to **psychosocial wellbeing** through building inclusive and culturally competent workplaces.” (p.11)

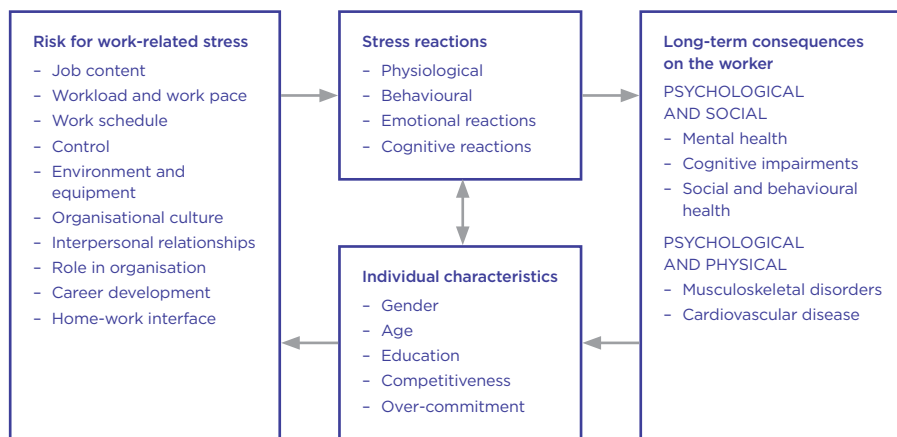
A definition of psychosocial hazards

The move away from deficit models of health was an important development with profound implications for the various state agencies and non-governmental organisations (NGOs) interested in, or responsible for, addressing the psychological and social aspects of work-related health. While the various definitions of ‘psychosocial hazards’ are very broad, the breadth accurately reflects the complex nature of the relationship between the social environment, individual psychological factors and health outcomes, in this instance the work social environment and health outcomes. The term encompasses the evidence-based understanding that **humans are bio-psycho-social beings**.

This horizon scan takes as its starting point an established definition of psychosocial hazards from the discipline of occupational health:

When referring to work, the term ‘psychosocial hazard’ refers to the ‘aspects of the design and management of work, and its social and organisational contexts that may have the potential for causing psychological or physical harm’.¹⁰

More simply, a work-related psychosocial hazard (or risk) is an adverse workplace interaction or condition of work that compromises a worker's health and well-being (see Figure 2). Definitions of psychosocial risks are broad, largely because of the number of potential social and organisational aspects of work that can be hazardous to workers' health. The area is complex primarily because not all workers experience these organisational aspects in the same way, with workers' needs, competencies, perceptions and experiences mediating the nature of the health outcome. Regardless, evidence definitively shows that the psychosocial working environment has a direct role in organisational health, is quantifiable using measures of absenteeism, presenteeism,¹¹ sickness absence,¹² productivity,¹³ intention to resign and high employee turnover. Problems such as work-related stress, harassment, bullying and workplace violence are psychosocial hazards that are significant occupational health and safety issues. On the other hand, research has also established that 'good work is good for mental health' and that work 'quality' is important for well-being.^{14,15} This scan canvasses these occupational health issues, beginning with a contextualised description of stress.



Source: Kompier & Marcelissen, 1990¹⁶

FIGURE 2:
Long-term exposure to stressors in the workplace impacts on health

1.3 Stress and stressors

Accepting that psychosocial hazards can adversely impact worker health begins with models (eg Figure 2) that invariably involve the concept of psychological stress. Fortunately, in modern times, stress is a relatively well-defined concept in both psychology and physiology. Experientially, an individual responds to environmental (physical) and life (psychological) events as they strive to execute goal-directed behaviours. Stressors are defined as those events that are evaluated as harmful or threatening by the individual and that elicit a stress response from the body. At the psychological level of description, stress is characterised by varying degrees of distress and anxiety and associated with high-arousal cognitive states that, if sustained, lead to mental fatigue and sleep disruption. At the physiological level, stress is characterised by metabolic changes that prepare the organism to survive a stressor (ie the so-called 'fight or flight' reaction), notably the mobilisation of the sympathetic nervous system. Decades of biomedical research have conclusively demonstrated that, while acute stress can be adaptive, chronic stress negatively impacts health. The classical explanation of the relationship between a stressor and poor health is conceptualised in Figure 3.

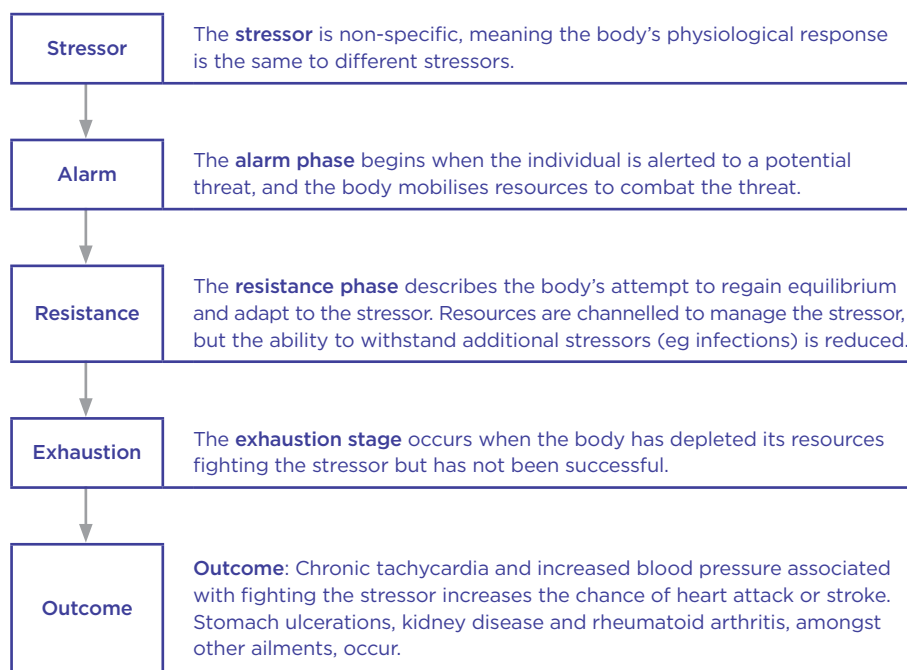


FIGURE 3:
The general adaptation syndrome

Source: Han Selye's classic model of stress, 1956¹⁷

When a worker is faced with a challenge (**stressor**) the initial reaction is adaptive (**alarm phase**), that is, the worker evaluates the event as harmful or threatening and in response mobilises energy resources to deal with the stressor. As the worker attempts to overcome the stressor (eg a harsh deadline), physiological activity such as heart rate, blood pressure and breathing rate increase (**resistance phase**).¹⁸ When the exposure to the stressor is prolonged, continuous or severe (such as ongoing workplace bullying), the body starts to approach its physiological limits and enters a state of high allostatic load (**exhaustion phase**). Allostatic load occurs with chronic exposure to stressors and is physiologically manifested in elevated levels of adrenalin and cortisol. Generally, sustained physiological arousal to an unresolved workplace stressor indicates that the worker is no longer coping physiologically,¹⁹ with exhaustion, organic damage or death now a possibility (**outcome**).²⁰

At the occupational level, exposure to stress-inducing psychosocial hazards is widespread, and these psychosocial stressors are known to increase the risk of chronic disease and contribute significantly to health burden. For example, across the OECD it is estimated that 25% of women and 18% of men are exposed to work stressors and experience strain. However, unlike the relatively predictable nature of physical stressors, the relationship between a psychosocial stressor and the resulting stress response is dependent on individual factors such as coping strategies and resilience. Rather than there being a proportional relationship between the intensity of the stressor and the magnitude of the stress response, as Figure 3 implies, modern conceptualisations of stress emphasise the importance of cognitive processes such as threat evaluation (Figure 4). These processes help explain individual differences in the stress response to the same stressor. Furthermore, because these models embody the concept of coping, they predict that levels of stress will vary with the adequacy of coping resources.

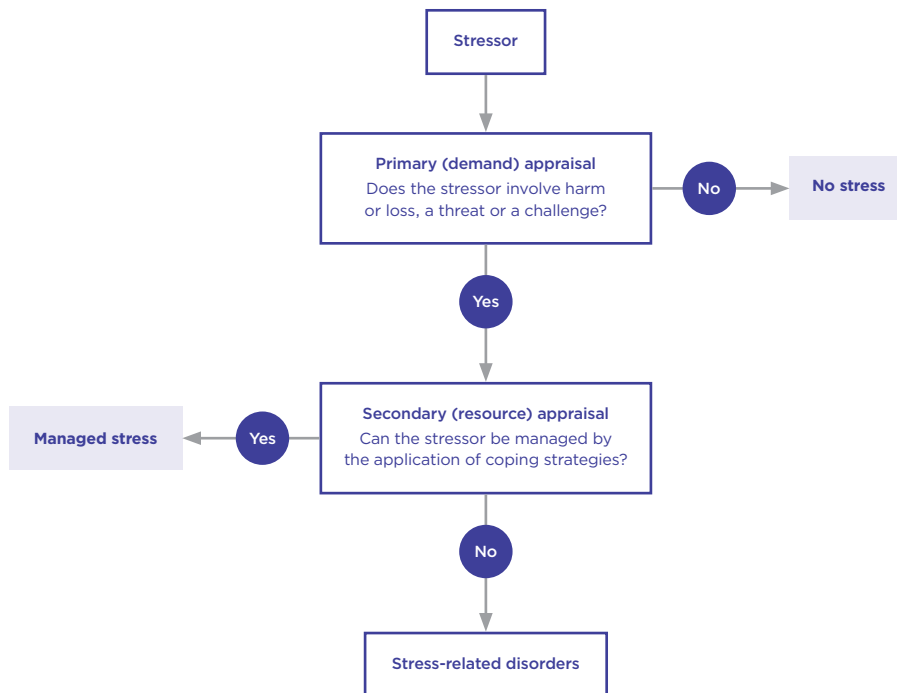


FIGURE 4:
The theory of cognitive appraisal

Source: Lazarus & Folkman, 1984.²¹

Note that the primary and secondary appraisals can occur in any order

Irrespective of causality considerations, decades of descriptive occupational health and safety research has reliably demonstrated that work-related stress stemming from psychosocial hazards is associated with various physiological pathologies²² including:

- hypertension
- coronary heart disease
- wound healing
- musculoskeletal disorders
- gastrointestinal disorders
- impaired immune competence.

In addition, health deficits that have been identified as part of stress-related disorders^{23,24} include:

- bronchitis
- mental illness
- thyroid disorders
- skin diseases
- certain types of rheumatoid arthritis
- obesity
- headaches and migraine
- peptic ulcers and ulcerative colitis
- diabetes.

1.4 Psychosocial stressors in the workplace

Aspects of work design and how work is organised and managed can have the potential to cause stress²⁵ While individuals vary in how they evaluate events and perceive stress, there is a growing body of research documenting the broad categories of stressors. Psychosocial stressors may act independently or at times interact **in the workplace** to produce poor health outcomes²⁶ Note that while on the surface the concepts of workplace hazards (see Table 1) and stressors are synonymous, a hazard can exist without necessarily being a stressor, with the latter necessitating the triggering of a stress response. For example, intense noise is not a stressor to a worker wearing hearing protection nor to a person at a music concert who may nevertheless be exposed to damaging levels of sound. Furthermore, whereas hazards exist externally to an individual, a stressor can be external or internal. Note, however, that the nuance between hazard (*aka* risk) and stressor is not acknowledged in the general literature, which uses the terms synonymously.

For the purpose of this report, a **psychosocial stressor** is defined simply as a workplace psychosocial hazard directly or indirectly inducing a stress response. Here, being bullied in the workplace is an example of a psychosocial hazard directly inducing stress, while witnessing workplace bullying would be an example of a hazard that could indirectly induce stress.

The research evidence documents a range of job characteristics, work environments and organisational aspects that have been shown to elicit stress and are harmful to workers' health. Figure 5, taken from a 2016 British study indicates that psychosocial stressors were identified as the dominant hazards in the work environment and that physical hazards were decreasing in significance while psychosocial hazards were increasing. As part of this study, 44% of workers in Britain reported knowing someone who had been forced to change jobs due to workplace stress.

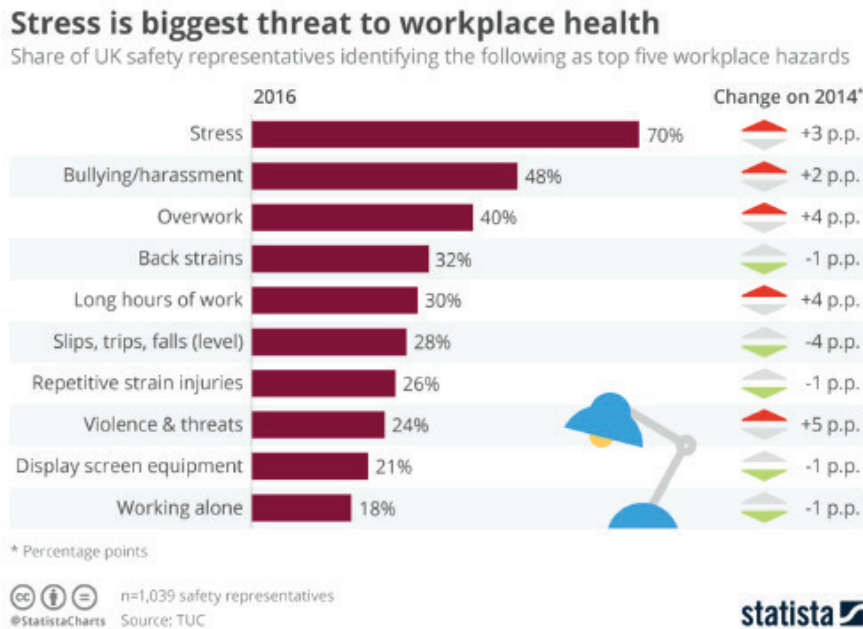


FIGURE 5: Top workplace hazards as identified by workplace safety representatives in the UK²⁷

Source: www.statista.com/chart/6177/stress-is-biggest-threat-to-workplace-health

Descriptions (or models) of how workplace psychosocial hazards induce stress can be found in the occupational health literature. The two-dimensional job strain demand-control model (Figure 6, left) models job stress (or strain) as an interaction between workload demands and decision-making authority (or latitude). The job strain demand-control hypothesis,²⁸⁻³⁰ argues that high decision latitude (ie freedom to make decisions) and low-to-moderate job demands are good for workers' health, and that the combination of high job demands and low decision latitude result in high psychological strain and physical illness.³¹ This hypothesis has received considerable empirical support.³²⁻³⁵ For example, the Whitehall II study (a longitudinal epidemiological study of London-based civil servants) demonstrated the link between low levels of job control and an increased risk of coronary heart disease, increases in obesity due to job strain and poorer health in workers at lower levels in the workplace hierarchy (the so-called socio-economic gradient in worker health).^{36,37} Another influential approach to workplace stress is the effort-reward imbalance paradigm (Figure 6, right), which also accounts for worker-related factors such as motivation. In this interactional model, the imbalance between high efforts and low rewards at work is central to the development of stress-related disorders. Reward can be money, promotion opportunities, job security and status and esteem. Additionally, stress effects can be amplified by a person's over commitment coping style, as is the case when the worker's motivation exceeds the demands of the job.³⁸

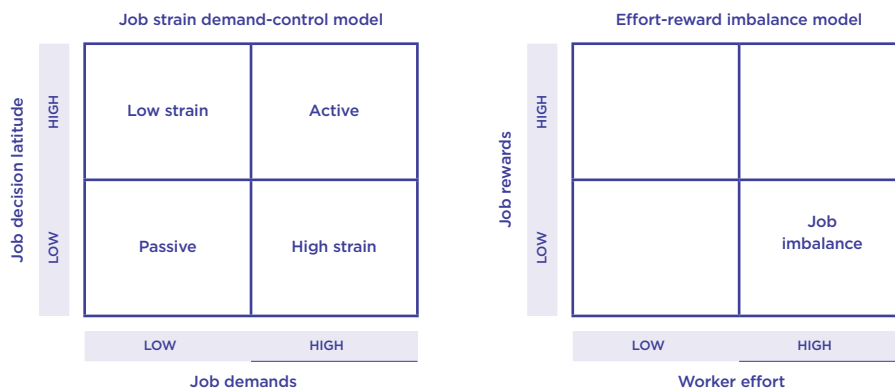


FIGURE 6: Two conceptual models of work stress: the job strain demand-control model (left) and the effort-reward imbalance model (right)

It should be noted that high workplace effort, while attractive to employers, has been linked to chronic heart disease. While the human body is resilient to short-term demands, in a long-term demand situation, the body needs periods of rest and recuperation to activate anabolic processes and other parasympathetic activities involving 'rest and digest'. Breaks such as lunch breaks, an evening of rest and longer break periods such as weekends and vacations are necessary to maintain health. Sleep is one of the most important rest periods as this is when important biological restoration processes take place. Arguably, modern life is characterised as fast paced, with demands for high productivity, efficiency and competitiveness. As such, modern lifestyles lend themselves to a lack of rest, recovery and restitution, which may be a greater health problem than the absolute level of stress on the job.³⁹ It is also possible, however, that modern work demands may increasingly lead to two classes of occupations – those with high control or those with low control, but **all** with high demands.⁴⁰ This shift is already evident in New Zealand, for example, tertiary-level researchers⁴¹ (high control, high demands) and forestry workers (low control, high demands).⁴²

Psychosocial stressors can lead to symptoms of strain for the worker, where strain is a concept used throughout the occupational literature and can be considered a conceptual approximation of stress elicited by the combination of high job demands and low control at work. Strain has cognitive and psychological manifestations, including:

- the inability to concentrate
- job dissatisfaction
- affective disorders – anxiety, depression and anger
- somatic symptoms such as headaches, perspiration, and dizziness
- sleep difficulties.

