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FINAL REPORT

Psychosocial Risk Management in a European Comparison

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Contents

Introduction

For years, psychosocial stress as a field of action has been of increasing significance in occupational safety and health policies in Germany and on a European level. At the same time, the great significance of psychosocial stress at work was not contrasted with suitable activity orientations and strategies on either a national or European level (Lenhardt, Ertel & Morschhäuser, 2010).

The findings of the first European survey of enterprises on "new and emerging risks", ESENER (Rial-González, Cockburn & Irastorza, 2010), carried out in 2009, were decisive for the formulation of the question. The focus of this comparative representative survey of the persons responsible for company occupational safety and health was on psychosocial risks. The findings showed that other European countries were much better positioned than Germany in the central aspect of implementing processes or procedures on work-related stress and with regard to the implementation of measures (European Commission, 2011, pp. 88f.). The findings led to debates in the occupational safety and health community and also gave rise to queries regarding methodology. For example, the term "procedures" as used in ESENER is very general, and – depending as well on the respective *(occupational health and safety) culture* and the status of industrial relations – can mean different things (e.g. in Germany company or service agreements, procedural instructions). In addition, doubts were expressed regarding the informative value based solely on these two indicators for effective practical occupational safety and health that takes suitable account of the significance of psychosocial risks (Walters, Wadsworth & Quinlan, 2013, pp. 48 ff.).

Against the background that in the European context the comparative consideration of activity strategies in occupational safety and health is gaining increasing significance (Ertel & Stilijanow, 2009), the question arose for the applicants of the additional aspects that a differentiated European ranking must take into account with regard to psychosocial risk management, and how these dimensions are each realised and embedded in a national context. For this purpose, implementation of the psychosocial risk assessment and management in *four selected EU Member States* was to be examined in greater detail (see below for the reasons for selecting the countries and cases). The aim of the project was to examine the process of psychosocial risk management in different linked steps. It was concentrated on three levels:

- Description: the first step was concerned with a reconstruction of the procedure for the psychosocial risk management in four countries. For this purpose, national framework conditions and stakeholder constellations on an intercompany level and their interplay with the company level were shown.
- Comparison: in the second step, differences and commonalities with regard to framework conditions and approaches were to be illustrated in more detail.
- Evaluation and explanation: finally, in the third step the question was to be gone into comprehensively regarding the conditions that apply for successful implementation of psychosocial risk management, and what significance is attached here to the relevant *contextual conditions*, such as

comprehensive (national) codes. In the process, success factors on an intercompany level were to be worked out and elucidated in interplay with the company level.

The study was carried out in the framework of the project "Psychosocial risk management in the European Union", funded by the Hans-Böckler-Stiftung (HBS) and was realised from October 2013 to March 2016 at the Federal Office for Occupational Health and Safety (BAuA). The present final report is an abbreviated version, the detailed version will be available as a book.

1. Research design of the study

A qualitative research approach that allowed the process of risk management to be traced in detail at company level as well appeared to be practical for clarifying these questions and for acquiring derivable findings for the operational practice of psychosocial risk management in Germany. Informative comparisons based on the relevant dimensions were decisive for the choice of countries and cases and, on the other hand, for enabling success criteria to be worked out. Accordingly, the following aspects were significant:

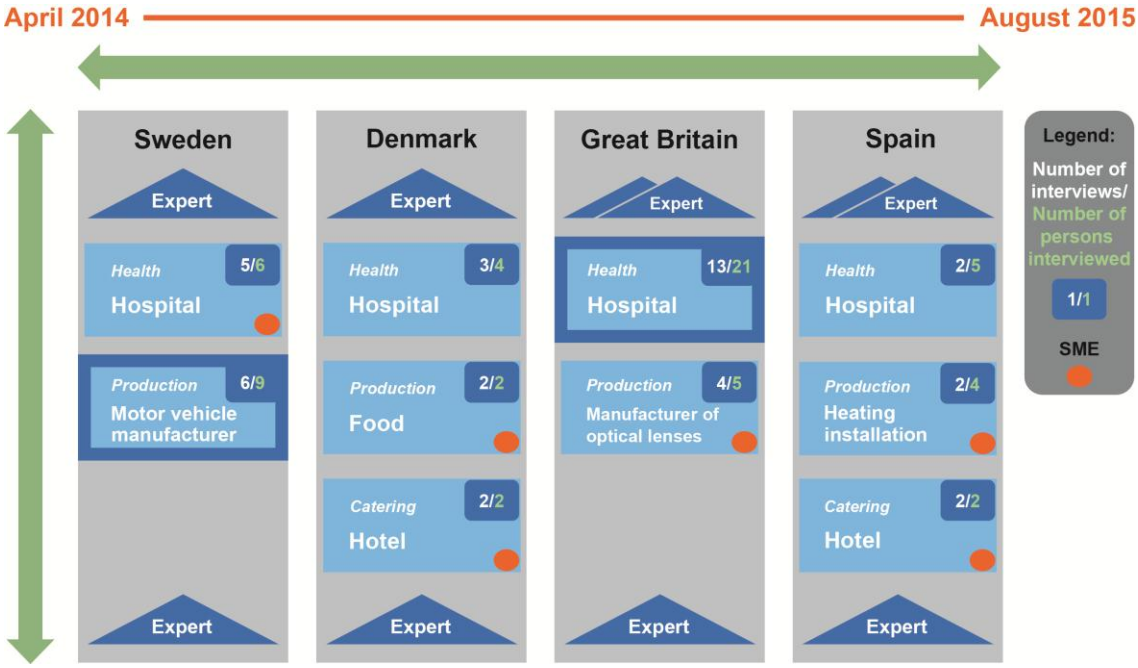
- inclusion of countries that according to the evaluation report of the EU Commission on implementation of the social partners' agreement on work-related stress (cf. European Commission, 2011, pp. 88 f.) were in leading positions in the rating with regard to both procedures and measures, i.e. Sweden, the United Kingdom and Denmark in particular
- a country mix that reflected at the same time the variety of EU Member States with regard to the socio-political development status and the occupational safety and health culture: countries from northern Europe (Denmark and Sweden), north-western Europe (United Kingdom), southern Europe (Spain)
- consideration of organisations from sectors with a high problem pressure resulting from psychosocial stress (e.g. the heath sector; Rial-González et al., 2010, p. 36)
- inclusion of organisations or enterprises in which psychosocial risk management has reached an advanced stage, i.e. beyond the phase of determining and assessing stress, work-related measures have been developed whose implementation were at least foreseeable
- at the same time, but in part difficult to reconcile with the previous specification, it was planned to place the focus on "typical" examples when making the selection, and less on "best practice" examples that are empirically seldom found but are overrepresented in publications

Methodology

Given the complexity of the problem under study, a two-stage approach that combines expert discussions with company case studies was pursued. The case studies approach enables complex processes to be reproduced in the *real* context and permits a detailed description and illustration of the process (Yin, 2003, p. 13). The chosen case studies approach describes a "*research strategy that through the*

combination of various social science data collection and analysis procedures is able in the analysis of a social process […] to take account systematically of the latter's context." (Pflüger, Pongratz & Trinczek, 2010, p. 30). In the present study the emphasis is on the analysis of national differences and common features. Accordingly, a "case" is much broader than a company case study comprising 2-3 company case studies *embedded* in the national context ("embedded design" with multiple case studies, Yin, 2003). A total of four cases were examined.

Fig. 1.: Description of the sample



Notes: white number (1st digit) = number of company interviews (n=41), expert interviews (n=8); green (2nd digit) = number of interviewed persons on company-level (n=60), number of interviewed experts (n=10); broad blue edging = intensive case study; red circle = SME (employees < n=500)

Preparatory expert interviews: to prepare the company case studies, at least one expert was consulted in each country who was able to provide information on national framework conditions. In this first step, experts with research experience in occupational health and safety were consulted. In Great Britain, two experts were consulted who played a double role, being active in scientific research associated and in the occupational safety and health inspectorate. Parallel to this, documents were analysed that provided insights into the special features of national framework conditions in Sweden, Denmark, Great Britain and Spain.

Company case studies: the company case studies were carried out following preparatory expert interviews. Here, cases were selected in which a psychosocial risk management had been initiated and the process was advanced at least so far that (first) measures had already been implemented beyond the phase of determining and assessing psychosocial risks. Thanks to this specification, the sample

was on the whole a positive selection. However, this restriction was necessary because the complete process of risk management was to be observed, so that success factors and obstacles in all phases could be examined[1].

Access to the companies took place in three countries from the beginning through national contact partners ("gatekeepers"), which simplified the acquisition of participants considerably because of existing trust-based relations with local enterprises, and is described by Vassy and Keller (2010) as a success factor for cross-country studies. All enterprises in Spain / Catalonia and Denmark were acquired through the national contact partners, in Spain through a research institute (ISTAS[2]) with ties to the trade union movement, and in Denmark via a private consultancy institute with research commissions (teamarbejdsliv). All three Spanish cases are linked by the strategic, participative approach that is pursued with the instrument known as ISTAS21 (see chapter 8). In Great Britain, the contact to a hospital was set up through the British Health and Safety Executive (HSE), the second enterprise (manufacturing) was acquired through an academic expert at the employers' association but not until after several unsuccessful attempts at contacting other enterprises (via direct approaches, trade unions, employers' association). In Sweden, there was already a direct contact to an enterprise (manufacturing). The second successful acquisition (hospital) was achieved through the contact of an academic colleague from Sweden at an international congress – in this case as well following several unsuccessful attempts at contacting other enterprises (via direct approaches, trade unions). Agreements on ensuring data protection and confidential handling of captured data were translated into the relevant languages and concluded with the company contact partners.

In order to guarantee a variety of perspectives, different key players in psychosocial risk management were interviewed in each company, at least one management representative and one representative of the workforce in each case. In general, two to three interviews took place in each company in which two to five persons per company took part. Only in the two intensive case studies in the very large enterprises (Sweden and Great Britain) were 6 and 13 interviews respectively carried out, and the views of 9 and 21 company players recorded.

Summarising expert interviews: following the company case studies, further experts from labour inspectorate were interviewed. Open questions and interpretations from the company case studies were played back to the experts in these interviews and consolidated.

The experts and the company dialogue partners were each interviewed in guided interviews. The expert interviews lasted between one and two hours, the company interviews varied between one and four hours. The interviews were recorded, transcribed and grouped thematically with the help of qualitative content analysis (Mayring, 2010) and pooled as case studies.

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[1] It can be seen from the case examples shown in detail below that there is still a variety of process developments and results.

