Psychosocial Hazards

Core Body of Knowledge for the Generalist OHS Professional

Second Edition, 2020
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This edition includes updates in commonly used terms and definitions, prevalence rates, psychosocial hazards, occupational stress theories and models (including integrative models), and standards and guidelines. The role of the digital economy, work climates, work design and management is further elaborated.

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Psychosocial Hazards

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Abstract
Exposure to work-related psychosocial hazards is escalating in today’s 24-hour society which is increasingly dominated by knowledge work and digital economies. This chapter – the first of three chapters focused on psychosocial hazards – introduces the topic and provides an overview of key concepts related to psychosocial hazards. It presents a framework of ten psychosocial hazards that increase the risk of injury/illness: time pressure/role overload; emotional demands; poorly defined work roles; interpersonal or team conflict; poorly managed change; lack of job control; lack of supervisor and/or co-worker support; organisational injustice; inadequate reward and recognition, and certain environmental conditions. The risk-assessment process for psychosocial hazards is outlined and implications for Occupational Health and Safety (OHS) practice are discussed.

Keywords
Psychosocial hazards, occupational stress, psychological injury, mental health, work stressors

Contextual reading
Readers should refer to 1 Preliminaries for a full list of chapters and authors and a synopsis of the OHS Body of Knowledge. Chapter 2, Introduction describes the background and development process while Chapter 3, The OHS Professional provides a context by describing the role and professional environment.

Terminology
Depending on the jurisdiction and the organisation, Australian terminology refers to ‘Occupational Health and Safety’ (OHS), ‘Occupational Safety and Health (OSH) or ‘Work Health and Safety’ (WHS). In line with international practice this publication uses OHS with the exception of specific reference to the Work Health and Safety (WHS) Act and related legislation.

Jurisdictional application
This chapter includes a reference to the Australian model work health and safety legislation. This is in line with the Australian national application of the OHS Body of Knowledge. Readers working in other legal jurisdictions should consider these references as examples and refer to the relevant legislation in their jurisdiction of operation.
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1 Introduction

During the last twenty years, Occupational Health and Safety (OHS) professionals have seen significant growth in the priority placed on risk management for work-related psychosocial hazards in businesses. This may be because psychosocial hazards are poised to eclipse many other hazards in terms of direct and indirect costs, contribution to ill health, and importance to business productivity. In addition, the regulatory space now clearly encompasses psychosocial hazards (Chirico, Heponiemi, Pavlova, Zaffina & Magnaviata, 2019; Potter, O’Keefe, Leka, Webber & Dollard, 2019). The National model Work Health and Safety Act (SWA, 2019a) specifies a definition of ‘health’ that includes physical and psychological health; a national guide for work-related psychological health and safety has been published (SWA, 2019b); many jurisdictions are drafting codes of practice; and international standards are currently under development (see ISO, 2020). The most recent Australian changes have been driven, in part, by recommendations from the review of the model Work Health and Safety laws (Boland, 2018) which specifically called attention to psychological health as a priority issue for reform in OHS laws.

Psychosocial hazards pose a unique challenge to OHS professionals. This challenge is fuelled by the volume and complexity of research findings, high media interest, the limitations of legal frameworks, unique skills required by professionals working in this area, and the often cumulative nature of injury or illness outcomes that are not proximal to one particular workplace event. Despite this, these hazards can, and should, be managed in the same manner as any other OHS hazard.

One of the defining characteristics of psychosocial hazards is their interface with the very core of work, including how work is designed and operationalised through management and human resource practices. This means the reach of the hazard can be long with tentacle-like influence on many aspects of organisations via the nature of work demands, the behaviours of workers and managers, and through organisational systems and policies. Attempts to manage risk can also meet more resistance as changing some psychosocial hazards (e.g. increasing worker autonomy) can wrongly be seen by some as an anathema to productivity. Despite these negative perceptions from some in business, it is important to recognise that psychosocial hazards are fundamental to OHS because they are fundamental to human health. They can occur in any workplace, regardless of industry, size, equipment or tasks, simply because organisations are comprised of humans. Accordingly, psychosocial hazards should be treated as a fundamental element of OHS, rather than an add-on element.

It is somewhat difficult to consider psychosocial hazards without a concomitant focus on mental health; however, it would be erroneous to believe that these workplace hazards are relevant only to mental health. In fact, physical health outcomes, such as cardiovascular and
musculoskeletal disorders\(^1\) were among the first to be recognised by researchers and these still loom large in terms of recognised health outcomes from exposure to psychosocial hazards (see section 3.1). As well as physical and mental health outcomes, psychosocial hazards can have a negative impact on worker health behaviours (such as unhealthy eating, low physical activity, and drug and alcohol consumption), and on organisational outcomes (such as engagement, absenteeism, turnover and performance; see section 3.2). It has also been recognised that psychosocial hazards can delay recovery from injury/illness and therefore can influence return-to-work outcomes (Goorts et al., 2020). These widespread effects reinforce how fundamental psychosocial hazards are to OHS practice and that they cannot be treated as an add-on. This chapter introduces psychosocial hazards and work-related stress. Two related chapters address the psychosocial hazards of fatigue\(^2\) and of bullying and violence.\(^3\)

### 1.1 Definitions

There are many terms used by those who work in medical, health, legal, or rehabilitation contexts, however, OHS professionals typically use the following terminology which are defined in sections 1.1.1-1.1.3 below.

- **Psychosocial hazards** – to describe aspects of work design and management which have the potential to cause stress-mediated harm.
- **Occupational stress** – to describe the mechanism by which harm manifests.
- **Psychological injury** – to describe the extreme psychological health outcome (also noting there can be other forms of harm from exposure to psychosocial hazards, such as psychological strain, cognitive effects, musculoskeletal pain and disorders, cardiovascular disorders, immune effects, and other forms of strain).

Figure 1 presents a visual representation of the causal flow from psychosocial hazards to health and safety outcomes via the mechanism of occupational stress and each of these terms are defined further below.

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\(^1\) See *OHS BoK* 16 Work-Related Musculoskeletal Disorders for a discussion on the role of psychosocial hazards in the causation of WMSDs.

\(^2\) See *OHS BoK* 20 Fatigue.

\(^3\) See *OHS BoK* 21 Bullying and Violence.
1.1.1 Psychosocial hazards

Broadly, the term ‘psychosocial’ refers to the interrelationships between an individual’s thoughts and behaviours, and their social environment. In literature outside the OHS field, this term often refers to social environments such as family of origin, socioeconomic status and level of education. Whilst it is important to be aware of individual and non-work psychosocial factors, in the OHS context psychosocial hazards have come to refer only to hazards created by work and the work environment.

National guidance for psychological health and safety defines psychosocial hazards as:

Factors in the design or management of work that increase the risk of work-related stress which can then lead to psychological or physical harm (SWA, 2018, p. 37)

In some literatures, contexts, and disciplines psychosocial hazards are also called work stressors, work conditions, work characteristics, psychological hazards, or organisational factors.
Established psychosocial hazards include:

- Time pressure/role overload
- Emotional demands associated with job
- Low job control
- Poorly defined roles
- Low recognition and reward.
- Poorly managed change
- Interpersonal or team conflict (including bullying, violence, and aggression)
- Organisational injustice
- Low co-worker or supervisor support
- Environmental conditions

These psychosocial hazards can work in combination to create risk and are explained further in section 4.2.

### 1.1.2 Occupational stress

Having a clear understanding of the definition of occupational stress is important as the psychological and physiological stress response is the mechanism by which psychosocial hazards have an effect on people’s health and wellbeing. The definition of ‘stress’ has been the subject of much academic and public debate. Although the term has been expected to support an immense breadth of meaning (and resultant research variability), it is now possible to draw the divergent threads together to outline the key defining characteristics of occupational stress, which stem from the evolution of stress theory. Specifically, occupational stress can be defined as:

> The physiological and psychological responses of workers who perceive that their work demands exceed their resources (e.g. skills, time, support) and/or abilities to cope with the work. (see for example, WSHQ, 2010; Leka, Griffiths & Cox, 2003).

There are three main points to consider in relation to this definition.

- The stress response is a multi-factorial (i.e. physiological, cognitive and emotional) response to a set of stimuli that can lead to ill health.
- Stress is not a disease in its own right, but a pathway that can lead to ill-health, whether mental or physical health outcomes. The ill-health pathway occurs when there is significant ‘imbalance’ between the demands placed on a person, and the resources they have to cope with those demands.
- The individual’s perception of their work characteristics (including their perceptions of their coping skills and how important it is to them that they cope) is an integral part of the stress equation.
1.1.3 Psychological Injury
Consistent with the terminology used in workers' compensation jurisdictions, OHS professionals typically use the term psychological injury rather than mental health condition, mental disorder, or mental illness. A psychological injury must be 'diagnosed by a medical practitioner and includes a range of recognised cognitive, emotional, physical and behavioural symptoms. These may be short term or occur over many months or years, and can significantly affect how a person feels, thinks, behaves and interacts with others' (SWA, 2019). It is important to be aware, however, that the alternative terms (mental disorder, mental illness, mental health condition) are often used interchangeably by other stakeholders in the field (e.g. legal or health practitioners).