Prolonged strain may lead to major mental illnesses and thoughts of suicide. The Whitehall II study found that, over time, the absence of social support at work, low decision latitude, high job demands and an effort-reward imbalance were associated with increased risks of psychiatric disorders⁴³ With strain, there are a number of workplace manifestations, including:

- increased or excessive use of alcohol or drugs (including tobacco)⁴⁴
- reduced work performance⁴⁵
- higher levels of absenteeism or sick leave^{46,47}
- increased accidents and injury
- high employee turnover⁴⁸

All of these, it should be noted, impact productivity. These problems may also spill over into home life and place strain on family and close relationships, leading to unhealthy behaviours in the community (eg substance abuse or domestic violence).

1.5 Predictors of psychosocial stress in the workplace

Table 2 summarises the factors that are known determinants of psychosocial stress and harmful to workers' health, with selected facets further elaborated upon below. Work organisation has been broadly defined as the way work processes are structured and managed⁴⁹⁻⁵¹ and includes the management and supervision of production. More recent reviews focusing on work stress and its measurement have noted the need to make a distinction between the structural (objective) characteristics of work and those that are more subjective in nature, such as how the worker evaluates stressors and their work conditions.⁵²⁻⁵⁴

JOB CHARACTERISTICS AND THE NATURE OF WORK

Job contents/demands	High physical, mental and or emotional demands, lack of variety, short work cycles, fragmented or meaningless work, under-utilisation, high uncertainty, continuous exposure to people through work
Workload/workplace	Work overload or underload, machine pacing time pressure, deadlines
Work schedule	Shift working, inflexible work schedules, unpredictable hours, long or unsocial hours
Job control	Low participation in decision making, lack of control over workloads
Physical environment and equipment issues	Inadequate or faulty equipment, poor environmental conditions (space, light, noise, thermal)

SOCIAL AND ORGANISATIONAL CONTEXT OF WORK

Organisational culture and function	Poor communications, low levels of support for problem solving and personal development, lack of definition on organisational objectives
Interpersonal relationships at work	Social or physical isolation, poor relationships with superiors, interpersonal conflict, lack of social support
Role in organisation	Role ambiguity, role conflict, responsibility
Career development	Career stagnation and uncertainty, under promotion or over promotion, poor pay, job insecurity, low social value to work

INDIVIDUAL RISK FACTORS

Individual differences	Coping style, personality, hardiness, resilience
Home-work interface	Conflicting demands of work and home, low support at home, dual career problems

TABLE 2:
Summary of psychosocial risk factors of workplace stress

1.6 Job characteristics and the nature of work

There are a range of upstream determinants on psychosocial health in the workplace including the state of the economy and the nature of contractual relationships governing workers' employment,^{55,56} and the relationship between precarious employment and working conditions and health.^{57,58} While it is accepted that there are beneficial health effects from being employed, it is also the case that poor psychosocial conditions can be more harmful to health than being unemployed.⁵⁹

The changing nature of work

The changing nature of the world of work refers to large scale socio-economic and technological changes and the reorganisation of work in relation to progress. These changes are manifest in the restructuring of organisations and organisation of work, where downsizing of organisations is often accompanied with subcontracting and outsourcing and, in many instances, shifting the risk to these providers. Change in an organisation is a stressor associated with violence, whether this is managed organisational change which undermines identity and control, or technological change. With increased emphasis being placed on lean production practices, there are pressures towards work intensification, which is itself often accompanied with diminished control. Other changes include the emergence of teleworking (or telecommuting) and the increased use of information and communication technology. Both are accompanied by changing expectations about constant connectivity and immediately responding without delay (time compression). The workforce is increasingly expected to be 'flexible' and for workers to have a range of skills and to be open to upskilling throughout their working lives. Consequently, there has been an increase in temporary employment, potentially inducing anxiety in workers. In post-industrial societies, a greater proportion of workers are employed in the service sector, and there are growing numbers of older workers. The labour force is also increasingly globalised, with temporary and permanent migration being the main means of addressing low birth rates and a shrinking supply of workers and consumers. 'Non-standard' and temporary employment, jobs with irregular hours such as shift work and demand-driven/insecure jobs including seasonal work are likely to proportionally increase and generally involve low levels of job certainty. Increasing numbers of workers are and will be self-regulating⁶⁰ and potentially working in social isolation without social support, often within the confines of their own home.

The changing nature of work has given rise to concerns around the impacts of psychosocial hazards, and it appears likely that temporary employment status, precarious employment, atypical working hours, multi-sited work, continuing organisational change and employment insecurity will increasingly become psychosocial risk factors.

Emotionally demanding jobs

Occupations high in emotional exchanges, such as those dealing with customers and patients, may be exposing workers to psychosocial stressors. Examples of such occupations include nursing,⁶¹ social work, call centres,⁶² police^{63,64} and crime scene investigations,⁶⁵ emergency departments, prisons,⁶⁶ teaching,⁶⁷ aged care⁶⁸ and disability support, hospitality,^{69,70} censorship, security and other occupations with exposure to trauma and to people who may be scared, stressed, under the influence of alcohol and other drugs, emergency workers such as ambulance workers,⁷¹ mental health workers,⁷² firefighters,⁷³ rescue workers (disaster responders).^{74,75} In the case of mental health practice, work with traumatised clients can be emotionally demanding due to the amount of emotional attention needed to process it, and there is a high likelihood of workers experiencing vicarious trauma or secondary traumatic stress, which can lead to burn out. Within the New Zealand context, Temitope and Williams (2015) reported a prevalence rate of 24.8% for burnout among the 129 counsellors in their sample.⁷⁶

The controlled expression of emotion to satisfy work requirements is known as emotional labour. Emotional labour is seen as a forced affective performance that may result in negative consequences for the performer, ranging from decreased job satisfaction to burnout. Emotional labour is performed when disparity occurs between workers' felt emotions and displayed emotions in a given occupational and organisational context. One New Zealand study reported substantial burnout among mental health field workers as a result of excessive emotional labour brought about by high workloads.⁷⁷

Low participation in decision making

Traditionally hierarchical command-and-control style management in certain occupations, for example, defence forces and police, can be considered a generator of psychosocial stress. Such structures often shun individual initiative and instead demand rigidity in decisionmaking using detailed rules. Military cultures, for example, may foster 'groupthink' and ostracise those within its ranks who question information and knowledge sourced from higher authority (ie higher rank). Such isolation combined with low decision latitude can be considered psychosocial stressors.

Performance targets

High-pressure work tasks such as challenging performance targets can give rise to workplace stress. Typical high-pressure sectors include sales and marketing, technological industries, finance and elite sport. Workers in market-dependent type sectors, which are often subject to unpredictable boom and bust cycles (or seasonal workers) may be especially vulnerable to stress, if there is uncertainty governing their employment positions. Furthermore, research shows that management that is characterised by abusive authority and setting unreasonable productivity targets is the most likely to induce violent events in the workplace. In addition, poorly organised workplaces characterised by unreasonable time pressures appear to be at greater risk of workplace bullying.⁷⁸

1.7 Social and organisational context of work

Work is rarely carried out in isolation, and an individual's interpersonal relationships within the workplace constitute another prominent source of stress. It has been argued that increased work stress is a precipitating factor in violent events ranging from bullying to homicide.

Workplace discrimination

Discriminatory behaviour involves the exclusion or restriction of a person or a group from access to opportunities that are available to others. The behaviour can cause harm, humiliation, offence or intimidation. In New Zealand, the Employment Relations Act and the Human Rights Act 1993 protect people from discrimination. Research focusing solely on discrimination in the workplace in New Zealand is limited but this is in part because discrimination invariably underpins bullying, harassment and violence. Prejudice (ideas about difference and attributing status to difference) informs discriminatory behaviour.⁷⁹

Workplace bullying

“Bullying at work is about repeated actions and practices that are directed against one or more workers, that are unwanted by the victim, that may be carried out deliberately or unconsciously, but clearly cause humiliation, offence and distress, and that may interfere with job performance and/or cause an unpleasant working environment.... The concept of bullying relates to persistent exposure to negative and aggressive behaviours of a primarily psychological nature....[and] describes situations where hostile behaviours that are directed systematically at one or more colleagues or subordinates and leads to a stigmatisation and victimisation of the recipient(s).”⁸⁰

There is a vast body of international research that has focused on workplace bullying,⁸¹ the sources of bullying,⁸² the impact on the well-being of its targets, as well as witnesses of bullying⁸³ and the association with job contentment, the social environment and health outcomes.⁸⁴ Comparatively, of all specific problems in the workplace, workplace bullying has received greater research attention in New Zealand. Research to date suggests that bullying (or ‘mobbing’) appears to be relatively widespread in New Zealand workplaces. To date there is no population prevalence data, but the results from the WorkSafe Worker Exposure Survey, available in March 2019, should provide the first estimates of the prevalence of workplace bullying in New Zealand.

Bullying has been investigated in a range of sectors in New Zealand, including the public service,⁸⁵⁻⁸⁷ social services,⁸⁸ tourism⁸⁹ and hospitality.⁹⁰ Rates of bullying appear highest in the public sector, health,⁹¹ education and hospitality. Based on the current research record it appears that New Zealand has higher rates of bullying when compared to equivalent jurisdictions.⁹² Bullying is more prevalent in workplace situations with role conflict and ambiguity and organisational change, in a climate of uncertainty and in a culture that is persuasively ‘get it done’, where negative interpersonal interactions may be overlooked, or even subtly encouraged.^{93,94}

Workplace bullying in New Zealand has been identified as a significant hazard,⁹⁵ and is multi-causal. At an organisational level, bullying has been associated with:

- ineffective leadership
- low levels of resourcing
- poor work organisation

- poorly defined roles and role ambiguity
- workplace cultures which stress 'get it done'
- workplace change and uncertainty
- poor human resources practices.

Workplace bullying is a psychosocial stressor that, both at the time and after it has ceased, can result in:

- low self-esteem
- anxiety
- stress
- fatigue
- burnout
- depression
- sleep disruption
- in extreme cases, post-traumatic stress disorder (PTSD).

In addition to having a significant impact on the person being bullied (both psychologically and socially), workplace bullying also:

- reduces worker productivity
- leads to increased absenteeism
- lowers morale
- increases mistakes being made and accidents happening
- damages the organisation's reputation
- leads to increased employee turnover and difficulty in recruiting employees
- reduces customer service and/or product quality.

Policy around workplace bullying and guidance on how to prevent it has also been developed by both WorkSafe and MBIE. Various articles of legislation in New Zealand also highlight workplace bullying and the role that employers have in addressing bullying in their workplaces, specifically: the Employment Relations Act (ERA); the Health and Safety in Employment Act, the Human Rights Act and the Harassment Act 1997.

Workplace violence

Workplace violence has been identified as a leading form of occupational injury and fatality.⁹⁶ Workplace violence is a core health and safety risk that has both physical and psychological impacts on a worker's health and well-being. Violence can be verbal abuse, threats, shouting or swearing, or it can be physical – stalking, throwing objects, hitting or damage to property. Workplace violence is illegal, and charges can be laid under criminal law. Effectively intervening to prevent violence effectively relies on addressing the full range of risk factors. Research in New Zealand suggests that it is not unusual for a workplace to have only one approach to violence mitigation (eg surveillance or training). Effective risk management for violence at work needs to address multiple aspects and avoid the narrow interpersonal interpretations of the cause of violence and allow for a systematic appraisal of the workplace context and factors that are known to trigger violence.

The International Labour Organization (ILO) has highlighted the importance of addressing violence in the workplace, the particular vulnerabilities faced by women workers, those in non-standard forms of employment (eg casual and informal work), workers who are subject to discrimination and workers at risk of exploitation and trafficking.⁹⁷ Women are disproportionately affected by violence at work and are also disproportionately represented in low pay and both precarious employment

and working conditions, exposing them to psychosocial workplace conditions that foster violence (see below). The identification of violence at work, including gender-based violence, should be integral to health and safety prevention programmes and risk assessments.⁹⁸

Frontline workers in the public service are especially vulnerable to third-party violence because their role involves situations where there is considerable tension. For example, it is well documented that police, firefighters, ambulance workers, teachers and teaching assistants, healthcare workers and nurses are at risk of third-party violence. WorkSafe Inspectors are also at risk. In addition, carers of the elderly and those working with people with mental health difficulties are also at heightened risk. Working in healthcare is a well-known risk factor for violence, and patient aggression and violence towards employees in public hospitals has been well documented. International research has identified employees at greater risk of violence are those working in health, public administration, education, transportation and hospitality.⁹⁹ New Zealand-based research has also found that workplace violence is notably higher among those working in health and public administration.¹⁰⁰

Workers who are perceived to be different because of the colour of their skin (ie not Caucasian) experience higher levels of violence at work than do workers who are perceived to be colour neutral (ie 'white'). In the United Kingdom, violence against black and minority ethnic workers has been well documented amongst those who work in high-risk employment and particularly amongst those who work at night. For example, taxi drivers, shopkeepers and workers in bars and dance clubs have an increased risk of being subjected to violence.¹⁰¹ Violence and harassment against lesbian, gay, bisexual and transgender (LGBT) workers is also well documented.¹⁰² In New Zealand, LGBT rights are covered by the Human Rights Act, but even when these rights are well protected legally, violence and discrimination persists and subsequently has been given attention by the UN Human Rights Council in drafting guidelines for businesses on how to address discrimination against LGBT workers.¹⁰³

Domestic violence has more recently been included in workplace union bargaining. This is in recognition of the connection between work and private life and, as noted earlier, that the separation of work and private life is largely an artifice. It also extends the reach of employment into the worlds of those who are workers who are also experiencing violence in their private life and acknowledges the impact it has on these workers and their working lives. Specifically, it recognises that domestic violence impacts on a worker's well-being while at work, has repercussions for safety at work and impacts on productivity and security. Evidence demonstrates that domestic violence also impacts on a person's work history by disrupting employment where the person changes jobs frequently and where the person is more likely to seek casual or part-time work and then also lives on a lower income. Protecting workers who are subject to domestic violence can help them retain stable work and a reliable income and may ultimately enable them to leave the violent relationship. The societal costs of domestic violence are considerable and the cost to employers of employees experiencing domestic violence is likewise high.¹⁰⁴

Recent New Zealand research estimated that domestic violence costs employers \$368 million a year, a cost that could be avoided through workplace provisions.¹⁰⁵ The Domestic Violence – Victims' Protection Bill passed its third reading in Parliament in 2018, and the new law will come into effect on 1 April 2019. The new law entitles employees who are affected by domestic violence up to 10 days of paid domestic violence leave per year. They will also be able to request a short-term variation to their working arrangements and the employer must respond within 10 working days to the variation (changes in hours, location of work and duties of work). The law also protects an employee from being treated adversely if they are known to be or suspected of being affected by domestic violence.¹⁰⁶

Harassment

Workplace harassment in New Zealand is covered by the Harassment Act. Harassment is defined as behaviour that is directed at another person such as watching, loitering, following, accosting, interfering with another person's property or acting in ways that causes a person to fear for their safety at least twice in a 12-month period. Harassment can cause humiliation, offence or intimidation. Usually, harassment behaviours are repeated, but one instance of harassment can cause reasonable stress and force an individual to resign from their job to avoid future episodes.