[2] Instititut Sindical de Trabajo, Ambiente y Salud (Trade Union Institute for Labour, the Environment and Health)

According to Vassy and Keller (2010), the advantages of a cross-country approach in comparison with studies in one's own country are that one's own (self-evident) preconceptions are made transparent. In the commonalities of the cases it becomes clear which processes "prevail" regardless of the national context, and in the differences, *how* processes are "shaped" by the context. A cross-country design presents the study design with special challenges. To be able to derive reliable statements it is important to ensure comparability of the cases examined with regard to central determinants.

Care was taken during the interviews that linguistic peculiarities were reflected. For example, interpreters (in Spain, Denmark and in one Swedish case) were asked to summarise the contents as little as possible and to translate as literally as possible. English was used to communicate in the other cases (one case in Sweden, British cases; expert interviews). Following prior clarification, dialogue partners could decide against an interview in English, if they preferred to communicate on the subject in their native language. Therefore, the problem of oversimplification, i.e. that points were reported simplified for linguistic reasons (Vassy & Keller, 2010, p. 627), was seen in just a few passages. According to Vassy and Keller, advantages of an interview in a foreign language are that a stronger feeling of anonymity is created and more intensive inquiries and explanations are possible. However, in comparison to the interviews with interpreters we did not observe any differences with regard to these points.

In addition, the national distinctive features that lie behind the central definitions were worked out through document analyses and expert interviews.

Description of the sample

In the framework of the ten case studies 41 interviews with a total of 60 dialogue partners were carried out and 8 expert interviews with a total of 10 national experts from academic and practical occupational safety and health. Of the 41 interviews, 17 were group interviews and 24 were individual interviews.

Notation of the quotations: quotations from the *company interviews* are identified as follows: country (SW=Sweden, DK=Denmark, UK=Great Britain, ES=Spain and enterprises in the company case studies) – operational function – page number. For example, if an interview is identified with SW1_A1: 5, this means that the quotation is from the case study in Sweden (SW) / hospital (1) with a management representative (A) and can be found on page 5. The abbreviation B stands for the workers representative. Branches are identified as follows:

- country supplement 1 (i.e. SW1, DK1, UK1, ES1) describes the *hospital*
- country supplement 2 (i.e. SW2, DK2, UK2, ES2) describes *manufacturing/production* and
- country supplement 3 (i.e. DK3 and ES3) describes the *hotel*

The branch supplement is omitted in the *expert interviews* – the country is described here (i.e. SW, DK, UK, ES) – as is the role of the experts (E1 refers to the scientific expert who was interviewed at the start of the case study and E2 to the expert from the government occupational safety and health system who was interviewed in conclusion – with the exception of Great Britain, where the interviewed players take on both roles right at the start).

Implementation of the interviews

Interviews with company players were carried out on site in the enterprises by means of a guideline. The guideline served as a rough orientation and was employed flexibly in dependence on the course of the discussion. In the process, sufficient time was provided for narrative passages from the dialogue partners in order to provide sufficient space for their personal interpretation systems. The following subject areas were surveyed in the interviews:

- Reasons and motives for psychosocial risk management
- Embedding of the process (initial organisational conditions)
- Implementation of the risk assessment
- Roles of participants (in particular management, worker representatives, occupational health and safety experts, workers, external consultants, occupational safety and health inspectors, social partners / employers' and labour representatives)
- Success factors and obstacles
- Results and benefits of risk assessment

The interviews were recorded on tape with the consent of the interview partners and subsequently transcribed.

The expert interviews were usually conducted by telephone, recorded with the consent of the dialogue partners and then transcribed. Only the interview with the British experts took place on site during a jointly attended scientific congress in London in April 2014. The expert interviews were also conducted on the basis of a guideline that was sent to the experts beforehand. The central subject areas were:

- Representation and priority of the subject "psychosocial stress" in the country's political and media discourse
- National, regional and sectoral developments
- National distinctive features in occupational safety and health (policy, rules, agreements)
- Central stakeholders in occupational safety and health
- Implementation of risk assessment and the role of internal and external stakeholders
- Common methods and instruments
- Challenges and obstacles

Data analysis

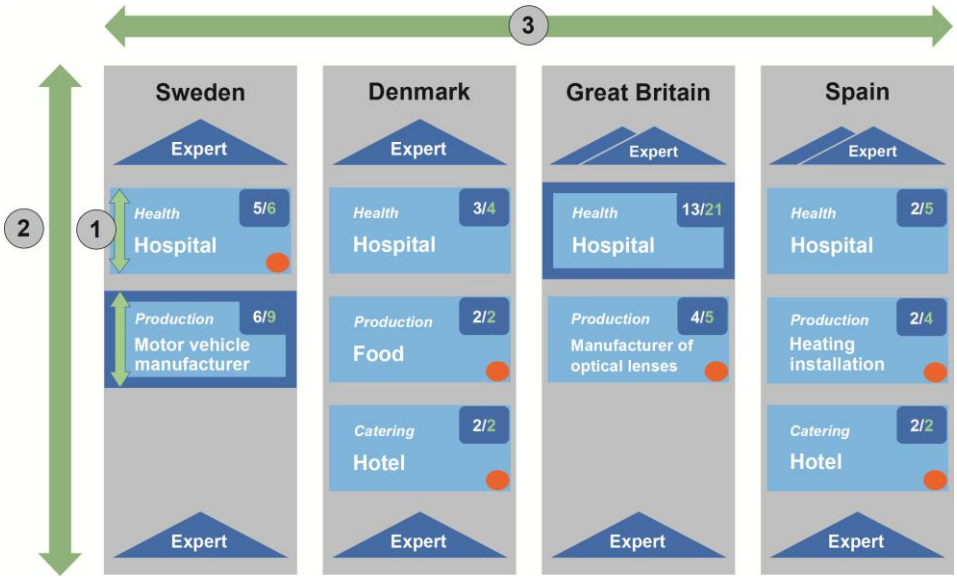
In the first step, the various data sources (company documents, perspectives of the various interview partners) were combined into one case study per enterprise.

In the second step, cases *within a country* were compared with one another and common features and differences were worked out, so that, on the one hand, the spectrum of approaches became clear and, on the other, distinctive features could be presented in detail. These results were cross-checked with statements from expert interviews and checked for conformity or deviation by means of further

information from national reports. Deviations between company and inter-company results are made the subject of discussion at the relevant locations in the text.

In the third step, the cases (that had been combined at country level in the second step) *between countries* were compared with one another. The results were cross-checked here as well, once again by means of (available) data from academic publications and documents.

Fig. 2.: Representation of the steps of analysis



The level of company case studies is used primarily to go over the concrete approach (*how?*) showing examples and procedures and to explain the interplay of relevant framework conditions with the company level. However, the case studies do not claim to make statements on the representative nature of the observed phenomena in the sense of a statistical generalisation "*from selected cases to a population or a class of cases*" (Przyborski & Wohlrab-Sahr, 2010, p. 320). A statistical generalisation "*is a form of generalisation that is basically reserved for standardised procedures and for which correspondingly a sample selected in accordance with the random principle is of decisive importance*." (ibid.). The claim of generalisability can apply to the case studies (in the sense of an analytical generalisation) only insofar as specific processes and interdependencies can be transferred to similar constellations, without this having to be interpreted necessarily on a country specific basis. In an analytical generalisation "*a specific context, rule or mechanism that is of general importance is worked out by means of the respective case or of the examined cases."* (ibid.).

The relevant context (framework for action) for the psychosocial risk management will be shown in several steps in the following chapters.

The starting point for the consideration outlined in *chapter 2* is the occupational safety and health framework on the ***legal level***, which is broken down from the superordinate European level to the national level of the countries examined in the project. The roles of the participating players on the na-

tional level will be shown in more detail in the subsequent chapters. First of all, *chapter 3* describes the role of the ***occupational safety and health inspectorate*** and its initial conditions in the individual countries, as far as structure, status of the subject, possible sanctions and support at company level are concerned. How the role of the occupational safety and health inspectorate is represented at company level is looked at in more depth at the end of the chapter. Conclusions from the company case studies are supplemented in some places (in the following chapters as well) by statements from inter-company experts or findings from other sources that confirm or differentiate the respective observations. Following this, in *chapter 4* the description of occupational health and safety frameworks is supplemented by the ***role of the social partners***, whereby first of all the self-perception of unions in the field of "psychosocial stress" is presented, before turning to the role of unions and their collaboration with employers' associations.

This is followed by an outline of the role of the social partners in the case studies, embedded in the respective system of industrial relations and codetermination at company level. The ***role of worker representatives*** in the selected countries is portrayed in *chapter 5*, starting from a comprehensive overview of the legal foundations through to country-specific specialisations in each case. In this section as well, the conclusion is formed by the findings from the company case studies. *Chapter 6* deals in detail with the ***role of prevention services and (external) consultants*** as essential resources in the process of risk management. The description of the occupational safety and health framework is rounded off in *chapters 7 and 8*, which also look at the ***occupational safety and health cultures*** and the ***methods and instruments*** that are applied for risk assessments of psychosocial stress in the four countries – in each case on the inter-company level first, followed by an examination in greater detail of how this is realised according to the case studies. Finally, *chapter 9* deals with ***central action steps*** in the framework of psychosocial risk management, starting from initiating, via the development of measures through to documentation and checks of effectiveness. Observations from the previous chapters are taken up here as examples and brought together on a process-driven basis. The conclusion consists of the ***summary and discussion*** of the findings.

2. Occupational safety and health framework

The legal framework for occupational safety and health is described in the following chapter – starting from the European Occupational Safety and Health Framework Directive (89/391/EEC) and its transposition into national law in the countries that were included in the project (Sweden, Denmark, Great Britain and Spain). Building on this, it will be shown whether and how far there are specific provisions on psychosocial risk management in the regulations of the respective countries, whereby current developments in each country were taken into account (for example in the area of case law).

European Occupational Safety and Health Framework Directive (89/391/EEC)

Council Directive 89/391/EEC of 12 June 1989 on the introduction of measures to improve the safety and health of workers at work placed occupational health and safety in the European Union (EU) on a new foundation. It "*demands preventive occupational health and safety and entrusts employers with the task of organising company occupational health and safety in an adequate manner*" (Larisch, 2009, p. 39). Under Article 6 of the Framework Directive, *employers* must carry out a ***risk assessment***, *document* it and stipulate *measures for avoiding or reducing dangers* to workers at work. Because employers are obliged to ensure the safety and health protection of workers in *every aspect related to the work*, and to evaluate risks to the safety and health of workers, mental or psychosocial stressors at work is included.

