Psychosocial risks in Europe

Prevalence and strategies for prevention

A joint report from the European Foundation for the Improvement of Living and Working Conditions and the European Agency for Safety and Health at Work

European Agency for Safety and Health at Work

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Project managers: Julia Flintrop, Oscar Vargas

Project team: Juliet Hassard, Xabier Irastorza, Malgorzata Milczarek, Jean-Michel Miller, Agnès Parent-Thirion, Gijs van Houten and Maarit Vartia-Väänänen

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Executive summary

Introduction

This executive summary is based on a joint report on psychosocial risks at work from the European Agency for Safety and Health at Work (EU-OSHA) and the European Foundation for the Improvement of Living and Working Conditions (Eurofound). It draws on the complementary work of the two agencies, which is reflected in their different roles. Acknowledging the complexity of the relationship between health and work, the report presents comparative information on the prevalence of psychosocial risks among workers and examines the associations between these risks and health and well-being. It also looks at the extent to which establishments take action to tackle psychosocial risks and describes interventions that can be adopted in companies. An overview of policies in six Member States is included.

Policy context

Raising the quality of working conditions is a goal of the EU; Article 151 of the Treaty on the Functioning of the European Union states that Member States should work towards the promotion of employment and the improvement of working conditions. Ensuring the health and well-being of workers throughout their working lives is a prerequisite to achieving the Europe 2020 objective to increase employment across the EU. The 1989 Framework Directive on measures to improve safety and health at work obliges employers to implement preventive measures to guard against occupational accidents and diseases; accordingly, psychosocial risks must be addressed in organisations' health and safety strategies. In addition, the European social partners have recognised the importance of psychosocial risks by signing the Framework Agreements on Work-related Stress (2004) and on Harassment and Violence at Work (2007). These agreements represent a commitment to the development and application of their content at national level.

Key findings

In Europe 25% of workers say they experience work-related stress for all or most of their working time, and a similar proportion reports that work affects their health negatively. Psychosocial risks contribute to these adverse effects of work.

The most common risks relate to the type of tasks workers perform – for example, whether tasks are monotonous or complex – and to work intensity. High work intensity is associated with negative health and well-being outcomes, especially work-related stress. Violence and harassment are less frequently reported, but have a strong negative relationship with well-being. Other working conditions, such as a good work–life balance and social support, have a positive influence.

The incidence of some psychosocial risk factors has fallen since 2005. Fewer people report working long hours and a lack of social support. However, job insecurity has grown, and one-fifth of workers still work long hours or have irregular schedules. Recently, increases in work pressure and violence and harassment have been reported in some countries; this is associated with workplace changes brought on by the economic crisis.

In general, differences in working conditions between groups of workers are sector-related. However, there are gender differences not necessarily related to sector – for example, men working longer hours or women facing more difficulties in their career development.

Psychosocial risks are of concern to a majority of companies: nearly 80% of managers express a concern about work-related stress, and nearly one in five considers violence and harassment to be of major concern. Looking at single risks, managers' greatest concerns relate to time pressure and difficult customers, patients and pupils. Despite these concerns, fewer than one-third of establishments have procedures in place to deal with such risks.

Evidence suggests that tackling hazards to psychosocial well-being is not a single event, but a process with different stages that require changes in the work environment. Interventions taken at company level are best implemented through a structured process, and this is most successful if accompanied by active worker involvement.

Information provided to companies to help them tackle psychosocial risks is most likely to be effective if it delivers an approach that can be targeted at the company's state of readiness for change, and at the specific risks in the company and sector. There is no single solution with regard to psychosocial risks, but many effective approaches have been implemented in companies all over Europe.

At policy level, legislation and social partner initiatives have contributed to the implementation of psychosocial risk prevention. Social dialogue is a driver for improving working conditions. Examples in the report highlight policies to deal with psychosocial risk at Member State level, either through legislation or inspection, by providing practical tools, or through the involvement of social partners. However, policies are not developed to the same extent in all European countries, which can be explained by the different traditions of social dialogue and different governmental approaches, often related to the importance countries give to psychosocial risks.

Policy pointers

- Policymakers and stakeholders responsible for improving working conditions and risk prevention have to consider the specific psychosocial risks for different groups of workers.

- In line with the Europe 2020 objective to increase employment rates, attention should be paid to tackling the risks to which workers are most commonly exposed, such as the specific problems related to task type or high work intensity, and those with a strong impact on work sustainability, such as violence or harassment.
- The increasing recognition of the importance of the psychosocial work environment and the need to tackle psychosocial risks has to be translated into actual implementation of preventive policies, especially in countries where few companies have procedures to deal with psychosocial risks. Practical guidance can play an important role in complementing legal requirements, especially for smaller companies.
- Social dialogue at different levels, from the EU to the workplace, helps raise awareness of psychosocial risks and helps in the development of policies and actions at establishment level. Further developments in this regard should continue, especially in countries where policies are still less developed.
- Measures to prevent psychosocial risks are best implemented on the basis of the traditional risk management framework. Companies are more successful in preventing psychosocial risks if well-functioning occupational safety and health management is already in place.
- Policymakers should reflect on how to increase women's participation in the labour market, while maintaining and improving working conditions in general. Addressing issues related to working time and career development can contribute in this area.
- Job insecurity is related to some negative health outcomes. Development of holistic policies on employment, career development, socioeconomic support and restructuring can help to address the causes and consequences of job insecurity.

Introduction

Workplaces are characterised by a particular social organisation that includes interpersonal relations, hierarchies and different management approaches. Psychosocial factors – such as the way work is organised, the working time arrangements, the social relationships, the content of the job and the workload – place certain mental and social demands on each worker. Consequently, psychological and social aspects of work are important factors in every workplace, and the recognition that these factors have an impact on the health and well-being of workers has grown in recent years.

Changes in the nature of work in recent decades have contributed to this development. The decrease in industrial employment and increase in the size of the service sector has led to a change in the work environment, with a shift from physical demands associated with manufacturing to psychosocial risks more typical of the service sector (Benach and Muntaner, 2007). Developments such as the economic crisis, cases of restructuring and the advance of information and communications technology (ICT) have affected the incidence of psychosocial risks (Eurofound, 2013a; EU-OSHA, 2007).

This report confirms that work can have positive consequences for individuals' health and well-being if working conditions that promote job quality are present, such as social support, meaningful work, work–life balance and the ability to influence how the work is organised (see also EU-OSHA, 2011, 2013; Eurofound, 2012b, c, 2013b). Work can provide individuals with purpose, financial resources and a source of identity, as well as personal growth, social integration and career development – all of which have been shown to improve mental well-being. In short, the workplace can be characterised as an important social context that can contribute to maintaining and improving health and well-being among workers.

On the other hand, research carried out over the past few decades has found that a poor psychosocial work environment may lead to work-related stress and to negative health and well-being outcomes, as well as dissatisfaction with the job and absenteeism (EU-OSHA, 2009; Eurofound 2010, 2012b, 2013b). The phrase 'psychosocial risks at work' refers to the likelihood that certain aspects of work design and the organisation and management of work, and their social contexts, may lead to negative physical, psychological and social outcomes. Typical psychosocial risks are adverse social behaviour, such as violence or harassment, and excessive work intensity. Variation among workers is also relevant. Reactions to the same circumstances vary between individuals; some people can cope better with certain demands than others. Furthermore, depending on personal factors, the same person might even cope differently with similar circumstances on different occasions.

In this context, the European social partners' Framework Agreement on Work-related Stress (2004) defines work-related stress as 'a state, which is accompanied by physical, psychological or social complaints or dysfunctions and which results from individuals feeling unable to bridge a gap with the requirements or expectations placed on them'. It adds that 'stress is not a disease but prolonged exposure to it may reduce effectiveness at work and may cause ill-health'. Therefore, stress is an experience workers can have due to exposure to certain working conditions, which can lead to health problems and reduce effectiveness at work.

This report aims to present up-to-date information on the nature and incidence of psychosocial risks in the workplace and on the approaches taken by companies to deal with such risks. It also provides examples of initiatives by social partners and governments at national level to tackle the issue in the context of EU-level actions. Finally, it describes a framework for preventing and tackling psychosocial risks at organisational level.

The report is addressed mainly to policymakers and social partners at European and national level, giving them a general overview on psychosocial risks and related working conditions. It also provides examples of actions taken at different levels – by governments, through social dialogue and within companies. Occupational health and safety and working conditions experts, worker representatives and employers could also benefit from the information provided. The report aims to contribute to the development of further initiatives in European countries and at European level.

Policy context

Since its inception, the European project has paid considerable attention to work, and improving working conditions is a central goal of the EU. Article 151 of the Treaty on the Functioning of the European Union (TFEU) states that Member States should work towards the promotion of employment and the improvement of working conditions 'so as to make possible their harmonisation while the improvement is being maintained'. Framework Directive 89/391/EEC on measures to improve safety and health at work encourages improvements in occupational health and safety in all sectors of activity; this provision should be understood to apply to psychosocial risks as much as physical risks.

Good working conditions and prevention of psychosocial risk contribute to a healthy workforce, which in turn will help to support the financial sustainability of the European social model and strengthen social cohesion. In the context of demographic change, the Europe 2020 strategy sets the objective of increasing the participation of workers in the labour market. Good health and well-being is a pre-condition to make work sustainable throughout a person's working life and contributes to healthier, longer and more productive working lives. In response, some governments and social partners at European, national and sectoral level have recently developed initiatives or agreements to address the improvement of working conditions and the prevention of psychosocial risks, and to tackle the consequences of such risks.

The European Commission works with the European Agency for Health and Safety at Work (EU-OSHA)[1] and the European Foundation for the Improvement of Living and Working Conditions (Eurofound)[2] to disseminate information on, offer guidance on and promote healthy working environments.

Development of the joint report

This report is a joint initiative of Eurofound and EU-OSHA and is developed in the framework of their Memorandum of Understanding (2010). It draws on the complementary work of the two agencies that is reflected in their different roles.

As part of its role to provide knowledge in the area of social and work-related policies, Eurofound develops research on working conditions through the European Working Conditions Survey (EWCS), the European Observatory of Working Life (EurWORK) and strategic studies that aim to monitor and provide information on working conditions, including psychosocial risks and their relevance to health and well-being. Eurofound identifies groups at risk and issues of concern, providing homogeneous indicators and up-to-date information to contribute to European policy development.

Within its focus on collection and dissemination of information on health and safety at work, EU-OSHA monitors how occupational safety and health (OSH) risks are dealt with in European companies through the European Survey of Enterprises on New and Emerging Risks (ESENER). This includes a special focus on psychosocial risks and detailed analyses of certain aspects of managing safety and health in companies. EU-OSHA also collects and publishes practical information through several projects, showing how best to deal with certain risks at national level as well as in companies. This report supports the second pan-European awareness-raising campaign on psychosocial risks at work (2014–2015), coordinated by EU-OSHA and, at national level, by EU-OSHA focal points.

Both agencies deal with psychosocial risks, but from different perspectives. The joint initiative of the two agencies shows the complementarity of the various studies and the added value of this exercise for monitoring and disseminating findings, examples and guidelines among European and national stakeholders.

There are some limitations to this study. First, the two agencies have studied the issue from different perspectives, and it was not always possible to link the information and elaborate further upon it. One hurdle is the different methodologies and unit samples used in the EWCS and ESENER, which do not allow the comparison of data based on certain variables. Second, each chapter is based on specific sources or methodologies with their own strengths and weaknesses, which are explained in the introductory part of each chapter. Despite these limitations, complementarities and links between workers' and companies' experiences have been developed upon, as have policies relating to actions by the social partners and labour inspectorates and effective interventions at establishment level.

Content of the report

Chapter 1 of this report presents information, based on the analysis of Eurofound's EWCS, on the prevalence of working conditions considered to pose psychosocial risks to European workers across countries, sectors and occupations. Where relevant, this information is broken down by gender or age. In addition, relationships between these working conditions and health and well-being outcomes are explored. Findings from other Eurofound research on the topics addressed have been included, where appropriate, to complement and interpret EWCS results.

The perspective of the workforce is complemented in Chapter 2 by data from EU-OSHA's ESENER, which is obtained through interviews with managers from companies and public entities all over Europe. The survey aims to describe how OSH in general and psychosocial risks in particular are dealt with in practice in European workplaces. A special emphasis is put on drivers behind and barriers to dealing with psychosocial risks and on how worker participation is influencing the risk management process.

Chapter 3, written jointly by both agencies, introduces the EU-level policy context and gives different examples of how psychosocial risks have been addressed by governments, labour inspectorates and social partners. In particular, the role of social dialogue is highlighted. The chapter aims to give an insight into policy initiatives rather than providing a comprehensive overview of the situation across Europe.

Chapter 4 is based on EU-OSHA input on practical interventions for the prevention of psychosocial risks, providing an overview of different interventions and how they can be implemented in establishments. The intention of this chapter is to give an idea of what can actually be done at company level and to explain briefly what types of measures and procedures prove to be successful.

[1] The European Agency for Safety and Health at Work (EU-OSHA) is a tripartite European Union Agency whose role is to collect and analyse technical, economic and scientific data in Europe with regard to safety and health at work, to raise awareness about these issues and to assist the Commission to carry out tasks in this area. EU-OSHA's mission is to make Europe a safer, healthier and more productive place to work and to promote a culture of risk prevention to improve working conditions in Europe. EU-OSHA was established in 1996 by Council Regulation (EC) No 2062/94 of 18 July 1994 and is based in Bilbao, Spain.

[2] The European Foundation for the Improvement of Living and Working Conditions (Eurofound) is a tripartite European Union Agency, whose role is to provide knowledge in the area of social and work-related policies. Eurofound was established in 1975 by Council Regulation (EEC) No. 1365/75, to contribute to the planning and design of better living and working conditions in Europe. Eurofound is based in Dublin.

1 Working conditions and psychosocial risks in Europe

Introduction

Working conditions are the product of the interaction between a job, the work, the company and the individual (Gollac, 2004). This is the context in which psychosocial risk factors are at work. According to EU-OSHA, 'Psychosocial risks … which are linked to the way work is designed, organised and managed, as well as to the economic and social context of work, result in an increased level of stress and can lead to serious deterioration of mental and physical health' (2007, p. 1).

Three influential theoretical concepts establish a relationship between psychosocial risks and health.

- Karasek's job demand and control theory: Karasek and Theorell (1990) hypothesised that jobs with high levels of demand (for example, a heavy workload) coupled with low levels of control or decision-making latitude were associated with increased exposure to stress and negative health effects.
- The effort–reward imbalance model by Siegrist: The premise of this model is that psychological stress results from a mismatch between efforts made by workers and the rewards they receive from their employer in terms of pay, esteem, job security and career opportunities (Siegrist, 1996).
- The organisational justice concept: This is a more recently developed theory of the psychosocial work environment. It focuses on issues of fairness, justice and equity in the workplace, which may have significant influences on the path between work-related stress and ill-health (Elovainio et al, 2002).

This chapter is based on the analysis of data from the European Working Conditions Survey (EWCS). Key working conditions related to psychosocial risks have been selected, drawing from the relevant theories in the area and institutional studies on psychosocial risks, including the work of the World Health Organization (WHO), EU-OSHA and Eurofound, for example. The prevalence of these working conditions among European workers is shown and, when relevant, differences across countries, sectors, company sizes, gender and age are highlighted.

The psychosocial workplace factors examined have been classified as follows:

- job content, including type of tasks, contact with people through work (such as clients), changes in processes, restructuring and use of skills;
- work intensity and job autonomy, including aspects of workload, work pace and control;
- working time arrangements and work–life balance;
- social environment, including interpersonal relationships at work and social support;
- job insecurity and career development.

The chapter begins with a discussion of the characteristics of the European workforce in terms of employment, followed by a descriptive analysis of the prevalence of various psychosocial risks. It then presents the results of a multivariate analysis, which was carried out to assess the link between certain psychosocial working conditions and outcomes related to health and well-being.

Measuring working conditions and psychosocial risks

Measuring work and the conditions in which it takes places, including psychosocial risks, was one of the objectives of the first EWCS, which was carried out over 20 years ago. Another objective was to identify which work situations were associated with particular difficulties for workers and which groups of workers experienced them most so that action could be taken to address these issues. The aim was to do this in a comparable way across Europe so that the findings could be used to provide input into European policymaking.

The main challenge in measuring and assessing work and working conditions across Europe is to address the complexity of the situation (with different definitions, standards and expectations) in a meaningful and relevant way. For example, when analysing a psychosocial risk such as harassment, it is very likely that the social and cultural context at work and in the country play a role in whether workers report they have experienced this phenomenon. In the same way, work-related stress, another key concept in the field of psychosocial risks, can be reported with different intensity in different social contexts, under similar working conditions. However, an effort is made in this report to take these factors into account, and the multivariate analysis in the latter part of the chapter enables such influences to be controlled to some extent.

The European Working Conditions Survey

The EWCS started as a survey of 12 Member States in 1991 and now covers 34 countries. From a small and ad hoc survey looking at risks, work organisation and working time, the EWCS has expanded over its five waves. It now covers, among other things, physical and psychosocial risks, leadership, change in the workplace, work–life balance, flexibility and flexicurity. Nevertheless, it remains faithful to its original objectives to:

- assess and quantify working conditions across European countries on a harmonised basis;
- analyse the relationships between different aspects of working conditions;
- identify groups at risk and issues of concern, as well as areas of progress;
- monitor trends over time;
- contribute to European policy development, in particular on quality of work and employment issues.

The EWCS is targeted at 'workers' as defined by the International Labour Organization (ILO): those who have worked for at least an hour in return for some form of compensation in the week preceding the interview. The survey respondents, therefore,

include both employees and the self-employed. They were interviewed about their work, face to face in their homes, for about 40 minutes on average. Consequently, the information collected in the survey reflects workers' perspectives, the characteristics of the companies they work in, and the households in which they live. Although the survey questions are carefully constructed to tap into objective information as much as possible, given the unilateral perspective of the survey, there are some limitations in this regard. To ensure high-quality information, each stage of the survey was carried out according to strict guidelines that took into account the most up-to-date survey research methodology.[3]

Although fieldwork for the EWCS was carried out in 2010 when the EU had 27 Member States, the analysis for this chapter includes the present 28 Member States.

EurWORK and Eurofound strategic research

When relevant, information from Eurofound's European Observatory of Working Life (EurWORK) and the Agency's strategic research is used to develop further upon some of the issues analysed.

EurWORK was launched in mid-2014 to integrate two previous Eurofound observatories: the European Working Conditions Observatory (EWCO) and the European Industrial Relations Observatory (EIRO).

It provides regular information on quality of work and employment issues in the EU Member States and at EU level. The observatory is supported by an extensive network of correspondents covering all EU countries, plus Norway.

EurWORK is focused on the following research themes related to working conditions:

- career and employment security;
- health and well-being of workers;
- developing skills;
- working time and work–life balance.

Workers in Europe

Employment levels

When the fifth EWCS was carried out in 2010, almost 218 million people were employed in the EU28, according to Eurostat's annual European Union Labour Force Survey (EU-LFS). At the time, many European economies were feeling the full force of the Great Recession.

The EU workforce contracted by 2.2% between 2008 and 2012. Estonia, Ireland, Latvia and Lithuania saw their workforces shrink by 10% or more, while in Bulgaria, Croatia, Greece and Spain the shrinkage of the workforce exceeded the 10% mark in the next few years. In a few countries, the workforce grew substantially – by 8% in Malta and 17% in Luxembourg – between 2008 and 2012, and in others it remained fairly stable.

The different macroeconomic developments in the years just preceding the survey, as well as the anticipation of developments in the years just after it, are likely to have had an impact on both the working conditions and the health and well-being of workers. Findings from the report *Impact of the crisis on working conditions in Europe* (Eurofound, 2013a) show evidence of an increase in some psychosocial risks such as job insecurity, work intensity, and violence and harassment linked to changes that took place during the economic crisis (such as higher unemployment, flexibilisation of labour regulations and restructuring processes). The analysis of the impact of macroeconomic developments on the conditions and health and well-being outcomes of work is not part of this contribution, but should be kept in mind when interpreting the analyses of the responses from individual workers.

Profile of workers

In addition to the macroeconomic context, the structure of the workforce needs to be taken into account when interpreting the survey results. Different sectors and occupations attract different types of workers and are linked to different working conditions. [4]

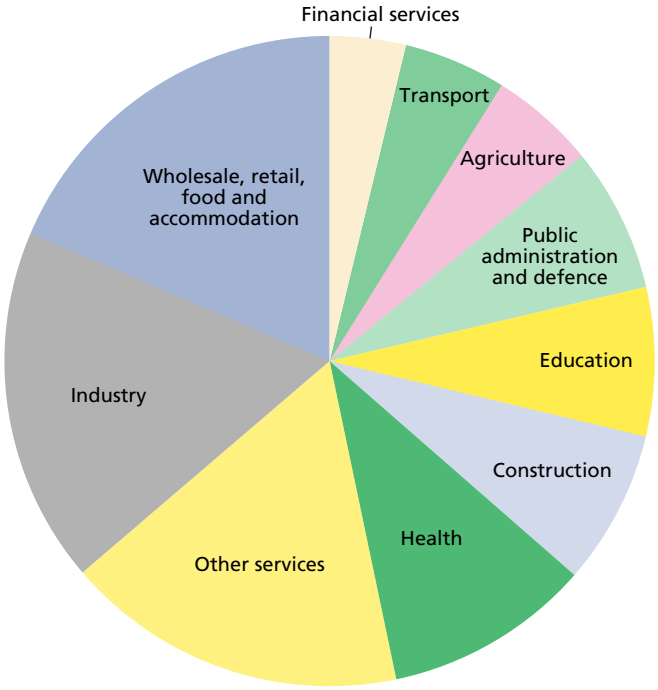
Figure 1 shows the distribution of the EU workforce across different sectors of activity. It shows that wholesale, retail, food and accommodation, industry and other services are by far the largest sectors in terms of employment, followed by construction and public services such as healthcare, education and public administration. This distribution varies greatly across countries; for example, in Romania, agriculture is the sector employing the largest number of people, and in Cyprus, Greece, Luxembourg, the Netherlands and the United Kingdom only half as many employees are employed in industry as in the EU as a whole.

In terms of types of occupation, the largest groups are technicians and associate professionals, professionals, service and sales workers, and craft and related trades workers (Figure 2). This again hides striking differences between countries; for example, clerical support workers are much more prevalent in Denmark, Finland, Ireland and the United Kingdom, and skilled agricultural workers (which includes fishery and forestry) are the largest occupational group in Romania.

[3] For more information on the survey methodology, see the EWCS web page at http://www.eurofound.europa.eu/surveys/methodology/index.htm.

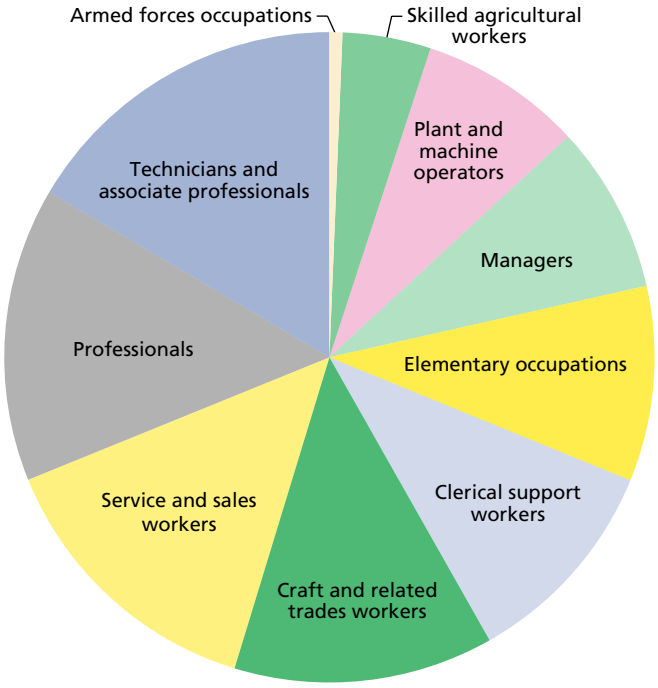
[4] This report uses the ISCO-08 one-digit classification system for occupations and NACE Rev. 2 for sectors. The 21 NACE sectors have been condensed into 10 categories for simplicity: agriculture – A; industry – B, C, D, E; construction – F; wholesale, retail, food and accommodation – G, I; transport and storage – H; financial services – K, L; public administration and defence – O; education – P; health – Q; other services – J, M, N, R, S, T, U.

Figure 1: Distribution of sectors of activity, 2010



Source: EU-LFS, 2010.

Figure 2: Distribution of types of occupation, 2010

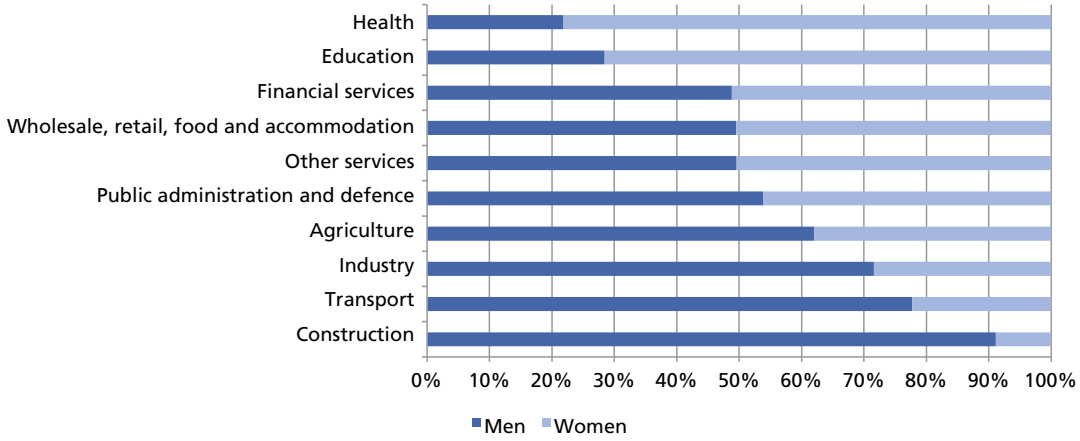


Source: EU-LFS, 2010.

The composition of sectors also differs by gender. Figure 3 shows that in health and education more than 70% of workers are women. Conversely, in construction more than 90% of workers are men. Within these sectors, men and women are also very likely to have different roles. For instance, in male-dominated sectors such as construction and industry, women are likely to be employed in administrative support roles. In health, while men are a small minority, the majority of doctors are men. This highlights that gender differences by occupation are also found. Not only are the vast majority of craft and related trades workers and machine operators men, so are two-thirds of managers. Women, on the other hand, dominate in clerical support and service and sales occupations.

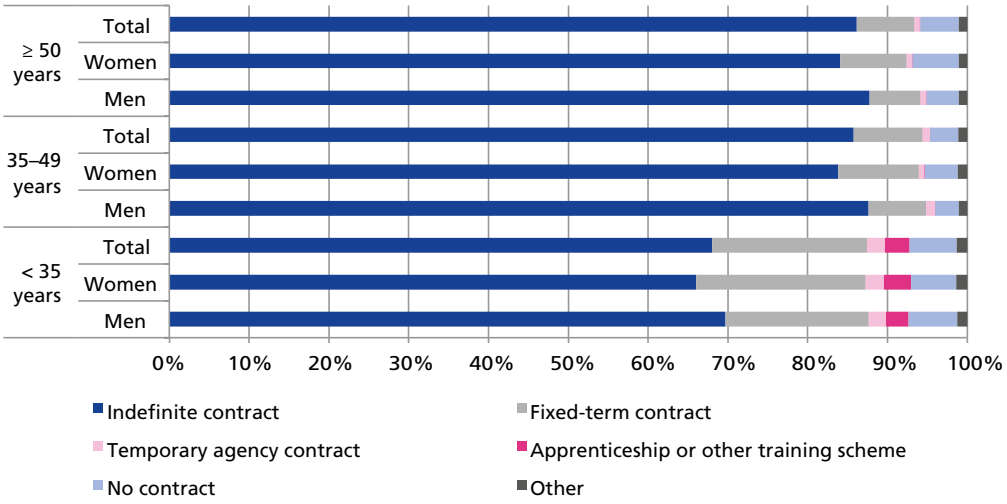
Age is another relevant variable with implications for the relationship between working conditions and health. Because of differences in demographic structure and institutional regimes, countries differ in the age distribution of their workforces. A relatively large proportion of workers are under 35 years in Cyprus (37%), Poland (38%), Ireland (39%) and particularly Malta (45%), compared with 32% in the EU. Conversely, workers over 50 account for a large amount of employment in Finland (32%), Sweden (32%) and Croatia

Figure 3: Sectoral distribution of workers, by gender, 2010



Source: EU-LFS, 2010.

Figure 4: Type of employment contract, by age and gender (% workers)



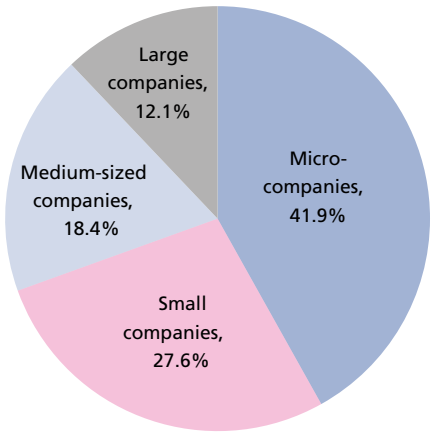
Source: EWCS, 2010.

(35%), compared with the EU average of 27%. Age differences are quite pronounced across sectors as well, with wholesale, retail, accommodation and food services employing a relatively large proportion of younger workers, while workers over 50 are well represented in education (33%) and agriculture (42%).

Another important aspect of people's jobs is the type of employment contract (Figure 4). Around 8 out of 10 employees in the EU are on an indefinite contract. One in 10 is on a fixed-term contract, and the remaining employees are on a temporary agency contract, work in an apprenticeship or other training scheme, or have another – informal – type of arrangement with their employer. However, there are quite large differences between men and women and particularly between younger and older workers in terms of the type of employment contract. Younger workers (under 35 years) are much more likely than older workers to have a fixed-term contract, a temporary agency contract or an apprenticeship. Across all age groups, women are slightly less likely than men to have an indefinite contract.

Company size is also relevant to psychosocial risk prevention (Figure 5). Almost half of European workers work in a small or medium-sized enterprise (SME): 28% work in a company of 10–49 employees, while 18% work in a company with 50–249 employees. Another large proportion of workers, 42%, works in a micro-company, defined as one with 1–9 employees, and the remaining 12% work in a large company of 250 or more employees. The highest percentages of large companies are found in the UK (19%) and Luxembourg (20%), SMEs are most prevalent in Sweden (59%) and Denmark (63%), and micro-companies can be found most in Cyprus (56%) and Greece (59%). Differences between sectors are even more pronounced, with around 80% of workers in agriculture and other services working in micro-companies, and 73% of workers in education working in SMEs.

Figure 5: Distribution of workers by company size (% workers)



Source: EWCS, 2010.

With regard to employment status, the majority of workers in Europe are employees (82%). Self-employed people without employees constitute 11% of the workforce, while 4% are self-employed with employees; a large proportion of self-employed people work in micro-companies. A small percentage (3%) are neither employees nor self-employed (for example, family workers).

Psychosocial factors in the working environment

The 'psychosocial work environment' is a collective way of referring to work-related psychological and social influences on health such as time pressure, monotonous work, social reciprocity, job control and autonomy, fairness, work demands and job security, as well as social contact with co-workers and supervisors (Cox and Griffiths, 2005)

The following section presents a descriptive analysis of the prevalence of different psychosocial risks that can cause stress and problems with health and well-being for workers. The distribution of these risks according to structural characteristics such as country, sector, occupation, gender and age will be presented when relevant.

Job content

The nature of work and the types of tasks involved might represent a challenge for workers or be the origin of stress at work if they cannot cope with demands. Individual differences play a role in how workers cope with those demands. The following section looks at how many workers report being exposed to difficult tasks and being unable to cope with the demands of the job.

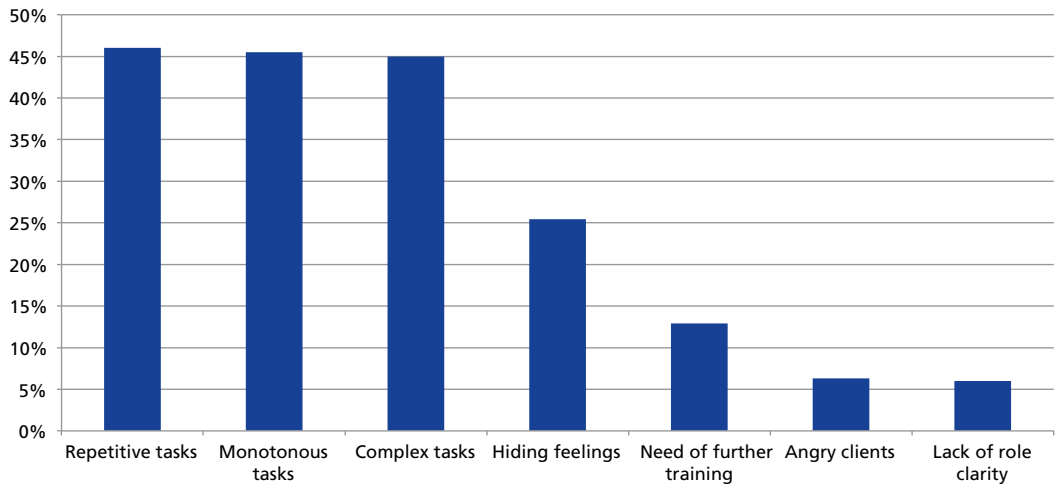
The intrinsic content of a job involves elements that can constitute risks for the well-being of workers. Creative work and task variation contribute to self-development at work, as well as being traditionally considered important intrinsic to work motivation when workers have the knowledge and skills to take up new challenges (see, for example, Hackman and Oldham, 1980). Jobs involving repetitive and monotonous tasks can be demotivating and can contribute to psychosocial problems. On the other hand, very complex tasks might contribute to stressful situations for the worker involved unless they have the skills and job design necessary to cope with them. Additionally, emotionally demanding interactions (such as dealing with angry clients and hiding feelings) might be required for jobs that involve contact with people. Finally, the lack of adequate skills to perform the job might harm the well-being of workers through increasing levels of stress. The exposure of workers to these risks varies, as shown in Figure 6. In general, more workers report a lack of variety in their work or complexity in tasks than they do emotional demands or lacking the necessary skills.

One of the job content variables that seems to have a significant impact on the health and well-being of workers is the monotony of tasks that jobs involve. This indicator has seen a small rise in recent years. In 2010, 46% of workers in the EU reported that generally their work involved monotonous tasks, compared with 43% in 2005. The differences across countries in 2010 were important: in Croatia, 64% of workers reported that their job involved monotonous tasks, whereas in Malta only 22% of workers reported the same (Figure 7).

Job content and the tasks involved are closely linked to the occupation of the worker (Figure 8). Workers at higher levels of the occupational structure carry out more complex tasks, while those at lower levels have more monotonous and repetitive tasks. The plant and machine operators occupational group has a high share of workers with monotonous tasks (62%), and they are also among the occupational groups reporting higher levels of jobs involving repetitive tasks (57%). As expected, more complex tasks are more often found among managers, professionals and technicians (from 72% to 76%). As a consequence, different occupations tend to involve different types of risks in relation to work tasks.

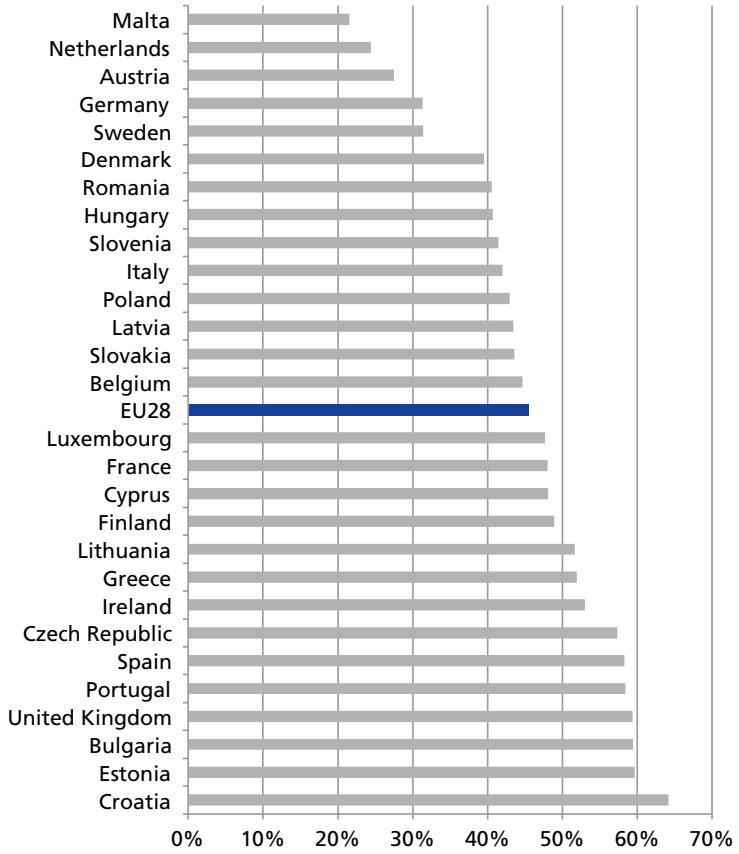
The role a worker has in an organisation is associated with the overall organisation of work and management. Sometimes there is a lack of role clarity, which has implications for the health and safety of workers. Sometimes the job content (for example, its complexity) as well as social isolation and absence of support through lack of communication and information can make a worker's role less clear. The consequence is that the worker may not know what is expected in the job, as is the case among 6% of workers in the EU. In almost all sectors of the economy, there is a small group of workers who 'at least sometimes' do not know what is expected of them at work. This is most common in financial services (8%), agriculture (7%) and construction (7%) and is less common in the health sector (4%).