The research record in New Zealand focusing solely on harassment is reasonably limited, and though harassment is often included in research on bullying, it is conceptually separated from it. International research provides strong evidence that organisational tolerance provides an environment within which harassment can thrive, including harassment of a sexual nature.

Workplace harassment is a psychosocial stressor that has similar effects to other workplace stressors. Some research has explored the negative relationship between workplace harassment and self-esteem.¹⁰⁷ A number of countries have passed legislation on sexual harassment in the workplace,¹⁰⁸ for example, the 2014 Belgian Act on wellbeing at work. This Act provides detailed requirements for employers where they are obliged to provide preventive and effective procedures involving a joint response from the employer, union, health and safety committees and workplace 'persons of confidence' who can provide confidential support to victims.

It is generally acknowledged that prevention of harassment requires effective partnerships between government, employers, unions and society at large. More generally, effective implementation of enabling legislation is dependent upon an effective industrial relations system.

1.8 Individual risk factors

Individual characteristics of workers can predispose them to psychosocial hazards.

Personality

There are a number of personality variables that may be predictors of workplace stress, including:

- type A¹⁰⁹ behaviour pattern¹¹⁰ (this is a contentious and debated concept within academia)
- hardiness¹¹¹ (or resilience)
- locus of control¹¹²⁻¹¹⁵ (internal vs external control of one's life events)
- negative affectivity¹¹⁶⁻¹¹⁹ (disturbance of mood, negative emotions and evaluations)
- self-esteem.¹²⁰

These factors can moderate the stressor-stress/stressor-strain relationship and shape how an individual appraises their environment. Additionally, these factors can in themselves induce stressful environments and influence the nature and response to stress. These factors also shape how an individual copes with stress and may also contribute to how an individual self-selects stressful or non-stressful working environments.¹²¹

Personality factors may combine to shape vulnerability to stress (eg type A behaviour pattern and locus of control) or provide positive support (eg internal locus of control, age, self-esteem, and skill and mastery). Negative affectivity (NA) is the most frequently noted individual factor in work stress situations. Research controlling for this trait has demonstrated, however, that work environment stressors remain strongly associated with job strain.

In personality research, there is a wide body of evidence indicating that high NA individuals appraise environmental factors more negatively than low NA individuals and, furthermore, they will also experience more distress and dissatisfaction in their working lives. As such, high NA individuals are more likely to report greater exposure to workplace stressors and greater strain across time. High NA has been linked to work and non-work measures of stressors and strains, and in occupational settings, NA is significantly correlated with a range of work stressors, including:

- role ambiguity, role conflict, interpersonal conflict, and situational constraints¹²²
- control, social support,¹²³ work demand,¹²⁴ various strain measures such as turnover intent and organisational commitment¹²⁵
- job satisfaction¹²⁶
- absenteeism¹²⁷
- burnout¹²⁸
- general psychosomatic distress.¹²⁹

Negative affectivity has generated considerable debate, with some arguing that it is a confounding¹³⁰ variable that should be controlled for in research, and others arguing that NA plays a direct and substantive role in the stress process. The latter viewpoint would argue that, because NA mediates the relationship between psychosocial stressors and strain, a high NA individual would be expected to have a heightened reactivity to stressors and more intense strain, regardless of the stressor.¹³¹

While many stress researchers have focused on individual personality differences, there are limitations to this approach. It has been observed that research in this area has been compromised by how stress is defined (varied and poorly), the use of unvalidated measures and failure to test for all the ways in which intervening variables might influence the stressor-stress-strain relationship. As such, it is recommended that caution should be exercised when the focus is on 'the individual' and psychological 'types'. A stronger focus on situational factors such as the work environment and sources of social support and training is likely to be more reliable than focusing solely on the individual.¹³² Primary and secondary interventions are likely to be more effective if this focus is adopted (Part Two of this report).

Gender

Women who work full-time, particularly those with managerial and professional roles¹³³⁻¹³⁵ who are single and have dependent children,^{136,137} report more ill-health and depressive symptoms than do their part-time or childless counterparts. Research has demonstrated that women are at greater risk of work stress because of home and work demands and also the type of occupation (ie caring and emotionally taxing occupations). Men are more likely than women to have high control over their work (see the job strain 'demand-control' hypothesis), and women are several times more likely to hold high-strain jobs. Some research has found that women with high job strain and large family responsibilities have greater cardiovascular risk.¹³⁸ Utilising the Whitehall II study data, researchers found that women in the lowest or middle employment grades who reported low control at work or home were at most risk for depression and anxiety. Additionally, men in the middle and highest grades were at greatest risk for both depression and anxiety if they reported low control at home.¹³⁹ Of relevance, in the Canadian SALVEO study, women reported higher levels of burnout than men due to lower levels of decision latitude and self-esteem as well as higher levels of work family conflict.¹⁴⁰

Gender can also be experienced as a disadvantage in some types of work, whether in terms of **discrimination** (un/conscious bias, targeted victimisation, language and other cultural differences) or **poorer handling of job stressors**.

Selected examples include gendered burnout¹⁴¹ and work strain,¹⁴² elevated risk of women to all types of workplace violence (even within similar occupational contexts to men).¹⁴³ Additionally, ethnic differences interact with gender, such as Māori women being twice as likely to categorise their job as very or extremely stressful than non-Māori women in the same job.¹⁴⁴

Ethnicity

There is a limited body of research that focuses on either the occupational health of Māori or psychosocial health. Some research demonstrates that Māori workers experience work-related stress differently from non-Māori, and the difference is primarily shaped by the experience of institutional racism.¹⁴⁵ Cultural safety is defined as social interactions that are guided by cultural respect, that is, respect of the cultural identity of the individual, family or social group. Cultural safety has been formally recognised in the health and disability sector in New Zealand since the early 1990s. Unsafe cultural practice is practice that demeans or disempowers an individual, family or social group on the basis of cultural difference (ie difference from the assumed norm).

Another psychosocial stressor identified in the research literature is the type of work undertaken by many Māori workers, where their role and relationship with their employer may not be their only workplace obligation. For example, in addition to their formal role obligations they may be informally (or formally) relied upon to be a role model for other Māori workers, be expected to provide advice on tikanga (Māori customs and protocols) and/or offer guidance on te reo Māori. If working in a sector or industry with low numbers of Māori workers or low levels of cultural competence amongst the Māori workforce, these expectations can mean a significant increase in workload for these workers.¹⁴⁶

Stewart and Gardner (2015)¹⁴⁷ developed a Māori specific measure of occupational stress and healthy work which aimed to have cultural and ecological validity for those working in the health and disability sector. However, the measure arguably has wider utility. The measure drew on established theoretical frameworks and includes a focus on demands (workplace characteristics), resourcing (how coping is shaped) and strain outcomes. The measure also incorporated Te Whare Tapa Whā¹⁴⁸ and the development of specific items for Te Whare Tapa Whā. Te Whare Tapa Whā is a widely applied model developed by Mason Durie (1998) possessing four key components for health that are symbolically represented through the four walls of a house: taha hinengaro (the thoughts and feelings side); taha tinana (the physical side); and taha whanau (the extended family side) and the most essential requirement for health: taha wairua (dignity, respect, cultural identity, personal contentment and spirituality). In addition, Kingi and Durie's (2000) measure for Māori mental health (see Table 3) which aligns with the four quadrants of the Te Whare Tapa Whā model was also included in the Mahi Oranga framework.

WAIRUA	HINENGARO	TIANA	WHĀNAU
Dignity, respect	Motivation	Mobility/pain	Communication
Cultural identity	Cognition/behaviour	Opportunity for enhanced health	Relationships
Personal contentment	Management of emotions, thinking	Mind and body links	Mutuality (reciprocity)
Spirituality (non-physical experience)	Understanding	Physical health status	Social participation

TABLE 3:
Māori mental health and alignment with the four quadrants of the Te Whare Tapa Whā model

The finalised Mahi Oranga framework drew on established occupational health research and was also informed by qualitative research conducted by Stewart and Gardner (2015) and is presented in **Figure 7**. This framework and the validated measures are a useful tool that can be utilised by organisations to assess occupational stress and the well-being of Māori employees as well as identifying what organisations are doing well.¹⁴⁹

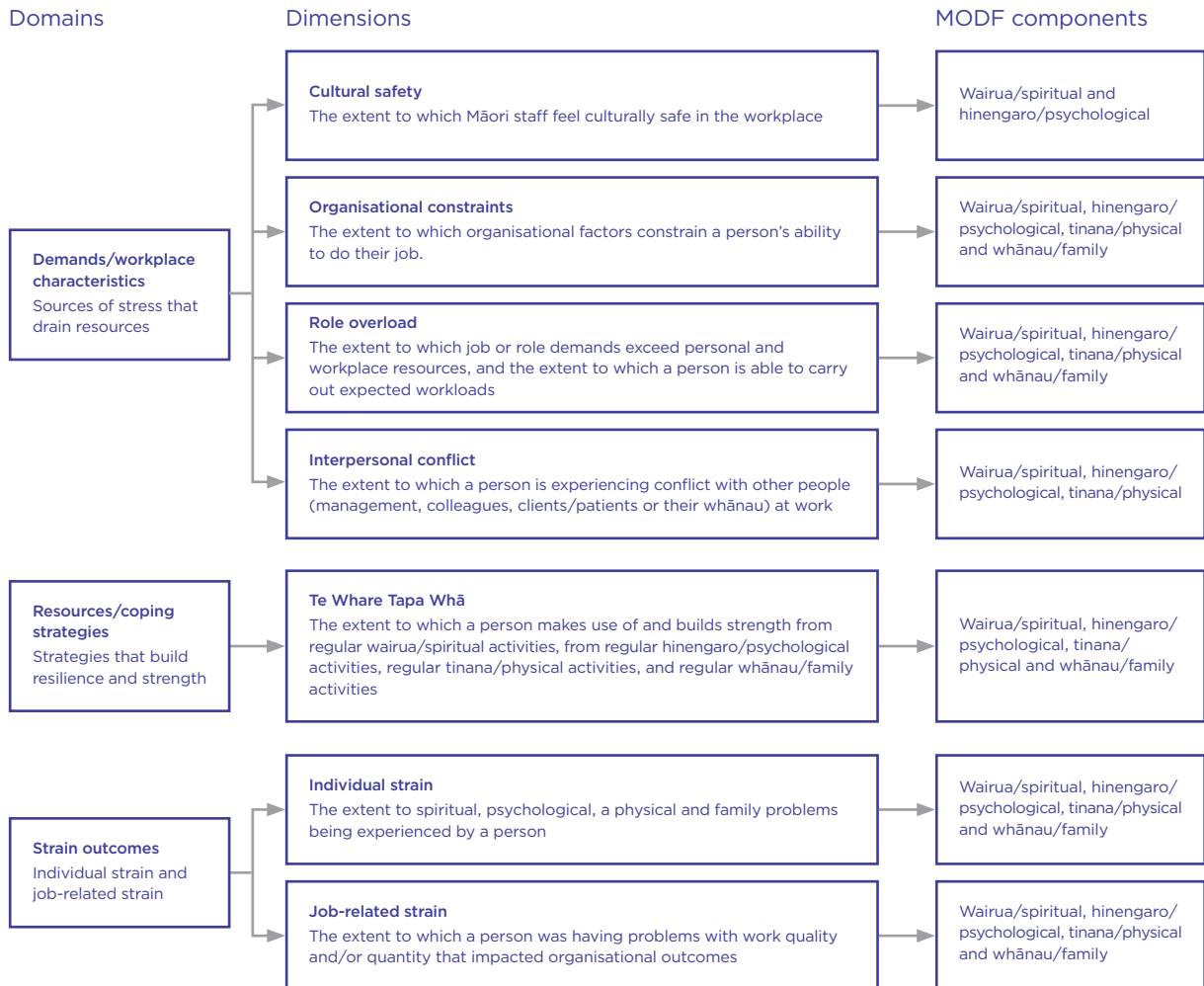


FIGURE 7: The Mahi Oranga measure of occupational stress: framework of well-being

Deprivation

A person's socio-economic status is closely aligned to their educational status, and it has been demonstrated that low socio-economic status is associated with poorer physical health and higher mortality. Job insecurity is a well-established risk factor in the stress literature.¹⁵⁰ It implies low control and low predictability, which are two of the fundamental dimensions of psychosocial stressors¹⁵¹ and low reward for high effort.¹⁵² There is increasing evidence that the effects of job stress on enduring health outcomes may be greater amongst lower socio-economic or occupational groups.¹⁵³⁻¹⁵⁵

Non-work factors

While conceptually, as well as in practice, work and home life are treated as separate entities by many, the divide is an artifice, as for most workers what happens at home can influence a working day, and what happens at work can influence events at home. Psychosocial risks and mental health are multifactorial entities and research has demonstrated that a worker's family and social networks can have both positive and negative mental health implications. Good mental health is associated with having and living with a partner, in households with young children, with low-strain relationships with partner or children, higher household income, less work/family conflicts; and, greater access to social support outside of the workplace.¹⁵⁶ Pertinently, the tensions provoked between family and work (referred to as Work-Family Conflict) can have a negative impact on mental health.¹⁵⁷

Non-work factors such as conflicted family situation, poor social support outside the workplace and personal characteristics are important factors associated with worker mental health symptoms and outcomes.¹⁵⁸ While non-work factors are outside of WorkSafe's core function, the dominant conceptual (and indeed often physical) separation of work and home has also informed the various functions and roles of ministries and Crown entities in the public sector – this highlights the very real need for a collaborative, combined and cohesive response across the public sector to the psychosocial health and mental health of New Zealanders.

1.9 The relationship between workplace psychosocial stressors and worker mental health

Psychosocial stressors can lead to stress that, if sustained, can result in mental illness. Mental ill-health is defined as maladaptive mental states that exceed clinical diagnostic thresholds according to established psychiatric classification systems.¹⁵⁹ It is estimated that, at any point in time, approximately 20% of the working-age population in the average OECD country have a mental disorder in the clinical sense. Generally, prevalence is greater amongst younger adults, women and people with low-level educational attainment.¹⁶⁰ Further, the risk of experiencing mental ill-health during a person's working life is high. Common mental disorders include mood disorders (depression), neurotic disorders (anxiety) and substance-use disorders. Of note, the 2002 Barcelona Declaration on Developing Good Workplace Health in Europe links the increase in mental disorders in Europe to increasing psychosocial stressors and strain in the workplace.¹⁶¹

Work-related stress, depression, and anxiety

The World Health Organization has projected that, by 2030, depression will be the leading cause of the global burden of disease and it is currently a leading cause of disability.¹⁶² Work-related stress, anxiety and depression are associated with exposure to psychosocial hazards in the workplace.¹⁶³ Specifically, lack of job control, having low decision latitude, low skill discretion, job strain, and effort reward imbalance are all associated with risk of depression, poor health functioning, distress, anxiety, fatigue, job dissatisfaction, burnout, vicarious trauma and increased sickness absence. There is compelling evidence that work-related stress, job strain and associated depression risks are a significant public health problem. There is also evidence that demonstrates that work-related psychosocial risk is inequitably distributed and contributes to mental health inequalities.¹⁶⁴ Work-related psychosocial hazards and exposures can be managed, and work-related incidences of stress, depression and anxiety can be prevented.