The term "psychosocial risk management" is common in the context of occupational safety and health in the EU. It has as its object "*aspects of the design and management of work and its social and organisational contexts that have the potential for causing psychological or physical harm, (…). They have been identified as one of the major contemporary challenges for occupational health and safety today and are linked to such problems as work-related stress and violence, harassment and bullying."* (Leka & Cox, 2009, p. 1). Consequently, the term "psychosocial strain", which we use with reference to EU terminology, is more comprehensive than the term "mental strain at work" pursuant to § 5, German Occupational Safety and Health Act. However, the "recommendations for implementing a psychosocial risk management"[3], which were first submitted by the GDA (Joint German Occupational Safety and Health Strategy) in 2014, take into account a definition of "mental strain" that is extended by aspects of work organisation and social relationships.

The European Occupational Safety and Health Framework Directive provides the foundation for statutory regulations in each of the Member States of the European Union, whereby the necessary transposition into national law was influenced to a considerable extent by national occupational health and safety traditions, the occupational health and safety infrastructure, the status of work relationships and existing regulatory practices (Karageorgiou, 2000).

Distinctive features of national legislation in the countries

According to Kothe (2005, p. 35), because of the model function of Swedish occupational safety and health legislation there was "*only a minor requirement for transposition*" in ***Sweden*** with regard to the adjustment of national laws to the requirements of the European Occupational Safety and Health Framework Directive. The guiding principle that working conditions should be adapted to the different physical and mental capabilities of workers was already anchored in the Working Environment Act ("Arbetsmiljölagen") in 1977 (Chap. 2, §1; European Commission, 2011, pp. 79 ff.). In the transposi-

[3] Recommendations for implementing psychosocial risk assessment; http://www.gda-psyche.de/ [as of 03.02.2016]

tion of the European Occupational Safety and Health Framework Directive (89/391/EEC) the Swedish Occupational Health and Safety Authority extended the 1993 occupational health and safety regulations to the *systematic management of the working environment* (Swedish Work Environment Authority, 2002).

In ***Denmark,*** activities for regulating the "psychosocial working environment", which already went back many years, led in 2001 to the legal obligation on employers to bear responsibility for workers not being exposed to any form of strain/harassment at work. The law on occupational safety and health (Arbejdsmiljøloven) was extended in 2004. Employers should make use of external if they lack expertise, or as a condition imposed by the occupational safety and health inspectorate, but responsibility always remains with the employer. Enterprises must repeat risk assessments at the latest every three years – or as soon as working methods or operational processes have changed. Companies with a formal "working environment certificate" are excluded from this requirement. An assessment of psychosocial strain in the framework of risk management has been obligatory since 2007.

In ***Great Britain*** the duties of employers regarding risk assessment are laid down in the Management of Health and Safety at Work Regulations 1999. They supplement the Health and Safety at Work Act, which has been in force since 1974[4]. In addition, together with the Safety Representatives and Safety Committees Regulations 1977 they stipulate that employers must let *recognised union-appointed representatives* for safety and health at work take part in matters involving safety at work (HSE, 2007; TUC, 2012, p. 24).

To assist employers in the implementation of psychosocial risk management, the HSE (Health and Safety Executive), the UK's highest occupational safety and health authority, has drawn up an evidence-based action concept with "management standards for work-related stress" (cf. chapter 8).

In ***Spain***, transposition of the European Occupational Safety and Health Framework Directive was carried out in 1995 with fundamental Law 31/1995 on the prevention of workplace risks (Ley de Prevención de Riesgos Laborales), the aim of which is to develop a preventive culture. Core elements are a proactive approach and the organisation of safety and health at work in accordance with the principles of priority for risk avoidance, followed by an assessment of unavoidable risks, controlling risks at the source, adapting work to people and holistic planning of preventive measures (Walters, 2011, p. 395). In conjunction with this are the regulations on prevention services (Reglamento de los Servicios de Prevención 39/1997) that put the requirements for preventive and systematic methods in occupational safety and health into concrete terms: work organisation is recognised as a cause of mental strain hazardous to health, workers and their representatives must be included in all phases of the prevention process, and employers have an obligation to state reasons if they reject suggestions by worker representatives (Moncada, Llorens, Moreno, Rodrigo & Landsbergis, 2011, pp. 592 f.).

[4] http://www.hse.gov.uk/stress/faqs.htm#legal [as of 02.02.2016] and Kothe (2005)

3. The role of the occupational safety and health inspectorate in each country

The following chapter describes the role of the occupational safety and health inspectorate in the context of the respective initial conditions in each country: structure, the relative importance of the subject, possible sanctions and incentives, and support at company level. The role of the occupational safety and health inspectorate at the company level will be looked at in more depth at the conclusion of the chapter.

Structure

The ***Swedish*** occupational safety and health authority (Arbetsmiljöverket / Swedish Work Environment Authority - SWEA) is an independent national authority attached to the Ministry of Labour. The SWEA consists of a total of 11 offices: a head office and 10 branches in the individual districts.[5]

The ***Danish*** occupational safety and health authority (Arbejdsstilsynet / Danish Work Environment Authority – DWEA) is also under the control of the Ministry of Labour. The DWEA has 4 branches: a head office in Copenhagen and 3 regional offices (EPSU, 2012, pp. 33 ff.). The authority is responsible for strategic and operative planning. An exchange of knowledge and experience in inspection practice is intended to take place in regional "inspection centres" that will support a consistent approach.

In ***Great Britain***, the inspection authority (HSE / Health and Safety Executive) is the largest inspection authority in occupational safety and health that is subject to and financed by the Department for Work and Pensions (ibid., pp. 82 ff.). The HSE has 33 offices with its head office in Liverpool. The board of the HSE is tripartite and comprises representatives of the government, trade unions and employers' associations.

The inspection authority in ***Spain*** (INSHT / Instituto Nacional de Seguridad e Higiene en el Trabajo[6]) is subdivided into two parts (ibid., pp. 76 ff.): territorially into 52 provinces that are subordinate to a central administration and in addition into 17 regions that act autonomously. Institutionalised cooperation between the central administration and the autonomous regions (CCAA) guarantees a certain amount of consistency in procedures.

Priority and resources

The significance that is attached to the field of "psychosocial strain" in these four countries is subject to fluctuations that are connected with changes to political priorities and strategies (e.g. as a result of political shifts, for example in Sweden and Great Britain, see below). In addition, there have been general funding cuts in occupational safety and health since 2008 as a result of the global economic crisis. On the whole, priorities for occupational health and safety or for specific fields of action are reflected on the one hand in political priority programmes and on the other in the resources that are

[5] http://www.ilo.org/labadmin/info/WCMS_DOC_LAB_INF_CTR_EN/lang--en/index.htm [as of 07.01.2016]; Denmark, Great Britain and Spain are described here as well;
[6] National Institute for Safety and Hygiene at Work

planned for staffing and for training inspectors. The ILO (International Labour Organisation) recommends a staffing ratio of one inspector to 10,000 workers.

Sweden has a long history of occupational safety and health and stress research, which was encouraged among other things by traditionally consensus-oriented industrial relations and a political system that is founded on a balance of interests, although this has been subject to change in recent years (Schippmann, 2008). In 2006, the budget of the national occupational safety and health authority (Arbetsmiljöverket) was reduced by one third by the conservative-liberal government, which has been in office since 2005. In addition, in 2007 the government closed the National Institute for Working Life (Arbetslivsinstitutet). According to ESENER, Swedish enterprises are fourth from bottom in a European comparison with regard to the frequency of control visits from the occupational safety and health inspectorate (Rial-González et al., 2010, p. 33).[7] Job cuts in the occupational safety and health authority caused by budget reductions led to approx. 260 occupational safety and health inspectors remaining in 2011, which corresponds to a ratio of 1:17,000 (inspectors to workers)[8] (Walters, Wadsworth & Quinlan, 2012, p. 101). This ratio is below the ILO recommendation and is interpreted as a regression towards the level of 1970. In consequence, inspections have become reactive and are concentrated more on traditional risks than on controls of psychosocial strain, which are regarded as more time consuming (ibid., pp. 416 f.). While structures and institutions of occupational health and safety in Sweden have thus been weakened in the last decade, contrary developments have been registered again recently. Critical reports on the implementation of occupational safety and health in Sweden, in particular in conjunction with stress at work, have ignited discussions on a need for reform that led to the adoption of rules on the "organisational and social working environment" on the part of the Swedish occupational health and safety authority in September 2015[9]. In essence, the responsibilities of employers for the "systematic working environment management" were put into precise terms here as a reaction to high stress-related sickness rates.

In both Sweden and Denmark the occupational safety and health inspectorate prioritises its inspection practice for psychosocial strain on the grounds of *research-based recommendations* for sectors and job groups with an increased risk of stress at work, i.e. "*they base their prioritisation on recommendations from their national research institutions on sectors and job groups at special risk of work-related strain and stress*" (Hansen et al 2015, pp. 61 ff.).

The interviewed occupational health and safety and health expert referred to the supervision ratio in ***Denmark*** as excellent – in an international comparison as well - which facilitates the on-site inspection of psychosocial stress. In contrast, legislation on the "psychosocial working environment" in this field is less developed in his view. "*In 2008 (last available data according to the SLIC report 2008) the DWEA had approximately 760 workers of whom around 520 were inspectors.*" (EPSU, 2012, p.

[7] This figure refers to general visits, not only in relation to psychosocial strain; Germany is in 7th place
[8] With a total population of 9.71mn [http://de.statista.com; as of 27.07.2015]
[9] https://www.av.se/en/health-and-safety/mental-ill-health-stress-threats-and-violence/questions-and-answers-about-organisational-and-social-work-environment/ [as of 07.01.2016]

33)[10]. According to ESENER, in a European comparison Danish enterprises are in 5th place with regard to the frequency of inspection visits from the occupational safety and health inspectorate.

The topic of "psychosocial strain" is of great importance in Denmark. From 2012 to 2020 the Danish occupational health and safety inspectorate will be concentrating on three key topics: accidents at work, musculoskeletal disorders and work-related psychosocial strain. With regard to psychosocial strain, a target has been set to reduce the proportion of "psychologically overburdened" workers by 20% (Arbejdstilsynet, 2011, p. 3).