It is also important to note that people may experience psychological harm without experiencing a psychological injury. Indeed, 'job strain' is a term that describes all negative responses that result when work demands are in excess of the coping resources of workers (Koslowsky, 1998).

The potential for work-related psychological harm is on a continuum from mild to extremely severe which is influenced by exposure to psychosocial hazards including:

- The frequency (how often)
- Duration (over what periods), and
- Intensity (how severe)

Mild exposure to psychosocial hazards can result in a stress response which can be distressing but doesn't necessarily result in psychological harm. However, in the most severe circumstances it can lead to psychological injury or physical ill-health.

1.2 A note on terminology
While these three terms are core terminology for OHS professionals, phrases such as ‘mental health’ (defined by the WHO, 2004 as ‘a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community’); mental illness, mental disorders, and mentally healthy workplaces, are commonly used by others in the workplace. Definitions for these terms can be found in relevant jurisdictional guidance.

Expression, terminology, and categorisation of specific psychosocial hazards can change across documents, tools and resources, depending on the context, purpose and perspectives relied upon. For example, academics trained in psychology may refer to these
hazards by using particular terms and frameworks, whereas OHS guidance, standards etc may use modified terminology to express the same ideas.  

2 Historical context

For the majority of the 20th century, Australia was a country where work-related psychosocial hazards were firmly believed to be outside the scope of OHS legislation and there was little recognition of the potential effects of psychosocial hazards on worker health. Health issues, and mental health issues in particular, were seen to be the concern of individual workers and their treating medical practitioners if, indeed, workers were encouraged to seek treatment at all.

By the end of the 20th century however, empirical evidence of the health effects from exposure to work-related psychosocial hazards was accumulating. Governments and employer groups began to see, in very real terms, the human and financial costs associated with exposure to work-related psychosocial hazards. As risks associated with the more traditional areas of OHS were being better managed, psychosocial hazards became the new frontier, compounded by economic turbulence, work intensification, and digital transformations. Policy directions in many countries were increasingly influenced by the World Health Organisation (WHO) and their report on social determinants of health (see, for example, CSDH, 2008). Even though psychosocial hazards were implicitly included in definitions of health, around the turn of the century Governments in Australia and overseas began to make the obligation to manage psychosocial hazards more explicit by drafting references into the scope of OHS legislation and releasing guidance, standards and codes of practice. This included the national model Work Health and Safety Act (SWA, 2019a), which defines ‘health’ as inclusive of physical and psychological health (WHSA s 4). Furthermore, research into how OHS regulators in Australia have been responding to psychosocial hazards found that there has been an increase in relevant interventions, campaigns and guidance (Johnstone, Quinlan & McNamara, 2011).

Development of empirical evidence of the significance of work-related psychosocial hazards has stemmed from large and separate bodies of literature on, most notably:

- Work organisation and job design
- Occupational stress

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• Workplace bullying and harassment, and other forms of negative workplace behaviours (such as workplace incivility, counterproductive workplace behaviours, mobbing, abusive supervision, workplace violence and aggression)
• Fatigue, and
• The application of risk-management principles to psychosocial hazards.

In the limited space available for this chapter, it is impossible to follow the historical developmental threads of each of these separate bodies of literature; however, two key threads and some influential contributing theories are outlined below.

1 The role of the design and management of work in creating psychosocial hazards and associated worker stress responses.

Kompier (2002) identified seven main theoretical approaches to psychological hazards and occupational stress:

1. Cherns’ 1976 Sociotechnical approach
2. Hackman and Oldham’s 1980 Job Characteristics model
4. Hacker’s 1964 Action Theory
5. Karasek and Theorell’s 1990 Job Demand-Control-Support model
6. Warr’s 1994 Vitamin model, and
7. Siegrist’s 1998 Effort-Reward Imbalance model.

More recently, the Job Demands-Resources model (Demerouti, Bakker, Nachreiner & Schaufeli, 2001) and the construct of psychosocial safety climate (Idris, Dollard, Coward, & Dormann, 2012) have also gained support.

Most of these theories highlight the design and management of work as fundamentally important in creating risk, but also that it is the workers’ cognitive appraisal of these work design and management factors that is important. The importance of cognitive appraisal in stress and coping was first proposed in Lazarus and Folkman’s (1984) highly influential Transactional Model of Stress appraisal and Coping.

2 The more recent push for integrative models and ‘psychologically healthy workplaces’

Dewe and Cooper (2014) track more recent historical influences including ‘the positive psychology movement’ (see, for example, Seligman & Czikszentmihalyi,
2000) with it’s focus on ‘making normal people stronger and more productive and making high human potential actual’ (p. 8); and the ‘good work agenda’ with it’s underlying premise that job quality is related to worker health and wellbeing. This focus on job quality or good work, is necessarily undergirded by theories and practice of work design (see for example Parker, Morgeson, & Johns, 2017). It is not difficult to see how these influences have translated into notions of ‘psychologically healthy workplaces’, and integrative models, which argue that interventions should consider combinations of health promotion for positive mental health, prevention of harm via management of managing risk from exposure to psychosocial hazards, and supporting recovery of those with a psychological injury or otherwise experiencing job strain. (See for example, LaMontagne et al., 2014)

3 Extent of the problem

According to the World Health Organisation, depression is a leading cause of disability (in terms of years lived with disability) (WHO, 2020a) and worldwide there has been a 13% increase in mental health and substance use disorders in the 10 years to 2017 (WHO, 2020b). In Australia, the prevalence rate of mental illness is greater than the mean across OECD countries and more than half of the Australian population will suffer from a mental illness during their lifetime (Productivity Commission, 2019).

From 2012-13 to 2016-17, mental-stress-related claims increased to average 6% of all serious claims and had the highest median payment ($30,800), more than double that of all serious claims ($12,100). The median lost work time (17.3 weeks) was nearly three times the median for all serious claims (5.8 weeks) (SWA, 2020).

Claims for other health outcomes associated with psychosocial hazards are also evident (e.g. musculoskeletal disorders), and although it is difficult to quantify the relative contribution of psychosocial hazards to these injury outcomes, it is important to consider them in discussion of the size of the problem.

5 See also OHS BoK 6 Global Concept: Health (in development at time of writing).
These data, based on compensation claims, are known to be a poor indicator of the extent of the problem. The likelihood of an individual making a claim for a mental disorder can be influenced by stigma and difficulty in having claims accepted. Indeed, of those employees that reported experience of mental stress, 60 percent stated they would not seek workers’ compensation despite being eligible to make a claim (ABS, 2014 as cited in SWA, 2017). In 2008, an Australian study quantified this underestimation of claims data, reporting that overall job-attributable risk for depression is 13.2% for males and 17.2% for females (LaMontagne, Keegel, Vallance, Ostry & Wolfe, 2008). It should be noted that this calculation does not include other mental illnesses, such as anxiety disorders and adjustment disorders, nor does it take into account physical illnesses that may be attributable to job strain.

In addition to compensation costs, mental ill-health and suicide has other economic implications with reduced economic participation and lost productivity in 2018-19 estimates ranging from $10 and $18 billion (Productivity Commission, 2019). In 2010, LaMontagne, Sanderson and Cocker reported that the societal cost of depression attributable to job strain in Australia was $730 million over one year and $13.8 billion over a lifetime.

The following sections consider the impact of psychosocial hazards firstly on the health and safety of the individual worker and secondly on organisational outcomes.

### 3.1 Psychosocial hazards and individual health and safety outcomes

Psychosocial hazards have been empirically linked with negative health outcomes including:

- Anxiety, depression, burnout, cardiovascular disease and associated risk factors (e.g. blood pressure, serum cholesterol and distribution of body fat) (Bishop et al., 2003; Bunker et al., 2003; Eddy, Wertheim, Kingley & Wright, 2017; Kivimäki et al., 2002; Harvey et al., 2017; Kuper & Marmot, 2003)
- Musculoskeletal disorders (Devereux, Vlachonikolis & Buckle, 2002; Engstrom, Hanse & Kadefors, 1999; Torp, Riise & Moen, 2001).
- Increases in alcohol consumption and smoking, and difficulty sleeping (see, for example, de Lange, Taris, Kompier, Houtman & Bongers, 2003).