Regulatory instruments for mental health and psychosocial risks are common in EU member states, yet while these instruments address aspects of mental health and/or the psychosocial work environment stress, mental health and psychosocial hazards are not explicitly identified.¹⁶⁵

Mental health in New Zealand

One in five New Zealanders in any year will meet the diagnostic criteria for a mental health and/or addiction disorder. The most common disorders to be clinically diagnosed are anxiety, depression or substance abuse.¹⁶⁶ Some population groups are more at risk than others. The rate for mental health and/or addiction issues for Māori over a 12-month period is 30% compared to 21% in the general population. Māori are also more likely to have multiple and more serious conditions.¹⁶⁷ The rate of Pacific peoples who have a mental illness or addiction over a 12-month period is 25%, and they have higher levels of substance abuse and gambling-related harm than the general population. Of concern, suicide is the leading cause of death among young Pacific peoples (aged 12-18 years). Of those who were accessing mental health and addiction services in 2016/17, 45% were in employment, education, or training. The majority were not in employment or study. For those with mental health conditions, being outside of employment impacts on their long term well-being, and employment improves mental health outcomes. In 2018 Māori unemployment rates were at a nine-year low. However, the unemployment rate for Māori is double the national rate. More than half of the increase of Māori in employment since 2009 has been Māori aged 15-24 years.¹⁶⁸

Depression is the most studied mental health outcome related to job stress. In New Zealand a longitudinal study (the Dunedin Study) reported a two-fold elevated risk of incident (that is, first diagnosis) of combined major depressive disorder/generalised anxiety disorder amongst a birth cohort ($n = 891$) of 32 year-old workers who were exposed to high job demands.¹⁶⁹ Relative risks (RR) remained significant after adjustment for socio-demographics, negative affect and juvenile psychiatric disorders, with an RR of 1.90 for women and 2.00 for men. When simultaneously exposed to high job demands, low job control and low social support at work, there were significantly elevated RRs of 2.10 for women and 6.32 for men. This is one of the first studies to rule out a history of psychiatric disorder previous to entry into the labour market as an explanation of the work stress-depression link. The researchers tested whether the association between workplace stressors and mental disorders in adulthood might be attributable to having previous mental disorders in childhood, which in turn could influence the perception of work or selection into poor-quality work. It was found that, while this does happen to some extent, it was nonetheless demonstrated that job stressors are an independent source of preventable psychiatric diagnoses in midlife. This finding was also demonstrated by a 1958 British Birth Cohort Study.¹⁷⁰ Thus, there is compelling evidence for a causal link between work stressors and depression.

In New Zealand, it is currently acknowledged that the mental health workforce is ageing, there are employee shortages and high turnover and morale is low and workers are stressed.¹⁷¹ This presents as a significant issue for those seeking care with common mental health disorders.¹⁷² The OECD is appealing for policy responding to the challenges for labour market inclusion of people with mental illness. Specifically, it is recommended that there be a three-fold policy shift, which will give more attention to common mental disorders and also sub-threshold conditions, disorders concerning the employed as well as the unemployed and preventing instead of reacting to mental health problems.¹⁷³ Preventive work-based interventions can be achieved by ensuring good working conditions to avoid job strain, sound management practices and monitoring of sick leave and, where there are repeated absences, the provision of management support.

The implications of poor-quality work for mental health

It is known that being in poor-quality work is detrimental to mental health. Those with mental health disorders are more likely to be employed in jobs that do not match their skill set and/or are in low-skilled jobs such as service work, clerical work, sales and elementary occupations. These occupations are known to have high psychological demand with low decision latitude that when combined, lead to job strain and unhealthy levels of work-related stress, which in turn can aggravate pre-existing mental health conditions.¹⁷⁴ Preventing the deterioration of mental health can and should be an outcome of good management, where the manager supports the worker, provides feedback and gives recognition for work effort.¹⁷⁵ Workers with mental disorders are absent more often than other workers or alternatively do not take sick leave (presenteeism) but are more likely underperforming in their role.¹⁷⁶

Work and positive health outcomes

Mental health includes not just a focus on the absence of mental health disorders. It is also about flourishing and positive well-being. The occupational approach embraced in the United Kingdom is:

“...we start from the position that the correct way to view mental health is that we all have it and we fluctuate between thriving, struggling and being ill and possibly off work. People with poor mental health including common mental health problems and severe mental illness can be in any of these groups. An individual can have a serious mental health problem but with the right support – can still be thriving at work.”¹⁷⁷

For many people, being employed and being at work is good for their mental health and well-being.¹⁷⁸ A recent systematic meta-review concluded that having a job is associated with a greater sense of autonomy, improved self-reported well-being, reduced depression and anxiety symptoms, increased ability to access resources to cope with demands, enhanced social status and unique opportunities for personal development and mental health promotion.¹⁷⁹ Work can improve the well-being of those who are employed, their families and their communities. For those who have experienced poor mental health, having and maintaining employment can be central to the recovery process through improved self-esteem, confidence and an enhanced sense of belonging.

Part 2

The development
of standards
and frameworks
and international
responses to
psychosocial health
risk management

In Europe there are numerous standards and frameworks that aim to address psychosocial hazards.

The World Health Organization (WHO) and the International Labour Office (ILO) have developed guidance on psychosocial hazards, work-related stress and psychological harassment.¹⁸⁰⁻¹⁸⁶ In Europe, the range of responses to mitigate psychosocial hazards in the workplace encompass regulatory standards, legal regulations, and voluntary standards. This part catalogues international standards and outlines various frameworks that can potentially be applied in New Zealand.

In the early 2000s two European surveys were conducted to understand perceptions towards psychosocial issues: 1) the ISPEL to understand the perception of work-related stress in 12 EU candidate countries and 2) the Fourth European Survey of Working Conditions. Additionally, the PRIMA-EF Stakeholder Survey aimed to investigate the level of knowledge of health and safety legislation at the workplace with a particular focus on psychosocial risk factors and perceptions of different aspects of work organisation and work-related stress among stakeholders representing employers' associations, trade unions and government bodies. These surveys played an important part in identifying where effort should be focused and understanding the implementation climate for psychosocial interventions as well articulating the importance of a standardised terminology to aid the translation of research and policies.

A review of standards addressing psychosocial hazards

A review of the standards revealed divergence in terminology related to psychosocial hazards.¹⁸⁷ Different terms have been applied to represent the spectrum of psychosocial hazards and their associated mitigation approaches. Non-standardised lexicons can lead to confusion and misinterpretation. The Psychosocial Risk Management Excellence Framework (PRIMA-EF) is an attempt to address these inconsistencies and to provide a unified terminology for psychosocial risk management for all EU countries. The review of terminology for basic concepts is detailed in Table 4, criteria for psychosocial hazards can be found in Table 5, while Table 6 defines health and occupational outcomes associated with psychosocial risk factors. Table 7 summarises standards covering preventive actions mitigating psychosocial hazards, Table 8 covers assessment of psychosocial hazards and the measurement of stress and Table 9 describes administrative infrastructure involved in psychosocial hazard assessment and prevention.

TERM	SOURCE DOCUMENT
<p>Psychosocial hazards</p> <p>“Interactions among job content, work organisation and management, and other environmental and organisational conditions, on the one hand, and employees’ competencies and needs on the other. Psychosocial hazards are relevant to imbalances in the psychosocial arena and refer to those interactions that prove to have hazardous influences over employees’ health through their perceptions and experience.”</p>	ILO, 1986 ¹⁸⁸
<p>Mental stress</p> <p>“The total of all assessable influences impinging upon a human being from external sources and affecting it mentally” Mental stress is a source of mental strain (= “immediate effect of mental stress within the individual (not the long-term effect) depending on his/her habitual and actual preconditions, including individual coping styles.”)</p> <p>“The total of all assessable influences impinging on a human being from external sources and affecting it mentally.</p> <p>This includes situational influences on mental stress:</p> <ul style="list-style-type: none"> - task requirements (eg sustained concentration, responsibility for others) - physical conditions (eg lighting, noise) - social and organisational factors (eg control structure, communication structure, organisational environment) - social factors, external to the organisation (eg economic situation).” 	<p>ISO 10075:1991¹⁸⁹</p> <p>EN ISO 10075¹⁹⁰</p>
<p>Stress</p> <p>“Stress is a pattern of emotional, cognitive, behavioural and physiological reactions to adverse and noxious aspects of work content, work organisation and work environment. It is a state characterised by high levels of arousal and distress and often by feelings of not coping.”</p>	EU Guidelines ¹⁹¹
<p>Mental strain</p> <p>“Mental strain is an immediate effect of mental stress. The impairing (short term) effects of mental strain are:</p> <ul style="list-style-type: none"> - mental fatigue and ‘fatigue like states’ (ie monotony, reduced vigilance, and satiation) - sources of fatigue (ambiguity of task goals, complexity of task requirements, adequacy of information, ambiguity of information, signal discrimination).” 	EN ISO 10075 ¹⁹²
<p>Violence</p> <p>“Violence at work occurs when one or more worker or manager are assaulted in circumstances relating to work.”</p> <p>“Physical violence: The use of force against another person or group that results in physical, sexual or psychological harm.”</p> <p>Psychological violence: Intentional use of power against another person or group that can result in harm to physical, mental, spiritual, moral or social development.”</p> <p>“Violence – a long-term, recurring bullying, oppression, degradation or other negative behaviour designed to make another person feel defenceless. It can be aimed at one or several individuals.”</p>	<p>European Framework Agreement on Harassment and Violence at Work, WHO, ILO, 2000¹⁹³</p> <p>Finnish Occupational Safety and Health Act¹⁹⁴</p> <p>Swedish Order on Victimization at Work¹⁹⁵</p>
<p>Harassment</p> <p>“Harassment at work occurs when one or more worker or manager are repeatedly and deliberately abused, threatened and/or humiliated in circumstances relating to work”.</p> <p>“Repeated acts of harassment aiming at or resulting in a deterioration of the employee’s rights and dignity, affect their physical health or compromise their professional future.”</p> <p>“Repeated abusive behaviour or any origin, external, or internal to the company or institution, particularly made evident by unilateral behaviour, speech, intimidation, actions, gestures and written communications aiming at worker’s personality, dignity or physical or psychological integrity, in the course of their job or create an intimidating, hostile, degrading, humiliating or offensive environment.”</p> <p>“When a person methodically and over a long period of time is exposed to unpleasant and/or humiliating actions that are difficult to defend oneself against.”</p>	<p>European Framework Agreement on Harassment and Violence at Work¹⁹⁶</p> <p>French Law number 2002-73 of 17 January 2002 and Labour Laws-Art L. 122-49¹⁹⁷</p> <p>Belgian Law of 11 June 2002¹⁹⁸</p> <p>Danish Equal Treatment for Men and Women Act, 1977¹⁹⁹</p>

TABLE 4: Terminology

CONTENT OF STANDARD	SOURCE DOCUMENT
<p>“There are four main categories of sources of mental stress: task, equipment, physical environment, social environment”</p>	<p>ISO 10075:1991²⁰⁰</p>
<p>“Sources of fatigue: intensity of mental workload and temporal distribution of mental workload.</p> <p>The intensity of mental workload is affected by the following characteristics:</p> <ol style="list-style-type: none"> 1. Ambiguity of the task goals 2. Complexity of task requirements 3. Serving strategies 4. Adequacy of information 5. Ambiguity of information 6. Signal discriminability 7. Working memory load 8. Long-term memory load 9. Recognition vs recall memory 10. Decision support.” <p>“Factors of temporal distribution of mental workload:</p> <ol style="list-style-type: none"> 1. Duration of working hours 2. Time off between successive work days or shift 3. Time of day 4. Shift work 5. Breaks and rest pauses 6. Changes in task activities with different task demands or kinds of mental workload.” 	<p>ISO 10075-2:1996²⁰¹ (Design principle)</p>
<p>“Stress at work can be caused by ... bad fit between worker and his/her work.”</p> <p>“... a problem of work-related stress can involve an analysis of factors such as ... match between workers skills and job requirements.”</p>	<p>EU Guidelines, European Framework Agreement on work-related stress²⁰²</p> <p>Directive 94/33/EC on the protection of young people at work²⁰³</p>
<p>“Stress at work can be caused by ... conflict between roles at work and outside it.”</p>	<p>EU Guidelines²⁰⁴</p> <p>Also:</p> <ul style="list-style-type: none"> - C 183 Maternity Protection Convention (ILO), 2000²⁰⁵ - Directive 92/85/EC on pregnant workers, women who have given birth, or are breastfeeding²⁰⁶ - Directive 96/34/EC on parental leave²⁰⁷
<p>“Stress at work can be caused by ... not having a reasonable degree of control over one’s own work and one’s own life.”</p>	<p>EU Guidelines²⁰⁸</p>
<p>“... a problem of work-related stress can involve an analysis of factors such as ... degree of autonomy.”</p>	<p>European Framework Agreement on work-related stress²⁰⁹</p>
<p>“Stress at work can be caused by ... over and underload.”</p> <p>“... a problem of work-related stress can involve an analysis of factors such as ... workload.”</p>	<p>EU Guidelines²¹⁰</p> <p>European Framework Agreement on work-related stress²¹¹</p> <p>Also:</p> <ul style="list-style-type: none"> - Directive 93/104/EC concerning certain aspects of the organisation of working time²¹² - Directive 2003/88/EC concerning certain aspects of the organisation of working time²¹³ - Directive 2002/15/EC of the European Parliament and of the Council 1 March 2002 on the organisation of working time of persons performing mobile road transport activities²¹⁴ - C175 Part-time Work Convention (ILO), 1994²¹⁵ - Directive 99/70/EC concerning the framework agreement on fixed term work concluded by the ETUC, UNICE and CEEP²¹⁶ - Directive 97/81/EC concerning the framework agreement on part-time working concluded by ETUC, UNICE and CEEP²¹⁷

CONTENT OF STANDARD	SOURCE DOCUMENT
<p>“... a problem of work-related stress can involve an analysis of factors such as: ... working time arrangement.”</p>	<p>European Framework Agreement on work-related stress²¹⁸</p> <p>Also:</p> <ul style="list-style-type: none"> - Directive 93/104/EC concerning certain aspects of the organisation of working time²¹⁹ - Directive 2003/88/EC concerning certain aspects of the organisation of working time²²⁰ - Directive 2002/25/EC of the European Parliament and of the Council of 11 March 2002 on the organisation of working time of persons performing mobile road transport activities²²¹ - C175 Part-time Work Convention (ILO), 1994²²² - Directive 99/70/EC concerning the framework agreement on fixed-term work concluded by ETUC, UNICE and CEEP²²³ - Directive 97/81/EC concerning the framework agreement on part-time working concluded by the ETUC, UNICE and CEEP²²⁴
<p>“Stress at work can be caused by ... lack of clear job description, or chain of command.”</p>	<p>EU Guidelines²²⁵</p>
<p>“... a problem of work-related stress can involve an analysis of factors such as ... uncertainty about what is expected at work.”</p>	<p>European Framework Agreement on work-related stress²²⁶</p>
<p>“Stress at work can be caused by ... inadequate time to complete our job to our own and others satisfaction.”</p>	<p>EU Guidelines</p>
<p>“Stress at work can be caused by ...:no recognition, or reward, for good job performance.”</p>	<p>EU Guidelines</p>
<p>“Stress at work can be caused by ...: no opportunity to voice complaints.”</p>	<p>EU Guidelines²²⁷</p> <p>Also:</p> <ul style="list-style-type: none"> - Directive 2002/14/EC establishing general framework for informing and consulting employees in the European Community²²⁸
<p>“Stress at work can be caused by ... many responsibilities, but little authority or decision-making capacity.”</p>	<p>EU Guidelines²²⁹</p>
<p>“Stress at work can be caused by ... uncooperative or unsupportive superiors, co-workers or subordinates.”</p> <p>“... a problem of work-related stress can involve an analysis of factors such as ... perceived lack of support.”</p>	<p>EU Guidelines, European Framework Agreement on work-related stress²³⁰</p>
<p>“Stress at work can be caused by ... no control, or pride over the finished product of work.”</p>	<p>EU Guidelines²³¹</p>
<p>“Stress at work can be caused by ... job insecurity, no permanence of position.”</p>	<p>EU Guidelines²³²</p>
<p>“... a problem of work-related stress can involve an analysis of factors such as ... employment prospects, or forthcoming change.”</p>	<p>European Framework Agreement on work-related stress²³³</p>
<p>“Stress at work can be caused by ... exposure to prejudice regarding age.”</p>	<p>EU Guidelines</p> <p>Also:</p> <ul style="list-style-type: none"> - Directive 2004/43/EC and 2000/78EC prohibiting direct or indirect discrimination on grounds of racial or ethnic origin, religion or belief, disability, age or sexual orientation - Directive 94/33/EC on the protection of young people at work²³⁴