Since 2012, the "National Centre for the Work Environment" (National Forskningscenterk for Arbejdsmiljø / NFA) has carried out a so-called "Virksomhedernes arbejdsmiljøindsats" (VAI), i.e. a survey of "company activities for improving work conditions", in Denmark every two years. In 2014 65% of the companies interviewed[11] carried out a risk assessment of psychosocial working conditions[12]. Guidelines on preventing and dealing with stress were drawn up in approx. 45% of the companies interviewed; in 55% there were guidelines on preventing and dealing with violence or threats of violence, and 48% of the companies had guidelines for preventing and dealing with bullying. The findings can be further differentiated on the basis of the size of the enterprises and the branches, and considerable differences can be seen for the branches relevant to this study: while nearly all interviewed hospitals (94%) had carried out a risk assessment of psychosocial work conditions in the previous three years, in the "hotel and catering" branch only about two thirds (64%) had done so, and only 40% in the metal and machinery branch.

In ***Great Britain***, less importance is attached to the field of work-related stress or psychosocial strain in comparison with the last ten years. Whereas in 2004 the management standards (see chapter 8) were still being developed, propagated and evaluated with considerable time and effort, funding for the occupational health and safety authority HSE was reduced from 2010[13]: *"In October 2010, the HSE saw its budget cut by 35% and the budget of the local authorities responsible for occupational health and safety cut by 28%.*" (EPSU, 2012, p. 85). In 2010, the HSE had 3702 workers, of whom just about 40% were responsible for field inspections (EPSU, 2012, p. 82)[14]. According to ESENER, in the European comparison British enterprises are in 14th place with regard to the frequency of inspection visits from the occupational safety and health inspectorate and are therefore just above the average for the EU (Rial-González et al., 2010, p. 33).

The occupational safety and health experts who were interviewed stated that a change in the political climate had resulted in a loss of significance of occupational safety and health . In addition, the substantive approach and focal point had been displaced: "*Psychosocial risk is not a current priority.*

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[10] With a total population of 5.61 million [http://de.statista.com; as of 27.07.2015]
[11] Approx. 4300 employers and employee representatives were polled in over 3500 companies, whereby weighting in accordance with enterprise characteristics (size, etc.) had not yet been carried out.
[12] http://www.arbejdsmiljoforskning.dk/da/arbejdsmiljoedata/virksomhedernes-arbejdsmiljoeindsats-20/resume [as of 12.01.2016]; expert information from Dr Birgit Aust (NRCWE)
[13] In Great Britain the Labour government was replaced in 2010 by a coalition government of Conservatives and Liberals.
[14] With a total population of 64.51 million [http://de.statista.com; as of 27.07.2015]

It's being played down and it's gone backwards, it's almost been medicalized again, yes, so we're now looking at strategies around CBT [computer based trainings] as a solution for everything, whereas no one is looking at the causes anymore." (UK_E1: 1). Reductions to resources and a partial withdrawal from the previous intensive exchange with enterprises are leading to a loss of competence on the part of the occupational health and safety inspectorate (HSE). However, in view of the considerable problem pressure the HSE executed a partial change of strategy in the second half of 2015 and is considering paying more attention once again to the subject of work-related stress[15].

In ***Spain***, the resources of the occupational health and safety inspectorate were strengthened from 2004 at the initiative of the social partners as a reaction to the inspectorate's acknowledged weaknesses (EPSU, 2012, p. 77). In the ESENER survey Spanish enterprises are still 7th from bottom in the European comparison with regard to the frequency of inspection visits from occupational safety and health inspectors. Since then, the supervision ratio in Spain conforms to the ILO specifications: "*Currently the Labour Inspectorate (Dirección General de la Inspección de Trabajo y Seguridad Social, 2011) employs 934 inspectors; a rate of one inspector per 10,000 workers.*"[16] (Walters et al., 2012, p. 84), whereby the trade union expert who was interviewed estimates that the ratio is lower.

There were no concrete and binding rules on dealing with psychosocial stress in Spanish occupational safety and health law and because of this, guidelines were developed in order to create greater confidence for occupational safety and health players (Walters, 2011, p. 405). However, in *operational occupational safety and health practice*, psychosocial risks are on the whole less important than traditional risks. A union consultant on occupational safety and health regards the situation in Spain in this respect critically: "*I mean, the most prevalent situation is that companies do nothing about psychosocial risks. We don´t have to lose this out of sight.*" (ES_ES1: 6). Even so, according to a survey on work conditions in Spain that is carried out every four years by the national occupational safety and health institute (INSHT, 2011, pp. 45 ff.), the proportion of those who stated that a psychosocial risk management was carried out in their company rose from 3.9% in 2007 to 10.5% in 2011[17].

Qualifications of inspectors

An important building block for the support of the inspection personnel in the field of psychosocial risks in a number of European countries was the main campaign carried out in the years 2009 – 2012 by the SLIC - Senior Labour Inspectors' Committee. The campaign, which was coordinated by the Swedish Central Agency for the Work Environment (Arbetsmiljöverket) aimed at developing instruments for assessing psychosocial risks in all participating countries and strengthening the competence of inspectors in dealing with these risks (SLIC, 2012).

[15] http://www.hse.gov.uk/aboutus/meetings/hseboard/2015/150715/pjulyb15078.pdf [as of 12.01.2016]
[16] With a total population of 46.51 million (2014, http://de.statista.com; as of 27.07.2015)
[17] Calculated from 13.9% of 28% or 28.8% of 36.6% that carry out a general risk assessment

Occupational safety and health inspectors in ***Sweden***, who generally have a university degree, are given 6 months' further training that in an individualised form takes a total of 3 years[18]. In ***Denmark***, from 2006 / 2007 all occupational safety and health inspectors were trained in dealing with psychosocial stress in a 25-day training period that was followed by a mentoring programme[19]. In ***Great Britain*** inspectors are trained in a trainee programme[20]. In addition, there are specialised inspectors for specific thematic areas who are expected to have occupational experience already. According to information from an expert, in the third year of training there is also a short training unit (4 hours) in the form of instruction on stress at work or psychosocial risks. In ***Spain*** occupational safety and health inspectors have a broad range of occupations and professions, but, according to the state occupational health and safety expert who was interviewed, lawyers clearly dominate on the whole, whereby some psychologists are employed as well for the psychosocial area: "*In Spain the OSH experts have a general training on OSH issues and a specialty in 'safety', 'hygiene', 'medicine at work' and 'ergonomic and psychosocial risks'. […] Many experts devoted to ergonomic and psychosocial risks are usually psychologists.*" (ES_E2: 5a).

Sanctions[21]

In ***Sweden***, occupational safety and health inspectors impose sanctions in case of noncompliance with occupational health and safety regulations, including with regard to psychosocial factors. Every year, occupational safety and health inspectors demand that enterprises improve the psychosocial working environment in about 2000 - 5000 cases. In addition, there are about 10,000 demands yearly for risk assessments to be carried out, many of which refer to psychosocial risks (Walters, 2011, pp. 424 f.). Fines of up to 11,000 euros are possible[22]. In 2011 approx. 13,700 inspection notices were issued, of which 18% were from the psychosocial and ergonomics area (Walters et al., 2012, p. 102). Sanctions are imposed comparatively less often with regard to psychosocial stress, but the possibility is present in the minds of operational players, for example in the education sector: "*I do know that it DOES happen also on psychosocial risks. For example on teachers' overload. And then the labour inspection will come. Nearly always they say, yes, the safety rep had a good cause for the complaint. They issue an injunction for the employer, you must specify for example the priority of what a teacher should do and should not do, if they have too much to do - which is of course very difficult for headmasters and schoolboards. They have to comply with that and otherwise they can have administrative penalty*

[18] http://www.ilo.org/labadmin/info/WCMS_156054/lang--en/index.htm%20/ [as of 12.05.2015]
[19] http://www.ilo.org/labadmin/info/WCMS_156045/lang--en/index.htm [as of 17.03.2015]
[20] http://www.ilo.org/labadmin/info/WCMS_112675/lang--en/index.htm [as of 17.03.2015]
[21] The difference in the legal systems can be seen as well in the different terminologies for sanctions. There are state requirements / notices (improvement / inspection notices), noncompliance proceedings with fines and criminal proceedings. In some cases, only the latter are described as sanctions. However, in the text we use a comprehensive social science definition of sanctions that comprises all state measures, so that not only orders under administrative law but also summary proceedings involving administrative penalties / criminal proceedings are covered. The various forms of sanctions are functionally partly interchangeable, so that a social science definition of sanctions is most suitable for the overview.
[22] This applies to psychosocial and "classical" risks.

which can be quite tough. This happens on the one hand regularly. But regularly means again only a fraction of all workplaces." (SW_E1: 6 f.).

In ***Denmark***, financial penalties and imprisonment of up to one year are possible for neglecting a risk assessment (Hofmann, 2014, p. 31). Along with direct sanctions, Denmark created symbolic sanctions and at the same time incentives as well. The results of inspections are published on the website of the occupational safety and health authority (DWEA) (based on a traffic light or smiley system). Enterprises with a verified good working environment have an opportunity to acquire a health and safety certificate, based on which checks are then only carried out as warranted (following industrial accidents and complaints)[23]. The occupational safety and health authority has a repertoire of graduated inspection notices or possible sanctions against enterprises. A total of approx. 60,000 of these inspection notices were issued in the years 2010-2012, of which 2.5% were in relation to the psychosocial working environment (Hansen et al., 2015, p. 73). In the same period, about 16,000 inspection notices were issued to enterprises with regard to initiating or up-dating risk assessments, which also have to include psychosocial risk factors (ibid.). Along with its supervisory and control function, the occupational safety and health inspectorate in Denmark pursues a dialogue-oriented advisory approach, which is to be strengthened still further by 2020. In accordance with the government agreement of 2011, an intensified dialogue with enterprises is not intended to replace controls and possible inspection notices (Arbejdstilsynet, 2011, p. 8).

In ***Great Britain***, the occupational health and safety authority (HSE) has a graduated range of sanctions available if enterprises breach occupational health and safety provisions. Improvement notices designate concrete violations of the law and prescribe appropriate improvement measures for the enterprise within a defined time limit. Enterprises are threatened with prosecution in the event of non-compliance. In addition, the occupational health and safety authority can issue prohibition notices, i.e. shut down operations or manufacturing activities that it regards as dangerous (EPSU, 2012, p. 84). In the event of breaches by enterprises of the duty to carry out a psychosocial risk management (Management Standards for work-related stress[24]), the British occupational health and safety authority usually only issues notices in the first category ("improvement notices"): "*HSE has issued improvement notices in respect of work related stress where employers have failed to assess the risk of work related stress at work or where having carried out a risk assessment they have failed to take adequate steps to address those risks.*"[25] HSE does not usually take the step of enforcing occupational health and safety provisions in cases of stress at work. However, it reserves the right to follow up complaints based on stress at work and to intervene if there is clear evidence of infringement by the enterprise of legal regulations. However, in the past workers have brought successful actions for stress-related overwork, for example in 1995, when a social worker sued his employer and obtained heavy damages. In the

[23] http://www.ilo.org/labadmin/info/WCMS_156045/lang--en/index.htm [as of 17.03.2015]
[24] See chap. 7 on the country-specific use of terminologies
[25] http://www.hse.gov.uk/stress/faqs.htm?ebul=stress-gd&cr=2/dec-10#q15 [as of 03.02.2016]

hospital in the British case study this case (*Walker's case*[26]) is anchored in players' consciousness and raises their awareness of these problems.