Figure 6: Reporting of selected job content characteristics (% workers)



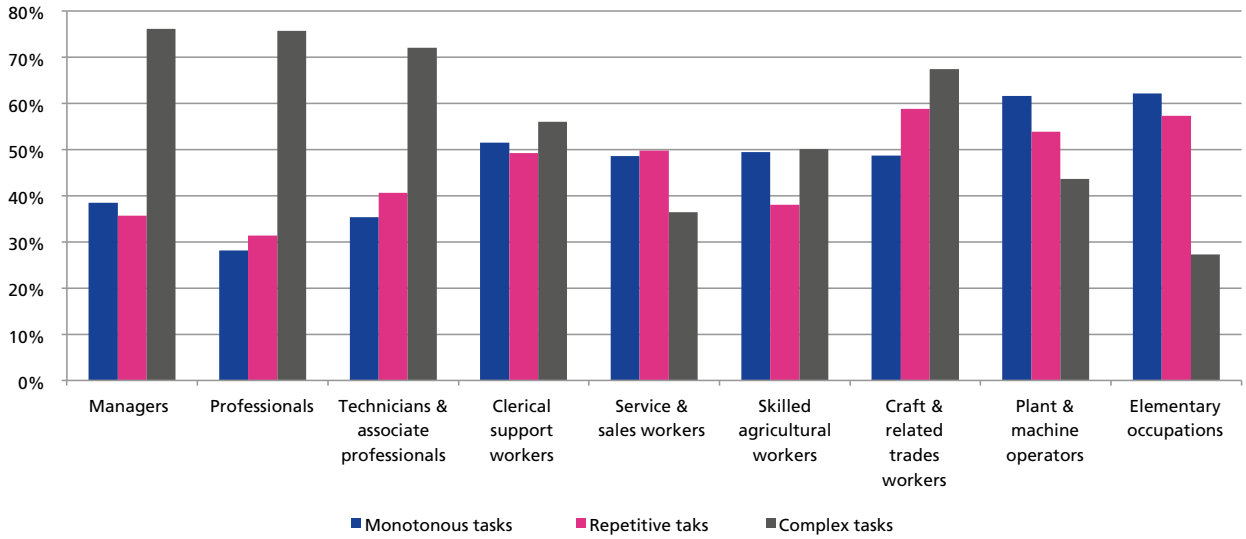
Source: EWCS, 2010.

Figure 7: Main paid job involves monotonous tasks, by country (% workers)



Source: EWCS, 2010.

Figure 8: Repetitive, monotonous and complex tasks, by occupation (% workers)



Source: EWCS, 2010.

Emotional demands are a characteristic of some jobs, especially in education, health and other services. This 'emotional labour' is work in which the job content is expected to affect workers emotionally. Typically, in their contact with clients, patients, customers and so on, some workers need to hide their feelings (such as hiding fear or remaining friendly) or manage their feelings (such as limiting compassion or empathy). Excessive emotional demands are shown to have a negative impact

on health. A possible long-term consequence is burnout (see the Maslach Burnout Inventory in Maslach et al, 1996), and links have also been found with physical reactions such as musculoskeletal disorders and high blood pressure (Molinier and Flottes, 2010). In the EU, 7% of workers indicate that part of their job involves dealing with angry clients, which is an example of emotional labour. Younger and older women are more likely than men of the same age to be in a work situation that involves handling angry clients. Hiding or suppressing feelings can result in psychological strain. In general, there is not much difference in the extent to which men and women report having to do this. However, there are large differences between sectors, with only a small percentage of workers in agriculture reporting that they have to hide their feelings, compared with a fairly large proportion of workers in health (38%).

Apart from the intrinsic characteristics of the job, it is interesting to look at the adequacy of workers' competencies for the tasks to be done, which is one indicator of the extent to which workers can cope with their tasks. Skills mismatch is a factor that can contribute to stressful situations for some workers. Across the EU, 13% of workers report that they need further training to cope well with their duties (Figure 9). A higher percentage of workers under 35 years of age report that situation.

Large proportions of workers in higher-skilled occupations, such as professionals and technicians, report that they need further training – a variable that is related to stress at work and health problems linked to the workplace. The prevalence among higher-level occupations might be related to the fact that they are more affected by changes in process and technologies as well as complexity of tasks. Skills mismatches are also more common among workers in service sectors, such as financial services, education and health.

Looking at Member States, the need for further training is reported more often among Austrian workers (24%) and also in Germany and the Baltic countries, whereas in Ireland only 7% of workers state that they need further skills.

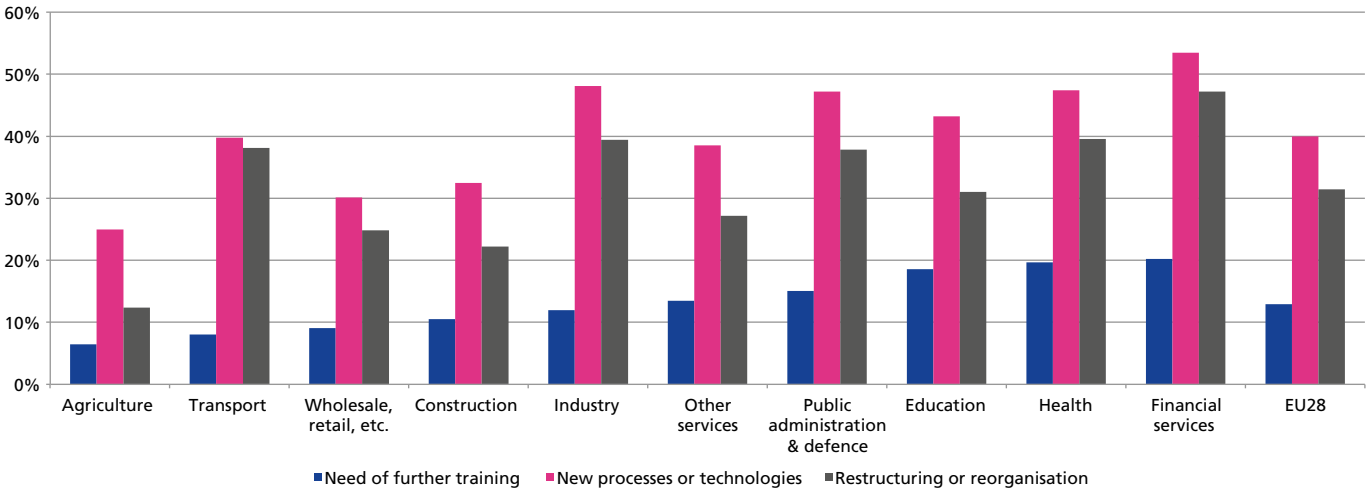
Developments in organisations related to processes, technology and restructuring give rise to changes in the work environment, and workers remaining in the organisation need to adapt to the new organisation. Along with industry, service sectors report a high share of workers going through changes in processes and technology during the three years prior to the survey, compared with the EU average of 48% (Figure 9). Restructuring (in the previous three years) affects a more diverse group of economic activities, especially financial services, health, public administration, industry and transport sectors. As for country comparisons, a high proportion of workers in the Scandinavian countries report experiencing changes in processes or technologies in their companies – 58% of workers in Sweden do so, for example.

Both aspects of organisational change can contribute to changes in workers' tasks as well as changes in the establishment's organisation of work and, therefore, might have consequences for individuals and for the workplace's social environment (Eurofound, 2013a, b).

Training can help workers to cope with task complexity or new technologies or to adapt their skills to the job requirements. In the EU, 34% of workers were offered employer-paid training in the year before they were interviewed. Workers in companies with fewer than 10 employees and workers over 50 years of age had fewer chances to participate in employer-paid training (20% and 30% respectively).

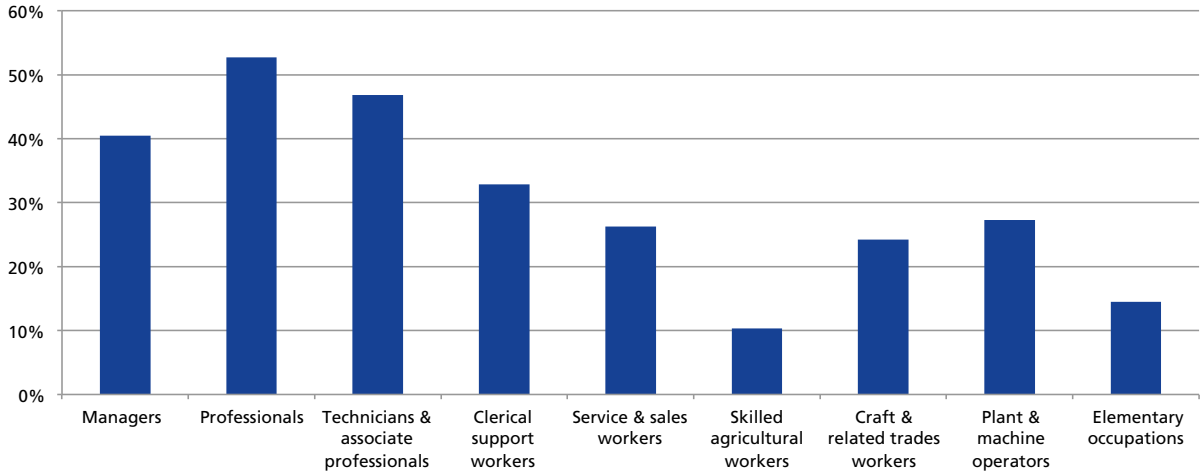
Figure 10 shows that a higher percentage of workers in higher-level occupations received employer-paid training than those

Figure 9: Need for further training, changes in process and technologies, and restructuring or reorganisation (% workers)



Source: EWCS, 2010.

Figure 10: Provision of employer-paid training, by occupation (% workers)



Source: EWCS, 2010.

in lower-level occupations, which probably has to do with the complexity of tasks, the introduction of new processes and technologies, and the greater access to continuous training among these workers.

Of all workers who said that they needed further training, 40% did not receive training paid for or provided by the employer during the previous year.

Within the set of risks presented in this section, the most prevalent are the various difficult types of tasks. However, the need of training to cope with one's duties is a factor closely related to negative health and well-being outcomes. Another characteristic of work that is certainly related to generic health and well-being status is jobs that involve monotonous tasks. (See the analysis in the later section 'Health and well-being and the association with psychosocial factors'.)

Work intensity and job autonomy

An important aspect of work in terms of psychosocial risks is work intensity; here, this indicator will be looked at in combination with job autonomy. Karasek and Theorell (1990) hypothesised that jobs with high levels of demand (such as heavy workload) coupled with low levels of control or decision-making latitude were associated with increased stress and ill-health effects. With regard to job demands, the literature also refers to work pressure, work intensity, work pace and so on. Control or decision-making latitude has also been called 'autonomy'.

'Demand' in this context refers to the effort (both cognitive and physical) a person has to make to carry out their work in terms of its volume, speed and nature. Demanding work can include emotional demands or long working hours. High intensity can also cause work–life imbalance, and the related strain causes problems and can lead to mental or physical illness.

The overview report of the fifth EWCS developed an index of work intensity based on three variables: working at very high speed, working to tight deadlines, and not having time to get the job done (Eurofound, 2012a). The findings show that developments over time give some cause for concern, with a slight long-term increase in work intensity in most European countries between 1991 and 2005. From 2005 to 2010, the figure was relatively stable and even showed a very small decrease. Looking separately at the three variables, the share of workers who reported that they work to tight deadlines at least a quarter of their working time did not change from 2005 to 2010 (62%). Working at high speed at least a quarter of the working time was reported by 59% of workers in 2010 (similar to 2005). The main reason for the small decrease in overall work intensity might arise from the fall in the proportion of workers having difficulty getting the job done in time, from 30% in 2005 to 24% in 2010.

More recently, the report *Impact of the crisis on working conditions in Europe* (Eurofound, 2013a) shows that in Europe during the early period of the economic crisis (2008–2010) some reduction of work intensity was observed in some sectors because of lower demand. However, in some countries, notably Ireland, Spain and the United Kingdom, work intensity increased between 2008 and 2012, and this increase seems to be linked to some extent to developments that have occurred as a consequence of the changed economic circumstances (Russell and McGinnity, 2013; Wanrooy et al, 2012; Eurofound, 2013a).

Following the Karasek model, an index for job autonomy was developed based on the following variables: ability to change the order of tasks (reported by 70% of workers); ability to change the method of work (67%); ability to change the speed or rate of work (70%); having a say in a choice of working partners always or most of the time (44%); and being able to take a break when desired (65%). From 2005 to 2010, the index of autonomy showed a small increase.

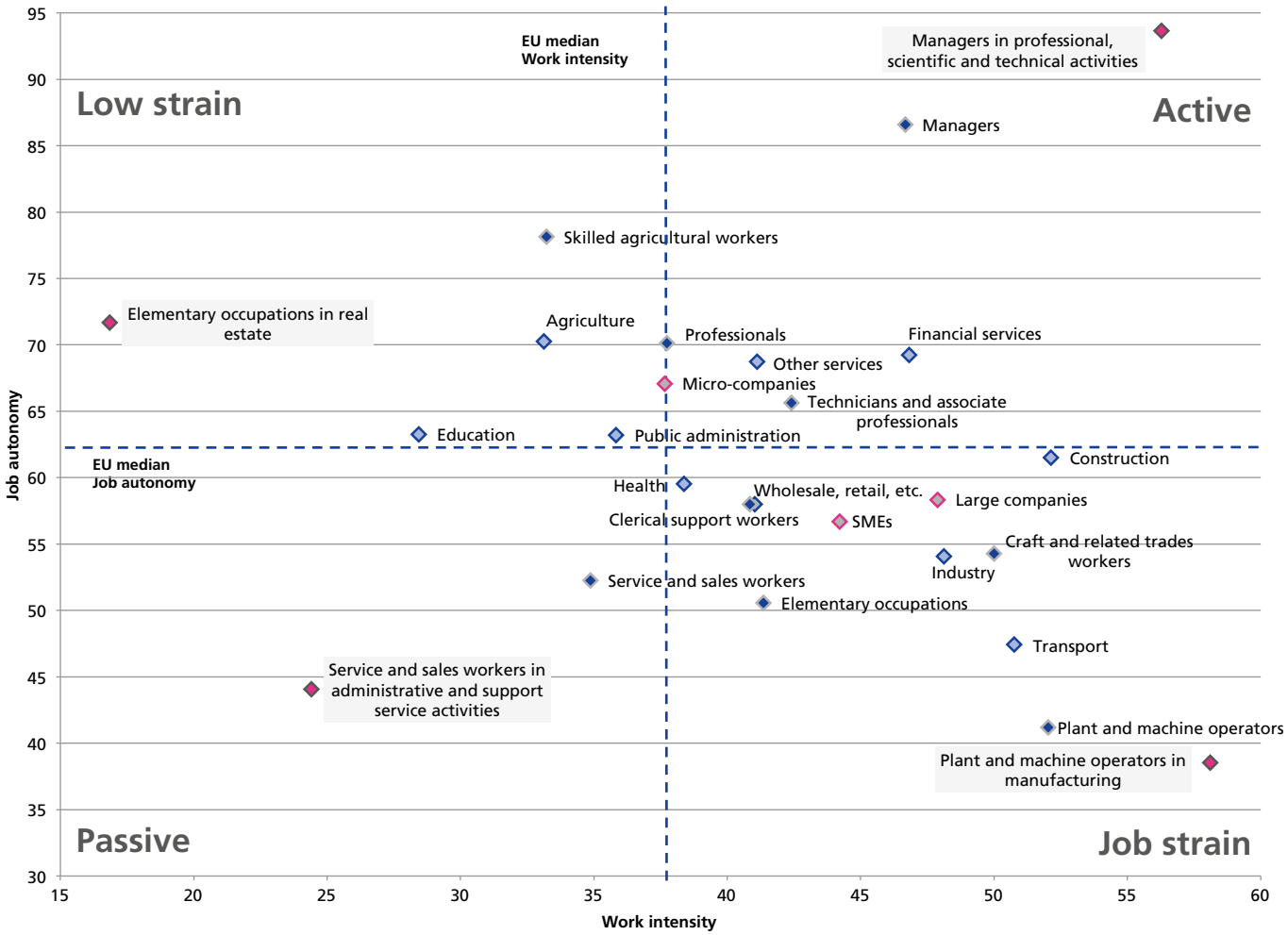
According to the Karasek model, the probability of experiencing work-related stress is highest when workers have a high level of work demands while being limited in the extent to which they control the way in which they carry out their job (low job autonomy) (Eurofound, 2012a).

Overall, small gender differences were found in relation to work intensity and job autonomy. In most countries, men report a slightly higher level of work intensity than women, for example in relation to working at very high speed. Men also have a slightly higher level of autonomy. Age differences are more significant than gender differences, with a clear reduction of work intensity in older age groups (Eurofound, 2012a). It seems that older workers try to gradually slow down in order to avoid further deterioration of their health.

Differences exist among countries in the prevalence of work intensity and job autonomy. Cyprus, Germany, Greece and Slovenia have high levels of work intensity, whereas Bulgaria, Latvia, Lithuania and Portugal have the lowest levels. In terms of autonomy, workers in Nordic countries and the Netherlands have high levels, whereas workers in Austria, Bulgaria, Germany and Slovakia show low levels of autonomy. There is more variability between countries in terms of work intensity than autonomy. Germany is an example of a country with a relatively high level of work intensity and a lower-than-average level of autonomy compared with the EU as a whole. Working conditions in Germany, therefore, are probably more conducive to stress than in other countries. Denmark has average levels of work intensity but high levels of autonomy; here, working conditions are less likely to generate stress. In fact, reported levels of stress 'always or most of the time' are higher among German workers (31%) than in Denmark (11%).

The differences between countries are partially influenced by variations in the importance of difference sectors in the economy. Work intensity and autonomy are also influenced to some extent by the characteristics of the occupation. Figure 11 illustrates how occupation and sector fit into the Karasek model. Low-skilled occupations such as plant and machine

Figure 11: Job demand and control model by sector, occupation and establishment size



Note: Axes show median EU values.

Source: EWCS, 2010.

operators and craft workers dominate in terms of high-strain work organisation, especially in the transport, industry, and wholesale and retail sectors. A specific example is plant and machine operators in manufacturing.

The top right quadrant contains workers in the financial services and other services as well as technicians and associate professionals, and managers. Workers in these sectors and occupations tend to be in active jobs with relatively high levels of work intensity but also with relatively high levels of autonomy. They include managers in professional, scientific and technical activities, for instance. Workers in services and sales are in the quadrant representing predominantly passive jobs, characterised by relatively low levels of intensity and relatively low levels of autonomy, which are not very much at risk of work-related stress, but do have a risk of low motivation. These jobs include, for example, service and sales occupations in administrative and support services. Finally, low-strain jobs are characterised by relatively low levels of work intensity and relatively high levels of job autonomy. Jobs characterised by low strain are mostly in agriculture, education and public administration, and a number of professionals have jobs of this nature. One specific example is elementary occupations in the real estate sector.

Although the EWCS data support this model for most groups of workers, it has been suggested that certain psychosocial factors are more important than others. Commentators have also highlighted the possibly mediating effects of individual-level factors, such as mastery or self-efficacy (Bambra, 2011). Moreover, this chapter will later show that, when the variables are considered individually, the role of work intensity contributing to stress is greater than the role of job autonomy in preventing stress. However, when the two aspects are combined, the probability of experiencing stress, or reporting that work negatively affects health, decreases to some extent.

It might be that in some cases workers who have more autonomy also have higher levels of responsibility, which can help increase their stress level. This can be understood by considering, for example, managers working long hours, with high work intensity and with a high level of responsibility; their levels of stress may be so high that an increase in job autonomy cannot always compensate for or reduce levels of stress. Therefore, although the model presented is still valid, it has limitations, and so other individual or organisational variables should be taken into account, as they can make the final outcome different from that expected.

Working time arrangements and work–life balance

Working time is relevant to health and safety, since high demand levels and specific working time arrangements can pose risks for the health and well-being of workers. Some of the changes to working time introduced in recent years in Europe are of fundamental importance for workers and companies.

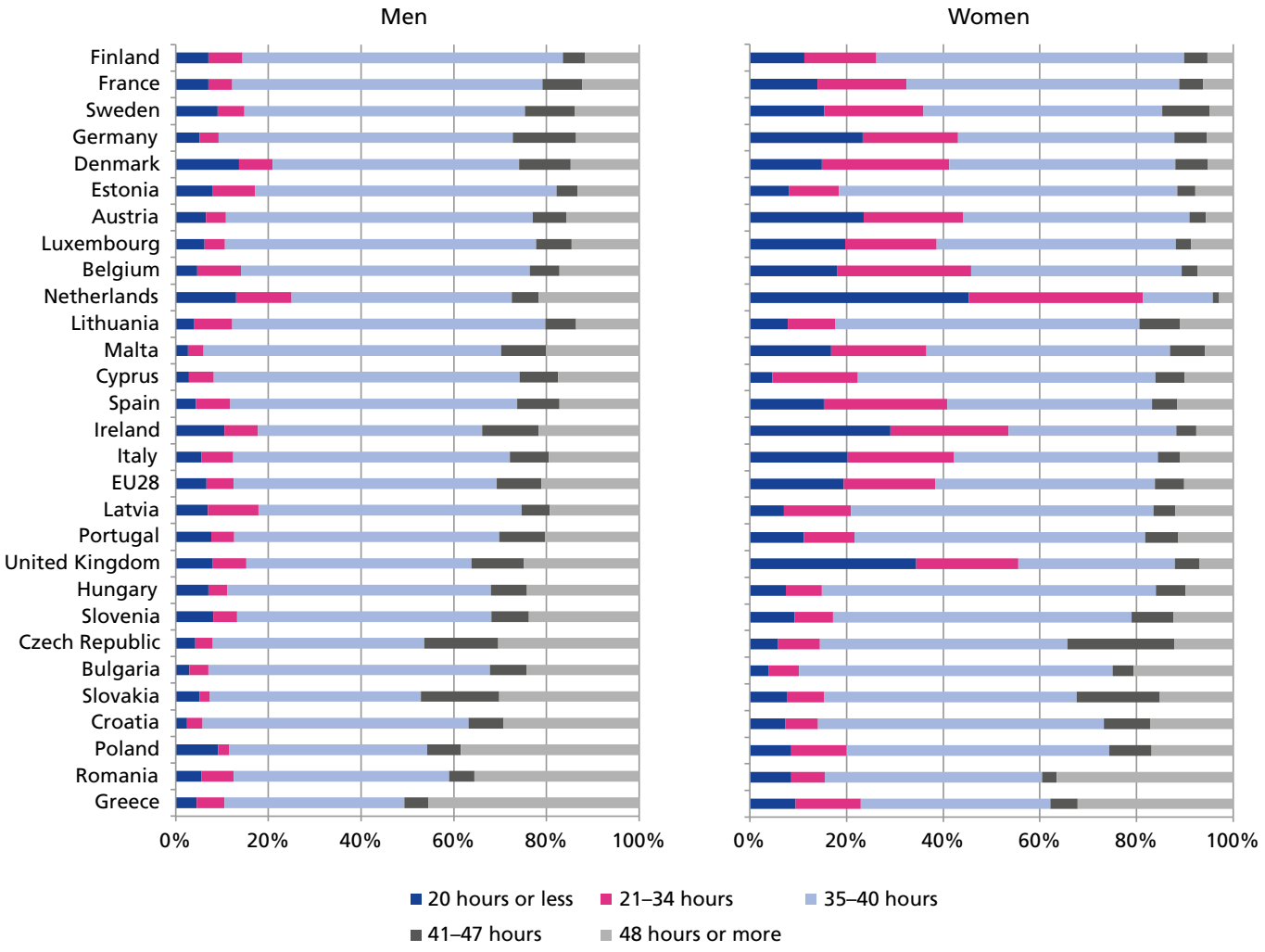
Working hours play a crucial role in the health and well-being of workers. The health consequences of long working hours, very high variability of working hours, and lack of rest are well known, and legislation limiting such working time arrangements and allowing a minimum of rest periods has been adopted. The effects on health and well-being of certain working time arrangements can include sleeping disorders, fatigue or tiredness. On the other hand, working hours that allow a good fit between work and private life can have positive effects on workers' health and well-being.

In line with the EU-LFS, the findings of the fifth EWCS show that average working hours have reduced in recent decades. The average working week in the 12 Member States in 1991 was 40.5 hours; in 2010, it was 37.5 hours in the EU28. However, the EU average masks important differences between countries, with the Netherlands having the lowest average (31.9) and Greece the highest (45.2). According to Article 6 of the Working Time Directive (2003/88/EC), Member States must take measures to ensure that working time, including overtime, does not exceed 48 hours over a seven-day period, in order to protect the safety and health of workers. In Europe, 21% of workers work longer than 48 hours on average each week. Greece has the highest percentage of workers in that situation, whereas Finland has the lowest share (Figure 12). Apart from Greece, many central and eastern European Member States show higher proportions of workers working more than 48 hours than the EU average. The gender dimension is very relevant, since the share of male workers in this group is double that of women. Although there are variations across countries, the difference between men and women exists in all EU Member States.

Not only long hours but also a high variability in working hours seems to pose a risk for workers' health and well-being. The Eurofound study *Organisation of working time: Implications for productivity and working conditions* (2012b) found that, in general, irregular working hours increase the probability of a worker reporting a poor work–life balance. There is also a relationship between arrangements where the variation of working hours is very common (for example, on-call work and shift work) and negative impact of work on health. Another factor to take into account is that workers' control over their working hours contributes to better work–life balance and better reported health even when workers are employed in jobs involving variable working hours.

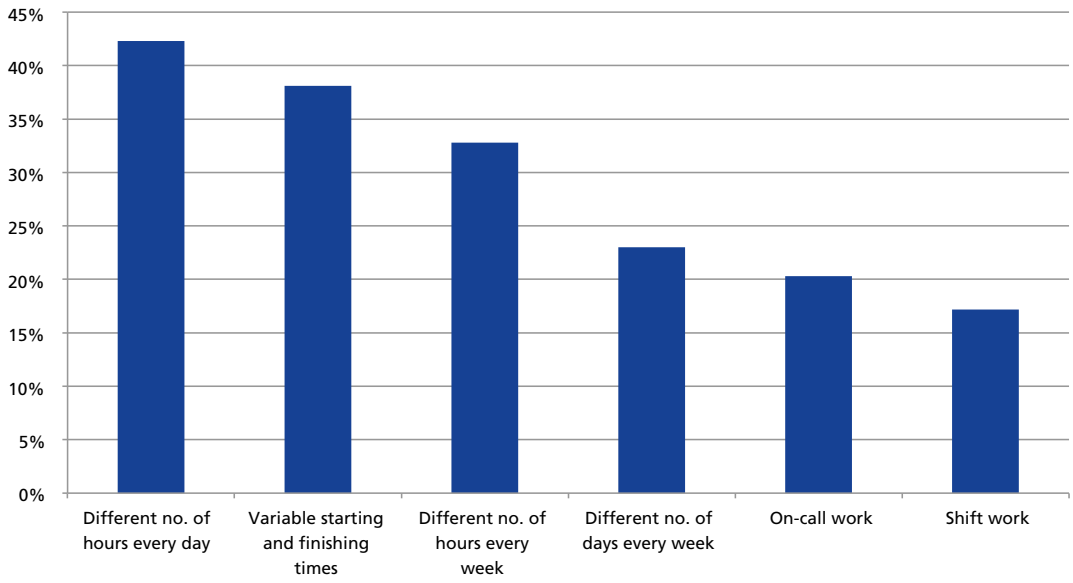
In the EU, 35% of workers indicate that their working time changes regularly. Figure 13 shows the forms that irregular working time takes. The most common irregular working time arrangements are working a different number of hours every day (42%), and variable starting and finishing times (38%). The prevalence of the first has increased slightly since 2000, whereas the second has fallen. These two variables of working

Figure 12: Working hours, by country for men and women (% workers)



Source: EWCS, 2010.

Figure 13: Irregular working time arrangements (% workers)



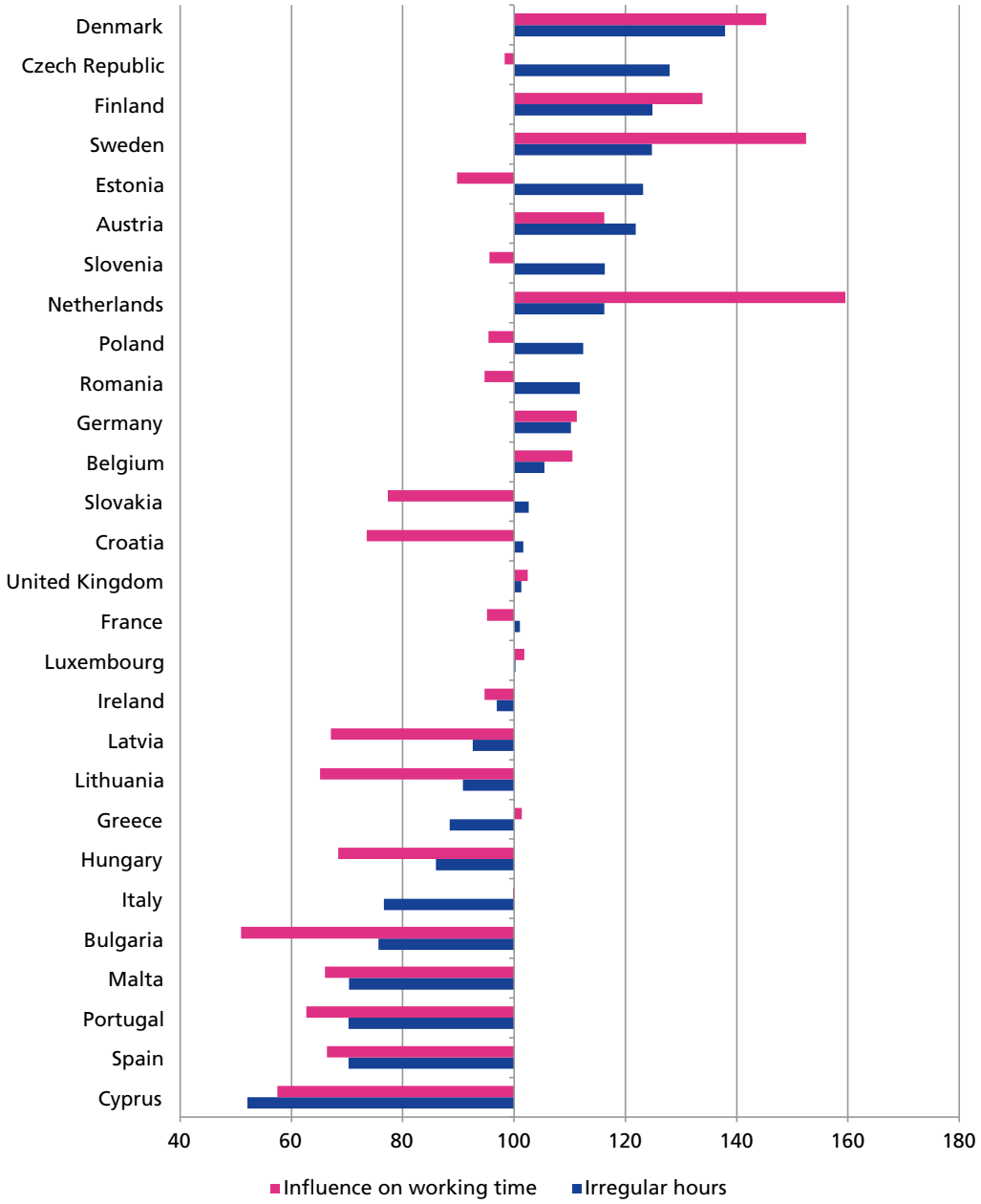
Source: EWCS, 2010.

time variability together with working a different number of days during the week and a different number of hours every week were included in a composite indicator of irregular working time. This irregular hours index shows a slight increase from 1991 to 2010.

Figure 14 shows that Denmark is the country with the highest irregularity in working time according to the irregular hours index, whereas Cyprus has the lowest irregularity. In general, workers can cope better with risks posed by irregular working time and work–life balance problems when they can influence the time setting. In the EU, 41% of workers can influence their working time in different ways.

An index of influence on working time was developed based on three variables: whether workers are able to determine their working hours entirely, whether they can adapt their working time within certain limits, and whether they choose between fixed schedules. To shed light on the potential consequences for the well-being of workers, Denmark and the Czech Republic can be compared. In both countries, high levels of working time variability are prevalent, but Danish workers also report

Figure 14: Irregular hours index and influence on working time index, by country



Note: For both indices, EU28 = 100.

Source: EWCS, 2010.

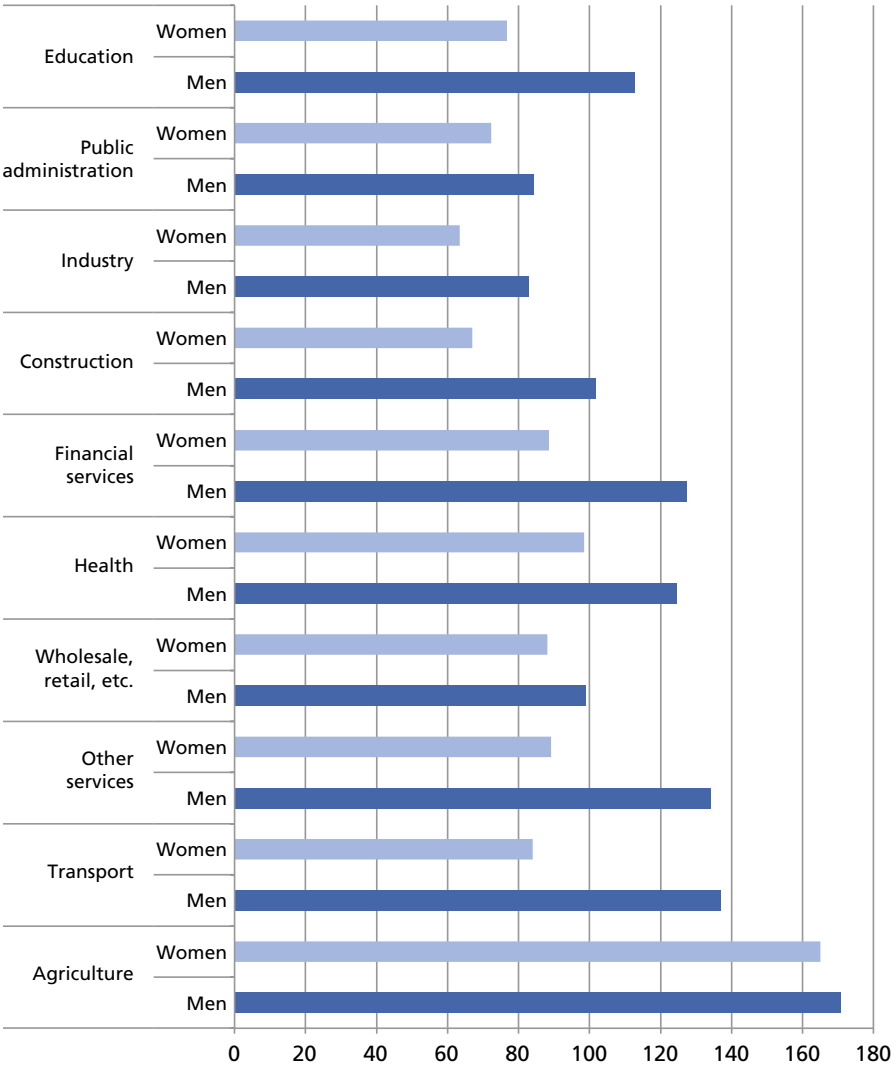
high levels of influence on their schedules, whereas Czech workers report a level of influence lower than the EU average. Based on these data, Danish workers are in a better position to cope with the risks posed by irregular working hours and therefore less likely to develop stress or even health problems because of working time and work–life balance problems. All Nordic countries and the Netherlands have similar patterns to those found in Denmark.