CONTENT OF STANDARD	SOURCE DOCUMENT
<p>“Stress at work can be caused by ... exposure to prejudice regarding gender.”</p>	<p>EU Guidelines²³⁵</p> <p>Also:</p> <ul style="list-style-type: none"> - Directive 2004/43/EC and 2000/78EC²³⁶ prohibiting direct or indirect discrimination on grounds of racial or ethnic origin, religion or belief, disability, age, or sexual orientation - Directive 76/207/EEC²³⁷ and - Directive 2002/73/EC²³⁸ on equal treatment for men and women as regards access to employment, vocational training and promotion and working conditions - Directive 2006/54/EC²³⁹ on the implementation of the principle of equal opportunities and equal treatment of men and women in matters of employment and occupation
<p>“Stress at work can be caused by ... exposure to prejudice regarding race, ethnicity, religion.”</p>	<p>EU Guidelines²⁴⁰</p> <p>Also:</p> <ul style="list-style-type: none"> - Directive 2004/43 EC and 2000/78 EC prohibiting direct or indirect discrimination on grounds of racial or ethnic origin, religion or belief, disability, age or sexual orientation²⁴¹
<p>“Stress at work can be caused by ... exposure to violence, threats, or bullying.”</p>	<p>EU Guidelines²⁴²</p>
<p>Sources of bullying</p> <ul style="list-style-type: none"> - “unreasonable deadlines - unreasonable workloads - remove work tasks within initial information - withholding of information which makes it difficult to perform work tasks - accusations about bad work performance - excessive surveillance and control.” <p>Sources of bullying</p> <p>“unilateral behaviour, speech, intimidation, actions, gestures and written communications aiming at worker’s personality, dignity or physical or psychological integrity, in the course of their job.”</p> <p>Sources of bullying</p> <p>“advanced behaviours aimed at harassing, persecuting, or discriminating a person and violate his/her dignity and health.”</p> <p>Sources of mobbing</p> <p>“any actions or behaviour directed towards an employee that aim at long lasting harassment or intimidation at an employee.”</p>	<p>Danish Equal Treatment for Men and Women Act 1977²⁴³</p> <p>Belgian Law of 11 June 2002 The German Employment Protection Act</p> <p>The Polish No.94, S 2 anti-bullying provision of Labour Code</p>
<p>“... a problem of work-related stress can involve an analysis of factors such as ... emotional and social pressures.”</p>	<p>European Framework Agreement on work-related stress²⁴⁴</p>
<p>“Stress at work can be caused by ... unpleasant or hazardous physical work conditions.”</p> <p>“... a problem of work-related stress can involve an analysis of factors such as: ... exposure to abusive behaviour, noise, heat, dangerous substances.”</p>	<p>EU Guidelines²⁴⁵</p> <p>European Framework on Work-Related Stress²⁴⁶</p> <p>Also:</p> <ul style="list-style-type: none"> - Directive 89/391 on Health and Safety at Work²⁴⁷ - Directive 89/654 on Workplaces²⁴⁸ - Directive 89/655 on the use of work equipment by workers at work²⁴⁹ - Directive 89/656 on the use of personal protective equipment²⁵⁰ - Directive 90/269/EEC on the manual handling of loads²⁵¹ - Directive 90/270/EEC on work with visual display equipment²⁵²

CONTENT OF STANDARD	SOURCE DOCUMENT
“Stress at work can be caused by ... no opportunity to utilize personal talents or abilities effectively.”	EU Guidelines ²⁵³
“Stress at work can be caused by ... chances of a small error or momentary lapse of attention having serious or even disastrous consequences.”	EU Guidelines ²⁵⁴

Source²⁵⁵

TABLE 5: Standards covering exposure factors (standards that indicate what should be considered psychosocial hazards, sources of work stress or strain)

CONTENT OF STANDARD	SOURCE DOCUMENT
<p>Mental stress</p> <p>“Impairing (short term) effects on mental stress are: mental fatigue, and ‘fatigue-like states (ie monotony, reduced vigilance, satiation)’.”</p> <p>Mental fatigue</p> <p>“Temporary impairment of mental and physical functional efficiency, depending on the intensity, duration and temporal pattern of the preceding mental strain.”</p> <p>Monotony</p> <p>“Slowly developing a state of reduced activation which may occur during long, uniform, repetitive tasks or activities, and which is mainly associated with drowsiness, tiredness, decrease and fluctuations in performance, reduction in adaptability and responsiveness, as well as an increase in variability of heart rate.”</p> <p>Satiation</p> <p>“State of nervously unsettled, strongly emotional rejection of repetitive task or situation in which the experience is of ‘marking time’ or ‘not getting anywhere’, with additional symptoms of anger, decreased performance, and/or feelings of tiredness, and a tendency to withdraw.”</p>	ISO 10075:1991 ²⁵⁶
“High absenteeism or staff turnover, frequent interpersonal conflicts or complaints by workers are some of the signs that may indicate a problem of work-related stress.”	European Framework Agreement on stress ²⁵⁷

Source²⁵⁸

TABLE 6: Standards identifying health and occupational outcomes of psychosocial risk factors and work stress/strain

CONTENT OF STANDARD	SOURCE DOCUMENT
<p>Employers have ‘a duty to ensure the safety and health of workers in every aspect related to work’. They have to develop ‘a coherent overall prevention policy’.</p> <p>Principles; “avoiding risks”, “combating the risks at source”, “adapting the work to the individual”</p>	EU Framework Directive 89 ²⁵⁹
<p>“In formulating its national policy, each Member ... in consultation with the most representative organisations of employers and workers, shall promote basic principles such as assessing occupational risks or hazards; combating occupational risks or hazards at source; and developing a national preventive safety and health culture that includes information, consultation and training.”</p> <p>“The principle of prevention is accorded the highest priority.”</p>	ILO Convention 187 (Convention concerning the promotional framework for occupational safety and health, 2006) ²⁶⁰
<p>“All employers have a legal obligation to protect the occupational safety and health of workers. This duty also applies to problems of work-related stress in so far as they entail a risk to health and society.”</p>	European Framework Agreement on work-related stress ²⁶¹ Also: - United Nations Treaty on Disability Rights, 2007 ²⁶² (promoting employment opportunities and career advancement for persons with disabilities)
<p>“Employers should carry out an active policy to foster safety, health and well-being.”</p>	WCA (Dutch Works Councils Act) ²⁶³
<p>“Employers policy to foster safety, health and well-being must be based on thorough written and regularly conducted inventory and assessment of all work-related risk, including psychosocial risk factors.”</p>	WCA (Dutch Works Councils Act) ²⁶⁴
<p>“Employers should engage experts from OHSSs to assist in approving out – or carrying out – the risk inventory and assessment as well as the plan of action.”</p>	WCA (Dutch Works Councils Act) ²⁶⁵
<p>“First step to prevent stress: to identify work-related stress, its causes and consequences by monitoring job content, working conditions, terms of employment, social relations at work, health, well-being and productivity.”</p>	EU Guidelines ²⁶⁶
<p>“Recommend checklists and questionnaires can be used to identify work-related stress, its causes and consequences.”</p>	EU Guidelines ²⁶⁷
<p>“Action should be taken to improve stress-inducing conditions in the workplace – organisational change by:</p> <ul style="list-style-type: none"> - allowing adequate time for the worker to perform his or her work satisfactorily - providing the worker with a clear job description - rewarding the worker for good job performance - providing ways for the worker to voice complaints and have them considered seriously and swiftly - harmonizing the worker’s responsibility and authority - clarifying the work organisations goals and values and adapting them to the worker’s own goals and values, where-ever possible - promoting the worker’s control, and pride, over the end product of his or her work - promoting tolerance, security and justice at the workplace - eliminating harmful physical exposure - identifying failures, successes, and their causes and consequences in previous and future health action at the workplace.” 	EU Guidelines ²⁶⁸
<p>“Considering organisational improvements to prevent work-related stress and ill health, with regard to the following (‘managerial standards’).”</p>	EU Guidelines ²⁶⁹

CONTENT OF STANDARD	SOURCE DOCUMENT
<p>Work schedule</p> <p>“Design work schedules to avoid conflict with demands and responsibilities unrelated to the job. Schedules for rotating shifts should be stable and predictable, with rotation in a forward (morning, afternoon, night) direction.”</p> <p>“Approaches to be considered include ... flexible work schedule.”</p>	<p>EU Guidelines²⁷⁰</p> <p>Also:</p> <ul style="list-style-type: none"> - Directive 93/104 EC on working time²⁷¹ - Directive 2003/88/EC concerning certain aspects of the organisation of working time²⁷² - C175 Part-Time Work²⁷³ - Convention ILO, 1994²⁷⁴ - C 183 Maternity Protection Convention ILO, 2003²⁷⁵ - Directive 92/85/EC on pregnant workers, women who have recently given birth, or are breast feeding²⁷⁶ - Directive 96/34/EC on parental leave²⁷⁷
<p>Participation/control</p> <p>“Allow workers to take part in decisions or actions affecting their jobs.”</p>	<p>EU Guidelines²⁷⁸</p> <p>Also:</p> <ul style="list-style-type: none"> - HSE (control)²⁷⁹
<p>“Approaches to be considered include participative management.”</p>	<p>Directive 2002/14/EC establishing general framework for informing and consulting employees in the European Community²⁸⁰</p>
<p>Workload</p> <p>“Ensure assignments are compatible and capabilities and resources of the worker, and ...allow for recovery from especially demanding physical or mental tasks.”</p>	<p>EU Guidelines²⁸¹</p> <p>Also:</p> <ul style="list-style-type: none"> - HSE (demands)²⁸² - Directive 93/104/EC on working time²⁸³ - C175 Part-time Work²⁸⁴ - Directive 2003/88/EC concerning certain aspects of working time²⁸⁵ - Directive 94/33/EC on the protection of young people at work²⁸⁶
<p>Content</p> <p>“Design tasks to provide meaning, stimulation, a sense of completeness and opportunity to use skills.”</p>	<p>EU Guidelines²⁸⁷</p> <p>Also:</p> <ul style="list-style-type: none"> - WCA (Dutch)²⁸⁸
<p>Roles</p> <p>“Define work roles and responsibilities clearly.”</p>	<p>EU Guidelines²⁸⁹</p> <p>Also:</p> <ul style="list-style-type: none"> - HSE (role)²⁹⁰
<p>Social environment</p> <p>“Provide opportunities for social interaction, including emotional and social support and help between fellow workers.”</p>	<p>EU Guidelines²⁹¹</p> <p>Also:</p> <ul style="list-style-type: none"> - HSE (support)²⁹²
<p>Future</p> <p>“Avoid ambiguity in matters of job security and career development, promote life-long learning and employability.”</p>	<p>EU Guidelines²⁹³</p> <p>Also:</p> <ul style="list-style-type: none"> - Directive 99/70/EC concerning the framework agreement on fixed-term work concluded by ETUC, UNICE and CEEP²⁹⁴

CONTENT OF STANDARD	SOURCE DOCUMENT
<p>Relationships</p> <p>“Employees indicate that they are not subjected to unacceptable behaviours (eg bullying at work).”</p>	<p>HSE (relationship)²⁹⁵</p> <p>Also:</p> <ul style="list-style-type: none"> - Resolution on Harassment at the workplace 2001/2339²⁹⁶ - International Code to Prevent Mobbing at Workplace - Swedish Order on Victimization at Work, 1993²⁹⁷ - French Modernization of Employment Act/2002²⁹⁸ - Belgian Welfare at Work Act, 1996²⁹⁹ - English Protection from Harassment Act/1997³⁰⁰
<p>Change</p> <p>“Employees indicate that the organisation engages them frequently when undergoing an organisational change.”</p>	<p>HSE (change)³⁰¹</p> <p>Also:</p> <ul style="list-style-type: none"> - Directive 2002/14/EC³⁰²
<p>“Workplace, working methods, tools, machines are in accordance with personal characteristics of the employees.”</p>	<p>Establishing general framework for informing and consulting employees in the European Community³⁰³</p>
<p>“Requested steps of intervention:</p> <ul style="list-style-type: none"> - 1st step: identify the incidence, prevalence, severity and trends of work-related stressor exposures and their causes and health consequences - 2nd step: characteristics of exposures as reflected in the content, organisations of work are analysed in relation to the outcomes found - 3rd step: the stakeholders design an integrated package of interventions, and implement it - 4th step: the short-and long-term outcomes of interventions need to be evaluated, in terms of (a) stressor exposures, (b) stress reactions, (c) incidence, (d) indicators of well-being, (e) productivity, (f) costs and benefits in economic terms.” 	<p>EU Guidelines³⁰⁴</p>
<p>“The aim of the standard is not to reduce mental workload (or stress to the minimum possible ... but to optimize it”; “What is really required is to avoid any kind of dysfunctional mental workload, and to provide for optimal mental workload which will avoid impairing effects and promote facilitating effects and the personal development of the worker.”</p>	<p>ISO 10075:1991³⁰⁵</p>
<p>“The specific design guidelines to optimize mental workload should take into account:</p> <ul style="list-style-type: none"> - <i>Effects</i> they are intended to influence (ie fatigue, monotony, vigilance, satiation) - the <i>level of design</i> (task, equipment, environment, organisation) - <i>quality and intensity</i> of mental workload - <i>temporal organisation of work</i> (eg duration of working hours, time off between successive shifts, shift work, breaks and rest pauses, as well as changes in task activities).” 	<p>ISO 10075:1991³⁰⁶</p>
<p>“Raising awareness and appropriate training of managers and workers can reduce the likelihood of harassment and violence at work.</p> <p>A suitable procedure will be underpinned by but not confined to the following:</p> <ul style="list-style-type: none"> - it is in the interest of all parties to proceed with the necessary discretion to protect the dignity and privacy of all - no information should be disclosed to parties not involved in the case - complaints should be investigated and dealt with without undue delay - all parties involved should get an impartial hearing and fair treatment - complaints should be backed up by detailed information - false accusations should not be tolerated and may result in disciplinary action - external assistance may help.” 	<p>European Framework Agreement on Harassment and Violence at Work³⁰⁷</p>

CONTENT OF STANDARD	SOURCE DOCUMENT
<p>“If it is established that harassment and violence occurred, appropriate measures will be taken in relation to the perpetrator(s). This may include disciplinary action up to and including dismissal. The victim(s) will receive support and, if necessary, help with reintegration.</p> <p>“Employers, in consultation with workers and/or their representatives, will establish, review and monitor these procedures to ensure that they are effective both in preventing problems and dealing with issues as they arise.”</p>	Swedish Work Environment Act ³⁰⁸
<ul style="list-style-type: none"> - “The employer must adopt an explicit policy against victimization - He must provide for an early detection of signs of and the rectification of ‘such unsatisfactory working conditions, problems of work organisation or deficiencies of cooperation’ as can provide a basis for victimization - He must take counter-measures if signs of victimization become apparent - He must provide support to the victim, and have specific procedures for that - He must provide to the management the training related to victimization at work, its causes, prevention and legislation issues - He must engage all workers in improving working conditions in order to prevent victimization at work - the physical organisation of the working environment aimed at preventing violence - quick and impartial investigation of cases of workplace violence - listening to and assisting victims - establishing proper assistance and support for the victim, the availability of an advisor on prevention and a complaint resolution officer - supporting and helping victims to return to work - line management’s obligations to prevent the situation envisaged - provision of information and training to all workers on preventing stress - informing the Committee for Prevention and Protection at work.” 	Belgian Law of 11 July 2002 ³⁰⁹

TABLE 7: Standards covering preventive actions mitigating psychosocial risk factors and sources of work stress

CONTENT OF THE STANDARD	SOURCE DOCUMENT
<p>“It was decided not to standardise individual methods or instruments of mental workload but to prepare a standard on requirements for such methods or instruments.”</p> <p>“A choice of the most appropriate measurement instruments/procedures in a given situation must take into account:</p> <ul style="list-style-type: none"> - the intended domain of measurement (assessing mental stress or mental strain or effects of mental strain) - the quality of measurement (categorised into three levels: orienting level, screening level, precision measurements) - measurement technique (ranging from job and task analysis through performance assessment and subjective scaling techniques to psycho-physiological measurements).” 	ISO 10075:1991 ³¹⁰
<p>“Measurement quality is defined via psychometric criteria: objectivity, reliability, validity, sensitivity, diagnosticity (<i>definitions for the above terms are given in the norm</i>).”</p>	ISO 10075:1991 ³¹¹

TABLE 8: Standards covering psychosocial risk assessment and the measurement of stress, and its causes and consequences

CONTENT OF STANDARD	SOURCE DOCUMENT
"Systems are in place locally to respond to any individual concerns related to the Management of Standards."	HSE (Management standards) ³¹²
"Recommended low-cost approach to reduce noxious work-related stress: internal control (= self- regulatory process carried out with close collaboration between stakeholders: in-house occupational health service, labour inspector, occupational or public health nurse, a social worker, a physiotherapist, personnel administrator)."	EU Guidelines ³¹³
"Independent commercial enterprises Occupational Health and Safety Services (OHSS) play a central role in psychosocial risk assessment and prevention. They sell services to companies."	WCA (Dutch Works Council Act) ³¹⁴
<p>"OHSS must be certified."</p> <p>"Each OHSS must employ at least one certificated professional from each of the following four fields:</p> <ol style="list-style-type: none"> 1. occupational medicine 2. occupational safety 3. occupational hygiene 4. work and organisation." 	WCA (Dutch Works Council Act) ³¹⁵
<p>"The W & O expert's job is to advise management on policy issues to improve work organisation. His (sic) four key tasks are:</p> <ol style="list-style-type: none"> 1. organisational advice and recommendation of measures 2. psychosocial risk assessment 3. implementation of organisation-based measures to reduce job stress and sickness absence rates 4. co-ordination and integration of measures – acting as a liaison between the company and the OHSS team." 	WCA (Dutch Works Council Act) ³¹⁶
<p>"Employer must have a prevention adviser with skills in the psychological aspects of work and violence at work, psychological harassment and sexual harassment on the staff of his (sic) company prevention service. There must be a prevention advisor on the external prevention service used. This person must not be an occupational health doctor. All firms of every size therefore must have a specialised prevention adviser. Employers can also appoint one or more complaint resolution officers to act as a "first line" player to listen to what victims have to say and attempt an informal reconciliation. A range of procedures are available. Victims may take their complaints through company internal procedures via the complaint resolution officer or specialised prevention adviser. Or they can complain to the labour ministry's medical inspectorate either because company procedures have not worked or because the victim lacks confidence in them. If mediation does not work, redress can be sought through the courts by the victim personally."</p>	Belgian Law of 11 July 2002 ³¹⁷

TABLE 9: Standards describing administrative infrastructure involved in psychosocial risks assessment and prevention

Part 3

Research-informed action, indicator development and risk management

IN THIS SECTION:

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Policy and practical applications – research informed action

Internationally, there is a degree of consensus about the nature and adverse consequences of psychosocial hazards, and while new forms of work will give rise to new psychosocial hazards, there is sufficient evidence available to develop policy frameworks and inform workplace interventions. To this end, a considerable amount of work has been undertaken in Europe, and there are frameworks and models that can be adopted to assess the risks associated with psychosocial hazards, the severity of their health impacts and the associations between psychosocial hazards and the healthiness of organisations (ie high employee turnover, productivity, absenteeism etc).