In ***Spain***, breaches by employers of the duty to carry out a risk assessment are illegal and the occupational safety and health inspectorate can impose financial penalties of up to €41,000. During the EU-wide SLIC main campaign in 2009 -2012 (see above) financial penalties were imposed in Spain in 13 cases involving psychosocial stress[27]. According to government occupational safety and health experts in Spain, sanctions are imposed overall in only 10 per cent of control visits. In most cases, the occupational health and safety inspectorate issues notices for the implementation of preventive measures. In approx. 40 - 50% of cases, in particular where bullying is involved, the inspectors offer mediation, which is a peculiarity of Spain with regard to other European countries and according to the expert is connected with the comparatively large number of lawyers among the inspectors.

Role of the occupational safety and health inspectorate at company level

The activities of occupational safety and health inspectorates in the examined case studies cover on the whole a broad spectrum, from knowledge transfer, through general on-site advice and checks of the implementation of the risk assessment and recommendations / sanctions. The activities are shown in the following table:

Table 1: Activities of the occupational health and safety inspectorate

Activities of the occupational safety and health inspectorate	**Dimensions**
Knowledge transfer	• Developing and supplying: information material, instruments, quality criteria for implementation, presentation templates • Information campaigns (in part specific to branches) • Training courses • Advice (by phone, online chats)*
Process support (on site)	• General advice (e.g. methods, drawing up plans of action*) • Mediation (in particular in Spain)*
Control of implementation	• Reviewing occupational safety and health structures (e.g. composition of the occupational safety and health committee / participation of worker representatives, qualification / training of members) • Reviewing policies / guidelines • Reviewing the implementation of the risk assessment (analyses, measures, follow-up) • Own spot checks (workplace inspections and interviews)

[26] http://www.healthandsafetyatwork.com/hsw/content/cases-point-stress [as of 03.02.2016]
[27] According to information from a representative of the Spanish occupational safety and health inspectorate of 14.08.2015

Table 2: Activities of the occupational health and safety inspectorate

Activities of the occupational safety and health inspectorate	**Dimensions**
Recommendations and sanctions	• Making recommendations • Issuing notices • Control of notices

Note: *In part information from expert interviews and document analyses

The proactive role of the occupational health and safety inspectorate in Scandinavian countries is reflected as well in the case studies: in Denmark, as in Sweden, occupational safety and health inspectors made regular on-site visits to the case companies that were supplemented in Denmark by the inspectors' own workplace observations. In some cases, the inspectorate issued notices on the reduction of psychosocial stress (e.g. in the Danish hospital and in the Swedish manufacturing plant). On the whole, the inspectorate is perceived there not only as a control instance but also as a consulting body.

The (reactive) role of the occupational safety and health inspectorate that was ascertained on the inter-company level was confirmed in the Spanish case companies. In two of the (adversarial) Spanish case studies the occupational safety and health inspectorate only became active on the initiative of worker representatives, but then accompanied the further process as an external controller. In the third Spanish case, in which management and worker representatives drove the process together, the inspectorate did not make an appearance.

In the two British case companies, the activity of the occupational safety and health inspectorate was proactive in one case (hospital), but did not make an appearance in the second (manufacturing). In both cases, the companies used the indicator tool, an instrument for the psychosocial risk management developed by the occupational safety and health authority – but with different degrees. However, in the proactive case the inspection of psychosocial stress was a non-recurring event and compliance with the recommendations was not reviewed later on.

In principle, company players were aware of the possibilities of sanctions by the occupational safety and health inspectorate even where controls were currently not carried out. They were thus effective in the background as motivators and means of applying pressure. In this, they developed their effect not only through the sanctions themselves but also through the (feared) image loss that goes hand-in-hand with the issue of notices by the occupational safety and health inspectorate.

4. Role of the social partners

This chapter deals with the role of the social partners (employers' associations and unions) as players in the context of psychosocial risk management. First of all, the self-perception of unions in the field of "psychosocial strain" is shown before the role of unions and their collaboration with employers' associations is dealt with. In conclusion, there is a deeper look at the role of the social partners in the examined case studies.

Social partners as inter-company players

The role of the social partners in risk assessment is formally separated from the company level, but is closely connected with the latter via the respective system of industrial relations, which is shown in the following chapter. This is expressed among other things by the possibility of strengthening direct participation of workers in occupational safety and health at company level through union support (Walters & Frick, 2000, pp. 43 ff.). On the whole, unions in the four countries displayed great awareness towards psychosocial risks, but there were clear differences in strategic orientations on company level.

In ***Sweden***, unions provide national and regional training sessions on the working environment and realise sector-related projects. On the whole, unions and employers' associations work well together, in that they develop occupational safety and health policies that are coordinated on national and sector levels (Frick, 2013, p. 71). However, Swedish unions maintain the opinion that more binding rules should be introduced, which is rejected by employers' associations in the same way as collective agreements in occupational safety and health (Frick, 2012, pp. 100 ff.).

In ***Denmark*** as well, the psychosocial working environment is an important element in the unions' strategy in occupational safety and health . Unions have many websites with offers of information, recommendations for action and instruments. At the same time, cooperation between the social partners is on the whole close. For example, both groups of players develop jointly sector-specific instruments for occupational safety and health (for instance in the construction industry). However, according to the interviewed expert from labour inspectorate, consensus is limited insofar as the extent of the problem and the need for regulations and inspections is evaluated differently.

In ***Great Britain***, the federation of trade unions, the TUC (Trades Union Congress), carries out a survey of union safety representatives every two years, in which stress at work was identified as a main problem. This led to a corresponding priority for action being established. This survey has a twin goal, namely to support worker representatives in their understanding of the demand in the companies, and to set priorities on the national level (TUC, 2014, p. 38). However, the union representative responsible for the branch of the British National Health Service (NHS) that was examined in the project denies the existence of an (overlapping) strategy of British unions with regard to stress at work. Ac-

cording to information from an employers' representative[28] there is no social dialogue on stress at work or psychosocial stress between employers and unions on a national or sector level, all that exist are agreements on company level (which are not legally binding there). Employers' associations (e.g. EEF) offer member companies workshops on the subject of stress at work, in particular on dealing with workers with long periods of absence resulting from stress or mental problems.

In ***Spain*** there are guidelines from both unions and employers on carrying out a psychosocial risk assessment. However, from the point of view of the interviewed expert from labour inspectorate the unions play a more active part. The strategic approach of the ISTAS institute, founded by the union CC.OO (Comisiones Obreras), should be emphasised here. The strategic comprehensive plan of action developed by ISTAS is based on using the preventive approach of the new Spanish occupational safety and health law (see chapter 2), in order to develop more potential influences for worker representatives in companies with regard to prevention of psychosocial risks. This approach contains intensive multiplier training, which is intended to prepare company worker representatives for a psychosocial risk management (Moncada et al., 2011). In 2003, this approach was honoured as the best Catalan project in occupational safety and health , and explicitly recommended by the regional government. The procedure at company level is described in detail in chapter 8 in the company case studies in Spain.

On the whole, cooperation between the social partners in Spain is described as limited, which is regarded by the Spanish expert from labour inspectorate as a major obstacle in the path of acquiring coordinated specifications and rules, and thus increased confidence. Likewise, Haas (2016) points to previously infrequent but now increasing collective agreements in Spain on psychological stress at work, which recognise the connection between work organisation and mental health and explicitly mention psychological risks as objects of prevention.

Role of the social partners at company level

At the company level in the case studies the role of employers' associations in comparison with union support was less clear – analogous to the observations on the level of national framework conditions.

Though, some activities were reported, such as the provision of information material and the conclusion of joint agreements with unions and government players, e.g. the introduction of regular worker surveys in the Danish public sector. In another Danish case company (hotel) the department for occupational health and safety / working environment of the employers' association was consulted. This is done in particular with the physical working environment, and less with psychosocial questions. In Great Britain (manufacturing), consultants were found through employers' associations. However, in the case studies employers' associations were not perceived as central players in the context of psychosocial risk management.

[28] The contact partner from the British employer's association for the manufacturing industry (www.eef.org.uk) set up at the same time the contact to the manufacturing company

Findings from quantitative studies on the role of unions are mixed – though they tend to indicate that unions have a positive influence on (general) occupational safety and health if they support the company level, e.g. through elections of representatives and the formation of committees. In qualitative studies, findings are more consistent in the direction of a positive effect. In addition, they enable a deeper insight into HOW this influence works (e.g. Robinson & Smallman, 2013).

What do union activities at company level for the psychosocial risk management look like? On the whole, the case studies revealed a broad spectrum of the following activities that were undertaken by unions in this context:

Table 3: Union activities

Focal points of union activity	**Dimensions**
Knowledge transfer	• Developing and supplying: information material, instruments, quality criteria for the implementation, presentation templates, information on statutory requirements • Information campaigns • Training courses • Advice (telephone, online)
Process support (on site)	• Technical advice (e.g. passing on specialist knowledge on the emergence, form and consequences of psychosocial stress at work) • Methods advice (e.g. surveying and demarcating psychological strain – selecting and adapting methods and instruments; compliance with quality criteria in analyses of psychosocial risks) • Process advice (e.g. on forming a steering committee, including workers, classifying groups, ensuring anonymity, carrying out polls, conducting focus groups) • Developing measures (e.g. drawing up suggestions for solutions) • Evaluating measures (e.g. reviewing the efficacy of measures) • Legal advice (e.g. comparison of statutory requirements with the implementation of the risk assessment) • Strategic advice (e.g. drawing up policies / company guidelines, drafting company agreements, conducting negotiations)
Political activities	• External committee work (e.g. quality criteria for implementing the risk assessment, introduction of overlapping analysis instruments, monitoring structural causes of strain / staffing ratio)

In all case studies, players reported on information offers and training courses from unions that were utilised by worker representatives (and in some cases by workers). In all cases, unions thus contributed to overcoming knowledge barriers. However, the offers differed with regard to specifics, scope and

company connectivity. Whereas comprehensive training courses were held in Denmark, Sweden and Spain that were linked to regular on-site consultations, worker representatives in Great Britain reported on less specific offers. However, training courses by the occupational safety and health inspectorate for worker representatives were reported there.