The irregular hours index can also be used to compare the situation between sectors in Europe and gender differences (Figure 15). The index shows that men in agriculture, transport, other services, financial services and health experience a high degree of irregularity in working hours, while women in public administration, construction and industry report low irregularity. Overall, men tend to report more irregularity in their working time than women. In relation to age differences, the higher the age, the smaller the percentage of workers reporting that their schedule changes regularly.

Overall, agriculture and transport are the sectors with the highest percentage of workers with irregular hours. Agriculture also has a smaller percentage of workers (20%) who are able to influence their working hours, while 38% of workers in finance are able to do so.

As suggested already, the difficulties that workers can experience due to long or irregular hours, such as poor work–life balance, can be eased if they have some influence on how their working time is organised. A high degree of working time autonomy, where the worker can determine their own working hours, is reported by 17% of workers in EU. Many of them are self-employed. The predictability of changes to working time can also contribute to managing irregular working hours and

Figure 15: Irregular hours index, by sector and gender



Note: EU28 = 100.

Source: EWCS, 2010.

to achieving a better balance between work and private life. Of all the workers who mention that their working hours change regularly, 50% say they are informed about the changes the same day or the day before. Notably, these workers might have problems reconciling their working and non-working life.

Working time arrangements affect how workers perceive their work–life balance: the less regular the working time scheme, the more problems workers have with their work–life balance (Eurofound, 2012b). A good work–life balance is also positively linked with psychosocial well-being. Reconciliation of work and private life is a key element in the quality of work and employment, meriting a mention in the Europe 2020 strategy (European Commission, 2010). Data show that some 18% of workers indicate they have problems with work–life balance and on average men (21%) have more difficulties than women (16%). Men in the transport sector are particularly affected, as 32% of them report poor work–life balance. Furthermore, older workers report better work–life balance than their younger counterparts. These results suggest that many women working shorter hours and with less irregular schedules do so in order to adapt work to family demands; in relation to the age dimension, women also try to adapt their roles in their 30s and 40s. In addition, it might be that workers with more experience in the labour market enjoy better conditions, allowing them to better balance work with other activities.

As regards countries, workers from northern Europe report a better fit between working hours and family life or social commitments; for example, in Denmark, just 6% report poor work–life balance. By contrast, some southern European and central and eastern European countries have higher proportions of workers reporting poor work–life balance; 25% in Italy, for instance. Results show that, apart from working time arrangements, national contexts in terms of family situation and composition, cultural traditions at work and in society, household arrangements, social protection, and access to childcare for young children play a role in people's work–life balance.

Further analysis of the EWCS confirms that both long hours and irregular working hours are related to health and well-being outcomes. Long hours have a relatively important effect on workers' experience of stress at work, and irregular working hours have an effect on specific health outcomes such as sleeping disorders and musculoskeletal disorders, as well as on overall health and well-being. However, a good work–life balance reduces the chances of reporting health problems. (These themes are examined further in the section 'Health and well-being and the association with psychosocial factors', below.)

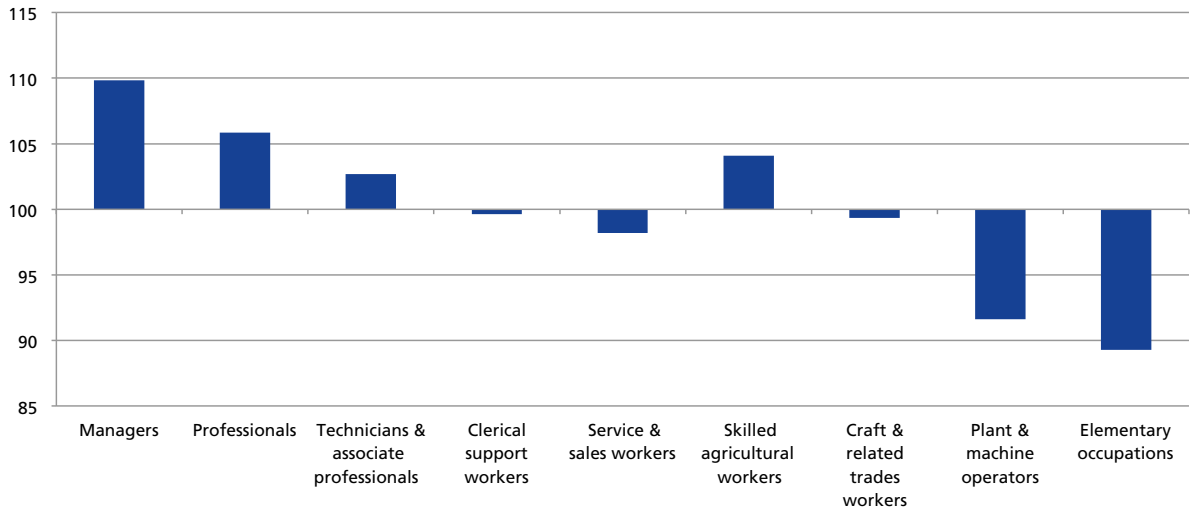
Social environment

Social environment relates to interpersonal relations at work, including support from colleagues and superiors. The social context of the workplace under certain circumstances can either prevent or be conducive to psychosocial risks. Some possible hazards are lack of social support, poor relationships with one's superior, conflicts and the various types of adverse social behaviour. Adverse social behaviour means all acts of physical and verbal violence and intimidation at work. Harassment and violence in the workplace has been shown to be linked to mental health problems (Leymann, 1990). The relevance of the issue for European social partners was confirmed by the signing of the Framework Agreement on Harassment and Violence at Work in 2007. This section focuses on the negative consequences for health and well-being that result from a poor social environment, and on the social support that workers experience, which is a positive aspect of the workplace social environment. Cultural characteristics and social norms have an influence on dimensions of the social environment; therefore, the results could be affected by cultural differences.

It has been suggested that the presence of social support from co-workers and supervisors in the workplace might in some way moderate or act as a buffer to reduce possible psychosocial ill effects of working conditions (Stansfeld et al, 1997). Epidemiological studies have looked at the effect of social isolation at work and have found associations with absenteeism and the likelihood of having an accident at work, and also directly with physical health problems, such as cardiovascular diseases, as well as mental health problems (Lindblom, 2006; Ducharme et al, 2008). The EWCS explores workers' lack of social support in a range of questions on the practical support and assistance workers receive from their colleagues and managers. Overall, the proportion of workers in the EU reporting a lack of social support from colleagues declined from 15% in 2005 to 10% in 2010. Perceived lack of support from managers also fell, from 24% to 19% in the same period. Differences between countries in terms of workers reporting a lack of social support are not high; however, in Denmark, Ireland, Malta and Portugal, the lack of social support is more than 5 percentage points higher than in the EU as a whole (9%), while in Italy only 1% of workers report a lack of social support. As regards sectors, lack of support is reported more often in agriculture and transport, very likely related to carrying out activities in isolation due to the nature of the job.

The role of managers is important for social support. There is a sizeable body of research on leadership styles in relation to creating good working conditions and in achieving the goals set for the organisation. Eriksson et al (2010) distinguish between management support for health-promoting activities and supportive management, meaning that work is managed in a health-promoting way – for example, balancing the demands put on employees, supporting their participation and providing social support and recognition. An index of leadership and relationship with one's superior was created using EWCS variables and included the following items: immediate manager respects worker as a person; manager provides help and support, is good at resolving conflicts and in planning and organising work; receive feedback from manager; and being

Figure 16: Index of leadership and relationship with one's superior, by occupation



Note: EU28 average = 100.

Source: EWCS, 2010.

encouraged to take part in decisions. Based on this index, the majority of EU workers have a positive relationship with their superior. However, differences exist according to occupation (Figure 16). In general, workers in lower-level occupations have poorer relationships with their bosses. The importance of this index for well-being is demonstrated by the finding that employees who evaluate their manager positively are almost twice as likely to report being satisfied with their working conditions as those who evaluate their boss negatively.

As mentioned above, social partners at European level considered it important to address one aspect of the social environment at work – harassment and violence – in a framework agreement. The EWCS contains questions relating to aspects of harassment and violence, and an index on adverse social behaviour was created using these. The variables used were verbal abuse, unwanted sexual attention, threats and humiliating behaviour, physical violence, bullying and harassment, and sexual harassment.

Before discussing the extent of adverse social behaviour, it must be highlighted that levels of reporting are different for each specific question. Verbal abuse is quite prevalent in the workplace, with 11% of workers reporting having experienced it within the previous month. Humiliating behaviour occurs less frequently, with 5% of workers reporting having been humiliated or threatened in the previous month. Unwanted sexual attention is the least prevalent form of adverse social behaviour, being reported by just 2% of workers. A significant gender difference is found with regard to sexual behaviour, with women twice as likely as men to have received unwanted sexual attention. In relation to the other three variables, 4% of workers report having been subjected to bullying or harassment in the year preceding the survey; 2% report having been subjected to physical violence; and around 1% say they were subjected to sexual harassment. Only with regard to sexual harassment is there a significant gender difference, with women almost three times as likely as men to be subjected to sexual harassment.

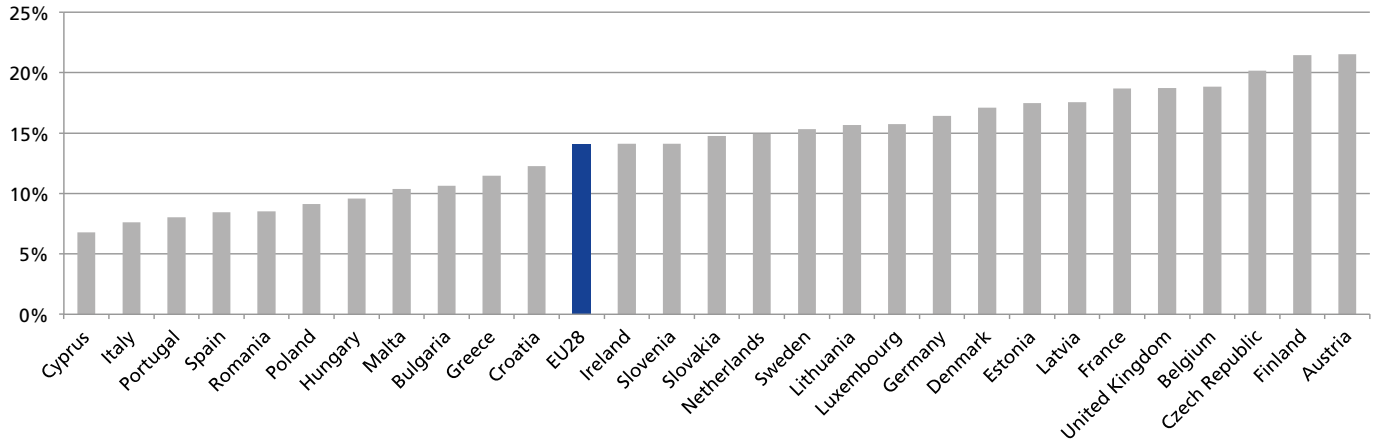
Overall, the percentage of workers reporting any type of adverse social behaviour in the EU is 14% (Figure 17). Reported levels of exposure to adverse social behaviour are lowest in some southern European countries (Cyprus, Italy, Portugal and Spain) and highest in Austria and Finland. Finland also stands out as the country with the widest gap between the level reported by men (16%) and women (27%).

The social context of some economic activities seems to make them more prone to adverse social behaviours than others (Figure 18). Reported exposure to adverse social behaviour is lowest in agriculture and construction, and highest in transport and health. In some sectors, men and women do not differ significantly in the extent to which they report exposure to adverse social behaviour, but in sectors where they do differ, the difference can go either way. In health and education (sectors where female workers are in the majority), men are more likely than women to report having been subjected to adverse social behaviour; however, the same pattern is found in construction, which has more male than female workers. In agriculture and financial services, on the other hand, more women than men report having been subjected to adverse social behaviour.

Eurofound (2013a, b) found that during the economic crisis events linked with violence and harassment increased, especially in workplaces going through restructuring processes.

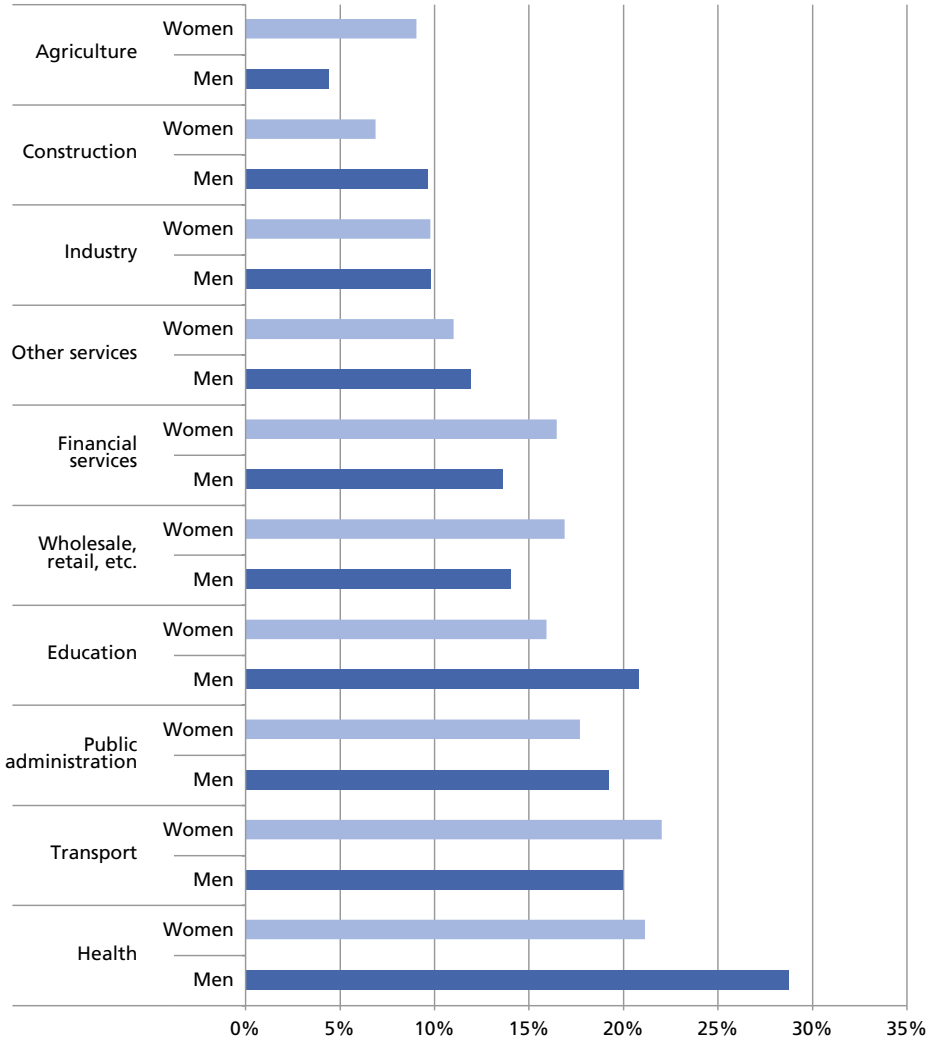
The concept of organisational justice helps to identify other important constructs that shape the psychosocial work

Figure 17: Experience of adverse social behaviour, by country (% workers)



Source: EWCS, 2010.

Figure 18: Experience of adverse social behaviour, by sector and gender (% workers)



Source: EWCS, 2010.

environment. One of these is discrimination in organisations, which may have a significant influence on the connection between work stress and ill-health (Bambra, 2011). Moreover, discrimination might be linked to the probability of adverse social behaviour as a consequence of discriminatory attitudes and behaviours. Only 6% of workers report having been subject to some form of discrimination in the workplace. However, differences can be found between some countries. The highest percentages of workers reporting discrimination are in Belgium (11%), Luxembourg (11%), Finland (10%) and France (10%) and the smallest in Italy, Lithuania and Poland, with 3% in each.

The three elements of the social environment discussed in this section – social support and leadership, adverse social behaviour and discrimination – vary in prevalence across EU countries. For example, Italy has better results related to social support and leadership, whereas in Finland there is a comparatively high share of workers reporting discrimination and adverse social behaviour.

The importance of dimensions of the social environment is highlighted by further analysis of the EWCS (see the section 'Health and well-being and the association with psychosocial factors', below). Adverse social behaviour is one of the risks that have a higher association with negative health and well-being outcomes, especially in terms of experiencing stress at work, having sleeping problems or overall negative impact of work on health. Discrimination is mainly related to workers reporting sleeping problems. However, experiencing high levels of social support diminishes the probability of suffering these problems and reporting general poor well-being.

Job insecurity and career development

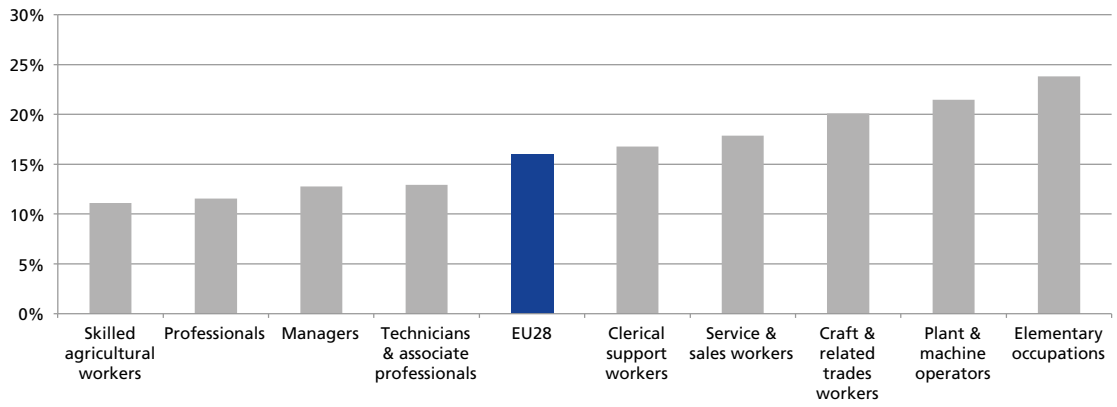
The premise of the effort–reward imbalance model is that psychological stress results from a mismatch between efforts made by workers and the rewards they receive from their employer in terms of pay, esteem, job security and career opportunities (Siegrist, 1996). One example of a stressor in this context is the confinement to fixed-term contracts and a dearth of alternative labour market opportunities, particularly when unemployment rates are high. Related to this is the concept of job insecurity.

The fear of losing one's job and the effects that this might have, as well as the lack of career prospects, can have implications for psychosocial health and well-being. According to secondary analyses of the fifth EWCS in the reports *Health and well-being at work* (Eurofound, 2013c) and *Impact of the crisis on working conditions and industrial relations* (Eurofound, 2013a), the context of the crisis has strengthened the relationship between poor mental well-being and job insecurity.

It is important to differentiate between type of contract and job insecurity. When looking separately at the average well-being associated with having a permanent contract (versus a temporary one) and perceived job security (versus job insecurity), job security has a bigger influence than the type of contract. The fear of losing a job is associated with a remarkable drop in average well-being. Levels of job and employment insecurity increased from 2005, as recorded by the EWCS, to 2012, as recorded by the European Quality of Life Survey. This can be clearly related to changes in the economic climate and, in some cases, probably also to changes in employment protection legislation (Eurofound, 2013a).

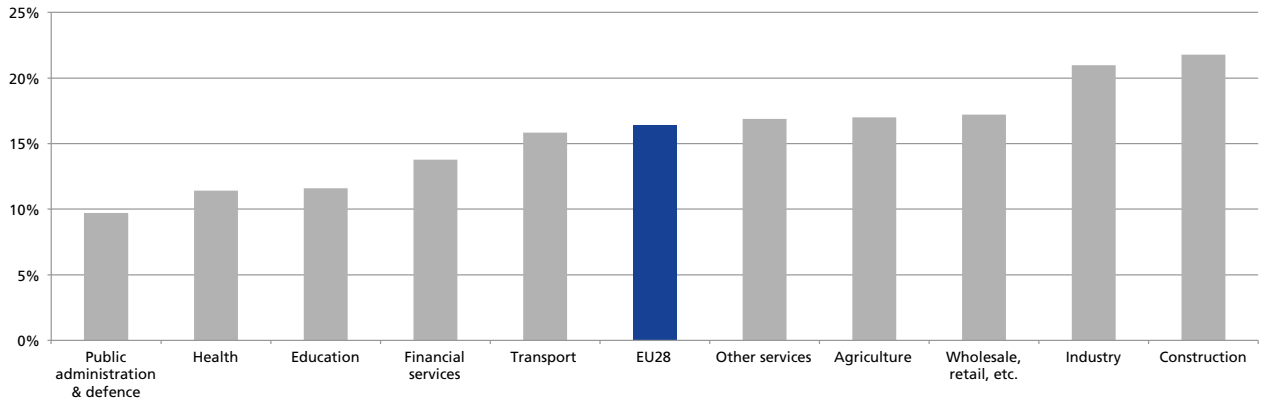
In terms of job insecurity, 16% of EU workers in 2010 said that they expected to lose their job in the next six months. There are significant differences by country: the lowest level was found in Denmark (10%) and the highest in Lithuania (40%). From the beginning of the crisis in 2008 until 2012, the share of workers reporting job insecurity rose only slightly, by 2%. However, there have been striking increases in the Baltic countries (for example, by 23 percentage points in Lithuania) and Ireland (by 16 percentage points). There are also relevant differences with regard to job insecurity according to occupational level. Elementary occupations, operators and skilled workers in industry and construction show higher levels of job insecurity, while, in general, less insecurity is evident in higher-level occupations (Figure 19).

Figure 19: Perceived job insecurity, by occupation (% workers)



Source: EWCS, 2010.

Figure 20: Perceived job insecurity, by sector (% workers)



Source: EWCS, 2010.

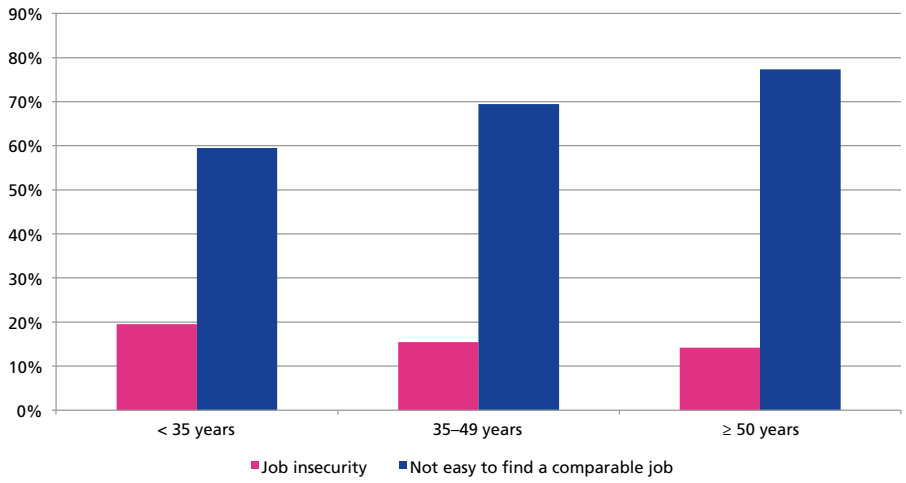
Level of job insecurity also varies between sectors (Figure 20). Workers in the public sector express the lowest levels of job insecurity, which rises to 22% of workers in construction.

However, a different picture emerges when respondents are asked if they would find it easy to get a new, equivalent job, with similar pay, in the case of job loss. Workers in transport (42%) are the most optimistic, while workers in financial services are the least convinced they would be able to find a similar job (19%). If the different groups are considered according to gender and age, it emerges that the proportion of older workers reporting that they might lose their job in the next six months is lower than other age groups (Figure 21). However, when it comes to finding a comparable job, this group of workers is less confident. Therefore, older workers have more secure jobs but feel they are less employable. This is to some extent related to the fact that young workers are more likely to have a fixed-term contract. It is important to note that many older employees would have been recruited into permanent posts before the flexibilisation of the labour market; therefore, the differences are not necessarily explained by age discrimination. At aggregate level, there are no gender differences for either job insecurity or subjective employability.

Apart from job insecurity, the literature mentions other aspects of employment and career development that are potential psychosocial risks. The issue of fairness takes into account different aspects of reward for workers: being well paid, feeling the work is well done, doing useful work and having career prospects. There is a relevant gender dimension to 'being well paid', as women in all age groups are less convinced that they are (Figure 22).[5] Career prospects vary according to age, as younger workers expect to have greater opportunities for career development. This is understandable since, as workers get older, their career shortens. Differences are also found by economic activity: workers in financial services are by far the

[5] Evidence shows that the pay gap is a reality; see Eurofound, 2010a.

Figure 21: Perceived job insecurity and employability, by age group (% workers)



Source: EWCS, 2010.

Figure 22: Indicators of career development, by gender and age group (% workers)

Source: EWCS, 2010.

most positive about the prospects for career advancement (51%), and workers in agriculture the least optimistic (14%).

As for other forms of intrinsic rewards such as doing useful work or having the feeling of work well done, there are no significant differences by gender or age.

In total, 84% of workers feel that their work is useful, and 95% typically feel that they have done the work well. Differences exist with regard to occupation. For example, 75% of employees in elementary occupations report feeling their work is useful, while 92% of professionals hold that opinion. And 91% of workers in elementary occupations feel that they normally do their work well, whereas this is the case for 99% of professionals.

EWCS analysis also shows the implications for job security and career development of health and well-being. Job insecurity is related to poor well-being (and to a lesser extent to sleeping problems), while career prospects, the feeling of being well paid, and the feeling that the work is well done reduce the chances of reporting poor well-being (see the section 'Health and well-being and association with psychosocial risks').

Establishment size and the self-employed

When looking at implementation of preventative measures or procedures related to psychosocial risks, establishment size is a relevant variable as larger companies differ from smaller ones in terms of interventions put in place (see Chapter 2, 'Management of psychosocial risks in European establishments'). In addition, there are some working conditions that might differ according to company size, which should be considered when planning policy initiatives and organisational interventions. This section explores the effect of differences in establishment size. It should be borne in mind that the size of a workplace is also related to economic sector. For example, companies in the chemical sector are bigger than those in retail. It is also important to remember that, according to the EWCS, the biggest group of European workers (42%) work in micro-companies (with between 1 and 9 employees) and that only 12% work in large companies (with more than 250 workers). In addition, an important composition variable to consider is the percentage of self-employed people within establishment groups of different sizes. They represent 33% of workers in micro-companies, while their number is almost negligible in aggregate data for bigger companies.

Differences between small and large companies exist in terms of job content and change in the workplace. For example, the proportion of workers with jobs involving complex tasks increases with the size of the establishment. The same pattern is observed for training: the bigger the workplace, the more workers have received training offered by the employer. Restructuring and other changes in the workplace (related to technologies, processes and organisation) are also more frequently reported in bigger companies. However, no relevant establishment size differences have been found as regards some working conditions having a stronger link with health and well-being outcomes (for example, monotonous tasks and the need for skills to cope with duties).

Based on the Karasek model (described above), job autonomy is greater in micro-companies than in large companies, while work intensity rises slightly with establishment size. The increased autonomy in smaller companies is a result of the large proportion of self-employed people in these companies, as their index of autonomy is higher than for employees. Excluding self-employed workers, there are no relevant differences in job autonomy between the micro-companies, SMEs and large companies.

Due to the large proportion of self-employed workers in micro-companies, more than double the percentage of workers in these companies work long hours (more than

48) in comparison with workers in larger establishments. However, employees in SMEs are to some extent less exposed to working irregular hours than workers in large companies. The index of irregularity is very high for self-employed workers. This working time pattern might influence the percentage of self-employed reporting poor work–life balance: 22%, against 18% of employees. Despite these findings, there is no relevant difference by workplace size in terms of the extent to which workers are able to reconcile work and private life.

With regard to aspects of the social environment, and considering the variable social support for employees, there is only a very small difference between smaller and bigger companies. However, the share of self-employed workers in micro-companies with lack of support is higher than the proportion of employees reporting that situation. With regard to adverse social behaviour, a larger share of workers reports this problem in bigger workplaces than in smaller establishments.

Finally, differences have been found in perceptions of being well paid and career prospects. For both indicators, the share of workers is lower in smaller companies, meaning fewer opportunities for career development within these companies. With regard to job insecurity, jobs in the biggest companies are somewhat more secure than in SMEs. Interestingly, self-employed workers are less affected by job insecurity (10%) than employees, and a higher percentage of self-employed people report doing useful work (92%) than the workforce average.

To sum up, differences by establishment size exist mainly in job content, organisational changes, job security and career prospects. Large companies more often go through changes and the work involves more complex tasks. However, their workers have better conditions in terms of having the skills to cope with the work, career prospects and job security. Some of the findings for micro-companies are clearly influenced by the large proportion of self-employed workers in these establishments.

If just large companies and SMEs are compared, SMEs have slightly less irregular working times and less work intensity, but workers also have fewer opportunities to influence working time arrangements. It is evident, therefore, that workers in SMEs are as exposed as those in big companies to psychosocial risks, with some differences for certain factors. However, fewer SMEs have procedures to tackle psychosocial risks than large companies (see Chapter 2 for more information). This might be influenced by the fact that they have fewer resources and less awareness of the costs of non-compliance in terms of higher risks. Moreover, employee health and safety representatives are frequently lacking in smaller companies, making it more difficult to implement the participatory approach envisaged by the 1989 EU Framework Directive on health and safety. The situation is related to the fact that most countries require a threshold number of employees in order to introduce occupational safety and health (OSH) employee representatives. In view of limited company-specific resources, social dialogue and collective agreements at local, regional and sectoral level, as well as various bipartite and tripartite institutions, are much more important for micro-companies and small companies than for larger ones. One example is the existence of territorial-level OSH representatives or mutualisation of resources managed by social partners through bipartite bodies (Eurofound, 2014).

Some of the working conditions described in this chapter can be affected by national social and economic policies (such as regulations on labour and employment). Nevertheless, the consequences that psychosocial risks might have for the health of workers must be highlighted because, for some risks, organisations can implement interventions to prevent negative outcomes.

Health and well-being and the association with psychosocial factors

This section explores the relationship between the working conditions associated with psychosocial risks presented above and health and well-being outcomes. It first describes the outcomes that will be examined and briefly looks at their prevalence in the European workforce. The results of a logistic regression analysis are then presented to demonstrate the relationships between psychosocial risk factors and the selected health and well-being outcomes.

Work and health: A complex relationship

Establishing the relationship between work and health is not straightforward. Health might be affected by the work environment but is also determined by the personal behaviour, lifestyle and living conditions, institutional and economic context (such as welfare regime), and genetic make-up of workers. Simultaneously, their health is likely to affect the choices people make or see themselves forced to make in terms of their career and their employment in general, the opportunities they are offered, and the general demeanour of others in the workplace towards them.

In the workplace, workers are exposed to different risks that themselves differ in the way they affect health. Exposure to some risks has a direct impact on health: for example, exposure to loud noise may lead to temporary or long-term hearing problems. This is also true of work-related stress, which can have a direct influence on physical or mental health. Exposure to other risks affects health indirectly: for example, work-related stress has been shown to be related to smoking, and to eating and drinking behaviour that negatively affects health.

It needs to be noted, however, that some health problems are caused by a constellation of factors, rather than exposure to a single physical or psychosocial factor. Furthermore, the effect of exposure to risk factors is likely to differ depending

on a wide number of individual worker characteristics (genes, lifestyle and socioeconomic position, for example).

Finally, the extent to which negative direct or indirect effects of work on health affect the capacity of people to engage in paid work and their general quality of work and life depends on the extent to which these effects can be mitigated or remedied.

Challenges of measurement

Using the fifth EWCS to measure the impact of work on health presents a number of challenges. Firstly, the survey is carried out among workers and asks about the working conditions in their current job. Those workers whose health has deteriorated due to work or other reasons are likely to have left the labour force or moved to jobs that are less physically or mentally demanding. Due to this 'healthy worker effect', the survey results are likely to provide an underestimation of the negative impact of work on health. Secondly, the survey is cross-sectional rather than longitudinal, which means that workers are not followed over time, but a new sample is drawn for every wave of the survey. Given that exposure to physical and psychosocial risks is likely to have an impact on health not immediately, but rather gradually over time, this is a second reason to assume the survey results provide an underestimation of health effects. Thirdly, indicators of health and well-being in the fifth EWCS are self-reported by the respondent, which has its limitations. However, most of the indicators on self-reported health and on mental well-being are commonly used in international studies, and many of them have been validated in previous research.

Health and well-being outcomes

The WHO has shown that there is reasonable consensus in the literature about the association between certain working conditions and stress and, as a consequence, workers' health (Leka and Jain, 2010). The same report mentions the effects of psychosocial factors on stress, burnout, poor mental health, musculoskeletal disorders and sleeping problems.

According to Eurofound research on work-related stress (2010b), the main risk factors include a heavy workload, long working hours, lack of control and autonomy at work, poor relationships with colleagues, poor support at work and the impact of organisational change. The main outcomes are physical and mental health problems, absence from work, reduced quality of outputs, increased welfare and medical spending, and reduced productivity. Most of these risk factors, and some of the outcomes, are analysed in the following sections.

This chapter uses four types of indicators to assess the effect of psychosocial risks on health and well-being. First are health-related outcomes. These outcomes include a reported negative effect of work on health. The link between work and health is made by the respondents themselves, and the analysis can reveal when workers are more likely to perceive this negative association. In the survey, respondents are asked to indicate whether they suffer from a range of health symptoms. This analysis considers reported sleeping problems and musculoskeletal disorders; the latter category includes back pain, muscular pain in neck, shoulders and upper limbs, and muscular pain in lower limbs. Although it is still disputed, some studies have suggested a relationship between some psychosocial risks, such as lack of job autonomy, work intensity and effort–reward imbalance, and physical health outcomes, such as musculoskeletal disorders, as well as cardiovascular diseases (Niedhammer et al, 2013; Duburcq et al, 2013).

A final health-related outcome is poor mental well-being, which is measured using a validated index, the WHO-5 Well-Being Index. Respondents are asked to answer five questions assessing positive mood (feeling in good spirits and relaxed), vitality (feeling active and waking up fresh and rested) and general interest (being interested in things). A raw score (from 0 to 25) is calculated based on their answers; scores below 13 indicate poor well-being.

The second type of indicator considered here is work-related stress, which is indicated by respondents reporting that they experience stress in the job always or most of the time. Work-related stress poses some conceptual difficulties, as it can be seen both as an outcome of exposure to a constellation of psychosocial factors, and as a psychosocial factor in its own right. For instance, Karasek and Theorell (1990) argue that work-related stress is not necessarily problematic, unless it is accumulated without the possibility of relief, resulting in job strain. This would be the case particularly under circumstances where workers have little support from supervisors and colleagues and little control over the work process. Such work-related stress experienced over a long time would have a negative effect on health and well-being. It is therefore of interest to see how other psychosocial factors are associated with reported work-related stress.

The third type of indicator is 'work ability', and two outcomes are examined: work ability now, as indicated by reported absenteeism; and work ability in the future, as indicated by respondents' assessments of their ability and willingness to do the job at age 60.

The fourth indicator is satisfaction with working conditions as reported by respondents.

Figure 23 shows that women are slightly more likely to report issues related to health and well-being, apart from the negative effect of work on health (of either a physical or psychosocial origin), which men (27%) are more likely to report than women (22%). For work-related stress, there is little difference in terms of gender: 27% of women and 26% of men report having that problem always or most of the time. Sleeping disorders are reported by 20% of women and 16% of men, and

Figure 23: Health and well-being outcomes, by gender (% workers)

Source: EWCS, 2010.

musculoskeletal disorders are experienced by 61% of women and 58% of men. It has also been found that musculoskeletal disorders are more prevalent among older workers, among workers in lower-level occupations and among workers in the agriculture, construction and transport sectors.

Women are more likely to suffer from poor mental well-being (22%) than men (17%). As is the case with musculoskeletal disorders, the prevalence of poor mental well-being is higher among lower-skilled workers and it increases with age. As for sectors, a higher prevalence is found in agriculture, transport and industry.

In general, there is a straightforward relationship between the various indicators of health and well-being and occupation. Generally, workers in lower occupational classes are more likely to report poor mental well-being, musculoskeletal disorders and a negative effect of work on health.