One of the most influential studies in this area is the longitudinal Whitehall II study, which followed 10,308 British public servants over 14 years, and resulted in more than 100 published papers. Head, Martikainen, Kumari, Kuper and Marmot (2002) summarised findings relevant to the work-related psychosocial hazards and health outcomes for this research cohort (Table 1).
Table 1: Summary of findings from two Health and Safety Executive funded research reports using the Whitehall II cohort (Head et al., 2002, p. vi)

<table>
<thead>
<tr>
<th>Psychosocial Hazard</th>
<th>Associated with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low decision latitude (low job control)</td>
<td>Obesity</td>
</tr>
<tr>
<td></td>
<td>Alcohol dependence</td>
</tr>
<tr>
<td></td>
<td>Poor mental health</td>
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<tr>
<td></td>
<td>Poor health functioning</td>
</tr>
<tr>
<td></td>
<td>Increased sickness absence</td>
</tr>
<tr>
<td></td>
<td>Coronary heart disease</td>
</tr>
<tr>
<td>High job demands</td>
<td>Obesity</td>
</tr>
<tr>
<td></td>
<td>Poor mental health</td>
</tr>
<tr>
<td></td>
<td>Poor health functioning</td>
</tr>
<tr>
<td></td>
<td>Coronary heart disease</td>
</tr>
<tr>
<td>Low social support at work</td>
<td>Obesity</td>
</tr>
<tr>
<td></td>
<td>Poor mental health</td>
</tr>
<tr>
<td></td>
<td>Poor health functioning</td>
</tr>
<tr>
<td></td>
<td>Increased sickness absence</td>
</tr>
<tr>
<td>Combination of high effort and low rewards</td>
<td>Alcohol dependence</td>
</tr>
<tr>
<td></td>
<td>Poor mental health</td>
</tr>
<tr>
<td></td>
<td>Poor health functioning</td>
</tr>
<tr>
<td></td>
<td>Sickness absence (long spells)</td>
</tr>
<tr>
<td></td>
<td>Diabetes</td>
</tr>
<tr>
<td></td>
<td>Coronary heart disease</td>
</tr>
</tbody>
</table>

More recent meta-reviews (i.e. review of review articles) have again found evidence from multiple studies that these and other work characteristics are associated with the development of common mental disorders (Harvey et al., 2017).

### 3.2 Psychosocial hazards and organisational outcomes

Psychosocial hazards can have critical impacts on various areas related to organisational performance (Darr & Johns, 2008; Gilboa, Shirom, Fried & Cooper, 2008; Kahn & Byosiere, 1992). Negative organisational outcomes can include:

- **Absenteeism**: Mental health problems have been identified as the third most commonly cited reason for absence for Australian workers, with 18% of workers identifying anxiety, stress and/or depression as a cause of work absence (Direct Health Solutions, 2009; Goorts et al., 2020).

- **Presenteeism or disengagement**: Presenteeism is defined as the decreased productivity and ‘below normal’ work quality that occurs due to health problems when employees are physically present in their jobs (Koopman et al., 2002). Whilst unplanned or sick leave may be the most obvious cost associated with psychosocial
hazards, research has suggested that the cost of reduced productivity at work is much higher than the cost of absence; while 32.4% of the cost of work-related stress can be accounted for by absenteeism, 58.4% is due to presenteeism (Sainsbury Centre for Mental Health, 2007).

- **Other organisational outcomes:** Other outcomes that have been shown to be related to exposure to psychosocial hazards at work include turnover/attrition, elevated workers’ compensation cost, negative customer service impacts and relationships with stakeholders, and indirect costs (e.g. management time spent dealing with conflict, team disharmony, training and employee assistance program costs (Gilboa et al, 2008; Kahn & Byosiere, 1992).

## 4 Common work-related psychosocial hazards

### 4.1 An illustrative framework

It is important to consider how psychosocial hazards can be best represented in order to be easily understood by industry. As there may be many psychosocial hazards implicated in any risk assessment (10 evidence-based psychosocial hazards are noted in this chapter), authors have tended to use multiple ways to categorise them for example, stressors related to 'work content' or 'work context' (Cox, Griffith & Rial-González, 2000) or stressors related to 'job demands' and 'job resources' (Demerouti et al., 2001). Job demands have been conceptualised as psychosocial hazards that can have a negative effect on physiological and psychological health (e.g. time pressures, workplace conflict or high emotional demands). Job resources, on the other hand, have been described as having a motivating effect and/or creating a ‘buffer’ against the potential negative effects of job strain. This buffering effect occurs via a mechanism of increased coping. Examples of job resources include supervisor support or change management strategies.

The simple representation of hazards shown in Figure 2 is underpinned by several theoretical models described below, including the Job Demands-Resources model (Demerouti et al., 2001) and the Job Demand-Control-Support model (Karasek & Theorell, 1990), two of the most empirically tested and certainly most influential models of work-related stress. Also underpinning the representation of hazards depicted in Figure 2 is the Effort-Reward Imbalance model (Siegrist, 1998), which posits that effort invested by a worker is part of a social contract reciprocated by appropriate rewards (e.g. money, esteem and social control) they gain. Other psychosocial hazards listed, such as interpersonal conflict, (poorly managed) change and organisational (in)justice, have been included due to the strong evidence base regarding their association with job strain.
These hazards work in combination to create risk and recent studies have suggested that psychosocial hazards create harm in a more additive than multiplicative manner (Gonzalez-Mulé, Kim & Ryu, 2020).

The psychosocial hazards depicted as work resources or work demands in Figure 2, and described in more detail below, represent ways that organisations can influence the balance/imbalance at the worker-demands interface and thereby manage the risk of harm from exposure to psychosocial hazards. That is, the ‘see-saw’ can be tipped in favour of reducing stress responses by reducing the work demands (for example, by redesigning the work), and/or by increasing their job resources (for example, by providing additional support or increasing their job control). Importantly whether a work characteristic is a ‘resource’ or a ‘demand’ is dependent on the way it is perceived and appraised by workers adding importance to worker consultation processes.

4.2 Psychosocial hazards explained

4.2.1 Time pressure or role overload
Time pressure or role overload refers to the requirement to work very hard and/or very fast to meet key performance indicators set for the job or task, or having inadequate time to complete work tasks and requirements (Ohly & Fritz, 2010). Time pressure or role overload also may result from unrealistic deadlines or inadequate resourcing to achieve work tasks. Work pacing dictated by machines and electronic monitoring of performance have been shown to create time pressure if not well designed and implemented. Time pressure and role overload may not be problematic if it occurs infrequently or at certain defined times within the job cycle or year; however, where it is constant, frequent or excessive, it can create
harm (Örtqvist & Wincent, 2006; Rick, Thomson, Briner, O'Regan & Daniels, 2002).

Hours of work, including poorly designed/managed work scheduling, can create role overload and risks to health and safety via two mechanisms:

- **Exposure time**: hours of work may dictate how long workers are exposed to psychosocial hazards in a given working period and thereby directly influence the level of risk.
- **Fatigue**: hours of work, shift schedules, and work design can lead to fatigue by limiting the amount and/or quality of worker sleep. The lack of enough quality sleep is a significant predictor of:
  - Injuries and near-miss accidents at work (Gold et al., 1992; Swaen, van Amelsvoort, Bültmann & Kant, 2002)
  - Health outcomes, sickness and absenteeism (Dembe, Erickson, Delbos & Banks, 2004; Ganster, Rosen & Fisher, 2018; Janssen et al., 2002; Sparks, Cooper, Fried & Shimon, 2013; Wong, Chan & Ngan, 2019)
  - Depression and alcohol consumption (Virtanen et al, 2015, 2018), vascular disease (Kivimaki et al., 2015), obesity (Zhu et al., 2020)
  - Poor work-life balance (Lingard & Francis, 2004).

### 4.2.2 Emotional demands

The role of emotions at work (also known as affect) is the subject of an extensive body of literature (See Venz, Casper, & Sonnentag, 2020; Yang, Cropanzan, Daus, & Martinez, 2020 for an overview). Emotional demands or work-related emotional labour can include:

- Jobs requiring workers to show false displays of emotion, such as happiness or desire to please/serve, even in situations where the work has induced anger and resentment. The suppression of negative emotion combined with the job requirement for ‘surface acting’ positive emotion has been associated with detrimental effects on worker wellbeing (Brotheridge & Grandey, 2002; Zapf, García-Buades & Ortiz-Bonnin, 2020; Zapf, Vogt, Seifert, Mertini & Isic, 1999). Flight attendant and retail worker positions are examples where emotional labour may be a job requirement.