Support by unions for overcoming concrete realisation barriers in companies was evident in varying degrees in the cases. It was most obvious in two Spanish cases, in which committed worker representatives came up against an initially less (actively) supportive management[29]. Here, the internal cooperation between the members of different unions was put forward as a significant factor for the realisation of participative strategies in the psychosocial risk management (cf. Llorens & Moncada, 2014, on this as well). The least pronounced was external union support in the British cases, in which help was limited to advice by telephone, whereby the resources of the consultants were perceived to be very limited here as well.

The role of employers' associations was made a subject of discussion at company level only in Denmark and Great Britain, and consisted of a joint agreement to carry out regular polls of workers (DK1), an offer of advice (DK2) and recommendation of specialised consultants (UK2).

5. The role of worker representatives

The role of worker representatives in the four countries is shown in the following chapter, starting with a general overview of the legal foundations and country-specific elaborations in each case. As with the previous chapters, the chapter is concluded by a description of their role based on the company case studies.

General rights of worker representatives

If an attempt is made to find a common denominator for the characteristics of the *legally structured representative participation* of workers in the different countries, which differ in accordance with type and range, and to compare them with each other, the European Participation Index (EPI) is available as a summary (quantitative) measure (Vitols, 2010). This index was developed by the European Trade Union Institute (ETUI) in order to stimulate transnational comparative research in the field of industrial relations and co-determination. The basis is formed by country specific data on the following factors: proportion of countries with worker representation, existence and characteristics of co-determination rights at company level, pay scale density and level of union membership. In the two Scandinavian countries, the level of union membership is high, at 70% in Sweden[30] and 67% in Denmark, and low in Great Britain (26%) and in Spain (19%). The European Participation Index assumes

[29] In the case of Spain, it was not possible to consider these circumstances in detail in the framework of this project beyond the case examples in the autonomous region of Catalonia (for more details cf. Haas, 2016)
[30] www.worker-participation.eu [as of 30.07.2015]

values between 0 (min.) and 1 (max.). In its updated version (EPI 2), the situation for the countries examined in the project is shown as follows (ibid., Table 4, p. 12).

The corresponding value for Germany is 0.61:

Denmark:	0.83
Sweden:	0.82
Spain:	0.50
Great Britain:	0.16

Specific rights and role of company worker representatives in occupational safety and health

According to Kothe (2005, p. 7), worker participation is among the "fundamental elements" of the European Occupational Safety and Health Framework Directive (89/391/EEC)[31]. There is great leeway for the national transposition of general European specifications, and in individual European countries – as a result of different traditions – organisation forms, assumption of responsibilities and the actual influence of worker representatives in occupational health and safety differ[32]. Organisation forms will be discussed first of all. Four variants of how questions of occupational safety and health are mainly handled are differentiated:

- in a combination of occupational safety and health representatives (i.e. elected worker representatives with specific rights) and an occupational safety and health committee consisting of employer and worker representatives (most common type, among others in Sweden - "skyddsombud", Great Britain - "health and safety representatives" and Spain - "delgados de prevención")
- not by safety representatives with specific rights but solely by worker representatives in a joint employer-worker occupational safety and health committee (e.g. Denmark - "sikkerhedsrepræsentant")
- only by occupational safety and health representatives and not by a joint committee
- mainly in the works council or a sub-committee; in Germany there are in addition a joint employer and worker committee for occupational safety and health, as well as so-called occupational safety and health or safety and health representatives (workers appointed by the employer with the participation of the works or staff council)

Worker representatives entrusted with occupational safety and health are elected:

- through the workforce (among others Denmark)
- through the union, or in non-unionised companies through the whole workforce, if the employer supports this (among others Sweden and Great Britain)

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[31] The following discussion follows Kothe (2005) - with regard to Great Britain, Spain and Sweden, as well as http://www.worker-participation.eu/National-Industrial-Relations/Compare-Countries [as of 24.01.2016]

[32] http://de.worker-participation.eu/Nationale-Arbeitsbeziehungen/Quer-durch-Europa/Arbeitsschutz [as of 07.10.2015]

- directly through worker representatives and in companies without worker representatives, (among others Spain) 1) through the works council for worker representatives on the occupational safety and health committee (the works council is elected by workers), 2) through employers for safety representatives (with a duty to inform the works council) (among others Germany)

In ***Sweden***, in accordance with the law on the working environment employers and workers should cooperate to create a good working environment. This is put into concrete terms in Art. 6 of the statute, which obliges the two groups of players to organise occupational safety and health expediently. There are two essential co-determination bodies for workers in occupational safety and health: 1) the first are the safety representatives. These are worker representatives with broad consultation and information rights. Along with their monitoring rights, in concrete hazardous situations they can in addition "*order work to be suspended until an opinion has been received from the labour inspectorate*"[33]. Safety representatives are released from work entirely or in part. In addition, their status is protected by a prohibition of discrimination and security for their employment contract. 2) The second co-determination body in occupational safety and health is the safety committee (skyddskommitte). This committee must be established in all workplaces with at least 50 workers and comprises employer and worker representatives. In case of dissent between workers and employers on the safety committee, the question can be referred to the occupational safety and health authority for a decision (Kothe, 2005, p. 38). A special feature in Sweden are regional safety representatives, who are each responsible for several small companies that do not have a safety committee (ibid., p. 37). Employee participation and the focus on quality are especially pronounced in Sweden: *"workers are given a stronger right of participation than in the Directive. Unlike the Directive, the provisions also fulfil the quality control logic by stipulating a feedback and learning loop of internal audit and improvement*" (Walters et al., 2012, p. 97).

In ***Denmark***, worker interests in occupational safety and health are looked after in accordance with the consolidated law on occupational safety and health (Ministry of Labour, Statute No 1072 of 7 September 2010) by joint employer-worker panels. Enterprises with at least 10 workers are obliged to set up an occupational safety and health group in which managers and workers from the departments, work areas and shifts are represented. Enterprises with at least 20 workers are obliged to establish a Safety and Health Committee in which managers and worker representatives participate. This committee must be chaired by a representative of the company management. In larger enterprises there is a two-tier system, with a higher-level panel for strategic questions and a subordinate panel for everyday concerns. In enterprises with fewer than 35 workers, a single panel is responsible for both areas. The subordinate panel may order a work stoppage if in its opinion there is a serious and direct risk to the safety and health of the workforce. In addition, the principle of transparency applies: for example, the risk assessment must be available at all times for workers, managers and the occupational safety and

[33] According to figures quoted by Kothe (2005, p. 37), this possibility is used in 50 – 150 cases per year.

health inspectorate. In addition, workers have the opportunity to have recourse to the competent labour court if they are of the opinion that the risk assessment was not implemented or only in part**.**

In ***Great Britain***, because of political controversies regarding the union links of safety representatives, the British tradition of self-regulation and the general change in the socio-political climate, a set of rules has evolved for participation of workers that is characterised basically by few formal stipulations, clear precedence for management and a *fundamental division*[34]: in unionised companies in which unions negotiate with the employer, they have the right to appoint safety representatives who represent the interests of workers in the area of occupational safety and health. In companies in which the majority of workers are not unionised, the employer decides whether safety representatives are elected or whether he or she consults workers directly. Non-unionised safety representatives have fewer powers than those appointed by a union, because they may not carry out plant inspections, and, in contrast to union safety representatives, they may not demand that the employer establishes a safety committee either.

With regard to participation of workers in ***Spain***, the occupational safety and health law that was enacted in 1995 provides that safety representatives who are nominated by the worker representatives should be represented in companies with more than five workers. They have broad rights to monitor, examine and advise and may, for example, make suggestions on safety and health at work to the safety committees that must be formed in companies with at least 50 workers. In addition to this, they may suggest to the safety committee "*to adopt a resolution to suspend work in the event of a direct and serious risk pursuant to Art. 21 of the law*" (Kothe, 2005, p. 24). Apart from this, representative bodies in the area of occupational safety and health and company worker representative bodies enjoy special rights with regard to the occupational safety and health authorities. Among other things, they may involve the occupational safety and health authorities if they regard the measures taken by the employer as insufficient. Individual workers and their representatives are also entitled to this right. Whereas on average in the European Union there are safety representatives and/or safety committees at approx. two thirds of all workplaces, the corresponding value for Spain, approx. 43%, is clearly below the European average (Ollé-Espluga et al., 2014, p. 339).

Role of worker representatives at company level

In the case studies the interview partners described the following activities for worker representatives in the context of psychosocial risk management (and in the framework of stress prevention, which is often not demarcated in practice in companies):

[34] http://www.hse.gov.uk/workers/safetyrep.htm [as of 07.10.2015]

Table 4: Activities of worker representatives

Activities of worker representatives	Dimensions
Information	• Developing a communication strategy specific to the target group (in dependence on functions - worker representatives, middle management, top management and workers - and the occupational group)
Operative process implementation	• Participating in the implementation of analyses of psychosocial risks (survey, focus groups, workplace inspections) • Proactive suggestions and helping to shape the content for measures development • Planning training courses
Strategic planning	• Negotiating with stakeholders (on subjects such as implementation of the analysis, realisation of measures, monitoring realisation) • Mobilising workers • Coalitions with internal players (e.g. supporters in middle management) • Including external players where necessary, • Preparing guidelines, policies, agreements with employers • Strategic planning (integration into existing processes, coordination with other areas, such as, for example, Human Resources)
Monitoring	• Review of management qualifications (training courses) • Monitoring the conduction and analysis of surveys • Monitoring realisation (if need be, support from the labour inspectorate) • Implementing a check on effectiveness • Critical reflection on the check on effectiveness
Advising workers	• Individual advice for workers on (personal) problems

In Denmark and Sweden, the worker representatives on the different levels were integrated into the control structures of risk assessment and cooperated closely with management. Participation structures in which psychosocial risk management could be embedded already existed in all the examined Scandinavian enterprises.

In Denmark, the cooperative understanding is also reflected by both worker representatives as well as management representatives participating in the "cooperation committee" (samarbejdsudvalg). In one Danish case company, the works council and the occupational safety and health panel were amalgamated to prevent duplication of subjects and to accelerate decision-making. However, prerequisite of the rapid adoption of resolutions was that the participating management representatives were in possession of the necessary decision-making authority, which was not always the case, in particular with representatives of middle management.

Worker representatives have strong participation rights in Sweden as well, which in the two case studies here were merely reflected in the background as potential instruments of power because of the good cooperative relationships between management and worker representatives.