There are also differences between countries. For example, lower percentages of workers with poor mental well-being are reported in Denmark (7%), Ireland (9%) and Spain (9%) and higher percentages in Lithuania (41%), the Czech Republic (32%), Latvia (32%) and Croatia (31%). Important country differences exist with regard to musculoskeletal disorders; for example, only 34% of Irish workers report this type of problem, compared with 80% of workers in Finland.

There are no important differences between different establishment sizes. Workers in large companies are slightly more likely to report a negative effect of work on health (30%) than workers in SMEs (27%). A similar pattern is found for absenteeism. Inability or unwillingness to do the job at age 60 is also most prevalent in large companies and least prevalent in SMEs. Poor well-being and musculoskeletal disorders do not differ in prevalence across the different-sized establishments.

Associations between exposure to psychosocial risks and health and well-being

Logistic regression analysis was carried out to establish the relationship of the various psychosocial risks with the health and well-being outcomes described above. This analysis controlled for gender, age, country and exposure to physical risks, meaning that these variables did not affect the associations found.

The results of the analysis are shown in Table 1, where the figures indicate the likelihood of workers with a particular characteristic experiencing an event compared with those workers who do not have that characteristic. If the figure is greater than 1, workers with the characteristic are more likely to experience the event than those without; if the figure is less than 1, workers with the characteristic are less likely to experience the event. For example, the self-employed are 0.758 times less likely than workers who are not self-employed (in other words, employees) to report that work affects their health negatively.

When looking at self-employment, it is clear that, overall, the self-employed report somewhat better health and well-being than employees. Interestingly, the largest differences are found for the indicators of work ability: absenteeism and the ability to do the job at 60. No significant effects are found for musculoskeletal disorders, poor mental well-being and work-related stress.

Job content

Workers who work in an organisation that underwent some sort of restructuring in the previous year are more likely to report negative outcomes in terms of health and well-being. The association is strongest with regard to reporting work-related stress and absenteeism.

Table 1: Results of logistic regression of psychosocial elements of work on health and well-being outcomes

	Work affects health negatively	Sleeping problems	Musculo-skeletal disorders	Poor mental well-being	Stress at work	Absenteeism	Unable to do job at 60	Dissatisfied with working conditions
Status								
Self-employed	0.758	0.771	n.s.	n.s.	n.s.	0.504	0.570	0.652
Job content								
Restructuring	1.133	1.167	1.195	1.094	1.279	1.296	0.919	n.s.
Monotonous tasks	1.313	1.222	1.224	1.373	n.s.	1.105	1.136	1.610
Complex tasks	1.490	1.313	1.153	n.s.	1.401	1.126	0.868	n.s.
Repetitive tasks	n.s.	n.s.	1.087	n.s.	n.s.	1.098	n.s.	0.848
Need training to cope with duties	1.445	1.393	0.914	1.249	1.517	n.s.	n.s.	1.508
Has skills to cope with demanding duties	n.s.	n.s.	n.s.	0.907	n.s.	0.898	n.s.	1.140
Dealing with angry clients	n.s.	1.211	n.s.	n.s.	1.988	n.s.	n.s.	0.822
Job requires hiding feelings	1.185	1.393	n.s.	1.152	2.684	n.s.	n.s.	1.259
Knowing what is expected at work	1.150	n.s.	1.402	0.692	n.s.	1.186	n.s.	0.696
Work intensity and autonomy								
High job autonomy	n.s.	n.s.	1.172	0.880	1.229	n.s.	0.874	0.681
High work intensity	1.670	1.219	1.167	1.128	2.913	1.094	1.343	1.541
High job autonomy and high work intensity	n.s.	n.s.	n.s.	n.s.	0.804	0.887	0.865	0.801
Working time and work–life balance								
Part time (< 35 hr)	n.s.	n.s.	n.s.	n.s.	n.s.	0.785	1.145	n.s.
Long hours (> 47 hr)	1.322	1.349	1.201	n.s.	1.470	0.752	1.151	1.261
Irregular working hours	1.287	1.347	1.313	1.309	1.153	n.s.	1.101	1.137
Good fit between work and private life	0.621	0.682	0.838	0.649	0.559	n.s.	0.664	0.451
Social environment								
High social support	n.s.	0.678	n.s.	0.735	n.s.	n.s.	n.s.	0.612
Discrimination	n.s.	1.785	1.324	1.270	1.226	1.338	0.850	1.712
Adverse social behaviour	2.025	1.988	1.670	1.309	1.753	1.395	1.531	2.216
Job insecurity and career development								
Career prospects	0.713	0.845	0.693	0.621	n.s.	n.s.	0.765	0.397
Job insecurity	1.301	1.313	1.220	1.481	1.125	0.891	1.287	2.245
Well paid for the job	0.715	0.862	0.785	0.622	0.800	0.912	0.744	0.358
Feeling of work well done	0.797	0.838	0.813	0.615	0.691	0.668	0.697	0.332
Physical risks								
Posture- and movement-related risks	1.946	n.s.	2.175	n.s.	1.092	n.s.	1.871	1.228
Biochemical risks	1.534	n.s.	1.116	1.116	0.893	1.108	n.s.	n.s.
Ambient risks	1.486	1.208	1.323	1.215	n.s.	1.133	1.392	1.504

Notes: Control variables for sex, age and country were included in the model; n.s. = not statistically significant ($p < 05$).

Source: EWCS, 2010.

The associations found for monotonous tasks are in line with expectations: monotony is associated with negative outcomes for health and well-being, although no significant effect is found for work-related stress. The results for task complexity are perhaps more surprising, as carrying out complex tasks is associated with a greater likelihood of reporting a negative effect of work on health, work-related stress and sleeping disorders. No effect is found for poor mental well-being and dissatisfaction with working conditions, and complexity is associated with a decreased likelihood of reporting inability to do the job at 60. Carrying out repetitive tasks has a limited association with health and well-being outcomes.

Having a job that requires the worker to either deal with angry clients or hide their feelings increases the chances of reporting work-related stress and, to a lesser extent, sleeping disorders. Needing further training to cope with one's duties is associated with a greater likelihood of reporting a negative effect of work on health, sleeping disorders, poor mental well-being, work-related stress and dissatisfaction with working conditions. Among job content, this risk, together with complex and monotonous tasks, has a stronger relationship with negative health and well-being outcomes than other risks. These results emphasise the importance of ensuring a good match between skills and tasks, in terms of both health and well-being and worker motivation.

Work intensity and autonomy

Considering work intensity and autonomy individually, work intensity is much more consistently related to outcomes for health and well-being and is certainly one of the working conditions that have the strongest relationship with poor health and well-being. Workers reporting high levels of work intensity are particularly more likely to report a negative effect of work on health, work-related stress and dissatisfaction with working conditions. The association with work-related stress stands out: those reporting high work intensity (above the median) are three times more likely to report work-related stress than those reporting low work intensity (below the median). The association between job autonomy and health and well-being outcomes is not straightforward. However, the results for workers in 'active' jobs – reporting both high autonomy and high intensity – are in line with the expectations of the Karasek model in relation to work-related stress and dissatisfaction with working conditions: autonomy helps workers to cope with high levels of intensity.

Working time arrangements and work–life balance

The impact of working long hours is pronounced. Those working 48 hours or more are generally more likely to report negative health and well-being outcomes than those working 35 to 47 hours, with the largest differences found among workers reporting that work negatively affects their health, work-related stress and sleeping disorders. Irregular working hours are also associated with poorer health and well-being outcomes, particularly with sleeping problems and musculoskeletal disorders, which can be related to a greater prevalence of irregular hours in certain economic sectors.

Those reporting a good fit between work and private life are much less likely to report negative outcomes for health and well-being; notably, they are more satisfied with work and experience less work-related stress. The consequence for preventative actions seems to be clear: improving work–life balance prevents negative health outcomes.

Social environment

Workers reporting high levels of support from colleagues are less likely to report sleeping problems, poor mental well-being and job dissatisfaction. However, the relationship between levels of lack of support and health and well-being outcomes is not as strong as for the other two social environment risks: discrimination and adverse social behaviour.

Those who report experience of discrimination are more likely to report sleeping problems, musculoskeletal disorders, poor mental well-being, absenteeism and job dissatisfaction. However, the psychosocial factor that has the strongest associations with negative outcomes for health and well-being is adverse social behaviour. Those who have experienced adverse social behaviour are more than twice as likely to report a negative effect of work on health, sleeping problems and dissatisfaction with working conditions; they are also much more likely to report musculoskeletal disorders, poor mental well-being, absenteeism and inability to do the job at 60. These results must be taken seriously because cases of this nature can have devastating effects on workers and probably for the organisation as well.

Job insecurity and career development

Job insecurity has a strong negative impact on satisfaction with working conditions and is associated with an increased likelihood of reporting negative outcomes, especially with poor mental well-being. Surprisingly, it is associated with a slightly lower likelihood of reporting absenteeism. By contrast, having good career prospects and being well paid for the job have a strong positive association with satisfaction with working conditions and, overall, decrease the likelihood of reporting negative outcomes for health and well-being, especially poor mental well-being. In line with these results, those reporting that their job regularly gives them the feeling of work well done are also more satisfied with the job and are less likely to report poor mental well-being.

General picture and implications

As well as psychosocial risks, Table 1 shows how exposure to posture- and movement-related risks, biochemical risks and ambient risks are related to health and well-being. These variables were included as controls in the model because physical risks and psychosocial risks often coincide, and the results for physical risks provide a reference by which to assess the importance of the psychosocial factors. For instance, the experience of adverse social behaviour is associated with a greater number of negative health and well-being outcomes, and for the most part more strongly, than any of the physical risks. Similarly, work–life balance is more or less equally strongly associated with health and well-being as exposure to posture and movement-related risks.

Overall, adverse social behaviour, work–life balance, high work intensity and feeling of work well done stand out. These psychosocial factors are each in their own right related to health and well-being, and each of these individual effects can compensate for the others when less of the one coincides with more of the other. However, they can also reinforce each other, for instance when workers who are already faced with high work intensity, little job security and poor work–life balance also encounter harassment or other adverse social behaviour. Efforts can be made to prevent these factors from coinciding. Employers can improve the autonomy of workers, enabling them to cope better with work pressures. Workers can improve their employability to ensure better job and employment security. Campaigns can be organised to increase awareness of the detrimental effects of adverse social behaviour and to highlight the shared responsibility of governments, workers and employers to create good work–life balance.

Table 1 includes three outcome variables related to work ability and job satisfaction. The results suggest that many psychosocial working conditions are strongly related to job satisfaction. If we accept that job satisfaction contributes to work motivation and better performance, improving job security and aspects of career development as well as the social environment and work–life balance will have a positive impact for workers and organisations. The EU policy objective of higher participation in employment requires that workers be able to do the job when they reach the age of 60. Workers' feeling of work well done, good work–life balance and better social environment at work will contribute to this aim.

As a final point, the relationship between absenteeism and psychosocial working conditions seems to be more difficult to explain. It is clear that a hostile social environment (for example, one in which workers have to deal with adverse social behaviour) increases the chances of being absent, and that the feeling of work well done prevents absenteeism. However, some other risks that have a negative relationship with health outcomes do not seem to be related to higher absenteeism, for example job insecurity and long hours. Therefore, it can be argued that absenteeism levels are a result not only of workers' health but of other elements relating to their work and life.

Summary

Psychosocial risks that have a clear negative impact on workers' health and well-being include, among others, adverse social behaviour and a very high intensity of work. Some aspects of the work environment favour better health and well-being, such as an organisation of working time that favours work–life balance. The importance of a psychosocial risk can be analysed from the prevalence point of view (for example, the percentage of workers reporting a specific risk exposure) or by considering its relationship with health-related outcomes. Even considering those aspects, a proper assessment cannot be done until specific and contextual circumstances are considered.

In terms of prevalence, a considerable proportion of European workers report specific types of tasks (for example, tasks that are monotonous or complex) that can contribute to psychosocial problems if additional measures are not taken (such as variation in tasks or further training). Another risk that many workers are exposed to is high intensity of work (involving high speed or tight deadlines, for example). These are the two sets of risks most prevalent among workers in Europe, followed by aspects of working time organisation (irregular or long working hours, for example). Adverse social behaviour stands out unfavourably, as it is strongly related to stress and sleeping disorders; companies where workers experience this problem should be aware of the strong negative effects, which possibly extend to company performance. A good work–life balance seems to have a positive effect in preventing stress, sleeping disorders and poor mental well-being in general. Social support seems to have the same positive effect on well-being.

Different psychosocial risks affect different groups of workers. Irregular working time seems to be associated with specific economic sectors. Irregular schedules are more common in the transport sector than in manufacturing, for example, while adverse social behaviour is a greater problem in the health and services-related sectors than in other activities, such as manufacturing.

As regards establishment size, some differences exist in the prevalence of different psychosocial factors – for example, in terms of job content and career development in SMEs – and these should be taken into account for policies and organisational interventions. Overall, however, it seems that workers in SMEs do not experience a worse psychosocial environment than those in big companies. However, SMEs might be less well informed and have fewer resources to comply with OSH regulations. The next chapter shows that smaller companies are relatively less likely to implement psychosocial risk prevention procedures than large companies.

There are also some differences in exposure to psychosocial risks according to age. Younger workers report greater need for further training to cope with duties and more job insecurity, whereas older workers have more difficulties in relation to social support and career prospects. The situation as regards gender is somewhat more complex. Increasing incorporation of women into the service-related sectors means they are more likely to have to deal with angry clients. However, men in general work longer hours and report a slightly poorer work–life balance.

Eurofound findings confirm that SMEs face a number of difficulties in complying with OSH regulations owing to having fewer resources and less awareness of the costs of non-compliance in terms of higher risks. This result is corroborated by ESENER data presented in Chapter 2. Smaller companies frequently lack employee OSH representatives, making it more difficult to implement the participatory approach envisaged by

the EU Framework Directive on health and safety. The situation is related to the fact that most countries stipulate a threshold in terms of the number of employees before OSH employee representatives become a requirement.

Psychosocial risks are very sensitive to both an organisation's characteristics and its socioeconomic circumstances, and the results of this chapter have to be read in the context in which the information was obtained. The findings are policy relevant. Psychosocial risks are linked not only to health outcomes but also to aspects of performance such as absenteeism and job satisfaction. Moreover, in the context of the EU policy objective of higher labour market participation, the influence of these working conditions on the sustainability of work and how long workers can remain productive in employment has to be considered. Tackling these risks should be viewed as a priority because a better psychosocial environment at work can contribute to better health and better economic performance of workers, companies and countries in Europe.

2 Management of psychosocial risks in European establishments

As the previous chapter shows, a considerable percentage of European workers report being exposed at work to psychosocial risks that are related in various ways to health and well-being outcomes. Companies play a crucial role when it comes to preventing those risks. The European Survey of Enterprises on New and Emerging Risks (ESENER) aims to provide a better understanding of the management of occupational safety and health (OSH) risks in practice, with a special focus on psychosocial risks. Even though available evidence suggests that psychosocial risks are best prevented in the same structured way as other workplace risks, their practical management remains a challenge for most organisations, and little is known about how establishments actually tackle these risks. Therefore, ESENER seeks to:

- investigate how well psychosocial risks, including work-related stress, violence and harassment, are covered within the general framework of OSH management in European workplaces;
- explore the views of managers and workers' representatives;
- investigate the main drivers for taking action and the most significant obstacles, and what support is needed.

The survey was conducted in 2009 in establishments with 10 or more employees across 31 countries: the 27 EU Member States at the time plus Croatia (now a Member State), Norway, Switzerland and Turkey. It covered both private and public organisations from all sectors of activity except for agriculture, forestry and fishing, private households, and extraterritorial organisations. Between 350 and 1,500 establishments were surveyed per country and, in general, the samples were representative of close to two-thirds of employment in the countries covered. In total, around 36,000 computer-assisted telephone interviews (CATI) were carried out.[6]

[6] For more information on the methodology of this survey, see the technical report available at http://www.esener.eu.

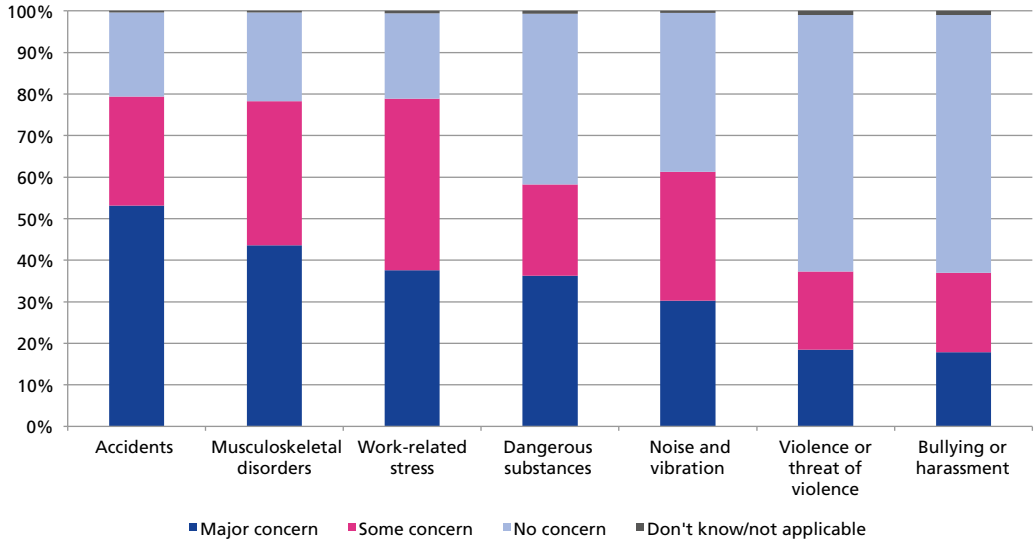
This chapter presents a summary of the main results for the EU28, complemented by a secondary analysis exploring in more detail drivers and barriers for the management of psychosocial risks and the role of worker participation in this process. The results are based on interviews with the highest-ranking manager responsible for coordination of safety and health at work at the establishments surveyed. For the full overview report, see EU-OSHA, 2010a.

Concern about psychosocial risks in establishments

Managers were asked whether different OSH risks, including work-related stress, violence or threat of violence, and bullying or harassment, represent a major concern, some concern or no concern at all in their establishments. As shown in Figure 24, work-related stress is of some or major concern in nearly 80% of establishments in the EU, which puts this risk next to accidents and musculoskeletal disorders among the most commonly reported risks by managers. Violence or threat of violence and harassment are less widespread concerns; nevertheless, nearly one in five managers surveyed considers these risks to be of major concern.

In terms of establishment size, concern over psychosocial risks increases steadily as the size of the establishment grows. Work-related stress is reported to be of some or major concern in around 90% of large establishments (with 250 and more employees) and in 75% of the smallest establishments (with 10–19 employees). For violence or threat of violence, the figures are also slightly higher for bigger companies than the smallest establishments (50% and 30%, respectively), and the same pattern is observed for harassment (around 60% compared with 30%).

Figure 24: OSH issues that represent major, some or no concern (% establishments)



Source: ESENER, 2009.

ESENER also asked managers whether any of 10 possible risks is a concern in their establishment (Cox, 1993; EU-OSHA, 2009). As shown in Figure 25, the most commonly reported risks are time pressure (identified by over 50% of managers) and having to deal with difficult customers, patients, pupils, etc. (reported by 50% of managers). Around one in four managers points to poor communication between management and employees and job insecurity. Again, smaller establishments are less likely to report that any of the risks is a concern, which raises questions of whether there are fewer risks present in these firms or whether they are less aware of those risks in their workplaces.

When examined by sector, all of the psychosocial risks are of greatest concern in health and social work, followed by education and public administration (Figure 26).[7] This reflects similar findings in other national and international surveys and in the scientific literature. The sectors other community, social and personal services activities, and electricity, gas and water supply stand out as having high levels of concern regarding violence and harassment compared with their levels of concern about work-related stress. This difference is also true for the hotels and restaurants sector as regards violence.

Prevalence of procedures and measures to deal with psychosocial risks

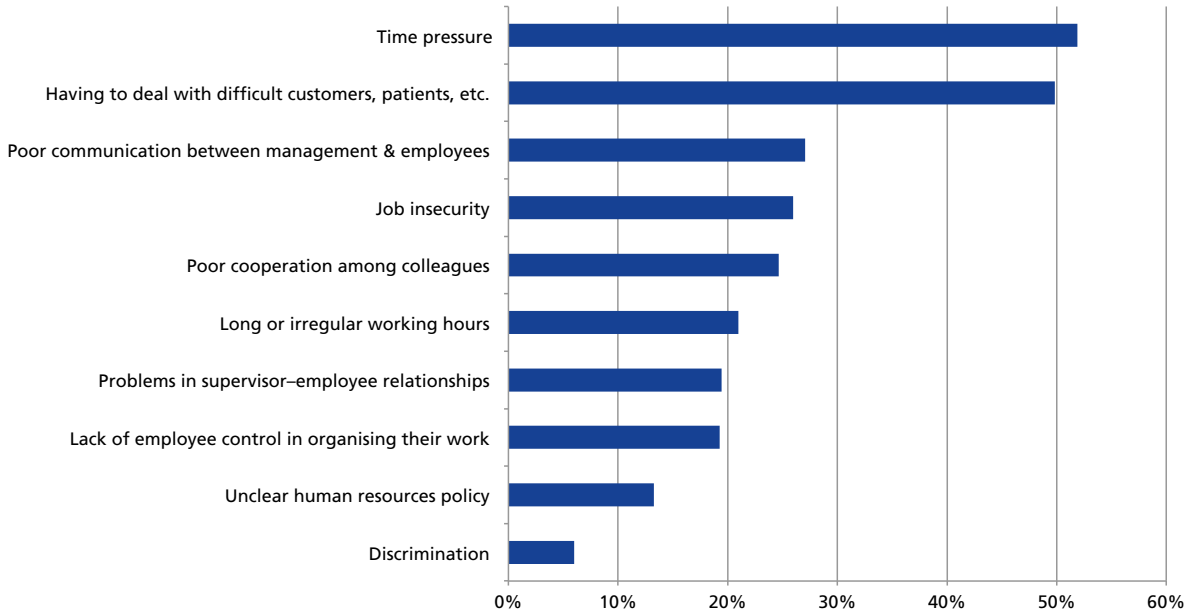
In its examination of how establishments manage psychosocial risks, ESENER collected data on whether there are procedures in place to deal with work-related stress, harassment and violence, and whether during the past three years measures have been taken to control specific psychosocial risks.

Procedures can be considered to represent a more 'formal' or system-based way of dealing with risks, embracing the whole process of addressing a particular issue at different stages and including a variety of actions to be taken, from preventive to corrective, at organisational and individual level. Specific *measures*, on the other hand, are regarded as more 'ad hoc' or reactive in nature. (Chapter 4, on organisational interventions, contains more information on what is meant by individual measures and on implementing more holistic processes and procedures.) It would be reasonable to expect smaller establishments to rely more on the latter approach – dealing with problems as they arise – than larger firms, which are more likely to take a proactive, systems-based approach to risk management in general and also to the management of psychosocial risks (see, for example, Bradshaw et al, 2001).

In general, the results show that between 25% and 30% of EU establishments have procedures in place to deal with psychosocial risks. Nevertheless, these more formalised procedures are widespread in only a few countries. The highest frequencies are reported in Ireland, the United Kingdom, Sweden, Belgium and Finland (Figure 27). By sector, these procedures are more frequent in health and social work, education, and financial intermediation, in line with the findings on concerns about psychosocial risks. Again, this might relate to the nature of the work in these specific sectors and to the level of awareness and custom in dealing with psychosocial risks in some countries. It is notable that, while

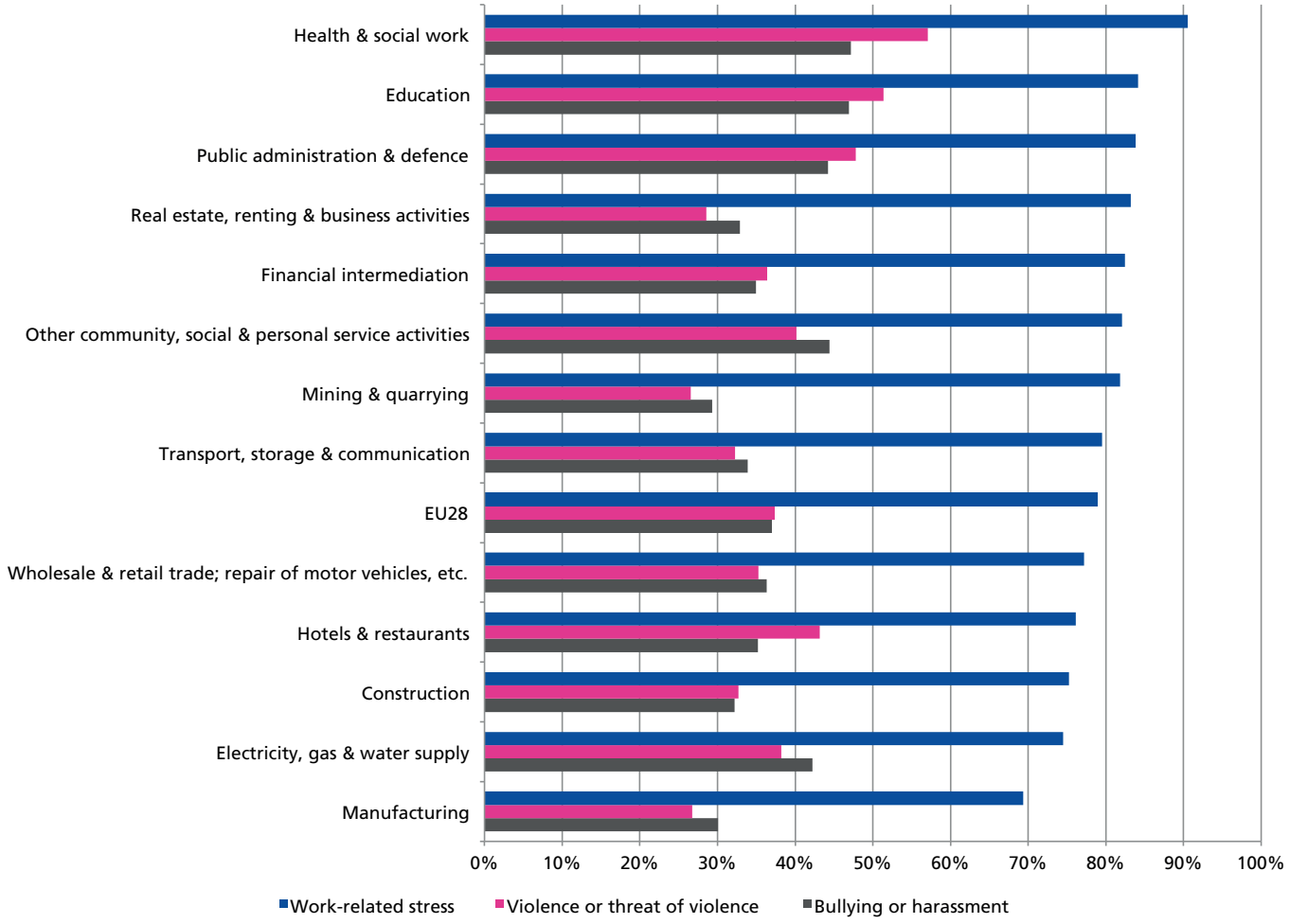
[7] In this chapter, the NACE Rev. 2 broad sector classification is used in the analytical breakdown by sector.

Figure 25: Managers' concerns over factors contributing to psychosocial risks at work (% establishments)



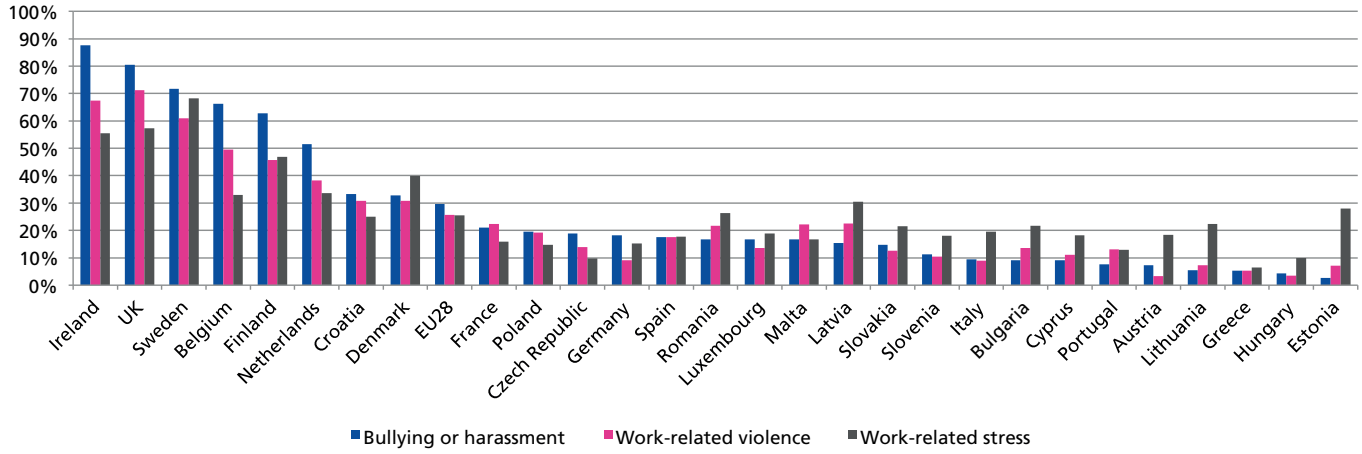
Source: ESENER, 2009.

Figure 26: Concern about work-related stress, harassment and violence, by sector (% establishments)



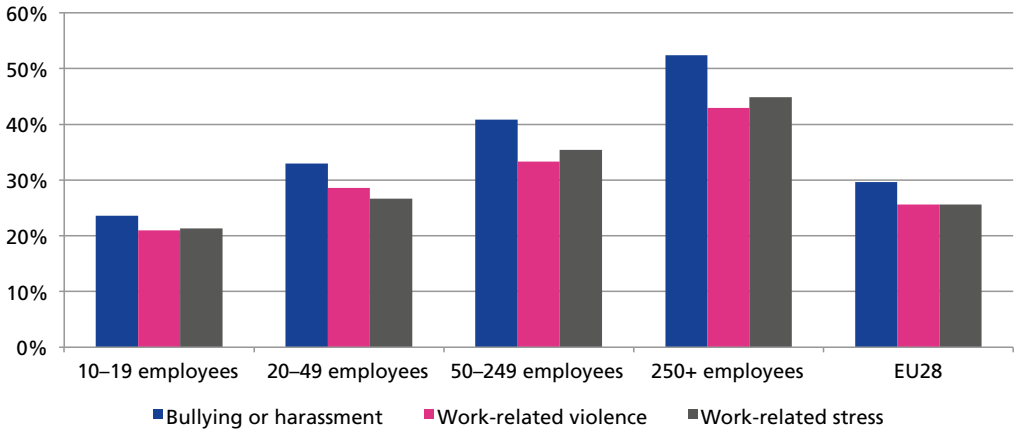
Source: ESENER, 2009.

Figure 27: Procedures in place to deal with psychosocial risks at work, by country (% establishments)



Source: ESENER, 2009.

Figure 28: Procedures in place to deal with work-related stress, harassment and violence, by establishment size (% establishments)



Source: ESENER, 2009.

concern is found to be high in the public administration sector, procedures are not nearly so prevalent here.

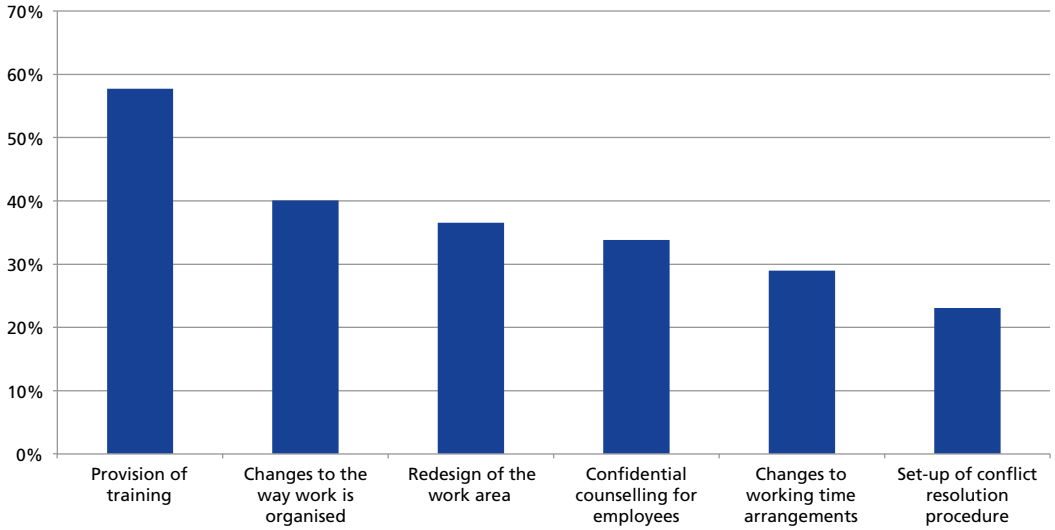
As expected, the existence of procedures is consistently reported more frequently in larger establishments. For example, the prevalence of the most common procedures for bullying and harassment reaches 50% among large establishments, but among the smallest establishments interviewed falls to 20% (Figure 28).

In terms of measures implemented to deal with psychosocial risks over the past three years, provision of training is the most frequently reported (nearly 60%), followed by changes in work organisation (40%), redesign of the work area (37%), confidential counselling (34%), changes to working time arrangements (29%) and set-up of a conflict resolution procedure (23%) (Figure 29). Nevertheless, ESENER shows that measures addressing different aspects of work environment combined with individual interventions are the most effective solution; single measures, especially when mainly targeting the individual (for example, offering training) do not prove very effective.

Establishments in the health and social work sector have the highest number of measures; 74% report providing employees with special training related to psychosocial risks, 60% report implementing changes in the work organisation and 55% report providing confidential counselling for employees. Establishments in construction and manufacturing report the fewest measures in place to manage psychosocial risks.

By country, having measures to manage psychosocial risks at work is reported most frequently in Finland and Romania and is least likely to be reported in Croatia, Slovenia, Hungary

Figure 29: Measures in place to deal with psychosocial risks at work (% establishments)



Source: ESENER, 2009.

and Greece. While the high prevalence of measures in Finland and low prevalence in Hungary and Greece are similar to the prevalence procedures, big differences exist between the numbers of procedures and measures for the other countries. For example, in Portugal there are high levels of concern about psychosocial issues and a higher-than-average prevalence of measures to manage them; however, procedures are used by a below-average number of establishments.

All types of measures are more widely adopted in bigger establishments, although the differences between size classes are not so great as for procedures to deal with psychosocial risks, reflecting the relative 'convenience' of measures for small firms. For example, provision of training is reported by over 70% of managers from large establishments, and by over 50% of managers from establishments from the smallest establishments, and changes to the way work is organised is reported by around 50% and 35% of managers in these size categories, respectively (Figure 30).

Other possible measures taken to address psychosocial risks specified by ESENER include:

- action taken by the establishment if individual employees work excessively long or irregular hours, reported by 40% of managers (more frequently by those from large establishments and in Finland and Sweden);
- providing information to employees about psychosocial risks and their effect on health and safety, reported by slightly more than 50% of managers (more frequently in large companies and in the health and social work sector, as well as in Poland, Romania and Spain);
- employees knowing who should be contacted in case of work-related psychosocial problems, reported by nearly 70% of managers;
- use of information or support from external sources on how to deal with psychosocial risks at work, reported by 55% of managers in the largest establishments, by 7% in the smallest establishments and by 38% in general (most frequently reported in Slovakia, Belgium and Sweden and least in Estonia, Germany and Greece).

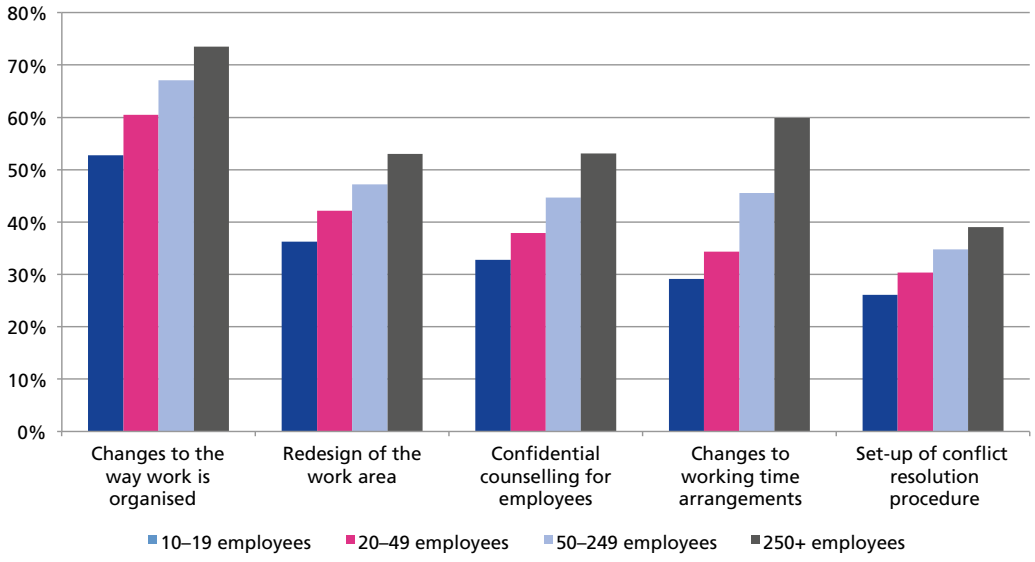
Drivers and barriers in psychosocial risk management

This section presents selected results of a secondary analysis of the ESENER data focusing on drivers of and barriers to psychosocial risk management, as reported by managers (for the full description of the theoretical background, the methodology employed and the results achieved, see EU-OSHA, 2012a).