Of interest to WorkSafe is a European-derived framework developed to assist in the management of psychosocial hazards at both the organisational and societal levels. The European Framework for Psychosocial Risk Management considers all major psychosocial risk management approaches across Europe and is informed by a theoretical analysis of the risk management process and an analysis of typical risk management approaches in the EU.³¹⁸ Importantly, this framework was developed to inform intervention to reduce harm caused by psychosocial hazards and was developed to assist in the promotion of mental health and safety at work and beyond it.

Key concepts and a review of models

The European Framework for Psychosocial Risk Management identified a number of key concepts through a review of models and psychosocial hazard mitigation across the European Union:

CONCEPT 1

Good psychosocial risk management is good business

Good business is best practice in terms of organisational management, learning and development, social responsibility and the promotion of quality working life and good work.³¹⁹

CONCEPT 2

Evidence-based practice

Managing risk in health and safety involves a systematic, evidence-based approach characterised by the provision of quality information affording the development of practical strategies to solve problems:

- identify the problem
- employ evidence to suggest ways to reduce risk
- evaluate risk management actions
- evaluation informs the whole process, informs reassessment of the original problem and informs organisational knowledge.³²⁰

Dealing with psychosocial hazards is complex, but it does not have to be exhaustive. It is not necessary to have a precisely measured account of all hazards and all health outcomes for all individuals. Not only is this not possible, but attempting this would likely lead to no action. The EU framework instead focuses on providing a reasoned account of the most important work organisation factors associated with ill health.³²¹ It is, however, most important that risk management of a hazard involves adequate analysis in the context of the workplace, and involves an informed assessment of the risk that the hazard presents. Ultimately, the end goal is to ensure that interventions are not simply addressing symptoms rather than causes, and that they don't avoid action on the basis of assumption of causes with a consequential waste of resources.

CONCEPT 3**Ownership**

The management of psychosocial hazards is connected to how work activities are organised and carried out. The key people involved are managers and the workers performing the work – both must own the risk management process. Outsourcing to external human resources companies is not recommended. Managers must be aware of the link between good worker health and good business and the benefits of addressing psychosocial hazards in their business cases.

CONCEPT 4**Contextualisation and tailoring interventions**

A good understanding of workplace context is necessary to effectively design risk management strategies, and ‘tailoring’ the intervention to the workplace is paramount. Tailoring involves knowing what the process will cover (hazards, target and data collection), who to involve in the process (people and agencies), what the process itself involves (risk assessment, goal setting and planning, implementation, monitoring, evaluation, etc) and who will review the process. Tailoring can assist in identifying the best mitigation tools to use in a workplace and the issues that must be addressed before action is decided on. For example, when tailoring, consideration must be given to a number of factors, including the size of the business and the availability of resources, particularly in small and medium-sized enterprises (SMEs), the nature of the workforce (demographics and established workplace and labour market inequalities), the occupational sector and the wider socio-political backdrop.

Tailoring enables policy aims to be matched to the management of psychosocial hazards. The application of this method needs to be carried out by those who are competent to do so, and the competency of the user (whether worker/manager/employer) also needs to be taken into account.

CONCEPT 5**Participative approach and social dialogue**

Involving all parties in the development of hazard mitigation interventions assists the effectiveness of change and reduces barriers to change. Those within the organisation have the expert knowledge of their work environment and inclusion fosters access to this knowledge. Good risk management models include recognition of the importance of worker participation. Evidence suggests that the reduction of psychosocial hazards at the source involves implementing good management practices and/or organisational development activities. Change needs to be owned by both workers and managers alike. Eliminating psychosocial hazards is facilitated by good business practices involving transparent and effective communication.

Meaningful participation of the employees that are targeted by the intervention is very important in work-related stress intervention primarily because it is integral to the prevention and control of work-related stress itself. To participate is an enactment of job control, demonstrates organisational fairness and justice and builds mutual support for all involved. There is a large body of evidence in the public health literature indicating that participation is essential for a range of reasons, including facilitating the tailoring of the intervention to the workplace context and allowing employees to share contextualised expertise. Risk assessment or needs assessment is another means by which to tailor the intervention to the context and likewise relies on a participative approach.

CONCEPT 6

Multi-causality and identification of key factors

Psychosocial hazards are multi-factorial, typically involving factors such as work organisation, work processes, workplace, work-life balance, team and organisational culture, and societal arrangements (occupational health support services and/or social security). Multi-causality requires in-depth analyses to identify key risk factors. There are no short-cuts to effective mitigation, and instead a continuous management process is usually required to monitor the dynamics of psychosocial hazards in the workplace.

CONCEPT 7

Solutions that are fit for purpose

Scientific evidence should inform the psychosocial risk management process. In the absence of a research record it is important to make the issues and barriers to risk management the starting point for development, and from this formulate solutions that are then fit for purpose.

CONCEPT 8

Ethics

Accepting that protecting workers from psychosocial hazards is not simply a legal obligation but also an ethical obligation.

3.1 Addressing different levels of interventions with a focus on the source

In the European Union the focus is on primary risk prevention targeted at the organisation, which is seen as the generator of psychosocial hazards. Actions may also be targeted at the individual level depending on the magnitude or severity of the problem. Prevention can be stratified thus:

Primary prevention

The focus is on the organisation as the source of risk and emphasises the need to identify causes and practices within the organisation that are in need of change. Primary prevention also promotes organisational healthiness through addressing key aspects of organisation culture and development. Interventions of this nature stress the importance of taking a participatory approach, tailoring the intervention to different contexts, and addressing risk systemically.

Secondary prevention

Interventions designed to address psychosocial risks have tended to be focused on individuals. Interventions of this nature have been found to be effective in reducing stress temporarily. These interventions emphasize the improvement of worker perceptions to risk mitigation and the direct management of psychosocial hazards for groups at high risk of exposure. Secondary preventions usually involve education, the provision of more training and knowledge, and the provision of tools to workers for managing risk, for example, relaxation techniques, reporting bullying, handling conflict, interpersonal relationships, and improved communication.

Tertiary prevention

This is when action is taken after an employee or group of employees have been harmed by exposure to psychosocial hazards and addresses the consequences of this exposure, both physical and psychological. For example, those who are suffering from burn out, depression or strain are provided counselling and/or therapy. If the worker has been off work, tertiary prevention would also involve assisting the worker in their return to work through rehabilitation programmes that enable effective reintegration into the workforce.

Psychosocial hazard management links to international policy agendas

The World Health Organization's (WHO) global plan of action on workers' health aims to protect and promote health in the workplace through employing integrated measures to manage psychosocial hazards, the adoption of clear occupational health standards to introduce healthy work practices and the assessment and management of occupational risks.³²² This plan addresses all aspects of workers' health and includes primary prevention of occupational hazards, the protection and promotion of health at work, safer employment conditions and the need for a better response from health systems to worker health. In New Zealand, this would involve collaborations between WorkSafe, Ministry for Business Innovation and Enterprise, Health Promotion Agency and the Ministry of Health, and addressing the gaps in the occupational health workforce so systemic change is possible. The global action plan developed by WHO is underpinned by five objectives:

Objective 1: Devise and implement policy instruments on workers' health.

Objective 2: Protect and promote health at the workplace.

Objective 3: Improve the performance of, and access to, occupational health services.

Objective 4: Provide and communicate evidence for action and practice.

Objective 5: Incorporate workers' health into other policies.

In Europe there have been a number of 'soft policy' initiatives targeting psychosocial hazards in the workplace,³²³ including:

- i. The Lisbon Strategy: EU goal for economic growth and competitiveness
- ii. Community Strategy on Health and Safety at Work, 2007-2012
- iii. Commission White Paper 'Together for Health'
- iv. Framework Agreement on Work-Related Stress
- v. Framework Agreement on Harassment and Violence at Work
- vi. Mental Health Pact.

A review of hard and soft policies (94 in total) revealed a number of differences between binding versus non-binding policies. Non-binding/voluntary policy initiatives made more explicit reference to mental health and psychosocial hazards in the workplace in their stated objectives and scope, covered exposure factors and typically addressed aspects of risk assessment and preventive actions in more detail than binding/regulatory policies.

There has, however, been little if no evaluation of the effectiveness of these policies in supporting existing legislation and binding requirements.

It has also been acknowledged that initiatives aiming to promote workers' health have not had the impact expected and that this is an outcome of the gap that exists between policy and practice.³²⁴

Some of the barriers in the development and implementation of policy level interventions experienced in the European Union include:

- lack of government support for macro initiatives
- conflict between government departments with different responsibilities, leading to un-coordinated activities or diffusion of responsibility
- lack of both awareness and prioritisation of psychosocial hazard management
- absence of clear guidance on how to establish if work-related stress is a problem and then, once identified, how to address it
- differences in opinion between the key stakeholders at the macro level is a key policy challenge

- the need for a clear communication structure between Ministries of Labour and Health
- the need for evaluation of policy initiatives
- implementation is not given enough time alongside poor support of employers and employees
- the fluid nature of work and worker characteristics challenges psychosocial risk management
- lack of enforcing mechanisms
- non-binding agreements
- lack of sanctions relating to voluntary agreements
- inherent power differences at all levels – from macro to enterprise (eg employers happy with tertiary interventions are more resistance to primary interventions)
- little consensus over source, that is, individual vs home life vs workplace.

Main drivers and success factors experienced in the European Union include:

- increased awareness of psychosocial issues in organisations and society
- the undeniable evidence of losses and harm caused by poor management of psychosocial hazards
- campaigns focusing on violence, bullying and harassment, that address the ethical and societal implications
- importance of recognition in the legal context-regulations encourage and increase discussion at the organisational level
- consultation with social partners and social dialogue
- research commitment and contribution a key driver – but dissemination of findings needs to be improved
- involvement of workers in developing interventions and long-term commitment from key stakeholders are central to successful implementation.

The authors of the Psychosocial Risk Management Excellence Framework (PRIMA-EF)³²⁵ made a number of recommendations for future action. Firstly, that the EU legislation be made clearer by either including specific terminology and harmonising it across other key pieces of legislation or by the development of a clear interpretation of the legal provisions in this area by the European Council. The authors also recommended that better coordination at the European Union institutional level was necessary in order to address unnecessary competition and non-cost-effective efforts. Finally, they recommended continuing with soft policy initiatives as they strengthen employer awareness and engagement with preventive actions.³²⁶

The PRIMA-EF project provided a framework for policy and practice at national and enterprise level within the European Union. It has more recently been articulated in the World Health Organization's Healthy Workplaces Framework (2010). The framework in summary identifies seven key features in relation to the design, content and implementation of workplace interventions.³²⁷

1. Workplace interventions need to be developed with a full understanding of theory and evidence-based practice.
2. A systematic and step-wise approach needs to be utilised with development of clear aims, goals, tasks and intervention planning.
3. A proper risk assessment needs to be carried out with the aim of identifying risk factors and groups of workers with potentially high exposure.
4. The interventions need to be tailored to suit a given industrial sector, occupation or workplace size but also remain flexible and adaptable for implementation in a specific workplace.

5. The most effective interventions are those which are accessible and user-friendly in their format, process and acceptable to individuals at all levels of an organisation (from lowest status workers to highest level managers).
6. A systematic approach was highlighted as the most effective with components of the intervention aimed at both the individual and the organisation.
7. Intervention programmes that facilitate competency building and skill development are important, they build leadership and management skills at the organisational level.

Australian policy context and the New Zealand situation

Closer to New Zealand, the Australian legislation is guided by a cluster of work, health and safety (WHS) laws³²⁸ that have been subsequently critiqued for their lack of explicit and well-defined conceptualisations of mental health and psychosocial hazards in the workplace. Safe Work Australia has acknowledged that the concept of mental health is not defined in their health and safety legislation and as such presents challenges for the implementation of compliance activities, identifying breaches and the ability to enforce.

In Australia, each state or territory has jurisdiction over WHS, with each jurisdiction having legally binding regulatory instruments that identify the legal obligations of employers to protect the health and safety of employees at work. Both physical health and psychological well-being are addressed at this top-level policy layer. In addition, there are a range of soft policies that focus on greater specificity around psychosocial hazards and the duties and obligations towards physical health and psychological well-being.³²⁹ Efforts are being made to reform and standardise the WHS regulatory framework across Australia, a process referred to as harmonisation (as it was in Europe) and where the goal is to standardise policies and reduce major differences across jurisdictions so that workers will not be disadvantaged nor privileged due to their state of residence. More recently, in January 2019 Safe Work Australia has produced national guidance material on work-related psychological health and safety which outlines a systematic approach to managing work-related psychological health and safety.³³⁰

The need for harmonisation is not an issue in New Zealand as we are not a federation. Of interest, however, is research undertaken between 2003 and 2007 in Australia that focused on workplace regulation and that sought to understand how inspectors respond to psychosocial hazards. The study showed that the general duty provisions of the legislation focused on bullying, harassment and stress, and that it was likely that other psychosocial hazards would be overlooked.³³¹ In addition, inspectors had issues with the resolution of psychosocial claims due to their complex nature, the need for more resources was also highlighted. Importantly, inspectors struggled to enforce prosecution because the law was inadequate in this area. This inadequacy also impacted inspectors' confidence in enforcing much-needed action in workplaces. In Australia 'a key issue is determining how to apply the general obligations in the laws for health and safety at work to psychosocial risks, in the absence of specific regulations.'³³² This is also arguably the case in New Zealand.

Since 2004 in Australia, there has been a prioritisation of psychological hazard mitigation in the workplace alongside attempts to raise awareness of their adverse consequences. It is now one of the key targets of the national Australian Work Health and Safety Strategy 2012-2022.³³³

A review of policy documents and a gap analysis was conducted in Australia employing the same methodology deployed in the European policy reviews.³³⁴ Thirty-nine documents, three Acts and three Regulations were identified. The researchers found that regulatory policy documents were less detailed than non-regulatory policy documents when considering psychological health, psychosocial hazards and risks. It was suggested that regulatory policy could

be strengthened by incorporating psychosocial risk management principles to improve health and well-being outcomes for Australian workers. The researchers also identified the need to evaluate the effectiveness of these policies in light of their stated objectives.