In all the Danish case studies and in the Spanish hotel the heterogeneous composition of the steering panel was emphasised as a prerequisite for the ability to take sufficient account of the different perspectives and psychosocial risks of the respective occupational groups. This objective was achieved either through a mixed composition of the panels - with regard to functions or departments - and/or through intensive preliminary talks with representatives of the relevant groups. In Denmark, account is taken of this principle as well through the division into *safety work groups*, which are found in the case studies at department level (hospital, manufacturing), and location level (hotel), and the superordinate *safety committee*, in which perspectives are bundled again.

The self-perception of worker representatives covers both participation in the process of risk assessment and individual advice for workers in problem situations. This double role was felt in some cases to be difficult, because representing worker interests in other subject areas may require a more adversarial attitude, while cooperation in the framework of risk management in the present cases (apart from a few exceptions) was less adversarial. There was no participation in strategic questions if worker representatives' own role understanding was mainly characterised by curative support for individual workers (in the sense of individual support) (e.g. in the manufacturing case example in Great Britain).

In places where the legal foundation of co-determination was less pronounced and/or there was no (active) support from management, great commitment and a high level of activity by worker representatives at company level was crucial for implementation of risk management (e.g. hospital and manufacturing in Spain). This went so far that worker representatives called in the occupational safety and health inspectorate to push through their interests, if - with regard to the implementation of risk management – they perceived considerable deficiencies in occupational safety and health in the company. In addition, in one Spanish company a strike was threatened. In a Danish company, worker representatives initiated a short-term work stoppage in order to draw attention to dissatisfaction with work conditions and the interim management. The right to strike, to which workforce representatives are entitled as well in co-determination law in Spain and Denmark, was then used as a means of applying pressure if cooperation between management and worker representatives was adversarial.

In contrast, if management perceived cooperation with worker representatives to be an asset (even in cases of adversarial cooperation), worker representatives (even with a restricted legal basis) could shift their commitment to informing the various target groups and to the constructive design of the process (e.g. in Great Britain / hospital and in Spain / hotel), insofar as they regarded not only individual support for workers but also shaping work conditions as their remit.

6. Internal and external prevention services

The following chapter deals in greater detail with the role of prevention services and (external) consultants as essential resources in the risk management process. Prevention services are internal (internal prevention services) or external specialists that, among other things, support the implementation of the process of psychosocial risk management. Following an overview of superordinate European and relevant national legal specifications, the quality assurance and utilisation of prevention services will be examined more closely, before the organisation of prevention services is described. Finally, how the role of external prevention services at company level in particular is manifested is illustrated based on company case studies.

Legal specifications for prevention services

For the EU, the rules for prevention services arise from Article 7 European Occupational Safety and Health Framework Directive (89/391/EEC)[35], whereby enterprises in Member States are obliged under Art. 7(3) to use their internal resources at first to organise safety measures and measures for risk prevention. If internal facilities in enterprises or establishments are insufficient for this, "*the employer shall enlist external specialists, persons or services*". This legal priority for using internal resources by establishments was affirmed by a judgment of the European Court of Justice of 22 May 2003.[36]

Quality (assurance) of external prevention services as a problem in the EU

The comparative study (Prevent, 2006) stated that an overall problem was that the Occupational Safety and Health Framework Directive does not specify any quality requirements for external prevention services. This loophole can also be found in the legislation of some countries (e.g. *Sweden* and *Great Britain*). In *Denmark*, external prevention services are obliged to employ at least five specialists with five different areas of expertise. In Spain, external prevention services must have at least one expert for each of the following disciplines: occupational medicine, safety at work, occupational hygiene, ergonomics and applied psychology. Eight of the fifteen countries examined in the study, including *Denmark* and *Spain*, have a certification or accreditation system for external prevention services. Compulsory evaluation of the quality of external prevention services is rather rare: *Swedish* legislation does not prescribe an evaluation of the work of external prevention services, and in *Spain* it is up to the employer to evaluate the work of external prevention services. In all four countries, the enterprises themselves must pay the costs of external services. However, in Spain insurance companies offer members risk assessments as an additional service without charge (Prevent, 2006, p. 17). In Spain, national legislation favours the award of preventive activities to outsiders - with regard to risk management ,as well – which leads to considerable problems involving the quality of prevention. In con-

[35]Protective and preventive services (services commissioned to carry out safety measures and measures to prevent risks)

[36] http://curia.europa.eu/juris/liste.jsf?language=en&num=C-441/01 [as of 24.01.2016]

trast, in Denmark companies are obliged by notices from the occupational safety and health inspectorate to bring in accredited external experts if they lack (internal) professional competence for problem-solving, in particular with regard to bullying and harassment.

Against this background, the authors of the comparative study see a trend to intensified competition among external prevention service providers that is taking place not on the basis of quality, but on the basis of cost, to the detriment of quality. A more recent publication from ETUC (ETUC - CES, 2013) drew attention to quality problems of external prevention services in the course of intensified competition between providers and increasing commercialisation[37].

Making use of prevention services

The first European Survey of Enterprises on New and Emerging Risks (Rial-González et al., 2010, p. 31) that was carried out in 2009 supplied data on the use of prevention services. In supplement, ESENER collected data on which players or organisations make use of establishments for information and advice on occupational health and safety – whereby in the same survey on average 36% of management representatives stated that they contract out (general) risk management to an external service provider, including 6% in Denmark, 9% in Great Britain, 12% in Sweden, but 67% in Spain (ibid., p. 27).

Organisation and specialist profile of prevention services

In ***Sweden***, external advice is largely provided by private organisations (Prevent, 2006, pp. 14 f. for the following comments). Major enterprises have internal services, SMEs use internal or sector-related services. The use of prevention services increased with the obligation on employers since 1991 to integrate prevention more intensively in operational processes. However, the number of providers has fallen since government grants for this service were cancelled in 1993. Service providers are under greater financial pressure and they are pursuing much short-term goals than before. At the same time, with regard to psychosocial problems, the occupational health and safety and health inspectorate notices to enterprises to obtain external advice tend to be issued rather infrequently: "*The SWEM provisions order employers without adequate internal working environment competence to hire such, but labour inspectors rarely enforce this as they consider most OH services to lack the necessary competence, e.g. on systematic working environment management or psychosocial problems (Frick, 2011a).*" (Walters et al., 2012, p. 100).

In ***Denmark*** as well, external advice is mainly supplied by private providers (Prevent, 2006, pp. 7 f. for the following comments). There are internal "health and safety services" and external "occupational health services". Some sectors (stipulated by law) must use external services (with a fixed period of time per worker / year). However, establishments that are not in these "risk sectors" can also be requested by the inspection where applicable to use external services. These external services must

[37] http://www.etui.org/Topics/Health-Safety/HesaMag/Occupational-health-services-in-need-of-emergency-care [as of 02.02.2016]

cover at least five areas with individual consultants: physics, chemistry, biology, ergonomics and psychology. The external consultants are under an obligation to document their company advisory work for the occupational safety and health inspectorate and to report on it. In doing this, the advisory process is to be described on the one hand. On the other hand, it should be made clear whether it was possible to solve the problem (e.g. bullying) that was the reason for the notice to the establishment from the occupational safety and health inspectorate to engage an authorised consultant. The assessment is signed by the enterprise. The consultancy company can lose its certification if it makes false declarations. In recent years, however, requirements for establishments to use external consultants have changed and have been restricted in the area of the psychosocial working environment to problems such as bullying and harassment, which in comparison to problems caused by "workload", are regarded as more easily to solve.

In ***Great Britain*** employers are at liberty in their organisation of occupational health services and how they identify the qualifications of consultants (Prevent, 2006, p. 14 for the following comments). There are different forms: inter-organisational (private providers), independent health services in large enterprises or other service providers. There are no specifications for the professional composition of the consultancy, but in most cases several areas are covered. According to the expert interviews, there are no official specifications with regard to quality standards either, only a few voluntary certifications from private organisations, e.g. certificates from national further training institutes / IOSH or universities. The lack of (compulsory) quality standards for external consultants has already been criticised. In order to counter the lack of compulsory quality standards, "*a voluntary Occupational Safety and Health Consultants Register (OSHCR)*" was introduced on the initiative of the government occupational safety and health inspectorate and supported by a number of professional companies in which qualified consultants are listed who are "*properly accredited to one of the professional bodies in the industry*" (EU-OSHA, 2013, p. 10). Suitable experts who are listed in the OSHCR can be found on the HSE website using key words (e.g. stress). HSE provides enterprises here with decision-making tools with regard to "whether" and "how" external support is to be used, but enterprises are recommended at first to check the possibility of using internal expertise.

In ***Spain***, risk assessments of psychosocial stress are very often outsourced to private external prevention services (servicios de prevención). According to ESENER, in 2009 Spain was in second place in Europe in this point with just about 70% (Rial-González et al., 2010, p. 27). The reasons for this are, on the one hand, financial and, on the other, that companies must satisfy greater requirements if they carry out a risk assessment internally, e.g. in the form of regular audits (every 4 years). For this reason, there is greater incentive to outsource risk assessments. The external services must cover the same five areas as the internal services (see above) and show proof that their consultants have the necessary qualifications. However, according to the interviewed occupational safety and health expert, the quality criteria that regulate the specifications for the consultancy service are not uniform for all regions and are not checked consistently everywhere. There is no unity in this respect on the part of the

social partners either, which the interview partner from occupational safety and health regards as a problem.

Role of external prevention services at company level

The analysis of the case studies should now make clear what the tasks of external consultants exactly consist of and how cooperation with the internal players is organised. At company level, the external consultants covered the following range of activities:

Table 5: Activities of external consultants

Focus of advisory work	Dimensions
Process support (on site)	• Technical advice (e.g. passing on specialist knowledge on the emergence, form and consequences of psychosocial stress at work) • Methodological advice (e.g. selecting and adapting methods and instruments) • Process advice (e.g. information on moderating) • Legal advice • Strategic advice (e.g. conducting negotiations)

Table 4 (cont.): Advisory activities

Focus of advisory work	Dimensions
Operative process implementation	• Carrying out surveys • Moderating focus groups • Moderating control groups • Proactive suggestions and helping to design content • Project management (among others reminders about carrying out surveys, monitoring)

External consultants were involved in the process of psychosocial risk management in all the examined case studies –even if this was only selective. Advice was provided by academic institutes (in part from universities, as in Denmark, in part close to unions, as in Spain) and by private consultancy companies, some of which were independent and others attached to insurance companies (Spain), employer associations (Great Britain / manufacturing) or were found through professional associations (Denmark / Spain). Advice was not free, apart from university and union advice, and advice from workers of the employers' association.