The analysis aimed to explore the relationships between the barriers and drivers and the actual management of psychosocial risks, namely having in place procedures for work-related stress, harassment and violence, as well as having a high number of measures to deal with psychosocial risks ('high number' means 5 or more out of a possible 10 different measures or actions distinguished by ESENER).[8] The logistic regression enabled the strength of the associations between those variables to be

[8] The measures and actions include changes to the way work is organised; redesign of the work area; confidential counselling for employees; establishment of a conflict resolution procedure; changes to working time arrangements; provision of training; action taken by the establishment if individual employees work excessively long or irregular hours; providing information to employees about psychosocial risks and their effect on health and safety; designating who should be contacted in case of work-related psychosocial problems; and use of information or support from external sources on how to deal with psychosocial risks at work.

Figure 30: Measures in place to deal with work-related stress, harassment and work-related violence, by establishment size (% establishments)



Source: ESENER, 2009.

determined, while controlling for other potentially influential factors such as establishment size, sector and country of origin, as well as legal status (private or public establishment).

Key drivers of psychosocial risk management

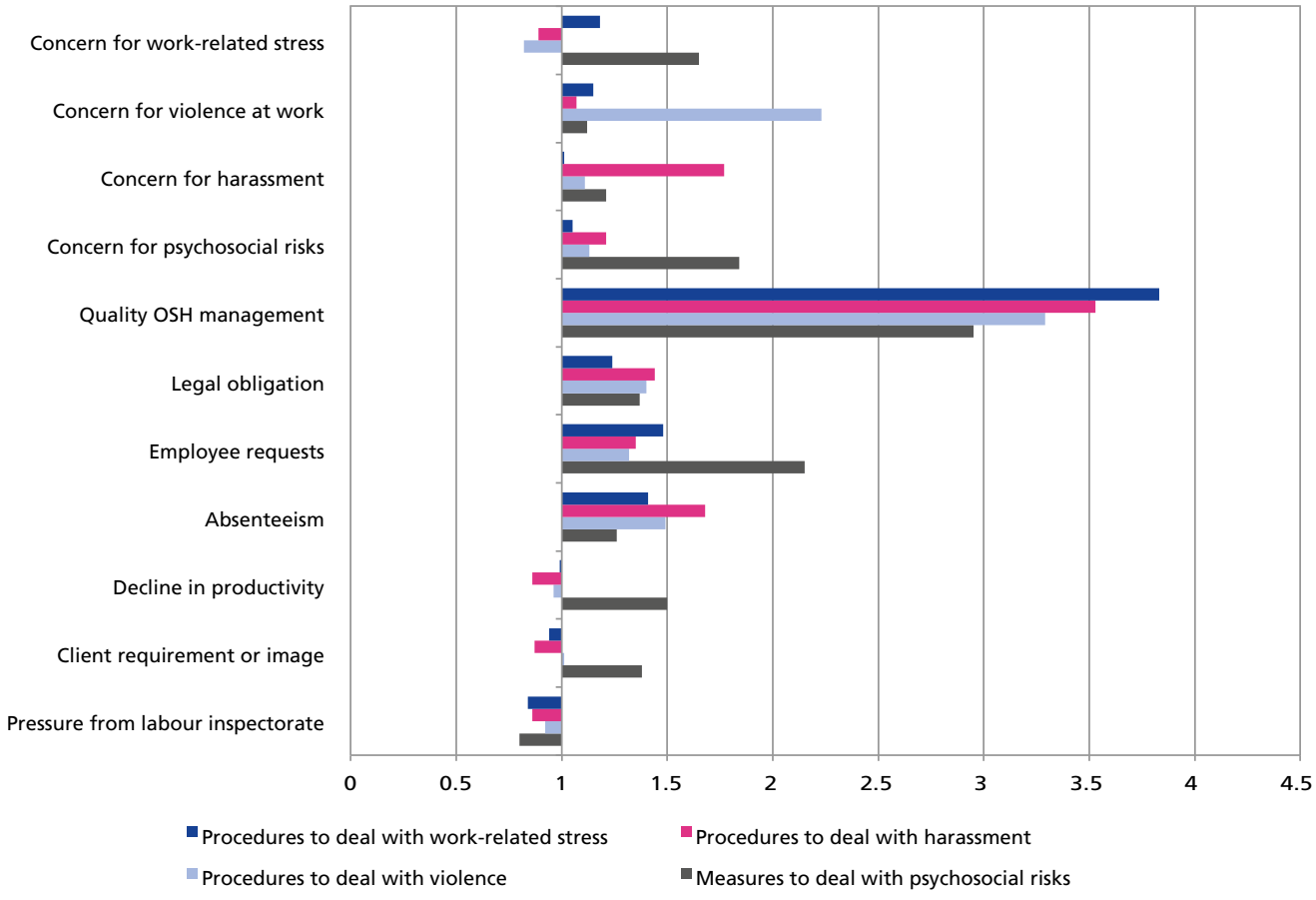
The empirical model used to explore the drivers of psychosocial risk management comprised a number of variables that were expected to be positively associated with procedures and measures to deal with psychosocial risks implemented in the workplace. They included:

- some or major concern for psychosocial risks reported by managers;
- the quality of establishment's general OSH management (reflected by, for example, carrying out a regular risk assessment, routinely analysing the causes of sick leave, having in place a documented OSH policy, and regularly raising OSH issues in high-level management meetings);
- factors that 'prompted their establishments to deal with psychosocial risks', as reported by managers (managers were asked to choose from a list of potential drivers that included fulfilment of legal obligation, request from employees or their representatives, high absenteeism rates, a decline in productivity or in the quality of outputs, requirements from clients or concern about the organisation's reputation, and pressure from the labour inspectorate).

The results of the analysis showing the strength of the relationships (not causality, however) between these drivers and having in place procedures and measures to deal with psychosocial risks are presented in Figure 31.

Overall, the driver with the strongest association with the management of psychosocial risks is high quality of general OSH management in the establishment. Establishments with better general OSH management are nearly four times as likely to have in place procedures for work-related stress, over 3.5 times as likely to have procedures for bullying or harassment and work-related violence, and nearly three times as likely to have measures in place to deal with psychosocial risks. A strong association is also observed between the concern about psychosocial risks and measures taken to deal with them. The same pattern is found for concerns over work-related stress, harassment and violence and having in place procedures to deal with those risks. Managers who report some or major concern about psychosocial risks in their establishments are

Figure 31: Associations between drivers of psychosocial risk management and having procedures and measures to manage psychosocial risks



Source: EU-OSHA, 2012a.

nearly twice as likely to be implementing measures to manage those risks.

In terms of the drivers of psychosocial risk management, as reported by managers, the strongest relationships are observed for request by employees or their representatives, high absenteeism rates and fulfilment of legal obligation.

Employee requests are the strongest driver for having both measures and a procedure for work-related stress, and a weaker driver of having a procedure for harassment and a procedure for violence. Establishments where employee requests are reported to be a driver are twice as likely to have a procedure to deal with stress, and 1.5 times as likely to have in place measures to deal with psychosocial risks, than the establishments where this driver is not reported. Other drivers are more important for having a procedure to deal with harassment and violence. The results may be explained by the fact that more employees are affected by work-related stress, and requesting actions to improve the situation may be relatively easier for employees than in the case of more complex problems with harassment or violence.

Reporting high absenteeism rates as a reason to deal with psychosocial risks is especially strongly associated with managing harassment – establishments that report this driver are over 1.5 times as likely to report also having in place a procedure to deal with harassment. The relationships are also relatively strong in the case of procedures to deal with stress and violence, and a slightly weaker association is observed with regard to the measures taken to deal with psychosocial risks. The analysis in Chapter 1 supports these findings, showing that workers who have experienced adverse social behaviour (violence and harassment) are 1.4 times as likely to report that they have been absent from work for health reasons.

Establishments where the fulfilment of legal obligation is reported to be a driver have a slightly higher probability of having procedures (for stress, bullying or harassment, and violence) and a high number of measures in place to deal with psychosocial issues. The differences are rather small; however, it appears that legal obligation has a slightly stronger relationship with the adoption of procedures for harassment and violence at work, as well as with measures, than it does with procedures to deal with work-related stress. Decline in productivity and client requirements and employer image are associated with having in place measures to deal with psychosocial risks; however, they do not appear to be associated with procedures. Establishments where decline in productivity is a driver are 1.5 times as likely to have measures implemented and those where client requirements and employer image is reported are nearly 1.5 times as likely to have measures in place.

As far as pressure from the labour inspectorate is concerned, the associations are rather weak, although the relationships between reporting this driver and having in place procedures and measures to deal with psychosocial risks go in unexpected directions. Establishments indicating that pressure from the labour inspectorate prompted them to deal with psychosocial issues have a slightly smaller chance of having in place procedures for stress and harassment, and for violence, and also a smaller likelihood of reporting having implemented a high number of measures to deal with psychosocial risks. This driver is more important for establishments having in place a small number of measures addressing psychosocial risks. A possible interpretation of this result may be that the pressure from the labour inspectorate may not be so important for companies that are motivated to be highly involved in managing psychosocial risks. In fact, such companies quite often undertake activities aimed at reducing the impact of psychosocial risks that go beyond legal demands. On the other hand, establishments reporting a small number of measures implemented (for example, just training and changing the working time arrangements) may fulfil legal requirements and report pressure from the labour inspectorate as a driver motivating them to do so.

The secondary analysis shows that the frequency with which managers report particular drivers is not necessarily reflected by the strength of their association with having in place procedures and a high number of measures to deal with psychosocial risks. For example, while fulfilling a legal obligation is the most frequently indicated factor that prompted establishments to deal with psychosocial issues (reported by 90% of managers), followed by a request from employees (reported by 76% of managers), it is very rare to report absenteeism as a driver (fewer than 20% of managers select it). Nevertheless, as the secondary analysis shows, reporting absenteeism is strongly associated with high involvement in managing psychosocial risks (having in place procedures and many measures). On the other hand, some other drivers reported more frequently than absenteeism, such as client requirements and employer image (reported by 67% of managers), do not seem to have the same effect. Similarly, although pressure from the labour inspectorate is reported by nearly 60% of managers, it is not associated with having in place procedures or a high number of measures to deal with psychosocial risks. These findings provide a valuable insight that may be taken into consideration while planning psychosocial risk management promotion strategies or enhancing the possible impact of particular drivers. It seems that pressure from the labour inspectorate can act as a driver; however, this action might need to be accompanied not only by controls but also by support and guidance in order to help companies actively and successfully tackle psychosocial risks.

Key barriers to psychosocial risk management

In general, ESENER shows that 42% of managers consider it more difficult to tackle psychosocial risks than other OSH issues. This opinion is more widespread among large companies (reported by over 60% of managers) than among the smallest establishments (reported by nearly 40% of managers). This may indicate that the specific culture in small companies, which is likely to be more person-oriented, makes it easier

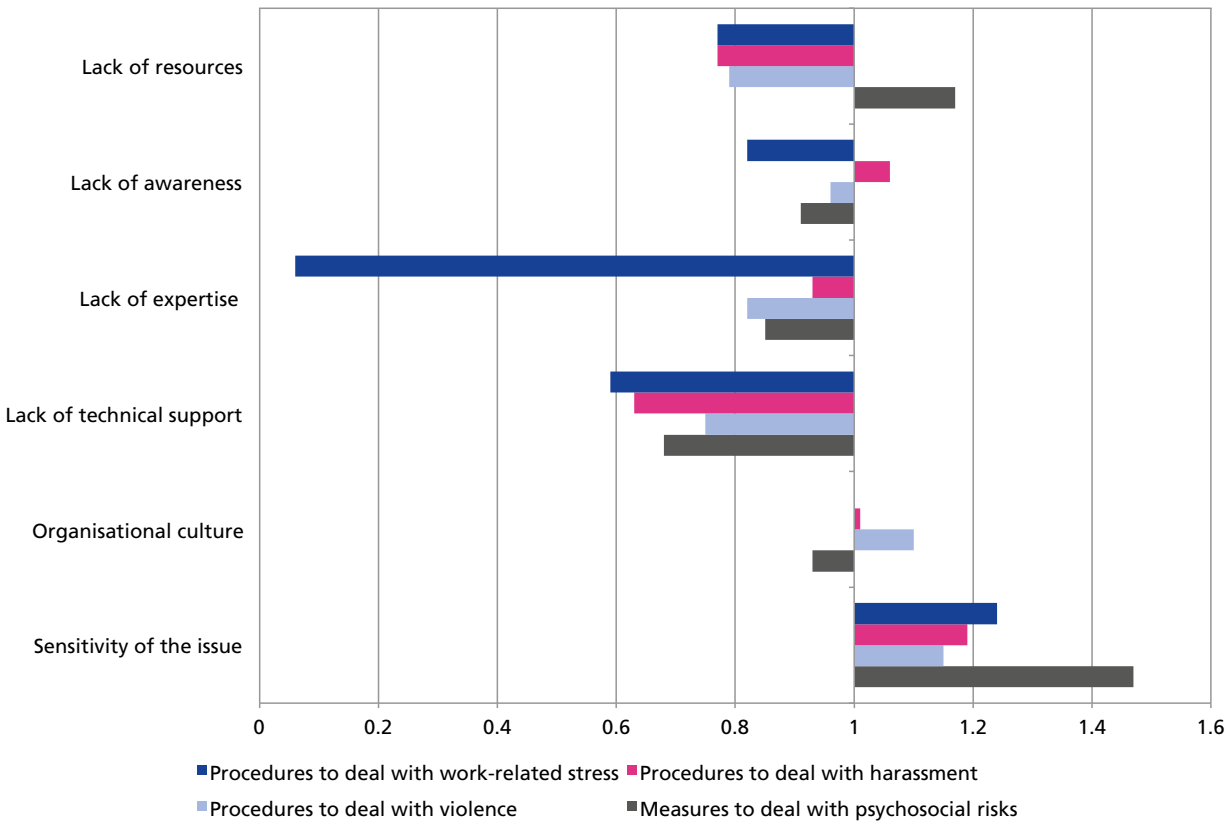
to tackle these issues, but it might also suggest that large establishments deal with psychosocial risks more frequently than smaller businesses, and, as a result of their experience, they are more aware of the difficulties in doing so.

ESENER further asked managers about factors, or barriers, that make dealing with psychosocial risks particularly difficult. The possible answers included a lack of resources such as time, staff or money; a lack of awareness; a lack of training or expertise; a lack of technical support or guidance; the culture within the establishment; and the sensitivity of the issue. The secondary analysis explored the relationships between these barriers and having in place procedures and measures to deal with psychosocial risks. The results of the analysis are presented in Figure 32.

The findings indicate that the strongest negative association exists between psychosocial risk management and lack of technical support and guidance. Establishments where this barrier was reported are the least likely to have in place measures and procedures for stress, harassment and violence. The next strongest, negative, relationships were observed between lack of resources and having in place procedures for stress, harassment and violence. In the case of lack of resources and the measures taken to deal with psychosocial risks, the observed association had an unexpected positive direction – meaning that establishments indicating that lack of resources is a barrier have a greater likelihood of reporting a higher number of measures in place than establishments not reporting this barrier. This result may suggest that establishments that have implemented many measures addressing psychosocial risks may be more involved in improving the psychosocial work environment, as they are more aware of the resources (such as time, staff or money) needed to implement further actions. This result also confirms that, even when a lack of resources is in general perceived as a barrier, it does not have to prevent establishments from taking action to deal with psychosocial risks.

A lack of expertise is also negatively associated with managing psychosocial risks, with the strongest relationships observed between this barrier and having in place a procedure to deal with stress and implementing a high number of measures taken to deal with psychosocial risks. When it comes to taking measures, a lack of expertise is the second most important barrier (after lack of technical support and guidance). Another reported barrier, lack of awareness, is negatively associated with having in place a procedure for stress, and, very weakly, with having in place a procedure to manage violence and a high number of measures taken to deal with psychosocial risks.

Figure 32: Associations between barriers to psychosocial risk management and having procedures and measures to manage psychosocial risks



Source: EU-OSHA, 2012a.

A weak, but unexpected, positive relationship exists between lack of awareness and having a procedure in place to deal with harassment. This finding could indicate that lack of awareness works as a barrier when an already established procedure to deal with harassment is being put into action.

Reported sensitivity of the issue also turns out to be positively associated with psychosocial risk management, meaning that establishments where this barrier was reported have a higher chance of having a high number of measures to deal with psychosocial risks and procedures for work-related stress, harassment and violence. These findings seem to suggest that the sensitivity of the issue is not a barrier preventing establishments from taking action to manage psychosocial risks. It can, however, make a process of psychosocial risk management that has already been implemented in a company more difficult, as establishments may become fully aware of how sensitive these problems can be only when actually dealing with psychosocial risks.

Finally, the findings show that organisational culture as a reported barrier is not significantly associated with having in place measures and procedures to deal with stress and harassment. In the case of a procedure to deal with violence, a very weak positive association was found. It may indicate, again, that, in the establishments that actually deal with workplace violence, the organisational culture is perceived by managers as a factor making this process harder.

Based on the results achieved, a conclusion can be drawn that reported barriers for managing psychosocial risks may relate to different stages of the psychosocial risk management implemented in the workplace. In general, around 40% of managers express a need for information or support on how to assess psychosocial risks and how to design and implement preventive measures to deal with work-related stress, harassment and violence. The findings of the secondary analysis suggest that adequate practical support must address specific problems that establishments may encounter with aspects of dealing with psychosocial risks.

Worker representation and managing psychosocial risks

While the role of workers in managing OSH is well established (see, for example, Walters and Nichols, 2009), the engagement of worker representation in the prevention of psychosocial risks at work has not been widely studied and remains a challenging aspect of OSH. This section presents selected results of the secondary analysis of the ESENER data focusing on the role of different forms of worker representation in managing psychosocial risks in the workplace (for a full description of the theoretical background, the methodology employed and the results achieved, see EU-OSHA, 2012b).

Associations between worker representation and psychosocial risk management

The ESENER questionnaire distinguished between two types of formal worker representation in the workplace:

- works councils or shop floor trade union representation;
- a specific health and safety representation (health and safety committee or health and safety representative).

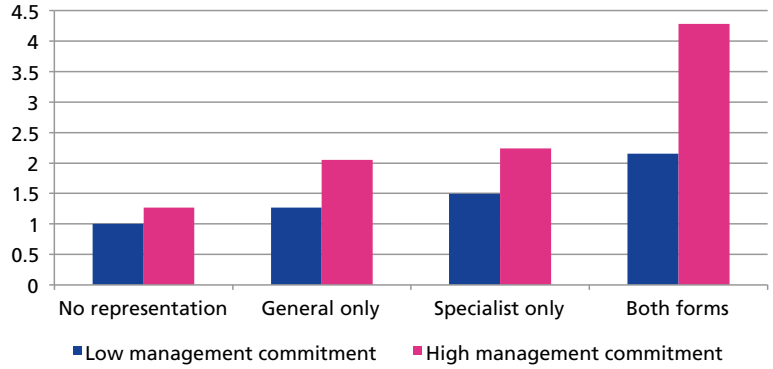
The secondary analysis aimed to explore the relationships between these two types of formal worker involvement and psychosocial risk management existing in the workplace. Establishments were regarded as having psychosocial risk management if they had in place a procedure to deal with work-related stress, harassment or violence, and if they reported the use of at least one measure for dealing with psychosocial risks.

The level of general management commitment to OSH was also included in the empirical model. The management commitment was considered high when managers reported that OSH issues were raised in high-level management meetings regularly and the degree of involvement of the line managers and supervisors in the management of health and safety was high. Establishment characteristics such as size, proportion of female and male workers, public versus private, sector, country and whether or not it was part of a larger multi-site organisation were included as control factors in the analysis. The strength of the relationships between formal worker representation and psychosocial risk management were assessed through the regression analysis.

The findings suggest that establishments with at least one form of existing formal worker representation have a higher likelihood of implementing procedures or measures or both to deal with psychosocial risks (Figure 33). The association is especially strong when combined with a high level of management commitment to OSH and the existence of both general and specialist OSH representation. Workplaces with both forms of worker representation and a high degree of management commitment to OSH were over four times as likely than workplaces without worker representation and a low level of management commitment to OSH to report that their organisation had implemented at least one procedure or measure to deal with psychosocial risks.

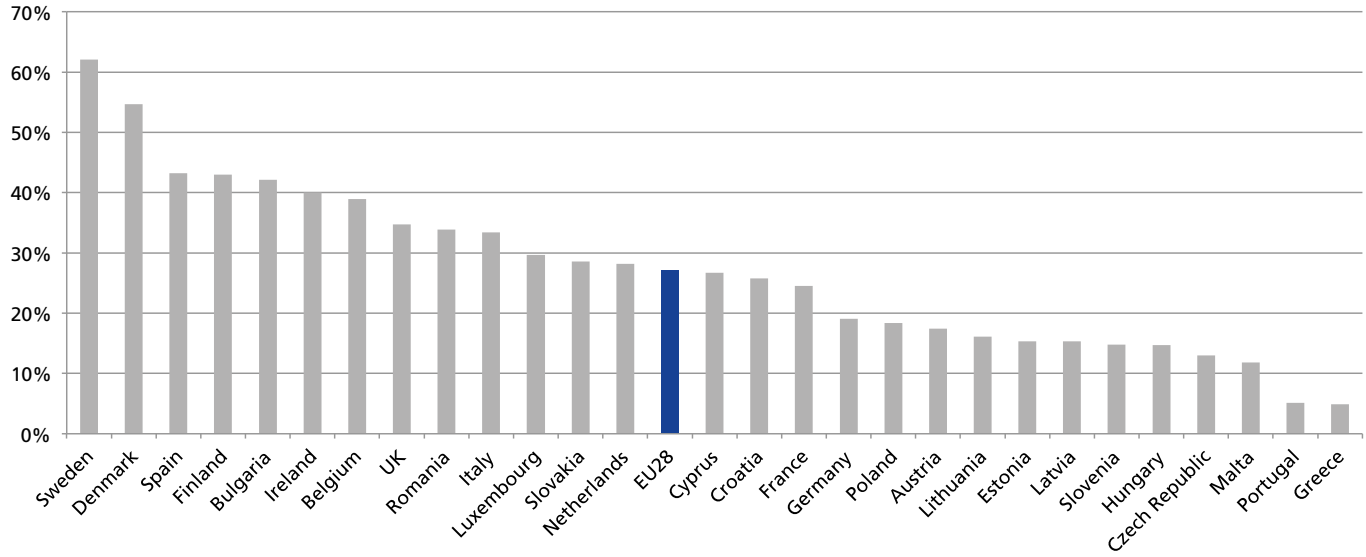
This most favourable situation in terms of psychosocial risk management (existence of both forms of worker representation and a high degree of management commitment to OSH) is reported by less than 30% of European establishments in general (Figure 34). Nevertheless, in some countries this number is significantly higher (more than 60% in Sweden and around 55% in Denmark) or lower (around 5% in Greece and Portugal).

Figure 33: Association between forms of worker representation, management commitment to health and safety, and reported use of measures to deal with psychosocial risks



Source: EU-OSHA, 2012a.

Figure 34: General and specialist OSH worker representation in combination with high management commitment to health and safety by country (% establishments)



Source: EU-OSHA, 2012a.

Direct worker representation

Among establishments where one or more procedures or measures to deal with psychosocial risks are in place, 54% of managers report consulting employees regarding those structures, and 67% report encouraging them to participate actively in their implementation. The percentage of establishments reporting that employees have been consulted increases modestly with establishment size: from 52% in establishments of 10–19 employees to 69% in large establishments. The further analysis showed that workplaces that have formal worker representation and a high level of management commitment to OSH are also more likely to involve employees directly in psychosocial risk management, in terms of both consultation and participation in implementation and evaluation.

Perceived effectiveness

In terms of reported effectiveness of psychosocial risk management, unsurprisingly, the majority of managers generally consider their measures to be effective. Among the EU countries, 14% of managers applying any of the procedures or measures consider these to be very effective, and another 62% quite effective. A minority are not satisfied with the measures taken and classify them as quite ineffective (8%) or even very ineffective (2%). A strong positive correlation is also observed between the direct involvement of employees and the reported effectiveness of procedures or measures. Overall, the vast majority of managers (91%) from establishments with direct employee involvement in the set-up of procedures or measures considers the actions to be very or quite effective, while a much smaller share of managers (59%) from establishments without this direct employee involvement do so.

Summary

Concern about psychosocial risks and their management

ESENER shows that nearly 80% of European managers are concerned about problems with stress in their establishments, and about one in five of them also considers workplace harassment and violence to be of major concern. However, it is rare for enterprises, especially SMEs, to integrate psychosocial risks into the general OSH management; in general, less than 30% of European organisations have procedures in place to deal with psychosocial risks. While among large enterprises (250+ employees) this percentage grows to 40%–50%, for the smallest workplaces (10–19 employees) it falls to around 20%. Distribution of specific measures taken to deal with psychosocial risks also varies considerably according to establishment size, sector and country. Hence, a systematic, comprehensive and preventive approach to managing psychosocial risks in European workplaces should be further promoted and supported.

Legal obligations

The secondary analysis of ESENER data shows that existing legal requirements play an important role; they must, however, be complemented with practical guidelines and support at national and organisational levels. Limiting activities to the implementation of legislative requirements related to psychosocial risks is unlikely to be efficient in terms of actual management of psychosocial risks. To provide firms with better support and guidance, consideration should be given to the potential influence of labour inspectors, as recognised in a Senior Labour Inspectors' Committee (SLIC) campaign (see Chapter 3 of this report) and in other national approaches, and the importance of having OSH service providers properly trained in psychosocial risk management practices. Examples can be found in the next chapter, which discusses policy initiatives in detail.

General OSH management

The clear link between general OSH management and psychosocial risk management emphasises the importance of establishing an OSH policy and action plan, or using an OSH management system that incorporates psychosocial risk management as an essential part. When taking this approach, involvement of top management combined with worker participation is essential for dealing with psychosocial risks effectively.

Worker involvement

The results of ESENER on both formal and informal forms of employee participation in the management of OSH, and in particular of psychosocial risks, clearly show that involving employees pays off and leads not only to the application of a broader range of measures, but also to their improved effectiveness. The next chapter, on policy initiatives, gives some examples of social partner initiatives at European, national and sectoral level for preventing psychosocial risk, harassment and violence at work. Chapter 4, which deals with organisational interventions, further explains how specific measures and procedures can be set up in establishments.

Absenteeism

Although high absenteeism ratios are not a reason commonly reported by European managers for dealing with psychosocial risk, those who do report this driver significantly more often also report that procedures and measures to deal with those risks have been implemented in their establishments. Studies focusing on collecting and analysing data that examine the link between the psychosocial work environment, absenteeism and general level of organisational performance should be encouraged and supported.[9] Promotion of psychosocial risk management based on the results of such studies is likely to be particularly effective.

Lack of information and know-how

Providing support for tackling psychosocial risks should take into consideration all consecutive phases of the process of management, as explained in more detail in Chapter 4. Technical support and guidelines should include assessment of risks, formulating policy and procedures, planning, implementing, and evaluating interventions. Advice in relation to factors and problems that deserve to be looked at with the support of an external expert could be beneficial.

Resources needed

Support given to companies should include information on the resources (in terms of time, people and money) needed to implement different aspects of psychosocial risk management. This would be helpful in the process of planning and would also help to alter the common, but not necessarily correct, assumption that managing psychosocial risks is expensive and beyond companies' abilities. A process of collecting and disseminating practical solutions that do not require a high level of investment (especially financial) by companies should especially be encouraged at EU and national levels.

The unexpected character of some of the relationships between drivers and barriers and having procedures and measures in place seems to indicate that the importance of particular drivers or barriers can vary depending on what stage an establishment has reached in the process of managing psychosocial risks. This issue is also referred to as 'readiness for

[9] For more information on the financial burden of psychosocial risks at societal, organisational and individual level, see EU-OSHA, 2014.

change' in Chapter 4 of this report. The level of companies' involvement in dealing with psychosocial risks seems to be a crucial factor determining the effectiveness of practical support and organisational interventions.

Sensitivity of psychosocial issues

Technical support and guidance should cover the entire process of management of psychosocial risks and include difficulties that are likely to arise; for example, reporting and dealing with stress, harassment and violence may increase psychological vulnerability in workers and make them reluctant to participate in the interventions. Guidelines on how to deal successfully with this kind of obstacle would be invaluable.

Targeting support

As pointed out above, support provided should be continuous and adjusted to the current phase of psychosocial risk management in an establishment. Further targeting of interventions requires taking into consideration the cultural and legislative context, sectoral specificity, and other organisational characteristics such as size and legal status.

3 Policy interventions and initiatives

The EWCS and ESENER surveys show that psychosocial risks affect a considerable proportion of workers in the EU, and more work is needed to support companies to address this issue. In recent years, several activities have been developed at European and national level to combat this situation by changing legislation, raising awareness, providing tools and reaching agreements. This chapter introduces the legal background and describes European initiatives, before giving several examples from different Member States that show how psychosocial risks have been addressed by governments and social partners.

The legal background for preventing risks to the safety and health of workers is given by the Framework Directive of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health of workers at work (European Commission, 1989). The Framework Directive has a wide scope of application and sets out the minimum requirements and fundamental principles, such as the principle of prevention and risk assessment, together with the responsibilities of employers and employees. The Framework Directive obliges employers in Europe to assess all OSH risks in the workplace that could harm workers' safety and health. Accordingly, psychosocial risks should be included in any proper risk management approach. Directives must be transposed into national laws by Member States, and this has been done with the Framework Directive in Member States. However, the Directive is meant as a framework, giving the Member States the space for more detailed specification at national level to enable them to follow an approach that best suits their national situation. Accordingly, the degree to which psychosocial risks are included or explicitly mentioned in the legislation of the Member States varies significantly.

Besides the legal background, there have been diverse other initiatives at the EU level tackling psychosocial risks and mental health. The former European Strategy on Safety and Health at Work (2007–2012) highlighted the importance of workers' well-being by aiming to make the well-being of European workers a tangible reality (European Commission, 2007). The current EU Strategic Framework on Health and Safety at Work (2014–2020) highlights mental health among the main challenges based on changes in work organisation. In 2005 the European Commission published a Green Paper on mental health in Europe. The paper mentions the workplace environment and working conditions as important factors for preventing mental ill-health. Following the Green Paper, an EU high-level conference on mental health and well-being launched the European Pact for Mental Health and Well-being, which called for action in five priority areas. One of these areas was the workplace (European Commission, 2008). It mentions three key factors in preventing mental ill-health and promoting organisational practices conducive to good mental health: considering the culture of a company, leadership behaviour and measures to ensure a good work–life balance. The pact also highlights the importance of addressing abusive behaviours of any kind in the workplace, including violence, harassment, and alcohol and drug use.

In 2012, the SLIC ran an inspection campaign on psychosocial risks, supported by the European Commission. The SLIC has a mandate to give its opinion to the Commission, either at the Commission's request or on its own initiative, on all problems relating to enforcement by the Member States of Community law on health and safety at work. The campaign on psychosocial risks was led by Sweden. The main tool used was a psychosocial inspection toolkit that provides labour inspectors in all participating Member States with information and guidelines on how best to do an inspection with regard to psychosocial risks. In the framework of the SLIC campaign, more than 13,000 inspections on psychosocial risks were made in the 26 participating Member States as well as Iceland (SLIC, 2012a).

The Commission works closely with EU-OSHA and Eurofound to disseminate information, offer guidance and promote healthy working environments – particularly in small businesses.

Besides conducting the ESENER, EU-OSHA has been dealing actively with psychosocial risks for years, including implementing an expert forecast on emerging psychosocial risks related to OSH, publishing overview reports (such as *OSH in figures: Stress at work* (2009) and *Mental health promotion in the workplace – A good practice report* (2011)) and organising pan-European campaigns.

EU-OSHA's campaigns are one of the most significant tools for awareness-raising and disseminating information on the importance of workers' health and safety in Europe. Running since 2000, the campaigns are now the largest of their kind in the world. Each campaign is dedicated to a particular topic. The campaign in 2002 was dedicated to work-related stress, and in 2014–2015 EU-OSHA will again be campaigning on tackling stress and psychosocial risks at work. As part of its campaign 'Working together on risk prevention', EU-OSHA produced two practical guides – one jointly with BusinessEurope on management leadership (2012) and another with ETUC on worker participation in OSH (2012). Both were widely distributed to assist managers and workers respectively to implement risk assessment in the workplace.

One of the main monitoring systems of Eurofound, the EWCS, has since its launch in 1991 provided an overview of working conditions in Europe, including psychosocial risk factors. For Eurofound, health and well-being is addressed in its work programme for 2013–2016 under the priority area 'Improving working conditions and making work sustainable throughout the life course'. In the framework of the EurWORK observatory, Eurofound has developed comparative studies of all Member States on issues related to psychosocial risks (for example, work-related stress, violence and harassment, and the impact of the crisis on working conditions). Regular updates are published showing the latest information on trends and policies on working conditions.

The rest of this chapter highlights different ways of tackling psychosocial risks at a higher level than the workplace, looking

at various approaches that have been implemented at Member State level. It does not aim to give a comprehensive overview on the different situations in the Member States, which is beyond the scope of this report. The goal is to provide a brief insight into possible ways of tackling the increasing challenge of psychosocial risks and stress at work from government bodies and social partners.

Framework agreements – Role of social dialogue

Psychosocial risks in the workplace have received increasing attention from social partners at EU level and in various European countries in recent years. However, the level of awareness is uneven and so is the prominence given to this issue in collective agreements and in the development of strategies to reduce or prevent psychosocial risks at the workplace level.

Within the European social model, social partners and social dialogue in general have a key role in improving working conditions. At European level, this idea of social dialogue positively influencing working conditions is illustrated by sectoral and cross-industry social dialogue dealing with various aspects of working conditions. The social partners have influenced EU OSH regulations and, in some cases, have set minimum standards through agreements implemented by EU legislation. Moreover, the EU cross-industry social partners have signed autonomous agreements (which are implemented not by legislation at EU level, but rather by national social partner organisations in accordance with national procedures and practices) in relation to psychosocial risks based on Article 155 of the TFEU, the Framework Agreement on Work-related Stress (2004) and the Framework Agreement on Violence and Harassment at Work (2007). These agreements represent a commitment to the development and application of their content by social partners at national level. Moreover, several EU-level social partners[10] have developed multi-sectoral guidelines to tackle third-party violence and harassment related to work, which complements the work at cross-industry level. Initiatives on psychosocial risks have been taken in several sectors, for example the railways sector, education, telecommunications and the steel industry. Joint declarations are found in construction, electricity, private security and telecommunications.

At national level, analyses carried out by Eurofound (2008a, 2009, 2011) illustrate significant differences between countries with regard to links between social dialogue and improvements in working conditions, largely resulting from specific traditions and cultures of labour relations and labour market organisation. The regulations governing social dialogue in Europe allow for far-reaching and direct responsibilities in some countries, whereas, in others, social dialogue has a much less settled role. These studies show that trade unions and employer organisations can play an important role, since they organise and articulate the interests of the key actors at the workplace. Sector-based social dialogue is a crucial element in bringing about improvements in working conditions.

SMEs comprise a large share of companies in Europe and therefore play an important role with regard to implementing improvements in working conditions. For these companies, contributions from and dialogue with external actors – such as trade unions at sectoral or local level, employer associations, professional organisations and joint social partner or tripartite organisations – as well as governmental support (from the labour inspectorate, for example) are extremely important.

Both the Eurofound and EU-OSHA studies provide evidence that, in order to be effective and to see real improvements in working conditions in general, different actors have to work together in their joint interests and to achieve a shared understanding of challenges and expectations of a win–win situation, beneficial for both sides. In this regard, evidence has been found of the contribution of social dialogue at sectoral and company level to the improvement of working conditions (Eurofound, 2009, 2011). As demonstrated in Chapter 2, ESENER data show that management commitment and worker participation are important for effectively managing psychosocial risks and stress at work (EU-OSHA, 2012).