3.2 Psychosocial risk management

In the European Union, there are minimum standards for psychosocial hazard management that must be met, irrespective of workplace contexts. Pertinently, the European Union framework identifies a range of necessary capabilities for psychosocial risk management, including:

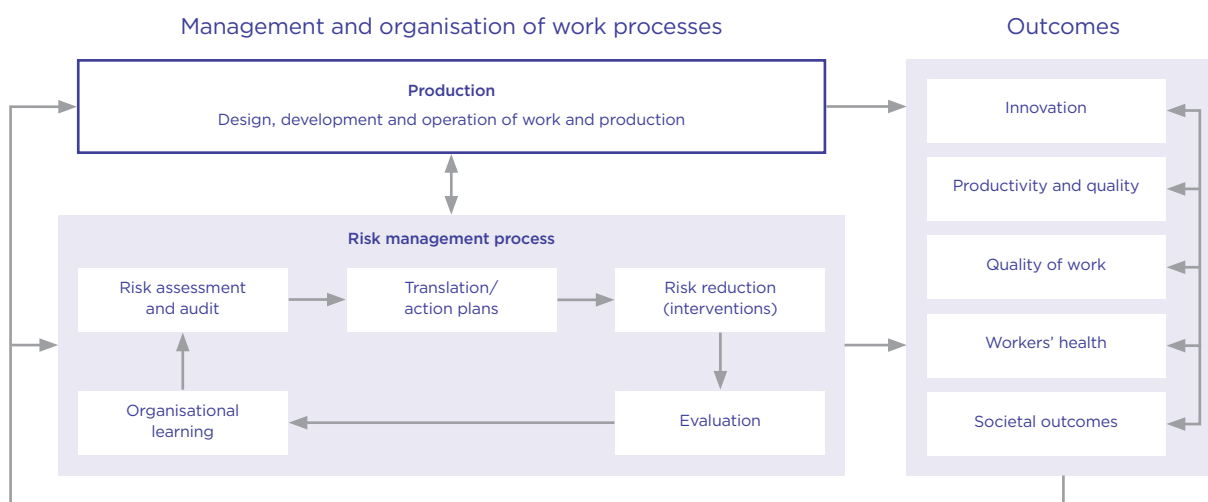
- adequate knowledge of the key agents (management and workers, policy makers)
- relevant and reliable information to support decision-making
- availability of effective and user-friendly methods and tools
- availability of competent supportive structures (experts, services and institutions, research and development).

Where only minor capability exists, successful psychosocial risk management will be limited as there is likely to be limited awareness and assessment of psychosocial risks and inadequate inspection of company practices in relation to psychosocial exposures.

Effective psychosocial risk management is also impacted by the role of cultural aspects such as risk sensitivity and risk tolerance at both the organisational and societal levels. WorkSafe's Health, Safety, Attitudes and Behaviour Survey results suggest that the tolerance of hazards is a prominent issue in some industries (eg construction and agriculture) in New Zealand.

3.3 Psychosocial risk management process and models at the level of the enterprise

There is a vast literature addressing risk management in health and safety. Initially, the risk management approach was developed to address physical hazards. However, many of these interventions are applicable to the psychosocial hazards context (see Figure 8).



Source³³⁵

FIGURE 8: The framework model for the management of psychosocial risks at the enterprise level

There are a range of risk management models, many of which draw on the Deming Cycle consisting of four steps: plan, do, check and act. These steps involve the following:

- i. A declared focus on a defined work population, workplace, set of operations or particular type of equipment.
- ii. An assessment of risks to understand the nature of the problem and their underlying causes.
- iii. The design and implementation of actions designed to remove or reduce those risks (solutions).
- iv. The evaluation of those actions
- v. The active and careful management of the process.³³⁶

Risk management of psychosocial hazards needs to be ongoing and part of the good management of work and the effective management of health and safety. Ideally, it should be conducted annually.

3.4 Psychosocial risk assessment

Risk assessment is defined by the European Commission as ‘a systematic examination of the work undertaken to consider what could cause injury or harm, whether the hazards could be eliminated, and if not what preventive or protective measures are, or should be, in place to control the risks’³³⁷ A comprehensive risk assessment will identify the indicators, consequences and underlying causes of psychosocial hazards.

The risk assessment provides information on:³³⁸

- the nature and severity of the problem
- the identity of the psychosocial hazards, the health implications and who is exposed
- the healthiness of the organisation, using indicators such as absenteeism, worker satisfaction, intention to leave, productivity, high employee turnover (ie harassment complaints, bullying complaints, incidence of violence, burnout should be regarded as a consequence of a poor psychosocial work environment and leadership styles)
- the challenges and positive aspects of the work environment
- identifies potential hazardous situations and assessment of risks to individuals
- effective approaches to risk reduction.

The risk assessment process:

- **Establishes a baseline** (survey, or qualitative methods for smaller enterprises).
- Documents diversity issues and the wider context (ie sector, socioeconomic issues, system issues).
- Utilises worker judgement on the adequacy of the design and management of their work (consensus level) and treats this as valuable evidence.
- Prioritises risk factors in terms of the nature of the hazard or the harm it causes or the size of the group affected.
- **Includes an audit** (review, analysis, critical evaluation) to identify what measures are already in place to deal with psychosocial hazards and their effects on the individual or organisation and what support is provided to employees if they are affected. Here, the risks that have not been managed should become evident.
- **Develops an action plan** to decide on what is being targeted, how and by whom, sets a timeframe, identify resource need, selects the health outcomes and determines how the implementation of this action plan will be evaluated.
- **Plans thoroughly.**

- **Sets priorities** Changing the work environment is the main preventive strategy for managing psychosocial hazards and ensuring there are clear organisational structure and practices, appropriate selection of employees and provision of training and employee development opportunities. Priority should be given to collective and organisational interventions so risks are tackled at source and worker measures can provide support to those who are exposed and at risk - interventions at both levels are important.
- **Results in low-risk implementation of the action plan.** The implementation must be managed and monitored and an evaluation plan needs to be made. The action plan is more likely to succeed if there is genuine participatory engagement between managers and workers.
- Evaluates (both process and outcome) of the risk management process. Evaluation informs the organisation how well something has worked and allows for reassessment and organisational learning, and this should inform the next cycle of the psychosocial risk management process.
- **Promotes psychosocial risk management as good business.**

3.5 Macro level work-related psychosocial risk management

The key principles and philosophy are the same as the risk policy process compared to the risk management process at the company level.³³⁹

Risk and psychosocial hazard monitoring

At the macro level this involves the systematic examination of the work conditions that cause injury or harm, whether workplace hazards can be eliminated and what protective and preventive measures are (or should be) in place to control the risks. What are the psychosocial hazards? Who is exposed to them and who is affected by them? Of note, psychosocial exposure data has been requested by WorkSafe and the results will be available in March 2019.

Policy audits

What policies are already in place to deal with psychosocial hazards, their effects on organisations and the working population? Policy audits (review, analysis and critical evaluation) should focus on existing policy practices and social partners. The development of a policy plan should be guided by risk monitoring data.

Develop a policy plan

This should draw on evidence of macro level problems and translate the risk monitoring data to formulate effective interventions. The plan should detail:

- who will be involved
- what resources are required
- how success will be measured
- how will the Plan be evaluated
- macro contextual factors that should be considered (eg industrial relations, changes in economic prospects (job insecurity, levels of unemployment) and political factors (level of regulation, union representation)).

Set clear aims and target groups

Ensure the participation of social partners and relevant stakeholders. Consider societal level factors which influence psychosocial risk management, for example, national capability, costs and expected economic benefits, feasibility of the measures or interventions (sufficient support from social partners, businesses and the general public) and anticipated future changes in the national economy.

Implement the policy plan

The implementation needs to be systematically monitored and reviewed so corrective action can be taken when necessary. The policy plan is likely to be realised and risk reduction achieved if there is ownership and involvement of partners and key stakeholders.

Evaluation

Both the **process** of implementation and the **outcomes** of the policy plan should be evaluated. Evaluation should be carried out periodically. The evaluation should explicitly identify and communicate what has worked well and what has worked less well.

Learn

Evaluation should be used as a vehicle for continuous improvement and inform the next cycle of the psychosocial risk management policy process.

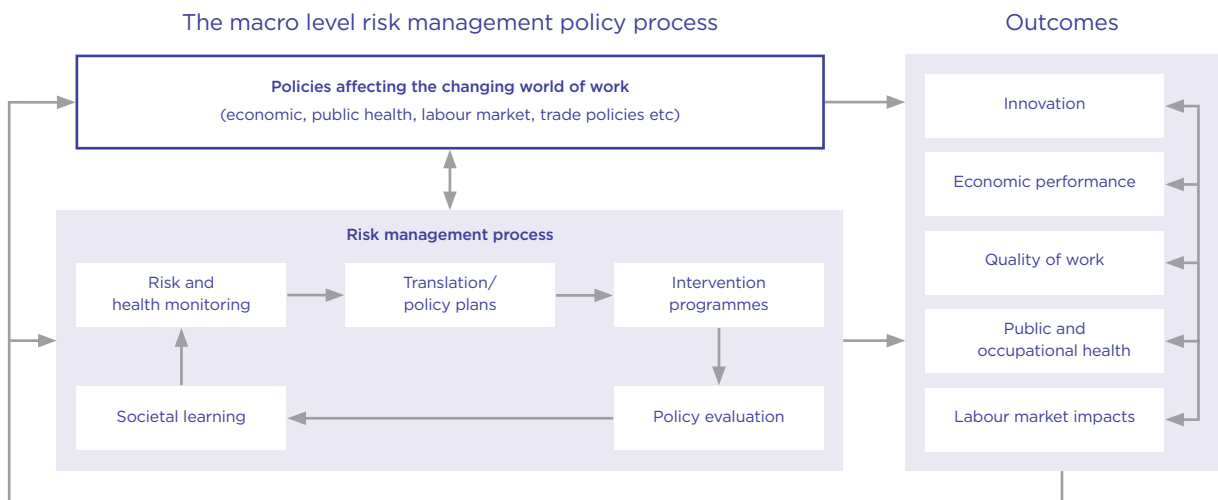


FIGURE 9: Framework model for policies regarding the management of psychosocial risks

3.6 Psychosocial intervention effectiveness

La Montagne et al (2007a) conducted a systematic review of 90 intervention evaluation studies focusing on interventions where organisations set out to address job stress proactively.³⁴⁰ Organisations were classified as high systems if they employed primary, secondary and tertiary preventions, moderate systems if they only applied primary presentation approaches, or low systems where those characterised by the absence of primary prevention.

The review made four main conclusions:

1. Studies of interventions using high systems approaches represent a growing proportion of the work stress intervention evaluation literature, possibly reflecting the increasing application of such approaches in practice internationally.
2. Individually focused, low systems approaches are effective at the individual level, favourably affecting a range of individual level outcomes (coping, time management skill development).
3. Individually focused, low systems approach work stress interventions tend not to have favourable impacts at the organisational level (reducing exposures, sickness absence).
4. Organisationally focused high and moderate systems approaches (addressing working conditions) work stress interventions have favourable impacts at both individual and organisational levels.

Egan et al (2007) conducted a systematic review of organisational level interventions implemented to increase job control and found some evidence of health benefits (eg in anxiety and depression). Specifically, an inverse relationship between employee control and work demands or a proportional relationship between employee control and support were shown to be associated with health benefits. The review also found strong evidence of an association between downsizing or restructuring and poorer employee health.³⁴¹ Another systematic review found that interventions increasing employee control improved health.³⁴² Further reviews established that organisational level changes to improve psychosocial working conditions can have beneficial effects on health.³⁴³ Taken together, these studies suggest that organisational interventions on the psychosocial work environment have the potential to reduce societal level health inequalities for the working population. Pertinently, systems (or comprehensive) approaches to work stress are more effective than other approaches and benefit both individuals (better health) and organisations (reduced absenteeism).

There are a number of longitudinal studies providing evidential support of a causal relationship between work stressors and health, in particular, the health effects of sustained poor or deteriorating working conditions. For example, a Dutch longitudinal study focusing on job strain and mental health over four time points that one were year apart, found that only changing from low to high job strain was associated with an increase in depressive symptoms.³⁴⁴ The Whitehall II study demonstrated that adverse changes in job demands and job control led to higher risks of psychiatric disorders, but improvements in demands and control had no effect.³⁴⁵ Wang et al's (2009)³⁴⁶ Canadian research examined job strain in relation to the risk of major depression and found elevated risks for those in high strain jobs. They also reported higher risks for those moving from low to high strain jobs, even after statistical adjustments for age, education, previous history of depression, perceived health status and childhood trauma.

Across the broad range of occupational literature there is strong evidence supporting the worth of national and international initiatives that address upstream determinants of job stress (eg reduction of psychosocial hazards in the workplace). Specifically, such initiatives not only have a positive impact on worker health, but they also have positive effects on productivity.

3.7 Successful risk intervention

There have been very few evaluations of interventions addressing bullying and work-related violence. A review of administrative and behavioural interventions for workplace violence identified 137 papers, 41 of which focused on interventions, of which only nine reported evaluation results.³⁴⁷ Generally, the review noted that the research designs were weak and the results inconclusive. There were no experimental designs, particularly randomised control trials.

Violence interventions ultimately seek to reduce the number of bullying cases, negative and inappropriate behaviours and violent incidents against employees. The application of surveillance equipment has contributed to a decline in third-party violence and also improved workers' sense of security, job satisfaction and well-being.³⁴⁸ There is evidence that training has also led to positive outcomes.³⁴⁹ Rehabilitation interventions have also had positive results³⁵⁰ for example, one trauma care programme significantly decreased the number of violent incidents and reduced sick leave by 30-50%.³⁵¹ Some success has been had with the therapeutic treatment of people who had been bullied and results from counselling and rehabilitation of workers who have been subjected to violence. Greater awareness and training on bullying also helps increase reporting and the possibility of redress.

Research has identified the importance of raising awareness of psychosocial issues and the role that education plays in successful interventions. There is also a need to address capacity and competency within organisations and within their management. At the macro level policy makers should be included. A range of other issues impacting intervention efficacy have been noted:

- The importance of establishing the business case for addressing psychosocial risk management and linking this to responsible business practices promoting the social well-being and health of employees.
- The importance of adopting a comprehensive approach to the management of psychosocial risk and the importance of robust evaluation of interventions.
- Ensuring the tertiary education sector provides psychosocial risk management courses at post-graduate level.
- There is no quick fix – psychosocial risk management must be continuous.

Examples of best practice: interventions targeting workplace bullying³⁵²

European Union research³⁵³ has identified priorities for action against workplace bullying, as articulated in Table 10.

BULLYING³⁵⁴

- Disseminating more information about bullying to all stakeholders.
- Development of legal regulations (in some countries).
- Anti-bullying policies and codes of conduct including clear and operable procedures to prevent and deal with bullying should be built in organisations.
- Evaluation of the effectiveness of different approaches and strategies used to prevent and tackle bullying at work (like policies, training, psychosocial work environment redesign, mediation).
- Offering practical measures for small companies to deal with bullying.
- Workable methods to stop the escalating process of bullying in the workplace should be developed and implemented.
- Development and evaluation of risk assessment tools for bullying at work.
- Development of methods to intervene in horizontal bullying (co-worker bullying) and in downwards bullying (bullying by supervisor/manager).

TABLE 10:
Priorities for action
against workplace
bullying and violence

A range of challenges and barriers have been identified for workplace bullying and violence interventions,³⁵⁵ as described in Table 11.

OVERALL CHALLENGES AND BARRIERS
<ul style="list-style-type: none"> - Bullying and violence are sensitive issues for organisations and individuals involved. Stronger professional focus is needed in the prevention of bullying and violence - attention should be paid to the competency of trainers and consultants involved in bullying and violence training and other activities.
BULLYING
<ul style="list-style-type: none"> - The level of evidence-based knowledge and know-how on bullying is still low in many organisations and among social partners. - Bullying at work is by nature a subjective and intangible phenomenon that makes it difficult to acknowledge. - When awareness and recognition of bullying is not sufficient in the workplace, resistance may appear to implement interventions that fit the readiness of the organisation and employees. - Bullying is dynamic and an escalating process - different measures are needed in the different stages of the process. - Power and control are often at the centre of bullying. - There may be cultural and structural barriers in organisations (eg hierarchical and authoritarian culture) that decelerate the recognition of bullying as a problem - even religion may increase resistance to recognise the problem. - Everybody in the organisation should be trained, but organisations have limited resources - those who need the training are not always reached.