- Jobs where workers are exposed to emotionally distressing or traumatic situations. Such positions have been associated with a heightened risk of illness (see for example, Schnurr & Green, 2004). For example, police officers, ambulance officers, defence personnel, and fire fighters may be exposed to hazards of this nature. National Australian guidelines exist for the prevention and treatment of disorders associated with trauma and trauma disorders (Phoenix Australia, 2020). These guidelines provide helpful definitions of trauma and potentially traumatic events as

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6 See OHS BoK 20 Fatigue.
well as recommendations for how to respond when adults are exposed to potentially traumatic events at work.

### 4.2.3 Poorly defined roles (role ambiguity or role conflict)

Role ambiguity and role conflict refers to workers’ understanding of their role within the organisation and whether the organisation ensures that roles do not conflict. This includes people having an unclear understanding of performance requirements and job responsibilities, frequent or sudden changes in roles, or problematic role overlap with others’ roles (see, for example, the seminal paper by Rizzo, House & Lirtzman, 1970 or more recent meta-analyses: Örtqvist & Wincent, 2006; Schmidt, Roesler, Kusserow & Rau, 2014; Tubre & Collins, 2000).

### 4.2.4 Interpersonal or team conflict (including bullying, violence and aggression)

Interpersonal stressors, which may include, for example, workplace incivility, conflict, abusive supervision, or workplace bullying, have been reported to be among the more extreme stressors at work (De Dreu, van Dierendonck & Dijkstra, 2004; Giebels & Janssen, 2005; Jex, 1998; Jex & Beehr, 1991; Smith & Sulsky, 1985), responsible for more than 80% of difference in daily mood (Bolger, DeLongis, Kessler & Schilling, 1989). Empirical evidence suggests that work-related interpersonal conflict is associated with compromised psychological and physical functioning (for a meta-analysis, see Spector & Jex, 1998) as well as contribution to psychological disturbance when controlling for health practices, age, stressful work events, stressful life events, and support from work and home (Gilbreath & Benson, 2004). Supervisors can play an important role in worker experiences of strain when workgroup conflict occurs (Way, Jimmieson & Bordia, 2014; 2019). Workplace bullying and harassment are particular interpersonal stressors, which can lead to outcomes of an even more severe nature (Einarsen, 1999; Verkuil, Atasayi, & Molendijk, 2015).

Occupational violence and workplace aggression are risk factors for work-related stress that are addressed in a companion chapter. Risks associated with this hazard can be heightened in remote and isolated work. (See for example Wressell, Rasmussen, & Driscoll, 2018.)

### 4.2.5 Change

This psychosocial hazard refers to how organisational change is managed, including how it is communicated. There is a large amount of research suggesting that organisational change is a psychosocial hazard as it increases uncertainty and reduces workers’ sense of

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7 See OHS BoK 21 Workplace Bullying and Violence.
8 See OHS BoK 21 Workplace Bullying and Violence.
control (see, for example, Falkenberg, Fransson, Westerlund, & Head, 2013; Jimmieson, Terry & Callan, 2004). Having effective systems to communicate and manage the change process can prevent or minimise the stress response of workers.

### 4.2.6 Environmental conditions

There are a number of noxious or hazardous physical and environmental conditions, that have been shown to result in a physiological and psychological stress response including loud or bothersome noise\(^9\) (Basner et al., 2014), certain types of lighting (Van Bommel, 2006), poor air quality, extreme temperatures/thermal discomfort\(^10\) (Parsons, 2014), having to wear uncomfortable personal protective equipment, or having to work alongside known, high risk hazards such as plant or biological hazards (Hoedl, Eglseer, & Bauer, 2020).

### 4.2.7 Job control/autonomy

‘Job control’ refers to how much say people have in the way they do their work; it has been studied extensively as a job resource, most notably in the influential Job-Demand-Control-Support model (Karasek & Theorell, 1990). In this model, the related term - ‘Skill discretion’ - refers to how much variety people get in their work and how much opportunity people get to use their skills; low skill discretion has been found to have a negative impact on a range of work-related outcomes, whereas decision authority or autonomy has been shown to buffer the effect of high job demands on health-related outcomes (de Lange et al., 2003).

Autonomy has been extensively studied within motivational theories such as the Self-Determination Theory (Ryan & Deci, 2017), which has found greater health and wellbeing when work is designed to have greater autonomy, and where leaders support employee autonomy (Ryan & Deci, 2017). It is this autonomy that is also argued to be one of the key mechanisms that drives the job resources-motivation pathway found in the JD-R model (Bakker & Demerouti, 2007; see Figure 5). For example, one of the reasons working from home (WFH) has been suggested to result in better health outcomes, is related to increased autonomy (when there is choice in when to WFH).\(^11\)

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\(^9\) See also OHS BoK 22.1 Occupational Noise.

\(^10\) See also OHS BoK 26 Thermal Environment.

\(^11\) See OHS BoK 37.4 Workers Working From Home for a discussion on the role of autonomy in designing work for working from home.
4.2.8 Co-worker and supervisor support

One characteristic of work that has been extensively studied both as a buffer in the stressor-strain relationship, and as a direct cause of strain, is social support (Karasek & Theorell, 1990; for a review see Mathieu, Eschleman & Cheng, 2019). Social support in the workplace can be provided by co-workers and/or supervisors and can be classified as ‘instrumental’ support or ‘emotional’ support. Instrumental support involves providing practical assistance to solve problems or offering tangible help, such as advice or knowledge, whereas emotional support involves listening empathetically or providing care (Swanson & Power, 2001).

Empirical evidence of the buffering effect of social support has been gathered in a meta-analysis by Viswesvaran, Sanchez and Fisher (1999). Beehr et al., (2003) found that social support weakens the association between work stressors and strain even when the source of social support and the source of the stressor are the same. This implies that the instigator of the stress (e.g. a supervisor) also may be able to provide social support although congruence between the type of support needed and the type of support offered is important if it is to be effective in reducing risk.

The psychosocial hazard of supervisor and co-worker support is of increasing importance with moves to greater use of working from home arrangements. With current and future work increasingly requiring distributed or virtual work teams more people are working from home sometimes for extended periods. This can result in social isolation which limits opportunities for social support. In addition, this can result in working longer work hours and blurring of work-home boundaries.\textsuperscript{12}

4.2.9 Organisational injustice

Fairness at work, or organisational justice, is considered a multifactorial construct comprising:

- \textit{Procedural justice}: the perceived fairness of procedures used in workplaces (e.g. the content, whether they are implemented consistently across time and workers) (Leventhal, 1980)
- \textit{Distributive justice}: the perceived fairness of decision outcomes (e.g. rewards are commensurate with effort, the candidate who best meets selection criteria gets offered the position/promotion) (Adams, 1965; Leventhal, 1976)
- \textit{Interactional justice}: the perceived fairness of interpersonal treatment (e.g. dignity and respect) (Bies & Moag, 1986)

\textsuperscript{12} See OHS BoK 37.4 Workers Working from Home
- **Informational justice**: the provision of information about the use of procedures, timelines, progress in application of procedures/decisions, and why outcomes were determined (Greenberg, 1993).

There is substantial evidence of associations between a sense of justice and health. (See for example, Brotheridge, 2003; Elovainio et al., 2003; Herr, Almer, Bosle & Fischer, 2020; Kivimäki et al., 2002; Robbins, Ford, & Tetrick, 2012, Taris, Peelers, Le Blanc, Schreurs & Schaufeli, 2001; Vermunt & Steensma, 2001; Ylipaavalniemi, et al., 2005.)

### 4.2.10 Recognition and reward

The Effort-Reward Imbalance model (Siegrist, 1998) centres on the concept of imbalance between the effort that a worker puts in and the rewards (e.g. money, esteem and social control) they gain. It is postulated that imbalances in this area are linked to negative effects on self-esteem, self-efficacy and numerous health outcomes (Eddy et al., 2016; 2017; Koch et al., 2014; Neidhammer, Tek, Starke & Siegrist et al., 2004; Pikhart et al., 2001, 2004; Rugulies, Aust, & Madsen, 2017; Tsutsumi, Kayaba, Theorell & Siegrist, 2001). Siegrist (1998) referred to ‘overcommitment’ to explain why people who are intrinsically high in effort are more at risk of ill health from stress at work. The person-driven effort and the need for reward are acknowledgement of the contribution of individual differences to the stress response.

### 4.3 Individual differences

While the psychosocial hazards outlined above influence the likelihood and severity of worker harm, there are individual differences in how people respond to psychosocial hazards which can exacerbate or buffer the strength of this relationship. Individual differences have been attributed to physiological and/or personality factors.