When examining the implementation of the Framework Agreement on Work-related Stress as an indication of how far policies on psychosocial risks have been developed by the social partners in the various European countries, it is important to bear in mind that implementation follows the rules of each country's national industrial relations system. These vary in terms of the roles of the national trade union and employers' organisations, as well as public authorities. In this regard, challenges existed mainly in Member States that joined in 2004 and 2007, due to their lack of experience with autonomous social partner negotiations and incompletely developed social dialogue structures (ETUC et al, 2008). The different structures and traditions also had an impact on the type of tools that were used to implement the agreement, as did the different starting points in different Member States.

Binding, cross-industry collective agreements that implement the EU-level agreement at national level and that establish rights and obligations for the signatory parties and their members have been concluded in Belgium (since 1999), Denmark (in the public sector), France, Greece, Italy and Romania. General agreements or guidelines for rank-and-file members are more widespread and their formal status varies. Examples are found in Austria, Finland, Ireland, Luxembourg, Spain and the United Kingdom. Substantial joint efforts of social partners resulting in a national collective agreement or social partner action based on the explicit legal framework are

[10] EPSU (European Federation of Public Service Unions), UNI Europa, ETUCE (European Trade Union Committee for Education), HOSPEEM (European Hospital and Healthcare Employers' Association), CEMR (Council of European Municipalities and Regions), EFEE (European Federation of Education Employers), EuroCommerce and CoESS (Confederation of European Security Services).

found in Belgium, Denmark, Finland, France, the Netherlands, Sweden and the United Kingdom. Other initiatives include joint social partner declarations or other complementary activities, such as the organisation of conferences and the development of web-based tools.

The evaluation of the EU-level agreement on work-related stress highlights that instruments that are jointly developed, disseminated and applied by social partners express a consensus and make policy on work-related stress more effective (European Commission, 2011). However, some of the initiatives were limited to joint social partners' declarations signed just after the EU-level framework agreement on stress was signed, without further development in terms of implementation through guidelines, legislative changes or other measures that would facilitate actual interventions at workplace level. However, there is a wide variation in the extent to which the initiatives have been developed. Whereas some countries developed guidelines, legislative changes or other measures to facilitate interventions at workplace level, in others the development was limited to translation and signature of a joint social partners' declaration following signature of the EU-level framework agreement on stress.

As for the EU-level Framework Agreement on Harassment and Violence at Work, the implementation report indicates that it has brought real added value in terms of raising awareness and better equipping employers and workers to deal with harassment and violence in the workplace (ETUC et al, 2011). As in the case of the agreement on work-related stress, the ability of social partners to effectively implement its content depends on the social dialogue structures and process within the national context. The flexible nature of the framework agreement is crucial in this respect, as it allows national social partners to decide on actions to implement according to their specific priorities and needs. Therefore, countries have used different instruments to implement the agreement. National social partner agreements include overarching agreement, joint guidance, joint declarations and integration into existing agreements. There are also sectoral social partner agreements, company-level agreements, assessments of national legislation and complementary activities.

Finally, the report mentioned above also recognises that in dealing with the topic of harassment and violence in the workplace, challenges include, in some cases, a lack of awareness or information on the topic, as well as lack of statistics and difficulties in collecting data.

Labour inspection and legislation

The different approaches to legislation as well as to inspection and other initiatives taken by ministries and labour inspectorates in Member States all over Europe indicate that there is no single best way to tackle psychosocial risks at national level. Initiatives and approaches have to be adapted to the national situation, and, as noted above, social partner involvement is an important aspect to bear in mind. There is broad variety in the way legislation in the Member States refers to psychosocial risks. A number of Member States keep the text of their health and safety legislation quite short and close to the EU Framework Directive and do not explicitly mention psychosocial risks (for example, Luxembourg, Poland, Romania, Slovenia and Spain). Others highlight in different ways in their legislation the need to take psychosocial risks or mental health into consideration when dealing with OSH (for example, Austria, Denmark, Estonia, Finland, France, Greece, Slovakia and Sweden). Some Member States specifically include the obligation to do a psychosocial risk assessment; examples can be found in Belgium, Bulgaria, Cyprus, Germany, Hungary, Italy, Latvia, Lithuania, Portugal and the United Kingdom. Very few Member States highlight in their legislation the option or obligation to involve an expert for certain aspects of psychosocial risk (just Austria and Belgium).

In some Member States (for example, Hungary, Lithuania and Slovakia) more detailed regulation not only mentions the obligation to take psychosocial risks into account but also gives a definition of what is meant by psychosocial risks and/or stress, and what has to be included in a risk assessment in order to ensure proper prevention of poor mental health. The Slovakian legislation is described in further detail below.

Public authorities play a crucial role and are important not only in providing support and guidance but also as a controlling authority. As shown in Chapter 2, pressure from the labour inspectorate can be an important driver for certain companies to deal with psychosocial risks.

Other governmental approaches

Some Member States include OSH approaches in a broader policy framework, for example by using non-binding guidance and other methods (this is the case in Austria, Finland, Ireland, Luxembourg, Sweden and many more). In Finland, the Policies for the Work Environment and Well-being at Work up to 2020 (Ministry of Social Affairs and Health, Finland, 2011) specify the ministerial strategy. In these policies, special attention is paid to those areas of OSH that deal with the work environment and well-being at work including psychosocial risks. The basis is tripartite consensus and network-based OSH cooperation. Based on this framework, the regional labour inspectorates are using a new inspection guide for psychosocial risks. Other activities conducted under this approach include the Working Life 2020 project, a Forum for Well-being at Work, the Leadership development network and Liideri – Business, Productivity and Joy at Work Programme 2012–2018. In Ireland, the psychosocial risk of bullying has been identified as a target area. A code of practice has been developed outlining the best ways to deal with such cases. In the UK, a standardised survey tool has been developed to support employers deal with work-related stress. Known as Work Positive, it is a free online tool that allows employers to audit employee groups

for stress-related hazards. This is a voluntary activity but is acknowledged as a form of risk assessment for psychosocial hazards by the labour inspectorate.

In Austria, Belgium and Germany, recent negotiations at Member State level to discuss further implementation by better definitions of risk factors and appropriate tools, often involving or initiated by the social partners, have been successful and have led to changes in the wording of the legislation. Within the Joint German Occupational Safety and Health Strategy, OSH actors agreed on the aim 'protection and promotion of health in relation to work-related stress', whereby the proportion of organisations conducting a psychosocial risk assessment is to be increased significantly by 2018. Prompted by the strategy, the Federal Ministry of Labour and Social Affairs and the social partners issued a joint declaration on mental health in the workplace.[11] In addition, the Occupational Safety and Health Act was amended in 2013, and it now explicitly states that employers have to conduct a psychosocial risk assessment.

Other Member States are currently in the process of designing a policy framework for tackling psychosocial risks at work. The National Commission of Safety and Health in Spain, for example, has set up a working group on psychosocial risks. The aim of this group is to analyse public policy on psychosocial risks and to develop an action plan aimed at raising awareness and improving implementation of measures on psychosocial risks in establishments. This working group includes representatives of regional administrations, central government and social partners.

Country examples

As mentioned above, in some countries certain stakeholders have developed initiatives dealing with policies on psychosocial risks. This section features examples from six countries – Austria, Denmark, Slovakia, Belgium, France and the United Kingdom – where governments and social partners have contributed to tackling psychosocial risks through legislation, labour inspectorate actions, agreements or specific initiatives.

Austria: Non-binding guidance from the Ministry of Labour

On 1 January 2013 a change came into force in the Austrian Health and Safety Act regarding psychosocial risks at work (AschG, BGBl. I Nr. 118/2012). The initiative was taken by the government, and the social partners were included in the decision-making process. The change in legislation better emphasises the importance of psychosocial risk prevention (Labour Inspectorate, Austria, 2013). The law now explicitly includes psychosocial risks as a potential cause of harm to the health of workers. It further clarifies that health is meant to be understood as physical and mental health. The Austrian Ministry of Labour, Social Affairs and Consumer Protection also emphasises that most of the changes are meant to be clarifications and that former legislation already included the requirement to comprehensively assess and manage any risk that could harm workers' health and safety at work (Federal Ministry of Labour, Social Affairs and Consumer Protection, Austria, 2013a).

The definition of the aspects of psychosocial risk to be assessed has also been specified and now explicitly includes the design of tasks, the working environment and work organisation. An accompanying explanation from the government further clarifies that these regulations are based on the International Organization for Standardization (ISO) standard 10075:1991 (parts 1–3), which deals with ergonomic issues relating to psychosocial factors at work (Federal Ministry of Labour, Social Affairs and Consumer Protection, Austria, 2013a). The amendments in the Health and Safety Act also require a new or reviewed health and safety assessment after incidents relating to psychosocial risks at work. The accompanying document from the ministry specifies that such incidents and indicators might include an unusual number of conflicts and complaints, violence in the workplace, or post-traumatic disorders occurring after workplace accidents (Labour Inspectorate, Austria, 2013).

Austrian law generally specifies that companies with more than 50 employees have to contract health and safety experts for a certain amount of time, depending on the size of company. Forty per cent of this time has to be completed by a health and safety engineer and 35% by an occupational physician; 25% of the dedicated time can be contracted to another kind of expert, such as a chemist or an ergonomist. The recent changes in the Health and Safety Act mean that staff psychologists, among other professionals, are now entitled to contribute to a risk assessment and conduct other activities related to health and safety at work. For companies with fewer than 50 employees, the percentages differ according to the size of the company (1–9 employees or 10–50 employees). However, those companies get additional free support within the AUVA (Austrian Workers' Compensation Board) health and safety model, ensuring a certain amount of free consultation every year, depending on the size of the company. Additional free consultation can be provided on request.

The changes in legislation are accompanied by a guidance document for labour inspectors on how to evaluate whether risk assessments and consecutive preventive actions have been carried out correctly (Federal Ministry of Labour, Social Affairs and Consumer Protection, Austria, 2013b). This guide describes what a labour inspector is expected to monitor and what support they are expected to provide to companies with regard to psychosocial risks. Tasks as well as the different actions necessary to reach these goals are defined. This includes the basic background knowledge on psychosocial risks at work and their possible impact on employees. Overview tables and a catalogue of criteria for assessing such risks are provided. The

[11] This document, *Gemeinsame Erklärung Psychische Gesundheit in der Arbeitswelt* [Joint Declaration on Mental Health in the Workplace], can be downloaded from the website of the Federal Ministry of Labour and Social Affairs at www.bmas.de.

guide has proved to be very useful for employers as well, and employers now consult it to learn more about what is expected from them with regard to psychosocial risk prevention. The ministry and the employer associations also developed a short guidance document for employers, summarising the requirements and giving advice and examples on how to deal with psychosocial risks in a company.

In parallel to legislative changes, the ministry increased the length of obligatory training for occupational physicians and included training on psychosocial risks (Huber, 2013). In addition to the guidance provided by the labour inspectorate, the social partners developed a free tool to help companies assess and evaluate psychosocial risks (Molnar et al, 2012).

Denmark: OSH strategy and labour inspection control and support

Labour inspectorate activities are comprehensive in Denmark compared with other European Member States. Several political initiatives have been set up to improve and enhance awareness of psychosocial risks at work, as well as the knowledge of how to deal with such risks. Psychosocial risks have been included as one of the priority areas in the national strategy for OSH for 2012–2020 (Ministry of Employment, Denmark, 2011). The strategy aims to reduce by 20% the number of employees who are psychologically overloaded by 2020. The parties have agreed to change inspection efforts to risk-based inspections (Initiative 1). This means that the sectors with the most serious health and safety problems, as well as certain enterprises scoring high on a related index, will be subject to more inspections. The parties also agree that these risk-based inspections will focus strongly on the psychosocial working environment. Another initiative (Initiative 5) is a tripartite collaboration between social partners, the Danish Working Environment Authority (DWEA) and the National Research Centre for Working Environment (NRCWE). Based on this, the DWEA developed a methodology in collaboration with the social partners to help enterprises identify and manage psychosocial risks. A special focus is put on organisational change, as well as employing people with mental illness and supporting existing employees with mental illness to stay in work (Lidsmoes, 2013a).

Activities of the DWEA

Since the early 1990s, the DWEA has been carrying out inspections focusing on the psychosocial work environment. Until 2007, however, inspections were carried out on a relatively small scale by a handful of highly specialised inspectors. Following political demand for an increase in inspections, the DWEA was given the task of inspecting psychosocial risks more systematically (Lidsmoes, 2013b). Against this background, and in the framework of a broader inspection campaign, the DWEA has carried out a programme of special intensified inspections with a focus on psychosocial factors (National Labour Inspectorate Prevention and Promotion Department, 2011). The special inspection effort targets enterprises in sectors that are exposed to potentially significant health and safety challenges, and focuses on ergonomic and psychosocial risks. The choice of sectors for special inspection was made in conjunction with the social partners. The DWEA initiated meetings with the social partners and enabled them to highlight possible branches in certain sectors.

More time is allocated to these inspections than for standard inspections. For the years 2007–2015, extra funding is available for such inspections (DKK 50 million, around €7 million, per year) and around 1,000 companies are visited each year (National Labour Inspectorate Prevention and Promotion Department, 2011).

Based on this programme, systematic inspections on psychosocial risks and ergonomics were conducted in 13 different sectors in 2007–2014. An additional nine sectors are planned for 2013–2015, where the focus is exclusively on the psychosocial work environment (Lidsmoes, 2013a, b).

Twenty-four sectoral guidance tools (including tools for the healthcare, transportation and construction sectors) were developed by the labour inspectorate to support inspectors in the risk assessment of psychosocial factors and to standardise the approach to assessment. Some of these tools have been distributed at the European level through the SLIC campaign mentioned earlier. The inspectors use the tools both to prepare for the inspection and during inspection, for example during interviews at the enterprise or while drawing up improvement proposals (Lidsmoes, 2013b). Some enterprises also use the tools themselves to prepare for an inspection or for routine risk assessment.

Bullying and harassment hotline

Besides systematic inspection programme, the DWEA has taken other measures to support employees, especially with regard to harassment and sexual harassment. For example, it has set up a hotline to support and advise employees seeking help with harassment, run by several specialised inspectors. A preliminary evaluation showed that the hotline was successful, and callers were generally very satisfied with the advice they were given.

Slovakia: Definition of psychosocial risks included in legislation

Slovakia has taken a reasonably comprehensive approach to legislating for the protection of workers against psychosocial risks in the workplace. The national labour inspectorate has also signed a cooperation agreement with the public health authority. One part of this agreement concerns coordinated inspections of health and safety in workplaces by the labour inspectorate and the public health authorities (Cardiff University, 2011). In keeping with this approach, provisions can be found in several legal instruments, not only those directly related to OSH but also those related to general public health.

In the area of OSH, there are several laws highlighting psychosocial aspects at work, which are supervised by the labour inspectorate:

- The Labour Code, in Article 133 on standardisation, states that employees' physical and neuro-psychic abilities have to be taken into account when setting standards for the volume of work and work pace. In addition, it states that such standards must be agreed before work is started and that this must be done by collective agreement or other consultation with employees' representatives. If parties fail to reach such an agreement, the labour inspectorate can be involved to take further steps and decisions.
- The Occupational Safety and Health Protection Act (No. 124/2006 Coll.) obliges the employer to ensure that health of workers is not threatened by, among other factors, psychological workload (Article 6). Article 21 highlights psychosocial risks to be taken into account by preventive and protective services hired by the employer.
- Article 7 of the Labour Inspection Act (Act No. 125/2006 Coll.) sets out that, among other aspects of mental workload and social measures, labour inspection activities include the supervision of company requirements to protect their workers.

Other legislation is under the supervision of the Ministry of Health. The Decree of the Ministry of Health (No. 542/2007 Coll.) on details of health protection against physical strain, psychical/mental workload and sensory load at work sets out a detailed framework for the management of work-related stress. Article 5 of the decree lists the risk factors that have to be taken into account by the employer when conducting a risk assessment with regard to mental workload. These include risks associated with the content of work, irregular working time and the working environment. The decree also highlights the importance of taking subjective reactions to mental workload into account (mental overload, boredom and reduced ability to concentrate). Article 7 of the decree defines the types of measures to be taken in order to prevent such risks. The measures, as well as the order in which they are described, respect the prevention principle of the Framework Directive, in other words first taking primary preventive activities such as technical and organisational changes. The SLIC report, however, highlights that the decree refers only to psychical workload and therefore does not cover all psychosocial characteristics of the workplace (European Commission, 2011).

In addition to legislation, the labour inspectorate is taking measures to support companies in dealing with psychosocial risk factors. The labour inspectorate, as well as the regional public health offices, provides employers and employees with information and counselling on work-related stress prevention (European Commission, 2011). The Labour Inspection Act also provides for free consultation for employers and employees on how best to follow the provisions. Employers as well as employees can get this support on request. In 2011 almost one-quarter (72 out of 299) of all labour inspectors had the competence to deal with psychosocial risks and to give counselling support to companies (SLIC, 2012b). In addition, the labour inspectorate has had a long-term focus on discrimination at work (Cardiff University, 2011). It includes a training module for labour inspectors on discrimination and offers counselling specifically on discrimination for companies. Nevertheless, labour inspectorate activities are still not very broadly implemented, and *The Nerclis report* summarises the situation in Slovakia with the following statement: 'The preventative actions of the Slovak Labour Inspection which play an important role especially in the case of new and emerging risks are at the time limited and are expected to increase' (Cardiff University, 2011, p. 373).

Belgium: In-depth legislation after multiple assessments and consultation of all stakeholders

The Belgian policy on psychosocial risks at work is based on both legislation and collective agreements. The Well-being Law of 1996 is the basis of the regulation on the theme, and it forms the starting point for further enlargements or new specifications (Federal Public Service Employment, Labour and Social Dialogue, Belgium, undated a). Employer and employee representative organisations are involved in the legislation through their membership of the High Council on Prevention and Protection at Work and through the National Labour Council. The curative policy measures on psychosocial risks are especially well worked out, as they include compulsory attendance by prevention advisors and stipulate concrete intervention procedures.

In 1999, the social partners represented at the National Labour Council agreed on a policy to prevent stress at work in the collective agreement CAO-CCT 72.[12] This agreement is a concrete implementation of the Well-being Law of 1996 and is declared generally binding by Royal Decree. It focuses only on problems of stress at collective level in the private sector, defined as

> *a situation experienced as being negative by a group of employees that is linked to complaints or dysfunction in a physical, psychological and/or social context and that is the consequence of the fact that employees are unable to meet the requirements and expectations imposed upon them on the basis of their work situation.*

In 2002, legal provisions related to protection against violence and harassment were introduced into the Well-being Law and put into practice by a Royal Decree (11 July 2002). This legislation was evaluated in 2004, which led to new modifications.

[12] Convention collective de travail n° 72 du 30 mars 1999 concernant la gestion de la prévention du stress occasionne par le travail [Collective Labour Agreement No. 72 of 30 March 1999 on the management of the prevention of stress caused by work].

A Royal Decree concerning prevention of psychosocial risks came into force in 2007 (Federal Public Service Employment, Labour and Social Dialogue, Belgium, undated b). This replaced the Royal Decree of 2002. It covers not only stress at work but also the following psychosocial risks:

- violence at work: physical or emotional intimidation or attacks on a person at work;
- sexual harassment: all undesirable verbal, non-verbal or physical behaviour with a sexual connotation;
- harassment at work: repeated offensive behaviour, inside or outside the workplace, meant to affect the dignity or the integrity of a person.

General health and safety law stipulates that each company with at least 50 employees is legally obliged to create a Committee on Prevention and Protection at Work (CPPT-CPBW) (Federal Public Service Employment, Labour and Social Dialogue, Belgium, undated c). This committee brings together employer and employee representatives in discussions on well-being and the prevention of psychosocial risks at work.

Employers have to take specific measures to keep psychosocial risks under control. As part of the general prescribed management approach to tackling health and safety issues, companies have to draw up a five-yearly global prevention plan, a yearly action plan and a yearly report on the internal system for prevention and protection at work. The plans and report have to be presented to the CPPT-CPBW. Psychosocial risks should be a main theme of these management instruments.

In addition, the employer has to appoint a prevention advisor specialised in the psychosocial aspects of work. The appointment of a confidential counsellor has to be agreed by the CPPT-CPBW. There has to be an internal procedure in case of a demand for a psychosocial intervention, and employees must be informed and, if necessary, instructed on the details of the process. Workers having contact with people who are not employees of the organisation (such as customers and clients) should receive specific attention and support, for instance a register in which unacceptable behaviour can be reported.

The official work rules of the company or organisation have to include internal procedures accessible to employees, and coordination with the confidential counsellor or prevention advisor on the issues of psychosocial risks, harassment and violence at work.

In 2010, the legal provisions were evaluated again by the Federal Public Service Employment, Labour and Social Dialogue and the Belgian parliament. The recommendations of the parliament led to new modifications into the legislation, and these were voted on in January 2014. Finally, on 1 September 2014, a new Royal Decree will replace that of 2007. An emphasis will be placed on the prevention of all psychosocial risks at work, going beyond violence and harassment. The decree will define the concept of psychosocial risks at work and clarify the obligations of the employer as well as the roles of all actors.

France: Emergency plan and branch-level agreements on stress

In France, the social partners began tackling psychosocial risk through social dialogue. In the context of raising awareness of mental health problems, the government developed plans aimed at implementing procedures at workplace level. In general, psychosocial risks have become a major topic in public policy because of their high social and economic costs. Recently, various sectoral agreements on psychosocial risks have been reached.

The Framework Agreement on Work-related Stress of 2004 was implemented through the national interprofessional agreement of 2 July 2008 on work-related stress (Accord national interprofessionnel sur le stress au travail). All social partners signed this agreement, which was extended by an order of 23 April 2009 (Arrêté du 23 avril 2009 portant extension d'un accord interprofessionnel sur le stress au travail). The agreement helped to speed up bargaining in France, a process that was also influenced by several suicides of workers in the car industry in 2007 (Eurofound, 2008b). The agreement defines the concept of stress and focuses on issues such as work organisation and subjective factors. Employers are given the responsibility for deciding the appropriate measures to prevent stress.

Furthermore, in October 2009 the government adopted an 'emergency plan' to prevent work-related stress, which included a commitment from employers to negotiate collective agreements on prevention of work-related stress in companies with over 1,000 employees before 1 February 2010. This emergency plan was adopted in the context of a wave of suicides in 2009 that affected employees of the telecommunications group France Télécom-Orange (Eurofound, 2010). The emergency plan also included the organisation of 22 seminars at regional level for SMEs with the support of the French national agency for the improvement of working conditions (ANACT) and the social security regional bodies (CRAM). About 5,500 participants have attended those seminars. Additionally, the ministry asked the labour inspectorate (Direccte) to monitor whether companies were taking into account the impact of restructuring processes on mental health.

In April 2011, the Ministry of Labour, Employment and Health published an assessment of the implementation of the emergency plan. The full study analyses the content of 234 company-level agreements signed between April 2009 and October 2010 in companies with over 1,000 employees (Ministry of Labour, Employment and Health, France, 2011a). Although a high number of agreements had been signed, it was felt that there was not enough evidence of concrete outcomes or specific details as regards companies' intentions. Therefore, the main employers' organisation, MEDEF, published guidelines showing companies how to implement the agreement.

As a logical continuation of the emergency plan to combat stress at work, psychosocial risks have been integrated in the occupational health plan 2010–2014, where they have been prioritised as a top risk in the field of OSH. In this context, government bodies have developed models for prevention as well as tools and guides for employers' and employees' representatives.[13]

In relation to company restructuring, the Protection of Employment Act (No. 2013-504) of 14 June 2013 implemented a social partner agreement on labour market reform from January 2013 (Eurofound, 2013). The agreement states that employers have to conclude an agreement with unions on an 'employment safeguard plan'. This commits employers to launch a plan in case of a restructuring leading to the reduction of 20 jobs or more; it also requires a consultation with the health and safety committee. If the two sides are not able to reach an agreement, the labour inspectorate has to decide on the plan. In either case, the labour inspectorate may ask the company to provide details on how it takes into account psychosocial risks. This regulation constitutes a tool for the labour inspectorate to influence the implementation of measures related to mental health.

In 2013, the social partners concluded an agreement on the quality of working life (Eurofound, 2013) and, together with the government, they established a mechanism to help companies and social partners to meet their responsibilities in the field of quality of working life, with the help of ANACT and the ARACT network (regional associations for the improvement of working conditions).

Although the agreement did not include a commitment to implement its measures at branch level, several branches have signed agreements to prevent work-related stress. Examples are found in the banking sector, electricity and gas, telecommunications, social economy, oil industry, pharmaceutical industry and agricultural cooperatives. These agreements have the following objectives:

- examination of health and prevention measures that can facilitate the identification of specific risk factors that must be evaluated in the respective sectors;
- providing information and raising awareness by making communication tools and actions available to establishments in the respective sectors;
- providing support and facilitating cooperation in applying for funding for prevention training.

[13] These include small business guidelines, available at http://www.travailler-mieux.gouv.fr/Aider-les-petites-entreprises-a.html; an implementation kit for companies produced by ANACT, available at http://www.anact.fr/web/services/kit-rps-du; and a guide on choosing a consultant on psychosocial risks, available at http://www.travailler-mieux.gouv.fr/IMG/pdf/RPS_WEB.pdf.

United Kingdom: Leading role of the national agency for health and safety

In the United Kingdom, debates about psychosocial risks in the workplace are led by the Health and Safety Executive (HSE), the national regulator for health and safety in the workplace. In consultation with others, including the social partners, the HSE has developed an organisational approach to psychosocial risks at work that focuses on collective issues related to the nature and design of work rather than on the behaviour and practices of individual workers.

Psychosocial risks were already high on the HSE's agenda before the conclusion of the European Framework Agreement on Work-related Stress in 2004. Immediately following its adoption, the UK social partners convened a working group, facilitated by the then Department for Trade and Industry, to oversee the implementation of the agreement in the UK. Within months, the HSE launched a strategy called the Management Standards for work-related stress (HSE, 2013), which is designed to help employers meet their general obligations to assess and manage physical and mental health risks, as required by both UK law and the framework agreement.

The Management Standards approach to tackling work-related stress includes tools to identify whether there is an organisational issue with work-related stress and guidance about what steps can be taken to try to tackle the problem. All these are made freely available to any organisation wishing to use them, and they have also been adopted by others outside the UK and the EU. These standards are not legally enforceable, and employers are free to take other equivalent action, but if they do follow the guidance they will normally be doing enough to comply with the law.

The Management Standards place a strong emphasis on employers, employees and their representatives working in partnership to develop effective and practical solutions relevant to their particular organisation and stressors. They also encourage organisations to pursue continuous improvement in recognition of the business and health benefits of tackling stress effectively. In practice, unions and professional associations now use the system not only as a basis for negotiation with employers and a way of educating line managers, but also as an access point to address diverse psychosocial factors in establishments. In the absence of specific legislation, the Trades Union Congress (TUC) acknowledges that the HSE's stress management standards are the most effective way of dealing with stress. However, they underline the importance of involving unions in the introduction of the standards at every stage.

At sector level, the HSE, with the support of the social partners, embarked upon a stress priority programme, which sought to concentrate efforts in five sectors that exhibited the highest levels of stress (central government, local government, health services, finance and education). This programme included

actions such as a dedicated helpline, guidance on the HSE website and ministerial events. The *Health and well-being* report (NHS, 2009) and the *Health, work and well-being in local authorities* report (Local Government Group, 2010) both recommended the involvement of the social partners and the adoption of the HSE Management Standards in their respective sectors.

More recently, work has focused on improving the people management competencies of managers. The HSE, in association with the Chartered Institute of Personnel and Development (CIPD) and Investors in People (IiP), has designed a series of tools to allow managers to assess whether they currently have the behaviours identified as effective for preventing and reducing stress at work. These tools are intended to help managers reflect on their behaviour and management style, and to gather evidence from their staff ('180-degree feedback') or their staff, peers and managers ('360-degree feedback'). In addition, the HSE has been working with a consortium based at Nottingham University that seeks to promote policy and practice at national and enterprise level, and includes both social partners and expert organisations. Their work has placed special emphasis on high-risk worker groups and occupational sectors, and has addressed gender and implementation issues, particularly in the context of different types of enterprise such as SMEs. Based on this work, a new British Standard has been developed: PAS 1010 (Guidance on the management of psychosocial risks in the workplace). Although not legally enforceable, British Standards provide a consensus-led benchmark of good practice. Organisations can show evidence of compliance with these normative standards by advertising the name and number of the standard or by displaying a certification mark such as the BSI Kitemark.

Summary

National legislative and social dialogue initiatives addressing psychosocial risks have been developed in several EU countries. However, the data presented in this report demonstrate that, given the challenge of psychosocial risks in workplaces, further measures and initiatives are necessary to support companies in implementing effective prevention policies.

The European Framework Agreement on Work-related Stress represented a key milestone in encouraging initiatives by social partners at national level and in raising awareness among the stakeholders responsible for developing prevention policies and actions. The role of social partners is important, both to influence legislation and to develop instruments for the implementation of psychosocial risk prevention procedures at company level. However, social partners' involvement and activities vary immensely between countries. This can be explained, first, by the differences in the development of social dialogue structures, second, by their tradition of involvement in OSH in general and, finally, by the prominence given to psychosocial risks in the country concerned.

The examples presented highlight ways of implementing policies to deal with psychosocial risk at Member State level, by legislation or inspection, by providing practical tools, or by means of social partner involvement. They also indicate that to some extent psychosocial risks are recognised in several countries as not only an important factor for the health and well-being of workers, but also a factor that can contribute to a company's performance.

Companies and countries with a significant proportion of workers exposed to psychosocial risks will probably have more difficulty in making work sustainable in future, and therefore will have more problems developing and maintaining a healthy and productive workforce, especially if measures to protect workers from those risks are not developed. In this regard, there is a need to actively tackle psychosocial risks on every level: within Europe, at Member State level and in all companies and establishments. In this context, the next chapter will present key aspects for the development of interventions in organisations in order to prevent psychosocial risks.

4 Organisational interventions on psychosocial risks

The previous chapter described the increased awareness of psychosocial risks at work and the action taken by stakeholders at European and national level to address such risks. Other sources also confirm that there has been a growing effort at European, national and organisational level to develop measures to effectively manage and prevent psychosocial risks (WHO, 2003; ILO, 2004). The aim of this chapter is to present and discuss the different levels and types of interventions adopted by establishments aimed at the prevention and management of psychosocial risks at work.

Types of interventions

Reducing hazards in working conditions and setting up good pre-conditions are not single events, but rather a process with different stages that require changes in the work environment and sometimes also in individuals. Within the workplace context, Oeij and colleagues (2006) define the term 'intervention' as a process of change that occurs within and with regard to the organisation and management of work. This process of change can be targeted at the organisation, but also at groups or individuals.

Traditionally, psychosocial risk management interventions have been distinguished according to whether they operate at the organisational, task/job or individual level (Murphy and Sauter, 2004). However, a more commonly used distinction is that between the stages of prevention and their associated targets of change, namely primary-, secondary- and tertiary-level interventions. Briefly, primary-level interventions attempt to tackle the source of the work-related problem or stressor; secondary-level interventions attempt to strengthen employees' ability to cope with exposure to these stressors, or to reverse, reduce or slow the progression of the situation; and tertiary-level interventions offer remedial support for the problems that have already been caused by psychosocial risks.

The EU Framework Directive 89/391/EEC on measures to improve safety and health at work makes reference to this concept by emphasising the importance of always first eliminating or avoiding risks (primary-level prevention); only if this is not possible should protective measures be taken. The following sections provide a more in-depth description and discussion of the various levels of workplace interventions.

Primary-level interventions

Primary-level interventions are proactive by nature and aim to prevent exposure to different occupational hazards and the effects of certain risk factors (for example, work-related stress and other symptoms of ill-health) from emerging by reducing the risks (see also the section on psychosocial factors in the work environment in Chapter 2). Consequently, the focus is on the identification of potential risks in the psychosocial work environment, and the main aim of interventions is to eliminate or reduce the identified risks at source.

In relation to harassment, the aim of primary-level intervention is to minimise the risk of harassment. This is accomplished by addressing the work and organisational factors (such as role conflicts, excessive time pressure, poor atmosphere in the workplace, poor leadership and uncertainty at work) that may lead to and sustain harassment behaviours, and by introducing an organisational zero-tolerance harassment policy that asserts that any harassment-like behaviours are not accepted in the workplace.

Examples of primary-level interventions are described below.

- Organisational policies and procedures: The organisation can develop written policies for dealing with work-related stress or specific psychosocial hazards (such as poor work–life balance or workplace harassment). These policies should typically outline what the organisation seeks to achieve with regard to the issue; how it intends to do so; and the responsibility of the organisation, the employees and other actors, such as safety and health representatives (HSE, 2013; Royal College of Nursing, 2009). In relation to workplace harassment, policies should include a clear statement from management that all types of harassment are unacceptable, procedures to tackle harassment, and instructions on how to act for all involved (those experiencing harassment, those who observe harassment, those accused of harassment, line managers and so on) (HSE, 2013; Leka and Cox, 2008; Royal College of Nursing, 2009).
- Job design and workload management: This intervention seeks to change aspects of work so that it better suits the skill set, interests or resources of the employee (Sauter et al, 1998). Job design can also help reduce any ambiguity or conflict that an employee might perceive in their job role (Tubre and Collins, 2000). Effective workload management can significantly reduce the amount of demand placed on an employee, without necessarily reducing the workload itself (Cottrell, 2001). In relation to workplace harassment, change can be accomplished by addressing, for example, role conflicts or excessive workload that may promote harassment behaviours (Einarsen et al, 1994; Vartia, 1996).
- Improving control: Increasing a worker's autonomy and ability to influence their work environment can be done in many ways. This may include giving workers a say on their workload, working hours, teams they work on, resources and personal development (Landsbergis, 2009).
- Training: Training interventions aim to increase employers' and workers' awareness, recognition and understanding of work-related stress and work harassment, their antecedents and negative health effects, and employer responsibilities. This can prompt employers to undertake preventative actions, and workers to take responsibility for their actions.

Secondary-level interventions

Secondary-level interventions aim to modify an individual's response to harmful work environment factors, and to reverse or slow down the progression of ill-health caused by chronic exposure to psychosocial hazards. In the case of harassment, this might also mean slowing the progression and escalation of the harassment situation and preventing the ill-health of individuals or the work unit from becoming more serious.

Some examples of secondary-level interventions include those outlined below.

- Stress management training: The aim of training is to increase essential skills. Active stress management training encourages workers to change the way they think about the stressor or stressful situation (Randall and Nielsen, 2010). Coping and positive thinking strategies are then taught to change the way workers perceive negative stressors.
- Time management training: This training provides tools and techniques to manage one's time.
- Organisational stress management interventions: These interventions may have various methods and approaches aiming to reduce the risks identified and to improve the psychosocial work environment. An example of such an approach is the participative work conference (Gustavsen and Engelstad, 1986; Mattila et al, 2006), also called 'search conference' (Emery and Purser, 1996). This is an intensive participative method for involving employees in organisational planning and decision-making.
- Settling of cases of harassment: Interventions on this hazard include the investigation of the complaint and settlement of the situation.

Tertiary-level interventions

Tertiary-level interventions are reactive in nature and aim to reduce or minimise the negative health effects associated with chronic exposure to psychosocial risks. In particular, the aim of these types of interventions is to adapt the situation at work to the employee's circumstances and needs. This is done by providing proper rehabilitation and return-to-work systems and enhanced occupational health provisions. The targets of tertiary-level interventions are typically individuals and work units (Murphy and Sauter, 2004).

Examples of tertiary-level interventions include those described below.

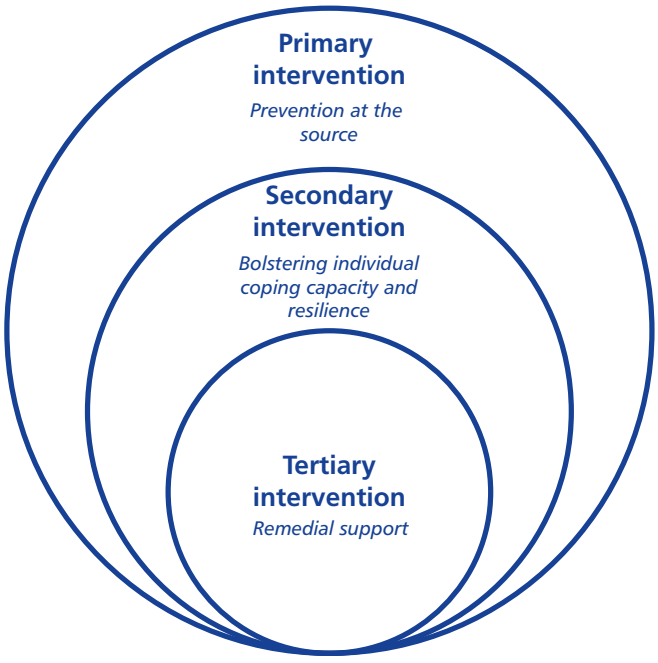
- Employee assistance programmes: These are worksite-focused programmes that identify and help resolve employee concerns that may affect their performance and well-being (Cooper et al, 2003). This is done by offering employees a range of work and non-work (such as debt management and legal advice) support, including counselling, skills training, health advice and access to preventative healthcare.
- Return–to-work programmes: These seek to help workers who have been on stress-related leave to adjust back to work (Blonk et al, 2006).
- Rehabilitative measures: These provide psychological support to address any trauma an employee may suffer, for example because of workplace harassment (Schwickerath and Zapf, 2011).