TABLE 11:
Challenges and barriers for workplace bullying

Table 12 presents actions as a function of prevention state (ie primary, secondary, tertiary) across the occupational hierarchy.³⁵⁶

LEVEL OF WORK ORGANISATION INTERVENTIONS	STAGE OF PREVENTION
Organisation/employer	<p>Primary Anti-bullying policies, codes of conduct, development of organisational culture, management training, organisational survey</p> <p>Secondary Handling procedures</p> <p>Tertiary Corporate agreements and programmes of after-care</p>
Job/task	<p>Primary Psychosocial work environment redesign, risk analysis</p> <p>Secondary Staff survey, case analysis, training (eg conflict management, conflict resolution), mediation</p> <p>Tertiary Group recovery programmes</p>
Individual/job interface	<p>Primary Training (eg assertiveness training)</p> <p>Secondary Social support, counselling</p> <p>Tertiary Therapy, counselling</p>

TABLE 12:
Actions as a function of prevention state (ie primary, secondary, tertiary) across the occupational hierarchy

Success factors³⁵⁷ for workplace violence and bullying interventions are identified in Table 13.

OVERALL SUCCESS FACTORS

- Intervention should be based on scientific knowledge and theory about the causes and escalating nature of bullying and violence situations.
- Tailoring of interventions which need to respond to the problems and needs of the respective organisations and should be integrated into the everyday work culture of the organisation.
- Use of multiple approaches and measures.
- Proper diagnosis of the situation and/or risk assessment.
- Top Management commitment.
- Ownership and participation and involvement of employees.
- Training of managers and supervisors.
- Sufficient and continuous communication.
- Sufficient time to ensure experiential learning.
- Occupational health and safety personnel and trade unions are good partners in cooperation.

TABLE 13:
Success factors for workplace bullying interventions

Examples of best practice: interventions targeting third-party violence³⁵⁸

As for workplace bullying, the European Union research has identified priorities for action,³⁵⁹ as displayed in Table 14.

THIRD PARTY VIOLENCE

- A need for attitude change as concerns staff as well as third parties. Any kind of physical or psychological violence should be unacceptable. All workplaces with high risk for violence by third parties should have codes of conduct, guidelines and crisis plans for the prevention and management of violence.
- The prevention of the fear of violence should be addressed.
- Practical means to address violence problems caused by alcohol and drugs.
- Conflict management and violence handling education should be offered in schools, in higher education and in induction training offered to new employees in occupations where the risk of violence is high.

TABLE 14:
Priorities for action against third party violence

Like the bullying example, a range of challenges and barriers have also been identified for workplace violence interventions, as listed in Table 15.

THIRD PARTY VIOLENCE

- Under-reporting of violent incidents.
- Attitude change - recognition that psychological violence and threatening is also violence should be promoted.
- Stigmatisation and blaming the victim.
- Training of customers and clients not to behave violently.
- Violence has become more serious than before, and employees need advice and means to act.
- There is a risk in some occupations that violence spills over in employees' private lives.
- Violence is nowadays more often met in sectors/occupations that were not problematic before (eg schools).

TABLE 15:
Challenges and barriers for workplace violence intervention

Intervention actions in relation to workplace third party violence are itemised in Table 16 according to prevention and organisation levels.³⁶⁰

LEVEL OF WORK ORGANISATION INTERVENTIONS	STAGE OF PREVENTION		
	Primary	Secondary	Tertiary
Organisation/employer	<ul style="list-style-type: none"> - Registration of violent incidents - Corporative agreements, action, models, guidelines - Crisis plans - Training 	<ul style="list-style-type: none"> - Security systems/arrangements 	<ul style="list-style-type: none"> - Corporate agreements and programmes of after-care
Job/task	<ul style="list-style-type: none"> - Designing out of risk (eg KAURIS-method, trauma risk assessment) 	<ul style="list-style-type: none"> - Management and employee training (eg conflict resolution, dealing and handling of violent incidents) 	<ul style="list-style-type: none"> - Counselling
Individual/job interface	<ul style="list-style-type: none"> - Pre-employment testing - Training 	<ul style="list-style-type: none"> - Training, coaching (interaction and physical interventions, copying with aggression) 	<ul style="list-style-type: none"> - Individual and group therapy - Councelling

TABLE 16: Different levels of third-party violence interventions

The success of intervention programmes targeting third party violence in the workplace mirror those for workplace bullying (re: Table 13 above), and include the points given in Table 17.³⁶¹

THIRD- PARTY VIOLENCE
<ul style="list-style-type: none"> - Attitude – all forms of violence, both physical and psychological, are unacceptable. - Different kinds of methods are needed in different sectors/occupations (eg police, care of people with dementia). - Adoption of an integrated organisational approach to violence. - Systematic registration and analysis of violent incidents. - Risk assessment should include work environment design, security devices, staffing plans, work practices, guidelines and training.

TABLE 17: Success factors for third party violence interventions

Examples of best practice: work-related stress interventions³⁶²

A range of success factors for work-related stress interventions have been identified as displayed in Table 18.³⁶³

INTERVENTION CONTENT
<ul style="list-style-type: none"> - Developing understandable and user-friendly tools for management/organisations. - Developing a comprehensive stress management programme. - Knowing when to intervene for rehabilitation and return to work. - Developing a focused and tailored intervention that addresses a wide spectrum of problems and health, distress and illness.
INTERVENTION DESIGN
<ul style="list-style-type: none"> - Attaining a strong research design for evaluation with control group. - Ensuring the reliability/validity of (particularly organisationally tailored) evaluation tools. - Assessing the cost benefit of interventions.

- Effectively evaluating organisational-level interventions given the continuous, adapting and evolving nature of the organisations.
- Effectively assessing the sustainability of intervention effects due to attaining adequate follow-up period, attrition rates/drop-out rates, maintaining organisational support and access and the ever changing organisational context.
- Effectively evaluating intervention process issues and underpinning mechanisms that may affect their impact.

INTERVENTION CONTEXT

- Organisational readiness for and resistance to change.
- Generating achievable solutions, spurring action and systematic implementation of intervention within the organisation.
- Retaining and recruiting management and organisational support throughout the intervention process.
- Retaining and recruiting participation and engagement of workers throughout the process.
- Availability of properly trained individuals to implement the intervention.
- Developing skills, abilities and sufficient dialogue within management and the organisation to promote sustainability and the continuous improvement cycle.
- Developing and maintaining trust and dialogue between the various stakeholders throughout the intervention process.

TABLE 18:
Recommendations
for work-related
stress interventions

Social dialogue (soft law)

According to the International Labour Organization, social dialogue is one of the four strategic objectives of decent work (ILO, 1999). The PRIMA-EF developed an indicator framework for social dialogue in the area of psychosocial risk management, as shown in Table 19.³⁶⁴

CONTENT DIMENSIONS OF INDICATORS

Context (general context factors that influence the social dialogue process)

- Economic context (eg unemployment rates, labour productivity etc).
- Freedom of association, union participation in public policy, political climate.
- Availability and provision of resources.
- Regulatory framework, OSH infrastructure (eg enforcing capability of labour inspectorates).

Actors (this dimension refers to adequate structures for social dialogue)

- Traditional indicators like union density or company employee participation etc.
- Unity within social partners and commitment to work together.
- Power relations between social partners.
- Availability of adequate assistance for conflict settlement (eg mediation mechanisms) between social partners, activities to build mutual trust and respect.

Processes (in order to tackle the dynamic quality of the process and to track progress)

- Information/dissemination activities/development of problem awareness.
- Negotiations.
- Implementation.
- Monitoring processes.
- Impact assessment.

Outcomes

- Collective agreements on different levels.
- Existence of policies on workplace level.
- Consideration of psychosocial issues in risk assessment.
- Public awareness of psychosocial issues.

CONTENT DIMENSIONS OF INDICATORS**LEVELS OF CONSIDERATION**

- Company level.
- Branch/regional level.
- National/political level.

SPECIFIC ISSUES TO BE CONSIDERED FOR PSYCHOSOCIAL RISK MANAGEMENT

- Different areas of psychosocial risks: work-related stress/violence and harassment.
- National, cultural and social differences in problem perception and problem awareness of relevant issues.
- Gender issues.
- Different enterprise sizes.

TABLE 19:
Social dialogue
indicator framework
for psychosocial risk
management

This framework would inform the development of concrete indicators and involve researchers and stakeholders addressing issues of data collection and how existing data sets might be ethically used.

Mental health interventions

It should not be assumed that mental health interventions will be effective in changing occupational outcomes.³⁶⁵ A recent systematic review concludes that there are empirically supported interventions that workplaces can use to prevent common mental illnesses and to help employees recover from depression and anxiety. The findings are summarised in Table 20.

INTERVENTIONS	SYMPTOM REDUCTION	OCCUPATIONAL OUTCOMES	MAIN CONCLUSIONS AND COMMENTS
Increased employee control	★★	?	Some interventions, such as problem-solving committees, stress reduction committees, self-scheduling of shifts and gradual/partial retirement appear to increase employee control and reduce mental health symptoms.
Physical activity	★★	★	May have an effect on employee mental health but type, amount and intensity of activity required is unclear. Mixed findings regarding effect on organizational outcomes.
Workplace health promotion	★	★	Mixed findings. May have an effect on absenteeism, but unclear which components most effective.
Screening	★	★	Limited evidence from a small number of Randomised Control Trials for the effectiveness of screening in certain work situations, but only when appropriate detailed post-screening procedures are in place.
Counselling	★	★	Strong evidence of customer satisfaction, but objective evidence of benefits remains unclear. Significant methodological limitations in research.
Cognitive behavioural therapy (CBT)-based stress management interventions (SMI)	★★★	?	CBT-based stress management interventions produce individual benefits in terms of reduced stress and symptoms, but this does not appear to translate to notable improvements in organisational level outcomes such as absenteeism.
Psychological debriefing following potentially traumatic event in the workplace	Strong evidence against	?	Psychological debriefing following a traumatic event unlikely to be of benefit and should not be offered routinely in the workplace.

INTERVENTIONS	SYMPTOM REDUCTION	OCCUPATIONAL OUTCOMES	MAIN CONCLUSIONS AND COMMENTS
CBT for established depression or anxiety disorder	★★★	★★	Strong evidence that CBT can reduce depression/anxiety symptoms but the impact on organisational outcomes less certain. Return to work programmes that incorporate CBT and problem-focused strategies have a positive effect on organisational and individual outcomes.
Exposure therapy for established anxiety disorders and post-traumatic stress disorder (PTSD)	★★★	★★	Exposure therapy can improve symptoms for individuals who have developed PTSD following occupation-related injury. Exposure therapy is also associated with reduced sickness absence and improved productivity in a range of anxiety disorder
Medication	★★★	?	Strong evidence that medication can reduce symptoms of established depression and anxiety disorders. Inconclusive results of the effect of antidepressants on organizational outcomes for depressed workers.

TABLE 20: Levels of evidence for mental health interventions in the workplace

3.8 The way forward

International experience in addressing psychosocial hazards in the workplace offers an opportunity to be aware of the potential barriers and facilitators. As noted previously, in the EU there were a number of drivers and success factors and barriers to the development and implementation of policy level interventions. They are worth repeating here.

Main drivers and success factors experienced in the European Union include:

- increased awareness of psychosocial issues in organisations and society
- the undeniable evidence of losses and harm caused by poor management of psychosocial hazards
- campaigns focusing on violence, bullying and harassment that address the ethical and societal implications
- importance of recognition in the legal context - regulations encourage and increase discussion at the organisational level
- consultation with social partners and social dialogue
- research commitment and contribution a key driver - but dissemination of findings needs to be improved
- involvement of workers in developing interventions and long-term commitment from key stakeholders are central to successful implementation.

Barriers include:

- lack of both awareness and prioritisation of psychosocial hazard management
- absence of clear guidance on how to establish if work-related stress is a problem and then, once identified, how to address it
- differences in opinion between the key stakeholders at the macro level is a key policy challenge
- the need for a clear communication structure between Ministries of Labour and Health
- need for evaluation of policy initiatives
- implementation is not given enough time alongside poor support of employers and employees
- the fluid nature of work and worker characteristics challenges psychosocial risk management

- lack of enforcing mechanisms
- non-binding agreements
- lack of sanctions relating to voluntary agreements
- inherent power differences at all levels – from macro to enterprise (eg employers happy with tertiary interventions are more resistance to primary interventions)
- little consensus over source, that is, individual vs. home life vs. workplace.

The World Health Organization's global plan of action on workers' health aims to promote health in the workplace through employing integrated measures to manage psychosocial hazards. This plan addresses all aspects of workers' health and includes primary prevention of occupational hazards, the protection and promotion of health at work, safer employment conditions and the need for a better response from health and regulatory systems to worker health. In New Zealand, putting such a plan into action would involve collaborations between WorkSafe, MBIE, HPA and the MOH and addressing the gaps in the occupational health workforce so systemic change is possible.

Effective psychosocial risk management is dependent on the key agents having adequate knowledge, relevant and reliable evidence and effective and user-friendly methods and tools, and the availability of competent experts, services and institutions, and research and development.

Appendices

IN THIS SECTION:

Appendix 1: References and notes

Appendix 2: Questionnaire

Appendix A: Glossary

TERM	DEFINITION
Absenteeism	Absence from work.
Anxiety	A nervous disorder marked by excessive uneasiness and apprehension, typically with compulsive behaviour or panic attacks.
Bullying at work	Repeated actions and practices that are directed against one or more workers, that are unwanted by the victim, that may be carried out deliberately or unconsciously, but clearly cause humiliation, offence and distress and that may interfere with job performance and/or cause an unpleasant working environment. The concept of bullying relates to persistent exposure to negative and aggressive behaviours of a primarily psychological nature and describes situations where hostile behaviours are directed systematically at one or more colleagues or subordinates and lead to stigmatisation and victimisation of the recipient(s).
Depression	Mental health condition characterised by pervasive low mood.
Engagement	Fulfilment from work, characterised by vigour, dedication and absorption.
Hazard	A physical or psychosocial condition, object or agent that has the potential to cause harm to a worker and/or to cause damage to property or the environment.
Musculoskeletal disorders	Disorders of the muscles, joints, tendons, ligaments, bones and nerves.
Organisational climate	Properties of the work environment as perceived by employees.
Occupational health risk assessment	The identification of occupational health hazards (through surveillance) and workers exposed to specific hazards followed by an analysis of how the hazard may affect the worker, followed by determination of intensity (level) and magnitude (volume) of risk, followed by the identification of individuals or groups with special vulnerabilities, followed by an evaluation of available hazard prevention and control.
Quality of life	General well-being of individuals and society.
Precarious employment	Employment terms that may reduce social security and stability for workers, defined by temporality, powerlessness, lack of benefits, lack of protection and low income. Flexible, contingent, non-standard temporary work contracts do not necessarily but often provide an inferior economic status.
Presenteeism	Being present at work but with reduced output.
Productivity	The effectiveness of converting effort into output.
Psychosocial work environment	The content of work and work demands, the social relationships at work, the organisation of work and the work culture, which each can affect the mental and physical well-being of workers including management.
Psychosocial hazard	Refers to the aspects of the design and management of work and its social and organisational contexts that may have the potential for causing psychological or physical harm.
Psychosocial safety climate	Type of organisational climate, characterised by prioritising employee psychological health.
Psychological distress	Negative emotional state including anxiety, sadness and depression.
Stress	A state of mental or emotional strain or tension resulting from adverse or demanding circumstances.
Stressor at work	A condition or circumstance in a workplace that elicits a stress response from workers.
Surveillance	The ongoing and systematic collection, analysis and interpretation of data and the appropriate dissemination of such data.
Work-family interference or conflict	A type of role interference that occurs when work demands and responsibilities make it more difficult to fulfil family role responsibilities.

Appendix B: References and notes

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- ¹⁸ Two neuronendocrine systems are at play here: (i) the sympathetic adrenomedullary (SAM) system with the secretion of the two catecholamines, epinephrine and norepinephrine, and (ii) the hypothalamic pituitary adrenocortical (HPA) system with the secretion of cortisol. In response to sympathetic stimulation, epinephrine and norepinephrine are rapidly secreted into the blood stream with pronounced effects on the cardiovascular system and the release of energy (glucose, free fatty acids). Cortisol secretion is regulated by the adrenocorticotropic hormone (ACTH) from the pituitary gland and reaches a peak in blood about 30 minutes after the acute stress exposure. Cortisol influences the metabolism of cells, the fat distribution and the immune system, and cortisol levels are controlled by a feedback system in the hypothalamus and the hippocampal formation. They can be measured in saliva, blood, urine and are used as objective indicators of stress in the individual. See 20, pp. 1–2.
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