There is evidence to suggest that individuals with high psychological wellbeing have substantially lower overall cortisol secretion, and also that oxytocin plays an important role as a biological mechanism underlying the stress-protective effects of positive social interactions (Heinrichs, Baumgartner, Kirschbaum & Ehlert, 2003).

Personality factors such as negative affectivity (‘the stable tendency to experience negative emotions’, Watson & Clarke, 1984) can increase the likelihood of job strain (see, for example, Spector, Fox & Van Katwyk, 1999) whereas core self-evaluations such as strong self-esteem, perceived competence, internal locus of control, and emotional stability can strengthen a worker’s belief in their capability and significance, and thus support active
coping in stressful situations (Jimmieson, 2010; van Doorn & Hülsheger, 2015). There is also evidence that chronic work stressors can have negative implications for worker personality over time, (increased neuroticism and decreased agreeableness; Wu, Wang, Parker & Griffin, 2020)

There is a large and complex body of literature focused on individual differences and stress responses as well as attempts to identify vulnerable groups of people. This research is perhaps best summed up by Cox, Griffith & Rial-González (2000, p. 52), when they stated “there appears to be little evidence of trait-like vulnerability to stress beyond that implied for psychological health by a personal or family history of related psychological disorders.”

Therefore, whilst it is important to acknowledge individual differences, health and safety legislation requires duty holders to act to control the risk of job-attributable strain. Control of risk associated with psychosocial hazards should be undertaken with a greater focus on aspects of the design and management of work that may be creating a risk of harm. To focus on individual differences at the expense of controlling risk from psychosocial hazards would constitute a failure to ensure health and safety.

5 How psychosocial hazards create harm

The causation and expression of psychosocial hazards is complex and variable. This section reviews what is known about how psychosocial hazards create harm via the individual’s stress response, the causal flow from hazard to health and safety outcomes, and the impact of organisational systems.

5.1 The stress response

Whilst a certain amount of stress can improve performance and motivation, extreme stress via prolonged or extreme exposure to psychosocial hazards can have negative effects on health and wellbeing. Although it has been criticised for its non-transactional view, it is useful to consider Selye’s (1956) seminal ‘general adaptation syndrome’ theory which demonstrates early understanding of the links between stress and ill-health. After exposing rats to prolonged stress, Selye generated a three-stage model of the body’s physiological response to stress encompassing:

1. **Alarm**: where the hypothalamic-pituitary-adrenal system is activated and there is preparedness for action (fight or flight)

2. **Resistance**: where there is an attempt to cope with a prolonged stressor by maintenance of high levels of arousal
3 Exhaustion: where the defence systems of the body become exhausted and health effects occur (e.g. high blood pressure). In this phase, responses to any additional stressors also become exaggerated.

Modern stress theories and concepts, such as allostatic load and burnout, apply this basic idea in more detailed and nuanced ways. For example, the concept of allostasis and the allostatic load model uses physiological measures (e.g. stress hormones, sleep disturbance, blood pressure, metabolic function) as a way to better understand chronic stress (Ganster & Rosen, 2013).

A more psychological concept, ‘burnout’ (Maslach and Jackson, 1984), was recently added to the International Classification of Diseases and can be defined as:

- a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions:
  - feelings of energy depletion or exhaustion;
  - increased mental distance from one’s job, or feelings of negativism or cynicism related to one’s job; and
  - reduced professional efficacy.

Burn-out refers specifically to phenomena in the occupational context and therefore is not applicable to other areas of life. (WHO, 2018)

These theories highlight that it is rarely a single acute episode of stress that leads to ill health, but prolonged exposure to stressors. Also related to this, the frequently cited Yerkes-Dodson Law (1908) suggests that for any particular task and worker there is an optimum level of arousal, or stress, at which performance is at its maximum capacity and, beyond which, performance decreases (Figure 3). This suggests that the stressor must be at a certain intensity for it to have detrimental effects.
5.2 The causal flow from psychosocial hazards to health and safety outcomes

Applying these principles to an organisational context, Figure 4 shows the causal flow from work characteristics (or psychosocial hazards) to health outcomes and adds in our modern understanding of moderating or buffering effects. This figure also depicts three intervention points which will be relevant to risk controls in section 8 noting that the OHS professionals’ focus is on primary prevention.
Psychosocial hazards are working conditions or work characteristics that workers perceive as threatening (e.g. role overload, certain tasks and role requirements, lack of support or autonomy, conflict, some management actions) whereas strains are negative responses that result when such demands are in excess of the coping resources of workers (Koslowsky, 1998).

‘Stress’ is a dynamic process in which physiological and/or psychological manifestations are relative to a perceived imbalance between work demands and ability to cope with those demands. This process elicits change in the normal psychological or physical functioning of the worker. Most theories of occupational stress conceive of this process as the mechanism or causal link between work stressors and worker strain or, alternatively, from psychosocial hazards to worker health outcomes (Lazarus, 1990; Lazarus & Folkman, 1984; Spector, Chen & O’Connell, 2000).

This understanding of the stressor-strain relationship has allowed research to identify measurable antecedents (stressors, or psychosocial hazards) and outcomes (strain e.g. anxiety, depression, neck and shoulder tension etc.). This pathway can be seen represented

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13 See OHS BoK 8 series chapters The Human and Psychology (in planning at time of writing).
14 See OHS BoK 9 The Human as Biological System.
in the JD-R model (see Figure 5) which draws on both work design and occupational stress literatures, and is one of the most influential and well-researched theories that underpin OHS-related psychosocial hazards (Bakker & Demerouti, 2017). It is important to note that in addition to the strain pathway represented in this model, a motivation pathway exists, thereby arguing that while poor work design can result in worker strain, good work design is motivating and improves worker health and wellbeing.

![Figure 5: The Job Demands-Resources (JD-R) Model (Bakker & Demerouti, 2007, p. 313)](image)

### 5.3 Impact of organisational systems

The type of psychosocial hazards that workers are exposed to, and the frequency and duration of exposure, are influenced by the organisational systems, structures, and their management.

There are a number of constructs or theoretical models that focus on this higher-level influence on psychosocial hazards usually measured as a specific type of climate or capitals. Although a number exist (e.g. safety climate and psychological safety climate), psychosocial
safety climate specifically considers workers’ shared perceptions of the “policies, practices and procedures for the protection of worker psychological health and safety” (Dollard & Bakker, 2010) across four domains of psychological health:

- Management priority
- Management commitment and support
- Organisational communication and employee voice
- Participation (Loh, Zadow, & Dollard, 2020).

There is growing evidence that psychosocial safety climate impacts psychosocial hazards and that the strength of this climate moderates (exacerbates or buffers) the impact of psychosocial hazards on a number of health and safety outcomes (see Zadow, Dollard, Parker, & Storey, 2019 for a review).

## 6 Risk management for psychosocial hazards

Risk management for psychosocial hazards follows the same principles as risk management for many other OHS hazards. Techniques and sources of data for identification of hazards and for risk assessment can include:

- Analysis of organisational data, such as absenteeism, turnover and injuries, and use of employee support programs (such as counselling and employee assistance programs (EAPS))
- Assessing worker complaints or hazard reports
- Observation of the workplace, work practices, and human interactions
- Use of worker surveys and/or focus groups
- Examination of data from the industry or sector, or other similar work environments.

Assessment should include data collection and measurement of the relevant psychosocial hazards outlined in section 4.2. Factors fundamental to successful risk management are discussed below.

### 6.1 Organisational and management commitment

Within a given organisation, initial recognition of the need for risk assessment and control for psychosocial hazards commonly stems from OHS or Injury Management work units or committees. This is not unusual as practitioners working in these areas see firsthand the everyday health and organisational effects from exposure to psychosocial hazards. Consequently, prior to commencing risk assessment, one of the first tasks is often gaining senior management commitment to addressing psychosocial hazards.
While senior management commitment is important for all areas of OHS, it is particularly important for psychosocial hazards because:

- Senior management involvement signals the importance of the work and can directly impact a sense of greater ‘support’ for the workforce. That is, a manager who openly, authentically, and convincingly expresses their desire for their workplace to be free from psychosocial hazards sends a message of care and concern for worker wellbeing. This can directly create a sense of emotional support which can buffer against worker strain. The visible commitment may involve, for example, email or other communication from the CEO or General Manager, senior managers sitting on steering committees, standing items on agendas at staff and executive meetings, and the CEO having final sign off/accountability for success.

- Resource commitments are required (e.g. time for staff participation, costs for interventions).