Multilevel interventions

Developing continuous and sustainable initiatives to promote employee and organisational health and well-being through psychosocial risk prevention and management requires the development of strategies that comprehensively address psychosocial risks and their associated health effects (Giga et al, 2003). This obliges practitioners and organisations to move beyond single-model interventions that practise either exclusively individual or organisational approaches to multi-model interventions that use a combination of such approaches (LaMontagne et al, 2007; Mellor et al, 2012; Sutherland and Cooper, 2001). Such comprehensive strategies should draw from across all intervention levels, as illustrated by Figure 35:

- eliminating psychosocial risks in the workplace to reduce and prevent stress and harassment (primary level);
- where psychosocial risks cannot be eliminated, training employees and providing them with resources to optimise their coping abilities and personal management strategies (secondary level);
- for those who 'fall through the cracks' and are experiencing symptoms associated with work-related stress, providing them with rehabilitative resources and support (tertiary level).

Figure 35: Comprehensive interventions for the management and prevention of psychosocial risks



Example from practice: A comprehensive intervention for psychosocial hazards

An example of a comprehensive psychosocial intervention is the Healthy Working for Health programme undertaken at a Dutch hospital (Lourijsen et al, 1999). It was initiated due to rates of absenteeism higher than national averages. At the primary level, job rotation provided employees with a variety of work tasks, and the archiving system was redesigned to facilitate storage and retrieval of records, which reduced the workload of employees. Colleagues were encouraged to support one another, and managers were given supervisory training to be more supportive. At the secondary level, employees were provided with courses on stress management, while specific departments were targeted with additional training on dealing with death, violence and aggression. At the tertiary level, supervisors were encouraged to participate directly in dealing with sick and absent workers, while changes in job roles were considered for those on long-term sick leave in order to facilitate a quicker return to work.

A holistic approach to workplace interventions

There is growing recognition of the importance of a holistic approach in the promotion and cultivation of a healthy work environment (Chu et al, 2000). A holistic approach aims to address all aspects of the work environment, including both physical and social determinants. This holistic approach should be part of any comprehensive OSH management approach that aims to protect workers' health and safety through prevention and management initiatives, and to promote resilience, engagement and well-being though health promotion activities. The holistic approach to developing healthy workplaces can be observed in two key models for workplace action: the WHO Healthy Workplace Model (WHO, 2010a), and the National Institute for Occupational Safety and Health (NIOSH) Total Worker Health strategy (CDC, 2013). Both models recognise that work-related injuries and disease do not stem from a single source, and therefore a comprehensive strategy that addresses a wide range of health and safety issues is needed. For example, the WHO Healthy Workplace Model seeks to bring together four elements: the physical work environment, the psychosocial work environment, the personal health resources in the workplace (such as encouragement of healthy lifestyles by the employer), and participation in and improvement of the surrounding community. Similarly, health protection programmes based on Total Worker Health that seek to reduce exposure to risks are merged with health promotion that encourages positive lifestyle changes. Fundamentally, both models advocate continual improvement towards the development of a healthy workplace, as there are business, ethical and legal arguments for doing so (WHO, 2010a). Furthermore, they highlight the importance of engaging leadership, as well as worker involvement, both of which are important not only in the success of an intervention, but in the day-to-day running of a business. To take a holistic approach, it is crucial to remember that proper risk management first has to be in place. This risk management should respect the order of implementing measures (first avoiding and eliminating risks, then taking secondary measures). It should also be highlighted that certain approaches, especially to health promotion activities, are based on voluntary action from both sides. Employers are not obliged to offer these measures, and employees' participation is totally voluntary.

Workplace interventions: Procedures, measures and processes

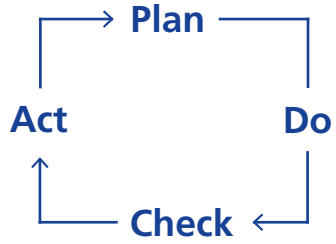
This section provides a reflective commentary on how interventions are designed and implemented, and will highlight some of the key practical and theoretical issues that need to be considered during the intervention process. Considerations and issues pertinent to tailoring interventions for SMEs are also highlighted and discussed.

Background to intervention methodologies

The evidence indicates that interventions have a better chance of having an impact upon psychosocial working conditions and the health and well-being of employees if they follow a structured process that involves the active involvement and participation of employees and social dialogue (EU-OSHA, 2010a; Leka et al, 2008; Nielsen et al, 2010). There are a number of models that describe the different phases of the intervention process. These include the OHSAS 18001, an International Standard for Occupational Health and Safety Standards (BSI, 2013); the ILO's five-step OSH Management System (ILO, 2001); the WHO Model of Healthy Workplace Continual Improvement Process (WHO, 2010a); and the Psychosocial Risk Assessment Framework (Cox, 1993; Cox et al, 2000; EU-OSHA, 2000).

These contemporary models are based on the first models developed, such as Deming's Plan-Do-Check-Act (PDCA) model developed in the 1950s (Imai, 1986). The basic principle of the PDCA model is that a strategy is made (Plan) and implemented (Do) before it is evaluated (Check) and then improved (Act). As Figure 36 demonstrates, the intervention process is intended

Figure 36: The Plan-Do-Check-Act cycle



Source: Adapted from WHO, 2010a.

to be a continual cycle of moving through each stage of the model, with the completion of each cycle bringing the organisation closer to its ideal goal (WHO, 2010a).

A number of central considerations underpin psychosocial risk management approaches:

- a declared focus on a defined work population, workplace, set of operations or particular type of equipment;
- an assessment of risks to provide an understanding of the nature of the problem and its underlying causes;
- the design and implementation of actions to remove or reduce those risks (solutions);
- the evaluation of those actions;
- the active and careful management of the process (Cox and Tait, 1998; Hurst, 1998; Stranks, 1996).

The following sections describe and discuss the procedural steps and considerations underpinning workplace interventions, with the focus on interventions that aim to manage and prevent psychosocial hazards.

Preparing for the intervention process

Preparation prior to starting an intervention is essential and is included as the first stage of many intervention models (for example, Nielsen et al, 2010; WHO, 2010a). Cultivating readiness for change is a key consideration of the preparation stage (Nielsen and Randall, 2012). Readiness for change broadly refers to the attitudes, beliefs and intentions of the management and workers within the organisation regarding the extent to which change is needed, and whether the organisation has the ability to make that change (Armenakis et al, 1993). In short, the 'readiness' of organisations or employees denotes the extent to which they are collectively prepared to implement and support the psychosocial risk management process and associated initiatives. In the context of the workplace, the primary aim of this preliminary stage is to cultivate employee interest and engagement, and mobilise management and employer commitment and support (Nielsen et al, 2010). Some initiatives and actions typically conducted during this preparation stage include establishing a steering group, raising awareness of the topic among employees and ensuring management support. The role of social partners and social dialogue at either national or sectoral level is also important as they can encourage implementation of interventions on psychosocial risks by application of agreements, through the role of affiliates within organisations, and by offering counselling and advice as well as practical guidelines to facilitate psychosocial risk management.

Some of these practical approaches are easier to implement within larger organisations that may have, for example, more readily available organisational resources or support from external or internal consultants than SMEs. Many of these practical approaches can be tailored to accomplish the same objective in the context of micro- and smaller-sized organisations. For example, cultivating senior management support and commitment may not be applicable in a setting where the owner is also the only manager (HSE, 2004). Similarly, establishing steering committees or complex communication strategies might be redundant in micro-companies; a better alternative may be the use of simple and more direct forms of communication, such as weekly team meetings, or message boards with news, events and announcements.

Employee participation: A key to success

The active participation of employees is crucial during all phases of the intervention. More specifically, workers should be made aware of progress and have their say about how appropriate they believe the interventions are. Participation of employees within this process can take three key forms:

1. strategic participation (involving general conditions of work and the employment relationship);
2. process participation (direct or indirect participation in the change process);
3. operational participation (referring to participation inside the transformation process).

Findings from the ESENER survey described in Chapter 2 showed that employees in 54% of European organisations were consulted regarding measures taken to deal with psychosocial risks, and in 67% of organisations employees were encouraged to participate actively in the implementation of those measures. Further analysis showed a strong positive correlation between employee involvement and the reported effectiveness of those measures – 91% of managers from establishments with employee involvement considered the actions to be very or quite effective, while only 59% of managers from establishments without employee involvement did so.

Along with active worker participation, middle managers are responsible for the implementation of initiatives, and for this reason they are an important driver of the change process at this stage (Kompier et al, 2000). When middle managers take responsibility for implementing intervention initiatives, they actively involve their subordinates. This, in turn, enhances employees' reports on the outcomes of interventions, which are more likely to be positive (Nielsen and Randall, 2009).

Risk assessment

Prior to the development and implementation of practical solutions (workplace interventions), it is essential that an accurate and thorough assessment of the psychosocial work environment is conducted (Cooper and Cartwright, 1997; Cox and Griffiths, 1996; Hurst, 1998). The aim of the risk assessment procedure is to systematically identify possibly

hazardous situations within the workplace that may harm employees' health and safety. It is important to highlight that the process of analysing potentially hazardous situations and then assessing the associated risks that they may pose to the health of workers does not have to be a complex or complicated procedure (Cox, 1993). The primary aim of such an assessment should be to collect information that is 'good enough' to provide sufficient and appropriate evidence to prompt discussions of psychosocial hazards at work; this, in turn, can provide an informed basis for managing those problems through an organisational action plan with a central focus on risk reduction (Cox and Griffiths, 1996; EU-OSHA, 2000; Leka and Cox, 2010). The risk assessment should take into consideration diversity issues and should not ignore the wider context, including occupational sector characteristics, socioeconomics and cultural variations across countries (Leka and Cox, 2010).

Identification of psychosocial hazards

Identification of psychosocial hazards can be carried out with different methods, the most common being surveys, interviews, focus groups and checklists. It is vital to include workers or their representatives in the risk assessment, taking into account the appropriate national, sectoral and company frameworks and practices. The views of workers on the management and design of their work can be collected through, for example, a survey or focus groups. In smaller organisations, the use of focus groups may be a useful alternative to conducting a survey. There are currently a number of freely available tools to help organisations, big and small, identify key psychosocial hazards. The EU-OSHA campaign 2014–2015 highlights possible tools at international as well as national level.

Toolkits and guidance for risk assessment of psychosocial hazards

There are a number of general toolkits developed for psychosocial hazards:

- the ILO's guide *Stress prevention at work checkpoints*;
- the SOBANE strategy applied to the management of psychosocial risks (Malchaire et al, 2004);
- in the UK, the HSE Management Standards (Cousins et al, 2004);
- in Ireland and Northern Ireland, the Health and Safety Authority's 'Work Positive Project 2005–2007';
- F-PSICO 3.0 from INSHT (2011) and the CoPsoQ-istas 21 method from ISTAS, both from Spain;
- the Scandinavian QPSNordic questionnaire (Norden, 2000);
- a French government website dedicated to supporting SMEs in dealing with psychosocial risks: http://www.travailler-mieux.gouv.fr/Aider-les-petites-entreprises-a.html.

There are also risk assessments developed for specific sectors. For example, in the retail sector KAURIS (Finland) was developed to manage workplace violence (see EU-OSHA, 2002); for managing work-related stress, there is the Workload Assessment Instrument from the Netherlands (see HBD, 2009).

Identification of health problems

To examine the possible harm associated with exposure to psychosocial hazards, it is crucial to link exposure to certain health problems. Adequate data are needed to fulfil this objective. Organisations may wish to collect and examine information on the health of workers and on health status across the organisation. This information may be collected from organisational records (such as absence data and occupational health referrals) or self-reported information from employees on their health, well-being and job satisfaction. This latter information can be collected through an anonymous employee questionnaire or through focus groups or interviews with employees. However, in smaller enterprises individual interviews might be a more useful technique. When investigating employees' health status, the employer should be aware that there are strict limitations on what they are allowed to ask. In addition, rules for proper data protection should always be taken into account. It is also important to consider the limitations and advantages of different data retrieval measures. While self-reporting is based on subjective data, other data such as sick leave records might sometimes miss out the personal perspective, which can add valuable information to the numbers recorded.

The risk assessment procedure is an important source for collecting information, and depending on the size of the company, it can be used as a baseline measurement by the organisation (Cox, 1993; EU-OSHA, 2000; Cox et al, 2000; Leka et al, 2005). This baseline measurement can be useful in tracking progress and in monitoring the effectiveness of the intervention in addressing and managing the identified psychosocial hazards and their 'knock-on' effects on the health and well-being of workers.

Getting an overview of existing management systems and employee support

Before an organisation can sensibly or appropriately plan how it will address the issues identified, it is necessary to examine what pre-existing systems and resources, if any, are in place to deal with psychosocial risks and their effects on individuals and the organisation at large (Cox, 1993; Cox and Griffiths, 1996; Cox et al, 2000).

Depending on the size of the organisation this analysis might require an audit (review, analysis and critical evaluation) of existing management practices and resources for employee support (Leka and Cox, 2010). The information collected from the audit, in combination with that of the risk assessment, will give the organisation an informed view of the degree to which

risks associated with exposure to psychosocial hazards are not currently being addressed or actively managed by the organisation (Cox, 1993; Cox et al, 2000; Leka and Cox, 2010).

Example from practice: Getting an overview of existing measures and implementing improvements

In the late 1980s, the UK Post Office identified work-related stress as an issue within the organisation and that steps needed to be taken to address it (Cooper and Cartwright, 1994). A review of their occupational health service revealed that, although counselling was offered, it was led by nurses and welfare officers, and was considered basic. As a result, a decision was made to develop an in-house specialist counselling team under occupational services to tackle more complex psychological issues resulting from work-related stress. Upon launch, the service had a very good uptake, and was subsequently shown to be effective in improving levels of self-esteem and decreasing levels of depression and anxiety. However, there was little impact on job satisfaction and organisational commitment, which was attributed to the lack of impact that stress counselling, as a secondary prevention measure, had on actual working conditions. Therefore, in a second step, it was decided to have a closer look at psychosocial hazards and take appropriate primary prevention measures.

Developing an action plan

The primary aim of this phase is to discuss and prioritise the identified risks and to develop an action plan to target these risks by means of specifically designed actions (Cox, 1993; Cox et al, 2003). As highlighted above, the information gathered through the risk assessment procedure is used as evidence on which to base the planning of interventions. In practice, those involved in action planning discuss and explore the results of risk assessment, with the aim of developing a collective understanding of the problems identified. A participatory approach is very important and should be laid down in any action plan. An effective way of developing the action plan using participatory methods is to use workshops or focus groups where employees together find appropriate solutions that they would like to implement (Dahl-Jørgensen and Saksvik, 2005). The discussion and exploration of the problems and likely risk factors help to uncover any major problem that may be hidden or poorly understood.

It is strongly recommended that problems identified at this phase should be prioritised in order to focus efforts on a small number of well-delivered and powerful initiatives (Nielsen et al, 2010; Nielsen and Randall, 2012). In addition to the intervention methods to be used, an action plan must also include:

- the communication plan – how the process is systematically communicated to all those concerned;
- the evaluation plan – how the outputs and effectiveness of the interventions will be assessed;
- a timetable for the whole intervention process;
- possible checkpoints for identifying and tackling risks;
- how to nominate the person (or persons) responsible for different actions.

Examples from practice: Identifying problems and generating solutions

A five-year psychosocial work intervention study in Denmark attempted to improve working conditions for workers of organisations participating in the study, which included nursing homes, pharmaceutical companies and municipal services (Nielsen et al, 2002). Once the data from the organisation (for example, absence and turnover rates) and the psychosocial risk assessment survey were available, workers at all levels were invited to participate in focus groups to discuss these findings, provide their opinions, prioritise problems and develop solutions. This then led to them influencing the intervention steps taken, including a greater emphasis on organisational-level interventions. Post-intervention results subsequently showed reduced absenteeism, a better psychosocial working environment and improved productivity.

In order to improve the working conditions of teleworkers in Germany, a series of health circles were conducted (Konradt et al, 2000). These are employee groups, without managers, which focus on workplace issues and psychosocial risk factors and intend to develop suitable coping strategies. Among the identified risk factors were being disconnected from the main company, assessment of work performance, poor time management and poor communication. As a result, solutions such as focusing on work output instead of hours worked, becoming more active in communicating with the main company, selecting a communication partner who works in the office, and periodic visits to the main company were all identified as steps which the teleworkers themselves could take. Two months later, follow-up assessments showed that the 17 teleworkers who took part in the health circles reported improvements in working conditions relating to time management, communication issues and ergonomic issues. Furthermore, the positive difference was much larger than in another group of teleworkers who did not take part in a health circle.

Implementing solutions and interventions

This stage of the process aims to implement the solutions and interventions agreed on in the previous phase. As the intervention progresses, any developments should be

monitored against the desired time frame set during the action planning stage to determine whether or not the intervention is proceeding as planned (Nielsen et al, 2010). In smaller organisations, conversations with employees can help gauge what employees feel about the intervention and whether it is working. In larger organisations, more formal engagement methods, such as questionnaires or team meetings, might be needed to gain the appropriate feedback. This then allows adjustments to be made to the intervention if necessary (Nielsen et al, 2010). The discussion that follows highlights a number of factors that aid in the effective development and implementation of interventions.

Where possible, the content of the intervention – key elements of focus, tools and implementation – should be derived from evidence-based practice and based on sound scientific theory (Leka et al, 2008). Some of the models mentioned in Chapter 1 are typically applied in organisational interventions for psychosocial risks, including the job strain model or the job demands–work resources model (Karasek and Theorell, 1990; Bakker and Demerouti, 2007; Schaufeli and Bakker, 2004), the effort–reward imbalance model (Siegrist, 1996) and the Healthy and Resilient Organization (HERO) model (Salanova, 2009). However, a lack of theoretical background knowledge within the company should not be a hindrance, as psychosocial intervention and risk assessment guides are typically based on some underlying theoretical approach. This means that, even if an organisation lacks the theoretical expertise, it can benefit from using a theoretical and evidence-based approach. Such guidance is often provided by authorities or social partners. Chapter 3 gives examples of authorities that provide such guidance, and the EU-OSHA Healthy Workplaces campaign website provides access to guidance and tools in different Member States.[14]

Research into practice: The Management Standards for work-related stress

The development of the Management Standards for work-related stress and accompanying toolkit (Cousins et al, 2004) by the HSE in Britain was informed by sound empirical research (for example, Cox, 1993). In one case study involving the Oxfordshire County school district in England, the Management Standards instrument was administered in schools to identify psychosocial hazards specific to each school (HSE, undated). Subsequently, staff within these schools were encouraged to generate and implement solutions for the hazards identified. A number of schools identified heavy workload as a key workplace issue. In one, the work schedule of teachers around busy times such as exams was examined and monitored to see how this issue could be addressed. Changes were then made that included adjusting the type of homework students received to reduce marking load, and rescheduling staff meetings for quieter periods. In another school, a rota system was developed to help the administrative team manage their workload. There has been a lot of anecdotal evidence suggesting this intervention process has helped manage stress levels in teachers. Moreover, every year, more schools are volunteering to take part in this initiative. Crucially, between 2006–2007 and 2008–2009, the Management Standards instrument showed a year-on-year improvement in the psychosocial climate in the participating schools.

Evaluation of interventions

The evaluation stage aims to critically assess the short-term and long-term outcomes of an intervention, as well as the process of implementation and the changes that have taken place (for example, in working conditions and procedures, in the health and well-being of employees, and in turnover and absenteeism) (Nielsen et al, 2010). Evaluation will allow organisations to determine how well and in what respect the intervention worked. Therefore, the aim of the evaluation process is to show what is, and what is not, working; and it seeks to identify factors inherent to the content and context of the intervention that are important for success (Biron et al, 2010; Cox et al, 2007; Nielsen and Randall, 2012). Bearing this in mind, the evaluation of interventions should aim to collect information on the potential effect of the intervention and to examine the contextual factors that might have influenced the outcome (Biron et al, 2010).

Evaluations should collect a variety of information and from a number of relevant perspectives, including those of staff, management and stakeholders. Depending on the size of the organisation, a mixture of approaches may be used to gather the information: setting up specific meetings with managers to review progress on major actions; setting up regular sessions with staff to talk about their experiences; or repeating the risk assessment procedure at adequate intervals to observe any changes.

The results of the evaluation will permit a critical assessment of the strengths and weaknesses of the action plan, intervention strategies used and the implementation process. This information can be useful in answering the questions: What worked? What did not work? What could be improved? What factors helped facilitate the process? What factors hindered the implementation of process? Although much has been written about how interventions should be evaluated, it is important to highlight that any form of evaluation is better than none at all as this information will undoubtedly help inform further and more tailored action in the future.

[14] See https://www.healthy-workplaces.eu/.

Smaller companies: Special issues

Within SMEs and micro-enterprises, evaluation can be far more informal. The closer proximity between workers and outcome data (such as performance or absenteeism figures) means that the business owner or person running the initiative is likely to be able to observe any changes or difficulties stemming from the intervention without having to undergo an evaluation process. For example, at the Merthyr Tydfil Housing Association in Wales, which has 37 employees, a small permanent manager–worker group was created to discuss and address various health topics. The close relationship this group has with the management board means that issues identified can be addressed quickly and, in turn, its effectiveness examined rapidly (Welsh Government, 2007). Similarly, the Austrian IT company AddIT regularly surveys its 80 workers on a 'survey/action swing' process, where staff are surveyed to determine the issues they face, action is taken and staff are surveyed again to see if the changes have been felt; the process is then repeated (EU-OSHA, 2010b). Within micro-enterprises, the evaluation–action relationship can be even quicker and more informal, as face-to-face meetings might suffice in evaluating and planning interventions.

Follow-up: A continuous improvement cycle

Psychosocial risks are a dynamic phenomenon, and are constantly changing within the context of an organisation. For example, changes in working life and in organisations, as well as in the features and organisation of work, have an impact on the psychosocial work environment. Consequently, if organisations are aiming to improve and maintain the health and well-being of employees, it is important that intervention initiatives as well as the organisational context should be continuously reviewed and evaluated (Biron et al, 2010; Cooper and Cartwright, 1997). Therefore, the final step of the intervention process (or the first in the next cycle) is to implement changes on the basis of the information collected through the evaluation phase, in order to improve the programmes and initiatives that have already been implemented.

Conducting follow-up assessments after a significant period of time is important to determine whether change has occurred and if it has been sustained (DeJoy et al, 2010). All lessons that have been learnt need to be discussed, and, if it is deemed necessary, the intervention should be redesigned. These lessons should be discussed in work meetings and in the organisation's social dialogue, where applicable and according to its particular modalities. It is recommended that the whole workforce be informed about this process, to show that the issue is taken seriously. This process of continuous evaluation and then adjusting implemented actions, practices and policies is central to organisational learning and development.

Example from practice: Continuous improvement

In attempt to improve staff morale and decrease absenteeism rates amongst workers in a call centre, health checks and relaxation classes were offered to workers for a six-month period. These measures all belong to the category of secondary interventions, which do not change the organisational arrangements but try to boost employees' resources. Evaluation of the measures showed it had no effect on absenteeism. Consultation with workers revealed that relaxation classes were not well attended, management was poor and workers had little control. A workers' committee was established to improve the approach, and this changed relaxation class times to better accommodate workers. Moreover, new assessments showed high error rates during weekday afternoons, and discussions revealed that this was partly due to mothers being concerned about their children returning from school. Hence, the company decided to also implement an organisational change and allowed a 10-minute break around 16.00 for mothers to call home. This led to a significant improvement in service quality and morale. (This case study was taken from Noblet and LaMontagne, 2006.)

What works and what doesn't

The previous section provided an overview of the psychosocial risk management process. Work-related stress and harassment take different forms, as do the interventions to tackle them. This section reviews the effectiveness of interventions for psychosocial risks, giving a brief and practical overview and examples of these different interventions. It does not aim to provide an exhaustive review of all types of organisationally and individually targeted interventions. Rather it provides a short description and discussion of several common types of interventions in the workplace, with the focus on work-related stress and harassment.

Effectiveness of interventions

Although there is a growing use of interventions to manage and prevent work-related psychosocial risks (Kompier and Kristensen, 2001), the vast majority of these programmes are not systematically assessed or evaluated (LaMontagne et al, 2007). This paucity of evaluative information means there is a restricted evidence base and, at a practical level, limited knowledge on what measures work and why. Many of the reviews in this area are restricted by the small number of studies that can be included, which is a consequence of the limited number of interventions that have been systemically evaluated and reviewed (LaMontagne et al, 2007). In addition, the relative heterogeneity of such intervention studies (for example, in terms of the diversity of outcomes measured used, duration of intervention and follow-up period, selection bias, and typically small sample sizes) makes it difficult to compare interventions. In turn, drawing clear conclusions regarding the overall effectiveness of an intervention, the mechanisms

that underpin the sustainability and longevity of observed effects, and the intervention's cost-effectiveness is exceedingly challenging. There is also a need for research investigating the unique challenges that are faced by SMEs, as they typically have low rates of participation in health and safety initiatives due, in part, to a lack of resources and lack of access to relevant information (European Commission, 2009).

However, some progress has been made over the last two decades in drawing attention to the evaluation of the effectiveness of interventions, and the evidence base is growing (Bambra et al, 2007; Bergerman et al, 2009; LaMontagne et al, 2007). Quite often, programmes seem to involve secondary-level interventions that produce favourable individual-level outcomes (LaMontagne et al, 2007). However, the favourable individual-level outcomes are mostly short-lived, and organisational-level outcomes are often not examined or do not yield positive results (van der Hek and Plomp, 1997; van der Klink et al, 2001). Research suggests that a mixed approach, including both primary and secondary forms of intervention, is the most effective in generating improvements at both the organisational and individual levels (LaMontagne et al, 2007).

Research has also started examining the cost-effectiveness of organisational interventions, with initial findings demonstrating that, over time, investment in workplace interventions can yield financial returns (Hamberg-van Reenen et al, 2012; LaMontagne et al 2007; Matrix, 2013). For example, different evaluations have shown that the cost of interventions is balanced by greater savings through reduced absenteeism costs (Lourijsen et al, 1999) and improved sales performance (Munz et al, 2001). Furthermore, a report by Matrix (2013) commissioned by the European Union Health Programme showed that primary-level work improvements yield a return of €10.25 for every €1 spent through improved employee mental health. Therefore, despite the restricted evidence base in the area, some general conclusions can be drawn. Interventions aiming to prevent work-related stress appear to be effective in improving the quality of working life for workers and their immediate psychological health, based on self-report data (Cox et al, 2000). In addition, there is a growing evidence base that multi-level interventions (also referred to as holistic or comprehensive interventions) are the most effective approach to address and manage psychosocial risks (LaMontagne et al, 2007).

Examples of successful interventions

Organisational policies

Regardless of which intervention an organisation decides to conduct, it is imperative that a work-related stress prevention policy is first in place. This helps establish an understanding of what work-related stress means to the organisation and how it seeks to address this challenge (HSE, 2013; Royal College of Nursing, 2009). Consequently, policy underpins and links all subsequent interventions to manage psychosocial hazards within the organisation. The success of an organisational stress policy depends on fruitful discussions and agreements between different stakeholders within the organisation, including employer, managers, staff or staff representatives and trade union representatives, as appropriate (Royal College of Nursing, 2009). For small companies and micro-enterprises, this interaction might take place between the employer and a staff representative or the staff directly. The organisational stress policy should be appropriate to the size and specificities of the company and provide explicit details on:

- the purpose and goals of the policy;
- the responsibility of management and staff;
- the responsibility of other relevant parties, if applicable (such as human resources and occupational health and safety representatives);
- the assessment and monitoring of workplace stress;
- where responsibility lies for managing and evaluating the policy itself (HSE, 2013; Royal College of Nursing, 2009).

For a smaller company, the stress policy developed may be much shorter and be limited to general definitions and actions, as well as a brief outline of the responsibilities of the employer, manager (if applicable) and staff members.

A failure to link workplace stress interventions to policy means such activities are often carried out in isolation from the organisation's purpose and vision, reducing their effectiveness of the intervention (Stokols et al, 1995). However, merely developing a stress policy is not sufficient, as frequently organisational policies exist on paper, but not in practice (Brough and O' Driscoll, 2010). The organisation has to be receptive to the policy developed, and the role of senior managers, or in SMEs the employer, in adhering to, communicating and implementing the policy are essential in demonstrating to workers that the company values the policy developed and takes seriously the issue of psychosocial risks in general (Brough and O' Driscoll, 2010; Elo et al, 2008). Information and guides on how to develop a stress policy can be obtained from international and national bodies, including *Stress prevention at work checkpoints: Practical improvements for stress prevention in the workplace* (ILO, 2012) and *An example of a stress policy* (HSE, 2013a).

Designing better jobs and workplaces

This type of intervention seeks to change aspects of work so that it better suits the skill set, interest or resources of the employee (Sauter et al, 2002). It may focus on adapting one or several job characteristics, including job demands, skill variety, task identity, task significance, autonomy and feedback, to name a few. It is important to note that the active participation of employees is central to many of these interventions (Parkes and Sparkes, 1998).

Two systematic reviews of organisation-oriented interventions provide an insight into the effectiveness of interventions with

a concentrated focus on enhancing employee control through job design and workplace reorganisation. The first systematic review identified several task-restructuring interventions that had been empirically evaluated (Bambra et al, 2007). The review found that decreased control and increased demand tended to have an adverse effect on health, while interventions that increased control and decreased demand resulted in improved health – although some effects were minimal. The authors of this review highlight that the findings lend support to policy initiatives (such as the EU Directive on the involvement of employees) that aim to increase job control and autonomy. The second systematic review examined worksite interventions that focused on employee participation and control through workplace reorganisation (Egan et al, 2007). This review found evidence to indicate that these types of interventions, with a concentrated focus on increasing employee participation through control, may also benefit employee health. However, the authors highlight that, despite such benefits, these interventions cannot protect employees from generally poor working conditions (Egan et al, 2007). This again highlights the importance of a holistic approach to workplace health, which actively addresses and manages risks associated with both the psychosocial and physical working conditions.

Example from practice: Job redesign and workplace reorganisation

This worksite intervention focused on redesigning the content of jobs or the organisation of work using a participatory approach. Bond and Bunce (2001) conducted the intervention amongst administrative employees in a central government department, which aimed to increase the extent to which people had discretion and choice in their work by reorganising work systems and processes. Work organisation changes were developed and implemented by a 12-member steering committee in a series of five two-hour meetings over a three-month period. Informed by previously collected data and the experiences of the established steering committee, three problem areas were targeted: assignment distribution procedures, within-unit consultation and communication, and informal performance feedback.

An example of one measure implemented was a formal procedure whereby every unit member was able to recommend and comment on the way in which their tasks were grouped, assigned and fulfilled. In one of the division's units, this innovative procedure resulted in administrative assistants establishing the practice of having quick, informal morning meetings to allocate their work and to establish the working methods needed to meet their deadlines. This allowed them to manage their workload in a more participative, controllable, planned and equitable manner. Another intervention took the form of a very brief email feedback form that could be sent to employees' supervisors if they were unsure about how well they had accomplished a task. This worker-initiated request for information provided people with fast feedback that could quickly shape any task behaviours and, thus, over time, provided people with a sense of control over their work. Line supervisors agreed to respond to the forms twice weekly. The results of a one-year follow-up evaluation found that the intervention significantly improved mental health, and sick leave was found to have fallen.

Interventions focused on supervisors and managers

Managers and supervisors have an important role to play in minimising stress-related risks for their staff. Indeed, manager behaviours can have a direct impact on staff well-being, in that they can be both the source of work-related stress and instrumental in its prevention among those they manage. The importance of leadership in OSH has been addressed by EU-OSHA's Healthy Workplaces campaign 2012–2013 (EU-OSHA and BusinessEurope, 2012). Consequently, there is growing awareness that positive leadership and manager behaviours are central to the management of the psychosocial risks. Therefore, part of this process is for managers to understand how their behaviours facilitate the active and positive management of their employees in a way that minimises work-related stress and promotes their well-being and performance. Indeed, there is a growing body of research that links organisational leadership to a wide variety of both positive and negative employee health and safety outcomes. This has led to growing recognition of leadership and management training as an effective form of intervention (Kelloway and Barling, 2010). Such activities typically include training in the form of workshops (Dvir et al, 2002), participation in coaching (Kombarakaran et al, 2008) or combinations of both approaches (Barling et al, 1996; Kelloway et al, 2000).

Example from practice: Toolkit to aid workplaces practices

Research commissioned by the UK HSE identified management behaviour and competencies that prevent and reduce stress at work (Yarker et al, 2007, 2008). Through this research, the Stress Management Competency Indicator Tool was developed, which aids managers in assessing their management competencies regarding work-related stress. More specifically, this tool examines 85 behaviours, grouped according to four competencies: managing emotions and having integrity; managing and communicating existing and future work; managing the individual within the team; and managing difficult situations. Managers can rate themselves on these behaviours, or they can ask their peers,

superiors and subordinates to rate their performance. To facilitate this process, a website has been set up to help collect the responses and to generate feedback to the manager (HSE and CIPD, undated). In addition, the feedback contains exercises and goals that the manager can work through to become more supportive. As the business owners frequently manage workers in SMEs, the manager competency tool is especially relevant for use within small companies and micro-companies. Business owners can also self-reflect and complete the questionnaire evaluating themselves, thereby identifying any self-improvement areas. Considering the relationship dynamics between owner and staff in smaller companies, the role of a supportive manager or business owner is even more important (Hasle and Limborg, 2006).

Work schedule interventions and flexible work organisation

There are a wide variety of interventions that involve change to traditional work scheduling. Indeed, flexible working arrangements are becoming increasingly more common. Flexible working time interventions take several forms.

- Self-scheduling or flexible scheduling: Self-scheduling interventions involve changes in start and finish times to enable increased choice and control regarding working hours. This type of intervention aims to accommodate the worker's individual needs when organising shifts, and in the development of organisation systems that yield higher levels of flexibility in the design of the roster (Barton et al, 1993).
- Flexitime: Flexitime offers workers a variable work schedule that deviates from traditional office hours and allows them to choose their own start and finish times (Kuang-Jung, 2001). If they work extra hours, they can take the accumulated time off. Flexitime schedules may require employees to be available and present in the workplace during a core period (Dunham et al, 1987).
- Teleworking: Teleworking is an arrangement that allows workers to work off-site and communicate with the office by telecommunication links. Working from home is one form of teleworking. Workers might work remotely for their entire working time, or they might telework for a proportion of their working time on a weekly or monthly basis (Buddendick et al, 1999).
- Job share: Job sharing is a voluntary arrangement where two or more individuals share the responsibilities of a full-time job and the salary, leave and benefits by working part time on an ongoing basis (Branine, 2003). The individuals participating in the job share are primarily responsible for dividing the workload effectively and equitably, and ensuring all duties are completed (Adamson et al, 1994).

Eurofound's report (2012) on the organisation of working time shows examples of companies from different countries where specific ways of implementing working time flexibility have led to improvements in productivity and working conditions. However, the report also demonstrates that, for this result to happen, elements related to workers' needs, as well as those of the business, have to be taken into account.

Example from practice: Open rota for work scheduling

This intervention focused on enhancing working time flexibility through flexible work scheduling (Pryce et al, 2006). It was introduced into a Danish psychiatric hospital to improve work scheduling for nurses, with the broader aim of increasing employee control and influence on their work schedule and thereby promoting increased job satisfaction and overall work–life balance. Participants were actively involved throughout the entire intervention process: design, implementation and evaluation. Each of the nursing teams, which voluntarily decided to participate in this project, began by forming a steering group composed of health and safety, trade union and project representatives. The steering group was supported by a larger project group of five or six employees and two external consultants. The external consultants invited the steering groups to attend a one-day workshop during which case studies of work scheduling interventions were presented and discussed. Following the workshop, the steering groups in collaboration with the larger project groups discussed and identified an appropriate work scheduling intervention to be implemented in the nursing teams.