- Upward communication regarding potential business implications is required (e.g. cost-benefit of intervening versus not intervening, potential lag times and realistic timeframes, likely business outcomes, possible associated business risks, links between psychosocial hazards and work design and management). Where management commitment is present and senior managers have a full awareness of implications, programs are less likely to be terminated prior to completion due to management surprise or anxiety regarding findings or recommendations.

### 6.2 Organisational communication
Organisational communication regarding any assessment and intervention is essential in order to convey management commitment to addressing psychosocial hazards. Also, it is integral to the logistics of implementation of risk management processes and, particularly, to ensure adequate worker participation. Communication may be in the form of broadcast emails, posters, workshops, focus groups, or standing items on management and team meeting agendas.

### 6.3 Worker participation
Consultation with, and participation of, workers is an essential part of any safety management system. Successful management of psychosocial hazards requires worker participation in:

- Risk identification and assessment
- Feedback of risk-assessment results
- Action planning
- Implementing interventions.
Worker participation influences success in the following ways:

1. Stress theory specifies that workers' attributions about psychosocial hazards influence whether they experience strain or not. Therefore, the only way an accurate risk assessment can be conducted is by asking workers about their perceptions of psychosocial hazards.

2. Involving workers in the process serves to increase their sense of 'work control' and 'support,' thereby having a positive impact on psychosocial hazards that may otherwise be increasing the risk associated with psychosocial hazards.

3. Worker input into action plans and interventions can mean that they are better targeted to problem areas as those who are familiar with the work have designed the risk-mitigation strategies.

7 Risk assessment for psychosocial hazards

7.1 Definition of areas/work groups for assessment

When undertaking risk assessment for psychosocial hazards, it is important to give careful consideration to work areas to be included in the assessment. For example:

- Will the whole organisation be included in the risk assessment or only departments identified as potentially higher risk?
- Will the assessment allow for risk profiles to be ascertained at the work unit level, so as to adequately target both causative psychosocial hazards and subsequent interventions?
- Should risk profiles be available at the occupational level for certain parts of the organisation?

In all of these decisions the aim is to ensure that work areas are defined and assessed to a level of detail that enables accurate targeting of risk-control measures.

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Defining work areas for risk assessment of psychosocial hazards

Organisation ZZZ employs 300 workers; of these 150 work in a manufacturing plant (across three day-shifts and one night-shift), 100 work in a call centre (across four work groups), and 50 work in head office functions such as HR, Marketing, Finance, Research and Development, and Management.

In identifying work groups for assessment, the steering committee decided they would like to see the psychosocial risk profiles for:

- Each of the three day-shift work groups in the manufacturing plant
- The night shift in the manufacturing plant
- Each of the four call centre teams
- HR, Finance and Marketing as one work group
Research and Development
As the organisation was concerned about stress on their line managers, they decide to assess the risk profile for the line managers as an occupational group.

When the risk profiles for these eleven work groups were analysed, it was clear that those with the poorest psychological wellbeing were line managers (with psychosocial hazards identified as time pressure/role overload, work-group conflict, and inadequate reward and recognition) and those working in the call centre (with psychosocial hazards identified as time pressure/role overload, emotional demands and lack of control).

The specificity of this risk assessment allowed for a risk-control plan to be targeted to the psychosocial hazards unique to each of these two different work groups/occupations.

7.2 Use reliable methods for risk assessment
Assessing risks associated with psychosocial hazards is commonly done via focus groups and/or worker surveys. Where either of these methods is used it is important that they focus on the psychosocial hazards known to have empirical links with health outcomes (as outlined in section 4 above).

In 2001, a review of psychosocial-hazard measures (Rick, Briner, Daniels, Perryman & Guppy, 2001) identified limitations to the reliability and validity of many tools. In response to this, in Australia, a consortium of OHS regulators and universities (Queensland University of Technology, Australian National University, Work Health and Safety Queensland, Safe Work NSW, WorkSafe Victoria, Comcare, Safe Work Australia and Beyond Blue), developed the ‘People at Work’ survey, a dedicated, free, risk-assessment tool for psychosocial hazards. This risk assessment tool has an associated Australian normative database against which organisations can benchmark their performance on the 10 psychosocial hazards discussed in section 4 (see Jimmieson, Tucker & Bordia, 2016). In addition, a measure of psychosocial safety climate is available and has been well validated (see Hall, Dollard, & Coward, 2010).

Some regulators have developed questionnaires that are not designed to measure psychosocial hazards, but rather the business level capability to provide mentally healthy workplaces across a number of themes (Leadership, culture, policy; Work design and management; Risk management; Consultation and engagement; Education and training; and Support services; see for example SafeWork NSW, 2019).

Internationally, the UK Health and Safety Executive (HSE) produced a worker survey that is freely available and is based on six psychosocial hazards (Cousins, Mackay, Clarke, Kelly, Kelly & McCaig, 2004). This ‘Management Standards’ framework, which has been in place in the UK since 2002, allows organisations to compare their performance to UK benchmarks sourced from five (predominantly public sector) high-risk industries. In addition to the many others identified by Rick et al. (2001), the National Institute of Occupational Health (NIOH) in
Denmark developed the Copenhagen Psychosocial Questionnaire (COPSOQ) for assessing psychosocial work environment factors (Kristensen, Hannerz, Høgh & Borg, 2005). The COPSOQ encompasses categories focused on job ‘tasks,’ ‘social and organisational’ aspects of the job, and ‘individual’ or personality factors. Recent work has used this measure as a way to test methods to quantify risk potential (Metzler, von Groeling-Müller & Bellingrath, 2019).

Proprietary surveys have also been developed to assess a myriad of outcomes in the workplace, including physical and mental health, emotional exhaustion or ‘burnout,’ workplace accidents, employee wellbeing, job satisfaction, productivity, engagement, morale, turnover, absenteeism, and distress. Although these outcomes may be important to employers, and therefore could be used as a lever to evoke behaviour change, OHS professionals’ primary purpose is to prevent illness and injury. Therefore, the single most important factor for choice of assessment method is its ability to reliably and validly assess the risk of illness and injury via measuring psychosocial hazards (as listed in section 4). Further, it is important that assessment tools can reliably and validly identify and assess significant (non-trivial) psychosocial hazards.

8 Risk control

8.1 Interventions
As well as a plethora of individual studies, several reviews of occupational stress interventions have been conducted (Biron, Karanika & Cooper, 2014; Brough, Dollard & Tuckey, 2014; Caulfield, Chang, Dollard & Elshag, 2004; Cox & Griffith, 2000; Giga, Garagher & Cooper, 2003b; Kompier & Cooper, 1999; Semmer, 2003; van der Kink, Blonk, Schene & Van Diijk, 2001). Overall, there is reason to be optimistic about the effectiveness of interventions as long as they are targeted accurately, use appropriate processes, and are clear and realistic about intended outcomes.

Intervention types studied have been many and varied and are classified in different ways. LaMontagne, Keegel, Louie, Ostry and Landsbergis (2007b) studied the efficacy of primary, secondary and tertiary interventions (Figure 4) and found that primary prevention had the greatest efficacy in reducing job stress (Table 2) and therefore should be the focus of OHS practice.
Table 2: A systems approach to job stress (LaMontagne et al., 2007b, p. 269)

<table>
<thead>
<tr>
<th>Intervention Level</th>
<th>Effect Rating</th>
<th>Intervention Targets</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary (Preventative) Goal: reducing the nature of the psychosocial hazard before employees’ experience stress-related symptoms or disease</td>
<td>+++</td>
<td>Psychosocial hazards at their source; organisation of work; working conditions</td>
<td>job redesign; workload reduction; improved communication</td>
</tr>
<tr>
<td>2. Secondary (Ameliorative) Goal: to help equip employees with resources to cope with stressful conditions</td>
<td>++</td>
<td>Employee responses to psychosocial hazards</td>
<td>cognitive behavioural therapy; coping classes; anger management</td>
</tr>
<tr>
<td>3. Tertiary (Reactive) Goal: to treat, compensate, and rehabilitate employees with enduring stress-related symptoms or disease</td>
<td>+</td>
<td>Enduring adverse health effects of psychosocial hazards</td>
<td>return-to-work programs; occupational therapy; medical therapy</td>
</tr>
</tbody>
</table>

A different classification structure proposed by de Frank and Cooper (1987) includes interventions targeted at:

The individual level – where they are aimed at assisting individuals to cope or build resilience. This includes activities such as training in resilience, stress and coping, relaxation, cognitive behavioural interventions (CBT), or energy management interventions.

The individual/organisational interface level – where they are aimed at improving the fit between the person and the organisational system. This includes activities such as improving interpersonal skills, job demand monitoring and improving role clarity.

The organisational level – where they are aimed at altering parts or components of the organisational system itself. This includes activities such as work redesign, improving management commitment, organisational communication, improving work content and managing change.

Table 3 provides a list of possible types of interventions, categorised using this framework.
Table 3: Overview of types of work-stress interventions classified according to de Frank and Cooper’s (1987) level of intervention classification

<table>
<thead>
<tr>
<th>Level</th>
<th>Intervention*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organisational</td>
<td>Improving work content via good work design</td>
</tr>
<tr>
<td></td>
<td>Management commitment</td>
</tr>
<tr>
<td></td>
<td>Management training</td>
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<tr>
<td></td>
<td>Selection and placement</td>
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<tr>
<td></td>
<td>Physical and environment characteristics</td>
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<tr>
<td></td>
<td>Communication</td>
</tr>
<tr>
<td></td>
<td>Job design/restructuring including hours of work and shift/roster design</td>
</tr>
<tr>
<td></td>
<td>Improving decision making</td>
</tr>
<tr>
<td></td>
<td>Conflict management systems</td>
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<td>Policies and procedures</td>
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<td>Individual-organisational</td>
<td>Time management, improving interpersonal skills, work/home balance</td>
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<td>interface</td>
<td>Increasing supervisor skills and competencies</td>
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<td>Job demand monitoring</td>
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<td>Role issues (ambiguity and conflict)</td>
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<td>Participation and autonomy</td>
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<td>Peer support groups, coaching, career planning</td>
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<td>Pre-employment medical examination</td>
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<td>Selection and placement</td>
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<td>Individual</td>
<td>Individual psychotherapy including didactic stress management, CBT</td>
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<td>Relaxation</td>
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<td>EAS – supportive counselling, CISD</td>
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<td>Stress management, resilience and fatigue management training</td>
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<td>Energy Management interventions</td>
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<td>Promotional materials</td>
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<td>Advertising – health promotion</td>
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# Intervention types summarised from multiple sources (including Cox et al., 2000; De Jonge & Dollard, 2002; Giga et al., 2003a).

*It is possible that some interventions fit into two of these categories (depending on how they are targeted and what their aims are) – this is why the individual/organisational interface category is sometimes omitted.

A theme evident in the literature is that the majority of interventions conducted in organisations have been individually focused and targeted towards helping those already distressed. This was the case for interventions in Australia (Caulfield et al., 2004) and
internationally (Giga et al., 2003b; Kompier & Cooper, 1999; LaMontagne, 2001; VanDer Kink et al., 2001). This tendency may be indicative of an underlying belief that experiencing work strain is a consequence of inadequate coping mechanisms of individuals rather than looking to potential work contributors to the risk of injury. It may further signal that organisations are not yet sharing responsibility for workers’ stress responses. However, it may be due also to lack of knowledge regarding how to best control the risk and/or to the belief that individual-level interventions are easier to implement than organisational interventions.

Whatever the cause, continuing to focus interventions on bolstering individual coping at the expense of organisational-level interventions is not in line with modern OHS practice. Indeed application of the hierarchy of controls indicates that individual-level controls, being low in the hierarchy do not eliminate or minimise risk to the same extent that organisational-level controls at higher levels of the hierarchy do. Therefore individual-level controls in the absence of organisational-level controls usually result in residual and uncontrolled risk.

Many studies have described processes used in successful interventions (Biggs, Noblet & Allisey, 2014; Giga et al., 2003b; Cox & Griffiths, 2000; Kompier et al., 1998). In addition to general principles (section 6) that should permeate the entire risk-management process, risk-control plans should embrace the following factors:

- Activities to control the risk should be organisation and work-group specific, and adapted to the needs, cultures, politics and economic realities of the organisation/work group
- Activities to control the risk should be targeted to problem psychosocial hazards identified via risk assessment
- Risk-control plans should focus on primary prevention, but also include secondary and tertiary prevention activities
- Risk-control plans should focus on organisational-level interventions, but also include individual-level interventions
- A focus on worker training, including mental health training, or off-the-shelf risk-control interventions is unlikely to ensure health and safety.

### 8.2 Realistic timeframes

Finally, it is important for managers and workers to have a realistic expectation of the timeframes for assessment and implementation of risk-control plans, and the lag times for interventions to take effect. The assessment and implementation process can take 12–18 months (depending on factors such as the size of the organisation) from initial organisational commitment to action through to implementation of risk control plans. Research into this area found the average lag time for individual interventions was nine weeks and was thirty-
eight weeks for organisational interventions (van der Klink et al., 2001). More recently, a useful taxonomy of time lags was presented by Dorman & Van de Ven, (2014, p. 96) ranging from minutes and one day for immediate and short-term stress responses, to many years for long-term stress responses.

In a complex system, it is perhaps unrealistic to expect change to last forever (Semmer, 2003) - the dynamisms of organisations can mean changes such as a new supervisor or new colleagues and changes in the prevailing economic or political climate. Such changes can make marked and unplanned alterations in stress responses of workers.

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**Risk management for psychosocial hazards in practice**

A large, 100+ seat inbound call centre has been getting feedback from the XYZ Union that their members are dissatisfied with working conditions. The most recent manifestation of this was the presentation of a letter, signed by 80 workers, itemising complaints relating to stress, inability to meet targets, not enough time to go to the toilet, and severe and unjust consequences for workers for minor discretions. This was on top of several individual bullying complaints that had been investigated and ‘resolved,’ but that had impacted negatively on worker morale.

In response to this, the company decides to undertake a systematic risk assessment and implement relevant controls to manage risks to health and safety. With the union’s support, they implement the following program.

**Program establishment**

1. Inform workers of the process and invite them to be active participants.
2. Form a steering committee with representatives from a vertical slice of the organisation, including workers, team leaders, union representatives, senior managers, and OHS and HR practitioners.

**Hazard identification - data collection and analysis**

3. Undertake an analysis of absenteeism, turnover and grievances, identifying trends in peak absenteeism and turnover times and locations within the centre.

They find that:

- **Absenteeism peaks at:**
  - The time of the monthly performance reviews
  - When there is implementation of new business practices, such as introduction of the new IT system
  - At times of high work demand, such as end of financial year

- **Absenteeism is trending upwards, costing almost half a million dollars per year**

- **Both absenteeism and turnover are higher in certain work groups.**

4. Conduct a staff survey asking specific questions about wellbeing and associated psychosocial hazards. They take an existing survey that will allow them to benchmark against other organisations and add some additional items (specific to the type of work they conduct and the issues raised by workers).

In addition to measurement of the psychosocial hazards of work demands, control, support, roles, relationships, change, recognition, and reward and justice, they add: perceived achievability of targets, dealing with difficult/aggressive clients, KPIs and performance reviews (including the use of electronic performance monitoring, and the frequency and quality of performance reviews).
5. Interview team leaders, call centre managers, and workers in HR, WHS, RTW and training and development roles, focusing questions on perceived psychosocial hazards and ideas for improvements.

Sharing and validation of outcomes
6. Provide interim results of the risk assessment to the steering committee.
7. Run focus groups with worker representatives to:
   • Provide results of the survey to staff
   • Seek worker input to clarify issues raised in the survey.

Develop risk control plan
8. Develop a risk-control plan with worker input.
9. Finalise the risk-control plan and present it to the steering committee for sign off.
   The risk-control plan includes five major (along with various smaller) activities:
   • As 80% of staff are currently not meeting KPI, a participative review of targets will be conducted; targets will be reviewed regularly with staff input
   • A review of the performance-management process will be undertaken, including the reasonable use of electronic performance monitoring, frequency of performance feedback and fairness around performance management; line managers will be provided with training and live coaching regarding performance management and review
   • Weekly standing team meetings will be instituted where workers have an opportunity to have input into their working conditions and raise concerns
   • Line-manager competencies for occupational stress will be assessed and they will work participatively to develop these
   • Workplace bullying policies will be drafted and implemented; line managers and staff will attend training to ensure they have the capacity to minimise risks associated with bullying and know how to respond appropriately should bullying issues be raised; monitoring and review processes for this are to be implemented.

Monitor implementation and improvement
10. Monitor implementation of the risk-control plan (i.e. by the steering committee).
11. Review improvements on a regular basis by checking with line managers and staff in weekly meetings, but formally review improvements in twelve months’ time by conducting another staff survey.

9 Implications for OHS practice

While understanding of the complex interactions between exposure to psychosocial hazards and modifying variables is still evolving there is a significant knowledge base to inform OHS practice. However, there is often a gap between this evidence base and workplace strategies.