The intervention selected by the majority of the intervention groups was implementing an open rota system, in which employees schedule their shift preferences into an open (and uncompleted) rota. Employees were asked to do this responsibly and fairly – in other words, considering the needs and preferences of work colleagues and the relief required in other departments. Following this, one or two employees had the responsibility of fine-tuning and finalising the rota; this responsibility was rotated between staff members each week. Employees reported a greater level of satisfaction with their work hours and were less likely to swap their shifts. Additionally, employees working within the open rota scheduling system reported a significant improvement in their work–life balance. Compared with the non-intervention group, significant positive differences were observed in the intervention group, including improved work–life balance, job satisfaction and social support, as well as an overall increased sense of community in the workplace.

A recent Cochrane-style review examined 10 intervention studies to establish the association, if any, between flexible work conditions and their effects on workers' health and well-being (Joyce et al, 2010). Overall, the findings suggest that flexibility in working patterns that gives workers more choice

or control is likely to have a positive effect on their health and well-being. However, the authors of the review highlight that, given the small number of studies included in the review and their methodological limitations, caution should be applied to this conclusion. This is a need for more systematic research examining the effectiveness and benefits, to employees and organisations, of flexible work arrangements.

Individually targeted interventions

This section looks at interventions targeted at individuals in the workplace and discusses two common types: stress management programmes and management of return to work from stress-related leave.

Stress management programmes

Stress management programmes seek to provide personal resources and strategies for employees to cope with work-related stress. This is a secondary-level intervention (Landsbergis, 2009), so the emphasis is not on reducing or removing the psychosocial hazards in the workplace, but on changing the way the worker manages these factors and how they react to them (LaMontagne et al, 2007). It involves training, which takes different forms, including cognitive-behavioural training and relaxation or meditation exercises (Flaxman and Bond, 2010; van der Klink et al, 2001). More recently, approaches that emphasise mindfulness (Gold et al, 2010) and acceptance and commitment (Flaxman and Bond, 2010) have also been shown to be successful. Despite evidence supporting the effectiveness of these approaches, stress management programmes are most effective when coupled with primary-level interventions to control or eliminate the psychosocial hazards (LaMontagne et al, 2007).

Example from practice: Stress management training

In one study examining the effectiveness of stress inoculation training and acceptance and commitment training on psychological distress, Flaxman and Bond (2010) randomly assigned 107 participants into one of two training groups or to a control waiting-list group. Participants assigned to the mindfulness group completed two half-day training sessions one week apart, where exercises were held to help workers reduce their struggle with undesirable thoughts and emotions, use cognitive diffusion techniques, and increase their awareness of the present moment (mindfulness). They also completed values and goals clarification exercises. In the stress inoculation group, participants also completed two half-day sessions one week apart, which focused on cognitive restructuring and relaxation exercises, and how these could be incorporated into participants' daily lives. The results showed that, three months after completing their training, participants in each training group had lower levels of psychological distress than before they started. Furthermore, participants who were on the waiting list and had not conducted either of the training sessions had no changes in terms of psychological distress over the same time period.

Return to work from stress-related leave

The process of an employee returning to work after work-related stress absence needs to be managed in a careful manner so that they can resume their duties without having their health affected (Blonk et al, 2006; Thomson et al, 2003). In fact, the management of this process is not confined to the actual return period but should begin as soon as the employee is absent (Thomson et al, 2003). Numerous factors should be taken into account, including understanding the key issues and factors underpinning the stress-related sick leave (Thomson et al, 2003); what form of rehabilitation to undergo (Netterstrom and Bech, 2010); whether the employee should return to work gradually (Blonk et al, 2006); and whether the identified workplace issues have been sufficiently addressed prior to the individual's return to the workplace (Blank et al, 2008).

A review of 14 organisational case studies on return to work after work-related stress absence in the United Kingdom led to the HSE developing best practice guidelines to assist employers in managing the return of such employees (Thomson et al, 2003). Firstly, when an employee is absent from work due to stress, it is important that the organisation make early contact with the employee. An appropriately trained person (their line manager or a human resources representative) should be selected to do this. Secondly, employers should arrange for the employee to have a health assessment with an appropriate specialist such as an occupational health therapist or physician. Here, it is important that an accurate diagnosis be obtained, from a sympathetic and supportive assessor, and that information be shared between all relevant parties. Next, the employer, health professionals and employee should agree on a rehabilitation plan. This should include timings, proposed therapeutic interventions and a review process. Fourthly, a flexible return-to-work option should be provided, as a graded return will allow a quicker return to former performance levels. Finally, where appropriate, any harmful aspects of work that might still be detrimental to the returning employee, and other employees, should be adapted or adjusted to prevent future harm.

Similarly, the Dutch Society for Occupational Medicine developed guidelines for occupational physicians on how to treat workers struggling with work-related psychological problems, based on the cognitive-behavioural therapy (CBT) approach (Blonk et al, 2006). In 2004, Nieuwenhuijsen examined the extent to which occupational physicians adhered to the guidelines provided in the treatment of 200 employees who were absent from work

due to psychological disorders. The guidelines followed a three-phase model. In the first phase, patients were educated on the causes and consequences of loss of control. The second phase focused on problem-solving strategies based on a stressors inventory done by the patients, and the third phase supported patients in putting the strategies into practice. The findings showed that, the closer physicians stuck to the guidelines, the quicker employees returned to work.

Prevention and management of harassment at work

Research and practical work to address workplace harassment (or workplace bullying) started in the Nordic countries in the early 1990s. Since then, acknowledgement and awareness of the problem has expanded in Europe and around the world. National studies of the subject are now available in most European countries. Chapter 3 includes some information on how it is dealt with at European and national level.

However, considerable differences still exist between European countries in relation to awareness, recognition, and acknowledgement of the problem (EU-OSHA, 2010c). For example, the ESENER survey found the proportion of organisations having procedures in place to deal with harassment at work ranges from about 90% in Ireland to almost 0% in Estonia (EU-OSHA, 2010a). Although activities to address harassment at the organisational level have increased, interventions with follow-up and evaluation of the effectiveness of different strategies are still limited (Illing et al, 2013). This may be partly explained by reluctance by both employers and employees to take action. The following section discusses some of the types of workplace interventions used to address the issue of workplace harassment in organisations and their effectiveness.

Anti-harassment policies

Organisational anti-harassment policies are recommended by both researchers and practitioners, and, in addition to training, they seem to be the strategy most often used in many countries to counteract workplace harassment. The role of policy in the management of workplace harassment is central to all concerned. A policy is the employer's statement of intent as regards addressing the issue of harassment, and it highlights a zero-tolerance approach, from both the employer and the staff, to any kind of harassment in the workplace.

A workplace anti-harassment policy should always include:

- a clear statement from management that all types of harassment are unacceptable;
- a description of the phenomenon and examples to aid conceptual clarity;
- reference to legislation and agreements regulating the issue;
- a clear outline of the responsibilities, duties and roles of management and other actors such as worker representatives;
- a description of procedures to counteract the issue in the organisation;
- instructions for targets, observers, persons accused, line managers, workers' representatives and other relevant players;
- a description of measures to be used in the organisation to prevent harassment and methods to monitor and evaluate effectiveness and use of the policy (Einarsen and Hoel 2008; Leka and Cox 2008).

The process of drawing up and implementing the policy is as important as its content (Einarsen and Hoel, 2008). For a policy to work, it must be promoted effectively. It must be communicated to everybody by all the necessary means, and managers and staff should be given training on the policy and related procedures (Rayner and Lewis, 2011; Vartia and Leka, 2011).

Many trade unions and employers' associations have produced policies and guidelines for organisations on how to draw up and implement an anti-harassment policy, including detailed instructions for employers (see Chapter 3 for more information). SMEs, in particular, can make good use of these examples when developing their own policies. It is, however, important that there be a certain commitment in the company, and that everyone feel that the way in which the policy is developed and operationalised is appropriate to the company culture. Examples of some organisational policies from across Europe for addressing harassment in the workplace are provided below. It is important to emphasise that these should be taken mainly as examples or documents to build on.

Examples of practical tools and guidance harassment policy documents for employers, managers and employees

Websites of the Belgian Federal Public Service for Employment, Labour and Social Dialogue, containing information on how to deal with harassment and violence at work: www.respectautravail.be and www.respectophetwerk.be

Norwegian guidance on how to deal with harassment and violence at work from the Labour Inspection Authority: http://www.arbeidstilsynet.no/binfil/download2.php?tid=103760

ACAS (UK) *Bullying and harassment at work: A guide for employees*, available at http://www.acas.org.uk/CHttpHandler.ashx?id=306&p=0

ACAS (UK) *Bullying and harassment at work: A guide for managers and employers*, available at http://www.

acas.org.uk/media/pdf/l/r/Bullying_and_harassment_employer_2010-accessible-version-July-2011.pdf

HSA (UK), *Code of practice for employers and employees on the prevention and resolution of bullying at work*, available at http://www.hsa.ie/eng/Publications_and_Forms/Publications/Occupational_Health/CoP_Bullying.pdf

Examples of organisational policies for harassment in the workplace

International Institute of Management Development, Switzerland, anti-harassment policy: http://www.imd.org/about/keyfacts/upload/Anti%20Harassment%20Policy.pdf?prog=

ESADE Business School, Spain: http://itemsweb.esade.es/rrhh_pas/Ingles/protocoloingles.pdf

University of Copenhagen, Denmark: http://personalepolitik.ku.dk/english/personnel_policies/University_of_Copenhagen_-_Action_Plan_for_Bullying_and_Harassment.pdf/

Although anti-harassment policies are common in organisations across a number of countries, there has been little evaluation of their effectiveness. Some evidence of effectiveness has been observed when a policy has been a part of a broader zero-tolerance approach where other initiatives are involved. Experts interviewed in the Dignity at Work project in the United Kingdom viewed the written policy as a central document that is vital to have in place before any anti-harassment initiatives are undertaken (Rayner and McIvor, 2008).

Example from practice: Evaluation of the effectiveness of an organisational 'dignity at work' policy

A case study of an organisation with 200 employees measured the relative success of bullying and harassment policy (Pate and Beaumont, 2010). The prevalence of bullying at work was analysed over a six-year period from 2001 to 2007. A policy called Dignity at Work was introduced in the organisation in 2005, and compulsory training in the topic was arranged for all employees. In line with the policy, reported incidents of bullying were investigated carefully and consequences were noted. A constructive way of communication strongly supported by the management helped to solve different cases of harassment. Only in very few cases was the dismissal of bullying employees seen as the only option. The results suggested that the initiative was successful, as a significant reduction in perceptions of bullying in the organisation from 2004 to 2007 was found.

Management training in harassment

Management training is mentioned in the literature as one of the key measures in counteracting workplace harassment (Rayner and McIvor, 2008), and it is often recommended that organisations should start with management training. Management training often includes detailed information about the phenomenon of harassment, antecedents and consequences of harassment at work; conflict management skills; the legal basis of management duties in relation to interpersonal conflicts and harassment at work; and methods and strategies on how conflicts can be handled. Role playing is often used as one method to train managers on how to address and manage conflicts in the workplace. Management training has been mostly rated favourably, and managers have reported that they found the training useful.

Example from practice: Effectiveness of conflict-management training to prevent workplace harassment

A conflict-management training intervention was carried out in a Spanish company that detected harassment within its workforce (Leon-Perez et al, 2012). The intervention aimed to decrease the number of conflicts at work, and to decrease the escalation of conflicts into harassment. Training was provided to 42 middle managers, supervisors and others involved in influencing working procedures and relationships at work. The training included three sessions, each lasting for four hours. Each session looked at different types of conflicts in the workplace and explored ways in which they should be handled, including the use of strategies to manage emotions in conflict situations and the use of effective communication. As part of the training programme, role-playing, group dynamics and constructive discussions were used.

Pre- and post-intervention surveys were carried out among 195 employees to assess the effectiveness of the intervention. In addition, the personal experiences of managers who underwent training were collected and assessed as a method to evaluate the intervention. One in three managers was not pleased with the training schedule and suggested that it should be reviewed; they also suggested that a multi-method approach would be preferable. Managers did, however, have a positive attitude towards the training and reported that it had improved their conflict-management skills. Role-playing activities and the group dynamics training, in particular, were perceived as interesting. The post-intervention survey found that employees perceived a behavioural change in their superiors and that there had been a decrease in the number of observed interpersonal conflicts.

Studies have suggested that training interventions for harassment can be effective if implemented in a favourable

organisational context. Important contextual factors include, for example:

- training a 'critical mass' of staff;
- providing access to training for all staff;
- clear support from the organisation, particularly senior management;
- developing training that is relevant and tailored to local needs;
- training delivered by credible instructors (Illing et al, 2013).

It has also been recommended that harassment training should be provided and included as part of induction for all staff (Rayner and McIvor, 2008).

For managers and employees in SMEs, there might be insufficient resources to arrange specific training in this area; if this is the case, virtual learning might be a suitable alternative. The PRIMA-EF training course was designed to be used in organisations to increase awareness and knowledge among line managers, employees and their representatives, and health and safety representatives, and to support them in developing strategies to manage psychosocial risks including workplace harassment. It gives employers and managers guidance on dealing with psychosocial risks, also addressing the role of line managers, and offers advice on how employees can deal with work-related stress and harassment at the individual level. The training course is available free in several EU languages.[15]

From single to multiform approaches

Research has shown an association between harassment and a poor psychosocial work environment. Psychosocial factors that may promote harassment at work include, for example, role conflicts and role ambiguity; heavy workload; lack of participation in decision-making; changes at work and job insecurity; poor social climate; lack of skill utilisation; lack of task-related feedback; and low satisfaction with leadership and laissez-faire leadership style (see, for example, Baillien and De Witte, 2009; Einarsen et al, 1994; Hauge et al, 2007; Hoel and Cooper, 2000; Notelaers et al, 2010; Skogstad et al, 2007; Vartia, 1996). Based on theory and research findings, assessment of psychosocial risks at work and the development of measures have been recommended to reduce the risk of workplace harassment.

Example from practice: Reduction of inappropriate behaviour

In an intervention project conducted in eight primary schools in Finland, the main aim was to reduce inappropriate behaviour among the staff (Vartia and Leka, 2011; Vartia and Tehrani, 2012). The intervention included two to three meetings in every school and a joint half-day event for all eight schools. More specifically, the intervention included training for all staff members on the harassment phenomenon; antecedents for and consequences of harassment; group work and joint discussions on antecedents of harassment in that particular school; and ways to reduce these risks.

A survey of the organisation, involving 318 employees, was conducted prior to intervention, and some psychosocial work environment factors were also assessed as potential antecedents of harassment. A follow-up survey was conducted following the intervention, and was compared with the pre-intervention assessment to investigate the effectiveness of the intervention. The evaluation of the project found some decrease in the exposure to inappropriate behaviour. A positive finding was that half of the participants reported that they took more notice of their own behaviours towards their co-workers after the intervention project than before. One out of four also said that, if they observed somebody being treated inappropriately, they intervened in the situation more readily or more often than before the intervention project.

An approach with multiform measures is recommended for the prevention and management of workplace harassment. Such interventions are still very few in number, but, although the results have been quite modest, they have a number of important lessons for researchers and consultants. Moreover, they highlight the drivers and obstacles that should be considered when planning and implementing organisational interventions for workplace harassment. More information on important drivers behind and obstacles to dealing with psychosocial risks can be found in Chapter 2 of this report.

Example from practice: A multiform approach

An intervention study was carried out in two Danish organisations (a hospital department and a business college) to prevent bullying and conflicts at work, and to identify process factors associated with the implementation and effects of such interventions (Mikkelsen et al, 2011). A variety of methods and strategies were used, including lectures on the causes and consequences of harassment; courses in conflict prevention, management and dialogue meetings; distribution of pamphlets, newsletters and posters to increase awareness; and steering group meetings. One year later a number of follow-up interviews were carried out to assess the effectiveness of the intervention.

The dialogue meetings and the courses in conflict prevention were seen as beneficial by those interviewed.

[15] See the PRIMA-EF website at http://www.prima-ef.org/.

The interventions seemed to increase awareness of the importance of constructive communications and, to some extent, to increase focus on managing conflicts. Factors obstructing the implementation were poor identification of bullying, lack of continuous commitment from management, and aspects of the organisational culture. Several actions planned in the dialogue meetings at the business college had never been implemented.

A review of published studies and interventions on workplace harassment (Illing et al, 2013, p. 16) came to a conclusion that:

> *Interventions designed to increase insight into the perspective of others, develop conflict management and communication skills, and instil personal responsibility to challenge negative behaviours are likely to contribute to an anti-harassment culture and develop skills that enable managers and employees to avoid conflict escalation.*

Promoting positive aspects of the psychosocial work environment

Kelloway and Day (2004) argue that good organisational health is not solely the result of the absence of stressors in the working environment, but also the result of the provision by the organisation of resources that enable employees to handle these job stressors. There is a growing move towards a more integrated and comprehensive approach to workplace health. This comprehensive approach aims to strike a balance between, on the one hand, preventing and managing hazards and occupational illness in the workplace and, on the other hand, promoting those positive characteristics of the working environment that enhance human vitality, strengths and optimal functioning (Bakker and Schaufeli, 2008; Bakker and Derks, 2010; Kelloway et al, 2008; Turner et al, 2002; Wright, 2003).

Recent trends in interventions have sought to move away from an exclusive focus on the detrimental aspects of work and instead aim to integrate an appreciation of the benefits that the working environment can bring, with the aim to enhance the optimal health and well-being of workers (Fullagar and Kelloway, 2010; Hart and Cooper, 2001; Mellor et al, 2012).

Organisational-level interventions underpinned by a positive approach still examine and address the causes of poor psychosocial working conditions and their consequences for employees' health and safety. At the same time, such approaches integrate a complementary focus on enhancing and cultivating factors in the workplace that support human health and well-being (Bakker and Derks, 2010). Such an approach is called 'salutogenic' and is based on the idea of enhancing factors that promote health instead of focusing on what factors might be damaging for health. The approach is therefore primarily centred on the support and use of personal resources – either inside a person or in the environment – that maintain optimal health and well-being (Billings and Hashem, 2010).

Promoting the positive: Job resources

In the context of the workplace, job resources are a typically discussed salutogenic factor. Demerouti and colleagues (2001) define job resources as those physical, psychological, social or organisational aspects of the job that not only potentially reduce the negative effects of job demands and help to achieve work goals but may also stimulate personal growth, learning and development. Examples of job resources are high job control and autonomy, positive interaction, high social support from colleagues, and a certain variety in skill use. A positive relationship between job resources and work engagement has been found by several studies. For example, among dentists, job resources (including craftsmanship, professional contacts, and long-term and immediate results of work) influenced future work engagement, which in turn predicted organisational commitment (Hakanen et al, 2008). Placing an emphasis on improving how workers perceive the clarity of their roles, goals and their managers will improve the organisational climate more than attempting to eliminate adverse working conditions (Mellor et al, 2012).

Proponents of focusing on positive factors argue that well-being and performance have a stronger relationship to these positive factors than negative risks (Vazquez et al, 2009). For example, Fredrickson and Losada (2005) found after observing 60 management teams that effective and flourishing teams had more positive communication and expressions of support than languishing teams. Furthermore, the 15 teams that had high positive speech (expressing encouragement or support, for instance) and low negative speech (expressing cynicism or sarcasm) also had higher profitability, better 360-degree evaluations and higher customer satisfaction. The 16 teams with mixed positive and negative speech had average performance, while the 19 teams who had the poorest outcomes also had high incidence of negative speech.

Organisational-level interventions that include positive factors develop work environments that encourage workers to make a positive contribution to themselves, the people around them and their work (Bakker and Derks, 2010). This can be done by developing and increasing the amount of resources that employees have in the workplace, as explained by the job demands–resources model (Bakker and Demerouti, 2007), which is a conceptual extension to Karasek's job demand and control model (Karasek and Theorell, 1990), described briefly in Chapter 1. The job demands–resources model proposes that working conditions can be split into job demands and job

resources. Job demands are the effort required in the workplace and are associated with psychological and physiological costs; job resources are a motivational component that encourages personal growth and learning.

Examples of job demands include irregular working hours, high work pressure and poor working conditions; examples of job resources are salary, job security, support and task significance. These overarching categories are not occupation-specific and are applicable to all workplaces (Demerouti and Bakker, 2011). There is preliminary evidence of the important buffering effect of organisational resources on the negative influence of high demands in the workplace (for example, Bakker et al, 2005, 2007; Xanthopoulou et al, 2007, 2013). Consequently, this research highlights not only the importance of targeting the reduction of demands in worksite interventions, but also the additional value of adopting a more positive perspective, by increasing the number of resources available to employees.

Example from practice: A positive workplace intervention based on high employee involvement

One example of an organisational-level intervention that focuses on increasing employee resource is 'job crafting' (Bakker and Demerouti, 2007; Tims et al, 2013). This refers to the redesign of the work environment driven by the employee (Wrzesniewski and Dutton, 2001). Employees' work tasks, their relationships and interaction with the people around them, and how they perceive their own work are aspects that they can change. Regardless of what form of change, the employee is encouraged to influence the level of demand that they face in the workplace or the resources available to them. Tims et al (2013) noted that chemical plant workers who crafted their job resources reported more social and structural resources two months later. More importantly, these job resources were then related to improved job satisfaction and engagement as well as reduced burnout. Although job crafting is employee-driven, organisations should take responsibility by creating an environment conducive to it. Managers are seen as key players in encouraging and managing job crafting behaviours. This can be done by supporting their staff in seeking more stimulating or difficult work, helping reduce the demands that employees face and providing more autonomy for employees to make their own decisions (Tims et al, 2013; Petrou et al, 2012).

In short, there is an emerging movement within organisational research and workplace practices to incorporate a positive approach to organisational behaviour and, more broadly, organisational change and development (Bakker and Derks, 2010; Luthans et al, 2007; Youssef and Luthans, 2010). This advocates interventions that focus not only on removing potentially detrimental psychosocial hazards in the workplace, but also on the enhancement of organisational resources and positive factors that improve employee well-being. However, while job crafting and the job demands and resources model are widely accepted, the application of these concepts to organisational-level interventions is still in its infancy. Consequently, further exploration of how worksite interventions can include positive factors is needed. Accordingly, the importance of mental health promotion has been recognised at the EU level and has been addressed in various projects and initiatives. Chapter 1 of this report gives some examples showing the prominence that is given to well-being and mental health promotion at work at the EU level and in national initiatives. EU-OSHA (2011) has also addressed the issue as a part of a workplace health promotion project and has published a report on mental health promotion, including several good practice examples from different Member States, which show how the issue can be approached in enterprises of various sizes.

Summary

This chapter presented organisational interventions for the prevention and management of psychosocial work environment factors, with a concentrated focus on work-related stress, including workplace harassment. The chapter discussed different types and levels of interventions, describing the different phases of the intervention process. It presented a variety of approaches and strategies used in practice within organisations to prevent and reduce psychosocial risks at work and their negative health effects. It also provided some evidence of the effectiveness of different approaches. Psychosocial risk management involves not only the prevention and reduction of risks, but also the development and expansion of the positive resources of work and workers.

In relation to the prevention and management of psychosocial work environment hazards, the important questions are (i) how to follow through a successful intervention project in an organisation and (ii) what kinds of approaches have been found effective in the prevention and management of psychosocial work environment risks.

It has been shown that interventions have a better chance of having an impact upon psychosocial working conditions and the health and well-being of employees when an intervention project is designed to follow a structured process. A successful intervention process includes several phases.

1. First is the preparation phase, in which, for example, the organisation's readiness for change is discussed and constructed. The preparation phase also includes the planning of the project and how it will be communicated to the organisation.
2. The risk assessment phase involves the identification of risks that have the possibility to harm the health or safety of employees.

3. The third phase is the development of an action plan. In this phase, the results of the risk assessment are discussed, the risks identified are prioritised and a practical comprehensive action plan to tackle the risks is developed. The action plan should include the measures to be used, the plan for the implementation of the interventions, and the communication and evaluation plans. A participatory approach is highly recommended.
4. The fourth phase is the implementation of the solutions and interventions (also called risk reduction) in which the interventions planned are carried out.
5. In the evaluation phase, the outcomes, the effectiveness, and the implementation process should all be considered and assessed. It is crucial for project success and future approaches that organisations use the results of the evaluation for organisational learning and continuous improvement of the psychosocial work environment.

5 Conclusions

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Psychosocial risks are among the most challenging risk factors in the workplace. In the context of an ageing workforce and taking into account EU policy objectives to raise employment rates, the health and well-being of European workers are fundamental. Research shows the complexity of the relationship between health and work. Bearing this complexity in mind, this report, carried out by Eurofound and EU-OSHA, examines the risk exposure reported by workers and how it is associated with specific health outcomes. It also includes information on the views of managers on risks in their establishments, the proportion of companies implementing actions to tackle these risks, and the drivers of and barriers to doing so. Examples of policies adopted in some European countries by governments and social partners are presented, as are practical interventions, which must be adapted to the characteristics of the company in order to prevent the exposure to psychosocial risks.

The need for action in this field is apparent from the worrying figure of 25% of European workers saying that they experience work-related stress always or most of their working time, and a similar proportion reporting that work affects their health negatively.

When looking at the prevalence of specific risks, it turns out that the most prevalent are those related to the type of tasks carried out (such as monotonous or complex tasks) and work intensity (such as working to tight deadlines or at high speed). Around half of the European workforce is exposed to some of these risks. Many workers report being affected by specific working time arrangements: one-third report working irregular schedules and one-fifth report working long hours.

However, from 2005 to 2010 the situation improved for some risks: the share of workers reporting that they work long hours or that they lack social support fell. The prevalence of high work intensity remained stable from 2005 to 2010, and job insecurity actually grew. In certain countries, there is some evidence of increased exposure to high work intensity and violence and harassment associated with changes experienced as a consequence of the economic crisis.

Most European managers (80%) are concerned about the problem of stress in their establishments; violence and harassment is a less common worry, with one in five managers considering this problem to be of major concern. Managers' greatest concerns with regard to specific risks are time pressure and difficult customers, patients or pupils. There is a gap, however, between having concerns and having procedures in place to deal with them. The figures are better in relation to having ad-hoc measures in place to address risks. Nevertheless, it can be assumed that a high percentage of European enterprises lack a systematic approach to stress and psychosocial risks at work.

In terms of sectoral and occupational differences, work intensity is higher among workers in certain occupations, covering a broad range from plant and machine operators in industry to managers in financial services. The workers most affected by monotonous tasks are those at lower occupational levels, whereas managers and professionals more often report carrying out complex tasks, which can lead to the experience of stress, especially if they lack the appropriate competences.

Psychosocial risks are of greatest concern to managers in the health and social work sector, followed by education. In general, it is found that companies in those sectors where psychosocial risks are of higher concern for employers also have more measures and procedures in place to deal with them.

With regard to age differences, young workers report better conditions in terms of social support and career prospects. However, they have a greater need for further training to cope with their duties, and they more often report job insecurity. Older workers, on the other hand, report better work–life balance, less irregular work schedules and lower work intensity. It is therefore important to always have the whole workforce in mind, with the aim of maintaining workers' health throughout the whole life course. Only in this way can workers continue to be healthy and productive in work until old age.

Gender differences are found in exposure to psychosocial risks: for instance, women face more difficulties in relation to handling angry clients and career prospects. However, the comparative situation between men and women is more complex as regards other risks. More men are exposed to working long hours (more than 48 hours), and a larger share of women work very short hours (less than 20 hours). Longer hours and working under more irregular time schedules might have implications for men reporting slightly poorer work–life balance than women. It seems that some women adapt their working hours to deal with work and family responsibilities, which may affect their level of income and career prospects. Besides the issues mentioned, other aspects seem to play a role. Traditional roles still seem to contribute to differences in working time and sectoral segregation, which is related to a different risk exposure.

As noted above, risks are differently distributed by sector, occupation and groups of workers. These results and specificities should be taken into account when developing strategies to encourage companies to deal with psychosocial risks. Certain factors that are of major concern in specific sectors might not be relevant for others. When planning campaigns and other initiatives, the target group and the most pressing aspects should therefore be carefully considered.

Psychosocial risks are associated with poor health and well-being; however, these associations differ in strength and outcomes. Work intensity has a robust relationship with work-related stress, and there is also a strong relationship between adverse social behaviour (all types of violence and harassment) and negative health and well-being outcomes, especially with work-related stress and sleeping disorders. In addition, workers

who have experienced adverse social behaviour are more likely to report that they have been absent from work for health reasons. From a positive perspective, evidence shows that some working conditions can improve workers' health and well-being. Facilitating a good work–life balance would especially benefit those 18% of workers who report having difficulties balancing work with family and other commitments. Other positive psychosocial factors that prevent negative health outcomes are social support and having career prospects.

It is worth mentioning that findings also show that psychosocial factors are linked not only to health outcomes but also to performance-related outcomes such as absenteeism, work ability and especially job satisfaction. All these aspects are of utmost importance to increase employment participation rates in Europe. Improving working conditions in the long term will help make work sustainable and increase worker participation in the labour market.

Given the present situation, interventions and initiatives are needed to tackle those risks that might have negative effects for health and workers' performance. There are different possibilities, including the reorganisation of work, appropriate staffing and worker replacement in case of sick leave for dealing with work intensity and monotonous work.

Research also shows an association between harassment and a poor psychosocial work environment. The assessment of psychosocial risks at work and the development of relevant measures have therefore been recommended to reduce the risk of workplace harassment.

The analysis shows that many companies are still not implementing measures for psychosocial risk prevention, or at least not implementing them in a systematic way. Interventions have to go beyond individual ad-hoc measures and be implemented in a concerted way. In order for interventions to have an impact upon psychosocial working conditions and the health and well-being of employees, such interventions should be designed to follow a structured process.

In addition, there is an emerging movement within organisational research, workplace practices and policymaking to incorporate a positive approach to organisational behaviour and, more broadly, organisational change and development, also known as mental health promotion. This advocates interventions that focus not only on removing potentially detrimental psychosocial hazards in the workplace, but also on enhancing the organisational resources and positive factors that promote employee well-being.

There are some elements that can contribute to motivate companies to tackle psychosocial risks. It was shown that companies that know how to successfully deal with OSH in general also were more successful in dealing with psychosocial risks. To help companies overcome their doubts, it might be useful to show them that it is possible to deal with psychosocial risks in the same logical and systematic way as with other risks.

Existing legal requirements also play an important role; they must, however, be complemented with practical guidelines and support at national and organisational level. Limiting activities to the implementation of legislative requirements related to psychosocial risks is unlikely to be efficient in terms of actual management of psychosocial risks. The technical support and guidance should cover the entire process of management of psychosocial risks and include difficulties that are likely to appear; for example, reporting and dealing with stress, harassment and violence may increase psychological vulnerability in workers and make them reluctant to participate in interventions. Providing support for successfully tackling psychosocial risks should also take into consideration all consecutive phases of the whole process of management. The level of companies' involvement in dealing with psychosocial risks seems to be a crucial factor determining the efficiency of practical support and organisational interventions. This issue is also well demonstrated by the fact that the sensitivity of dealing with psychosocial risks is mainly considered a hindrance by those companies that already have started dealing with the topic.

Support given to companies should include information on the resources – in terms of time, people and money – needed to implement different aspects of psychosocial risk management. A good way of providing such information is through case studies and accompanying background information. This is helpful in the process of planning, and also helps to adjust the common but not necessarily correct assumption that managing psychosocial risks is very expensive and beyond companies' abilities. A process of collecting and disseminating practical solutions that do not require much investment (especially financially) by a company should especially be encouraged at EU and national levels. Highlighting the return on investment for psychosocial risk prevention and health promotion can be an additional factor to motivate employers to take action.

In general, social dialogue between employee representatives and management in companies has been shown to be a key element for implementing improvements in working conditions. Both formal and informal forms of employee participation have a strong role to play in the management of OSH and, in particular, of psychosocial risks. Involving employees pays off and leads not only to the application of a broader range of measures, but also to their improved effectiveness. In addition, there is a strong positive correlation between the direct involvement of employees and the reported effectiveness of procedures or measures.

The analysis carried out in this report considers differences in company sizes. Compared with larger establishments, smaller companies appear less concerned about psychosocial risks in general and slightly less concerned about violence and harassment. They are also less likely to have procedures

in place to deal with psychosocial risks, and all types of individual measures tend to be more widely adopted in bigger establishments. Some factors can influence this pattern. Employee representatives, including health and safety representatives, are frequently lacking in smaller companies, which might make it more difficult to implement the participatory approach envisaged by the Framework Directive of 12 June 1989 on the introduction of measures to encourage improvements in the safety and health at work. The situation is related to the fact that most countries have a threshold for the number of employees a company must have before the law requires an OSH employee representative to be present.

SMEs are exposed to psychosocial risks, but to different extents depending on the psychosocial factor in question. Large companies are more likely to experience organisational changes, and the work can involve more complex tasks and, to some extent, more intensity. Nevertheless, bigger companies have better conditions in terms of skills to cope with the work, career prospects and job security. On the other hand, SMEs present better conditions in terms of more regular working time, but workers have fewer opportunities to influence their working time.

These results show that there is a need to raise awareness of psychosocial risks in small companies. While doing so, it should be taken into account that the prevalence of certain risks in smaller companies differs from those in bigger companies. In addition, as highlighted in Chapter 3, it might take a different approach in smaller companies to do a risk assessment and to implement solutions. More direct forms of communication are needed; for example, instead of surveys, focus groups and discussions involving the whole staff might be appropriate. Closer proximity between the staff and the business owner (or management) could enable more direct participation. The lack of official worker representatives might, however, present a challenge to the process, as the number of establishments reporting that employees have been consulted increases with establishment size. Therefore, initiatives such as joint sectoral or territorial representatives can be considered a contribution to better cover worker representation in small companies.

High levels of work-related stress and violence and harassment are two major psychosocial problems that can have very negative consequences for the health of workers and their performance. In relation to this, social partners at EU level agreed on framework agreements on both issues, which show that psychosocial risks are of concern to both sides of industry in Europe.

At national level, legislation, social partners and labour inspection can contribute significantly to the implementation of OSH management and psychosocial risks prevention and to support employees' influence in the work environment, as shown in the national examples in Chapter 3. Overall, during the last decade new policy initiatives have been developed, fostered in some countries by the EU social partners' Framework Agreement on Work-related Stress.

Examples from Belgium, France and the United Kingdom showed some ways in which social partners and social dialogue contribute to initiatives to tackle psychosocial risks. Social dialogue makes an important contribution to improving working conditions, not only at company level but also at sectoral level, where the social partners can create structures and support for SMEs. In this sense, the role of social dialogue may be particularly important for psychosocial risk management when it comes to translating the findings from research on the topic into agreements and actual workplace practices. However, initiatives at national or sectoral level are not developed to the same extent in all EU Member States, which can be explained by the different traditions of social dialogue and different governmental approaches, often related to the importance given to psychosocial risks in general in each country.

To provide firms with better support and guidance, consideration should be given to the potential influence of labour inspectors, as recognised in the SLIC (Senior Labour Inspectors Committee) campaign in 2012 and in other national approaches in Europe, and to the importance of having OSH service providers and labour inspectors properly trained in psychosocial risk management practices.

Furthermore, pressure from labour inspectorates seems to be especially effective for companies that do not have many measures or procedures in place. It could be that companies that are already dealing with psychosocial risks might already have changed their perspective and realised that the labour inspectorate can be a helpful source of information provision and support. Increasingly, labour inspectorates' work goes beyond control and inspection to support and counselling, which are recognised as important features to be offered to help companies overcome shortcomings in knowledge and expertise.

Designing further policies and initiatives requires consideration to be taken of the cultural and legislative context, sectoral specificity, and organisational characteristics such as size and legal status.

This report shows the present situation regarding the prevalence of psychosocial risks, their association with work-related health outcomes, and the advantages of creating a good psychosocial work environment – for workers, employers and society. Achieving a good psychosocial environment means raising awareness and demonstrating the widespread prevalence of psychosocial risks to motivate companies, social partners and governments to take action.

Further initiatives by governments and social partners might be required, especially in some countries, to help companies to tackle psychosocial risks effectively. The European

framework agreements on stress at work and on violence and harassment are good references for action. The country comparative information obtained by Eurofound and EU-OSHA research is a valuable source to be considered by national and EU policymakers when developing initiatives related to psychosocial risks. These considerations can also contribute to achieving the objectives of EU policy. As laid down in Article 151 of the Treaty on the Functioning of the European Union, 'The Union and Member States … shall have as their objectives, the promotion of employment, improved living and working conditions, so as to make possible their harmonisation while improvement is being maintained'. The Europe 2020 strategy aims at increasing employment by various actions, including improving the quality of jobs and ensuring better working conditions. The information in this report can contribute to reaching these aims.

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