OHS professionals have a responsibility to ensure that the management of psychosocial hazards reflects current knowledge. It is important that organisational decision-makers are aware that interventions that focus on bolstering individual coping at the expense of
organisational-level interventions are not in line with modern OHS practice nor with OHS legislated requirements. Rather psychosocial risk control activities should:

- Be based on a risk management approach including consideration of the hierarchy of controls
- Include a focus on organisational-level interventions especially aspects of the design and management of work that create psychosocial hazards
- Take a multi-disciplinary approach by engaging with in-house and external professionals in human resources, industrial relations, return-to-work, and health professionals
- Take account of the changing nature of work and be adapted to the needs, cultures, politics, and economic realities of the organisation/work group, including workers with a mental illness.

### 9.1 Risk management approach

The OHS professional should apply their knowledge of risk management processes and the principles of a hierarchy of control informed by the knowledge of specific psychosocial hazards, including their interaction and causation of harm, in order to manage risk. It is particularly important that risk assessment processes are inclusive and valid in that they focus on evidence-based psychosocial hazards rather than other organisational factors that may be perceived to drive related behaviour.

OHS professionals advising managers and involved in planning interventions for psychosocial hazards should have access to information to enable them to give managers a realistic estimation of time required to improvement to be realised.

### 9.2 Focus on design of work

One of the key roles of OHS professionals is to:

> Lead the development of OHS risk management processes and facilitate and support their implementation and maintenance. (INSHPO, 2017, p. 24)

In doing this, it is incumbent on OHS professionals to ensure that their advice is evidenced-based and takes account of recent research. Thus a key role of the OHS professional in managing psychosocial hazards is to ensure that, whilst it is important to acknowledge individual differences, control of risk associated with psychosocial hazards is focussed on aspects of the design and management of work that may be creating a risk of harm.  

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15 See *OHS BoK* 34.4 Design of Work (in development at time of writing).
9.3 Interactions between psychosocial hazards and HR practices, IR matters and line-manager skills

Risk management for psychosocial hazards often has implications for, and overlaps with, other areas of organisational concern including industrial relations (IR) and human resources (HR). Indeed, sometimes risk factors are directly within the domain of these areas of practice. Risk factors such as hours of work (and shift work), organisational (in)justice, and how management responds to issues such as workplace conflict and change, can be sources of job dissatisfaction, grievances, and industrial disputes. For this reason, it is important that OHS professionals work closely with practitioners in HR and IR using a multidisciplinary approach to psychological hazards. For complex risk management scenarios, it can be beneficial to engage professionals with specialist skills in psychosocial risk management (e.g. organisational psychologists or occupational physicians).

9.4 Return-to-work

The influence of psychosocial factors in delaying return to work after injury is well established (Goorts et al., 2020) with the medical profession now encouraged to assess psychosocial factors as a prognostic factor. A system of flags indicating possible obstacles to recovery includes psychosocial factors (Kendell, Linton & Main, 1997). In addition, research has identified competencies for line managers when they have workers returning to work after a psychological injury (Johnston et al., 2015). In 2019, work was undertaken by researchers at Monash University to identify recovery at work support tools for workers who may be at risk of or experiencing mental distress (Gray, Osborne, Di Donato & Collie, 2019). In practice, it is important for OHS professionals to work closely with return-to-work and disability-management practitioners to ensure that any risks associated with psychosocial hazards in the relevant work team are identified, assessed, controlled and monitored in any return-to-work scenarios.

Impact of psychosocial factors on RTW outcomes

Charles, an older worker, is a machinist in a metal fabrication plant. He had been working for the company for many years when he put in a worker's compensation claim for a musculoskeletal injury to his neck. When the return-to-work coordinator contacted Charles to facilitate a graduated return-to-work program, Charles stated he was happy to go back to work but did not want to work the same shift as Sam, another machinist.

Charles’s son, Logan, worked at the same workplace and had been in a long-running conflict with Sam; this had culminated in Logan making allegations that Sam had been bullying him, and had been stealing stock and selling it online. Sam, on the other hand, alleged that Logan had made comments regarding his integrity on a social networking site and had made threats to his safety. Sam had raised these issues with the company owner and the case was being investigated by the police.

Subsequently, Logan resigned from the company and investigation of the bullying complaint and stealing allegations provided no evidence of wrongdoing by Sam.
9.5 The changing nature of work

The nature of work and work tasks are changing in response to innovations such as artificial intelligence and automation, and due to labour force evolutions, such as the digital economy, gig work, and precarious employment. Artificial intelligence and automation have been found to increase monitoring and the control of work via automation meaning work is tending to modularisation (Tschang & Mezquita, 2020). Studies into the future of work have found that increasing numbers of Australians are working as independent contractors or otherwise conducting contract work. A recent report on this issue found this informal employment sector represented 11.6% of the workforce in Australia (BCEC, 2018). This same report also indexed precarious employment in Australia using the Household Income and Labour Dynamics in Australia (HILDA) data finding that precarious employment had increased for men and women since 2009, but more rapidly for men. These changing aspects of work, and the associated increases in distributed and remote work and work design, can have implications for both for the incidence of psychosocial hazards and how they can be managed (Horton, Cameron, Devaraj, Hanson, Hajkowicz, 2018; Nayani, Neilsen, Daniels, Donalson-Feider, Lewis, 2018).

9.6 Workers with mental illness

Given the prevalence of mental illness in the community, it is relatively commonplace for managers and employees to work alongside someone who has a mental illness. Consequently, in every workplace:

- Management, and the workforce in general, should have an understanding of mental illness
- Reasonable adjustment obligations under the anti-discrimination legislation should be met
- Steps should be taken to create a healthy and safe work environment for everyone at the workplace
- It should be recognised that effective communication skills are integral, particularly for line managers
- Support and coaching for line managers should be made available as needed
- Performance management and team dynamics considerations should be made.

This is a complex area, the nuances of which cannot be adequately dealt with in this chapter; however, for further information see the Australian Human Rights Commission (2010) or Heads up (2018).
10 Summary

This chapter has introduced the concept of psychosocial hazards and addressed it from the perspective of work-related stress. The prevalence of psychological injury is increasing in both number and severity and impacting both the health and safety of individuals and organisational outcomes.

A brief review of the historical literature revealed key principles:

- The design and management of work is fundamentally important in creating psychosocial hazards and associated worker stress responses.
- The individual’s cognitive appraisal of the work design and management factors is fundamental in whether a worker experiences a stress response.
- There is a more recent push for integrative models which promote a combination of health promotion for positive mental health and wellbeing, prevention of harm via reducing exposure to psychosocial hazards, and supporting recovery of those who are unwell.

The chapter noted that workers experience occupational stress when they are exposed to high work demands with low work resources and identified 10 psychosocial hazards contributing to occupational stress and psychological injury:

- Time pressure/role overload
- Emotional work demands
- Interpersonal conflict
- Poorly managed change
- Environmental conditions
- Job control/autonomy
- Role clarity
- Recognition and reward
- Organisational justice
- Co-worker and supervisor support.

The chapter then presents a risk management approach for psychosocial hazards that:

- Emphasises the importance of:
  - Organisational and management commitment
  - Organisational communication
  - Worker participation

- Prescribes two elements for valid risk assessment being
  - Clear definition of the work groups or work areas for analysis
Selection of appropriate risk assessment methods that measure psychosocial hazards

• Outlines options for risk control based on level of intervention.

The chapter concludes by drawing out implications for OHS practice.

Resources

Major international psychosocial policy frameworks/directions

Health and Safety Executive (UK) Framework (Mackay et al., 2004; Cousins et al., 2004)
Luxembourg Declaration, 1997 - The Luxembourg Declaration on Workplace Health Promotion in the European Union
WHO Social Determinants of Health -
https://www.who.int/social_determinants/sdh_definition/en/.
PAS 1010:2011 - Guidance on the management of psychosocial risks in the workplace

Australian Bodies/Initiatives with significant workplace resources

Health and Safety Regulators in each State and/or Jurisdiction, Safe Work Australia
Mentally Healthy Workplaces Alliance, National Workplace Initiative, Mental Health Commissions (National and in each State), Beyond Blue Workplace Initiative, Heads Up Workplace Initiative, Black Dog Institute, Super Friend.
References


Pikhart, H., Bobak, M., Pajak, A., Malyutina, S., Kubinova, R., & Topor, R. … et al. (2004). Psychosocial factors at work and depression in three countries of central and eastern europe. Social science & medicine, 58(8), 1475-1482.


SWA (Safe Work Australia). (2019b). Work-related psychological health and safety: A systematic approach to meeting your duties. Canberra, ACT: Commonwealth of
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Yerkes, R. M., & Dodson, J. D. (1908). The relation of strength of stimulus to rapidity of habit-formation. *Journal of Comparative Neurology and Psychology, 18,* 459-482.