In all large enterprises (> 500 workers) there was an internal prevention service whose work, however, was evaluated differently in dependence on management competence (or the assumption of the management role as a promoter of power). Given favourable conditions, for example strong support and assertiveness, management's will to implement, and internal expertise, an internal prevention service

could act effectively. But if these preconditions did not obtain, an external prevention service with the appropriate self-perception – multipartiality and quality consciousness instead of cost minimisation – was better able (in addition) to support the process of risk management.

7. Occupational safety and health culture

The following chapter is concerned with specific aspects of occupational safety and health culture that are significant for the realisation of r psychosocial risk management s. Following a brief overview of important dimensions of occupational safety and health culture, the following points in particular will be examined in depth by means of the workplace cases: the use of notions and the realisation of operational practices (holistic nature and integration of risk assessment in organisational processes).

Dimensions of occupational safety and health culture

On closer consideration, in some cases considerable differences between the countries can be seen with regard to the tradition of the welfare state, workers' participation rights, the weight given to social dialogue as an instrument of the balance of interests in conjunction with predominant management strategies, and political priorities in occupational safety and health (combined with facilities for the occupational safety and health infrastructure). These points, which relate to the culture of participation, have been dealt with already in chapters 4 and 5.

In the analysis of occupational safety and health culture, the focus will be placed below on visible artefacts (e.g. definitions, organisational practice) and less on fundamental values, norms and basic assumptions (cf. Schein, 1985, for this differentiation).

The ***Swedish*** approach of "systematic work environment management" conforms to the integrative approach of the European Occupational Safety and Health Framework Directive in the sense of integration of occupational safety and health into general management processes[38].

In ***Denmark***, "*formal rules (*were*) deferred in favour of problem solution based negotiation processes between management and workers*" (Larisch, 2009, p. 46)

This integrative approach is realised in ***Great Britain*** with the concept of "Management Standards" (see chapter 8), whereby here the aspect of the representative participation of workers in occupational safety and health, which is mapped in the European Participation Index (EPI) (see chapter 5), is relatively weak, unlike Sweden and Denmark in particular, but also Spain.

Orientation towards formal compliance with regulations, which aims at avoiding sanctions (Walters et al., 2012, pp. 92 f.), is characteristic for occupational safety and health culture in ***Spain***. Inadequate integration of occupational safety and health into company organisations, combined with delegation of responsibility for prevention to an external service provider, is regarded as a major obstacle for prevention at work in Spain.

[38] https://www.av.se/globalassets/filer/publikationer/bocker/books/systematic-work-environment-management-and-stress-h366-book.pdf [as of 09.10.2015]

The prevention culture is accentuated by the integration of occupational safety and health into company organisations that is called for by the European Occupational Safety and Health Framework Directive.

Distinctive features of occupational safety and health culture at company level

In the following section, three central aspects of occupational safety and health culture revealed in the case studies are shown in greater detail: 1) separation or connection of "traditional" and psychosocial risk management (holistic nature), 2) use of concepts and notions in the range of topics, 3) integration of risk management into operational processes.

In Denmark and Sweden, where psychosocial stress has already been regarded for many years as a fixed component of the "working environment" (prevention of psychosocial stress has been incorporated into law since 1974 in Denmark and since 1977 in Sweden), "traditional" and psychosocial risk management is interconnected. Although the issue has been discussed in Great Britain since the 1970s as well (statutory provisions since 1974), up to the present connecting the two areas has not been the object of statutory regulations or recommendations. In Spain, the issue of psychosocial stress is a comparatively new subject (incorporated into law since 1995) and up to now has been discussed on the whole separately from physical or "traditional" stress. While a holistic risk assessment in which physical and psychosocial stress were recorded jointly was practised in all the Scandinavian case studies, the two areas were separated in the case studies in England and in Spain.

Resource bundling and the improved approachability of the subject area of psychosocial stress, which is described as difficult, were stated to be advantages of *integration*. Interlinking draws attention to a holistic organisation of work conditions and makes the interdependence of the two areas clear. From the expert's point of view, one consequence is that accidents in the workplace that are the result of organisational problems can be prevented more easily. In addition, existing structures, procedures and instruments can be used – such as, for example, "safety rounds" in Sweden or workplace assessments (APV) in Denmark.

The reduction of complexity is referred to above all as an advantage of *separate processes*. In cases in particular in which management did not actively help to drive the process forward, separation of the two processes was regarded as facilitation of project management (division of responsibilities and fixing deadlines etc.) through a step-by-step process.

The many years of dealing with the topic becomes clear in the Scandinavian case studies through the use of terminology. The neutral and comprehensive term psychosocial "working environment" (arbetsmiljö) is used in Denmark and Sweden.

At company level there is a preference in the case studies for choosing positive terminology (e.g. "trivsel" in Denmark - "wellbeing"). At company level, the definition of risk tends to be used for *physical* stress and visible dangers (threats of violence, violent attacks).

In the case studies in Spain, where this topic was only taken up recently, hazards or the safety aspect is stressed with the term "psychosocial risks" (riesgos psicosociales – including instrument induced, because these notions are applied in the framework of ISTAS21), and in the British establishments in the study the consequences of stress are pushed into the foreground. In addition, the focus on stress is accompanied there by great emphasis on the share of the individual in the development of stress. However, with increasing involvement with the subject, a tendency can be seen in the two British establishments in the study as well to strengthen the positive focus in the choice of terms (stress *and well-being*).

An explicit separation of psychosocial risk management from activities in the area of workplace heath management – where a workplace health management system exists – cannot be found in any of the case studies. Different interlinking with other organisational processes takes place depending on where risk management is attached, to occupational safety and health or (more frequently) to the personnel department or subordinate organisational units (occupational health or organisational development). Better strategic coordination with other associated areas and more individual customising of training and measures to addressees with greater emphasis on organisational psychology issues (such as group dynamics etc.) are discussed as advantages of attachment to the personnel department.

8. Methods and instruments

First of all, methods and instruments that are used in the four countries in the survey for risk assessments of psychosocial stress are described in the following chapter. These are instruments that were developed for operational practice[39] (i.e. at company level). First of all, the methods and instruments are described for all the countries in the study on a superordinate level, before the operational examples from the case studies illustrate realisation in companies.

Approaches at national level

In ***Sweden*** there are numerous instruments available for psychosocial risk management at company level. In the judgement of the academic expert, new methods, checklists and instruments are constantly being developed for enterprises and it is difficult to retain an overview. According to the statement by the interviewed government occupational health and safety player, the government occupational safety and health authority does not recommend specific methods. The following are recommended as general methods for determining risks: questionnaires, interviews, safety inspections, group discussions at work, development discussions, examinations of individual workplaces, occupational medicine examinations, and measurements and surveys of workers on work conditions (The Swedish Work Environment Authority, 2002, p. 22). According to the statement by the interviewed expert from the occupational safety and health authority, checklists and worker surveys are most frequently employed

[39] Methods that are used by government players in the framework of occupational safety inspections are described in chapter 3 of the detailed publication.

in the framework of *psychosocial* stress. Examinations of individual workplaces (e.g. by external experts) are not usual.

There are also numerous instruments in ***Denmark*** that were developed specially for operational practice. On the whole, the Danish approach is characterised by great openness and distinctive pragmatism with regard to implementation of psychosocial risk management, which were described by the interviewed occupational safety and health experts as follows: "*But there aren't any formal demands on how to do the assessments. So you can do an assessment on the backside of an envelope and you can do a 100-page assessment. That's actually both okay.*" (DK_E2: 13). One instrument that is by now employed in many other countries is COPSOQ (Copenhagen Psychosocial Questionnaire). This instrument was originally developed 17 years ago at the Danish National Institute for Occupational Health in Copenhagen by Kristensen and Borg (Kristensen, Hannerz, Høgh & Borg, 2005) with the aim of integrating different theoretical approaches on the development of stress and identifying as broad a range as possible of psychosocial factors in the world of work. COPSOQ is now employed in approx. 20 countries as an instrument for screening psychosocial stress (Nübling, Burr, Moncada & Kristensen, 2014). This instrument will be described more exactly below in connection with ISTAS21 (ISTAS21 is based on COPSOQ).

The methods most frequently employed in ***Great Britain*** to identify "work-related stress" are worker surveys, risk assessment / stress audits, the HSE's stress management standards and focus groups (CIPD, 2014, p. 26)[40]. The HSE's management standards for work-related stress are a method that was developed by the HSE up to 2004 in the framework of a focus programme and recommended to establishments for the assessment and management of work-related stress.[41]. The management standards describe the standards of good management practice for dealing with work-related stress and comprise the following components:

- Definition of the process in five steps[42]
- Stipulation of six potential stress factors: work demands (*demands*), scope for action and decision-making (*control*), social support (*support*), social relations (*relationship*), role clarity (*role*) and organisational change (*change*)
- Formulation of objectives that are to be achieved in the six dimensions in the sense of positive work quality ("*states to be achieved*")
- Recommendations for threshold values (according to this, for the first three dimensions, which describe the work content, 85% should lie in the positive range, and for the last dimensions, which describe the context, 65% [43]) (Mackay, Cousins, Kelly, Lee & McCaig, 2004, p. 104)

[40] Evaluation methods and measures are mixed in a table in the report. Only the evaluation methods are reported on here.
[41] http://www.hse.gov.uk/stress/standards/index.htm [as of 07.01.2016]
[42] 1) Identify stress risk factors / understand the management standards, 2) Decide who might be harmed and how / gather data, 3) Evaluate the risk / explore problems and develop solutions, 4) Record your findings / develop and implement action plans, 5) Monitor and review / monitor and review action plans and assess effectiveness; http://www.hse.gov.uk/stress/standards/step1/index.htm [as of 10.07.2015]

- Provision of numerous instruments (e.g. checklists, questionnaires), templates, action guidelines and case studies to support the procedure[44]

A validated questionnaire, known as the "indicator tool", with a total of 35 questions for identifying stress factors is available on the website. An Excel spreadsheet that is also available enables automated evaluation. Quality criteria that alternative methods have to fulfil are defined in a checklist for enterprises that wish to decide on another procedure. These include in particular a systematic procedure on risk assessment, a preventive approach, focussing on behaviour-based preventive measures, support for the process by all relevant players in the enterprise and the involvement of the workforce [45].

According to a survey in Great Britain in 2014, 27%[46] of the interviewed enterprises work with the management standards, including 14% of all enterprises in private sector manufacturing, 24% of private sector service providers and 34% of enterprises in the public sector (CIPD, 2014, p. 26).

Various processes and instruments are used in ***Spain*** as well. According to experts, the most frequent methods are questionnaires. However, the occupational safety and health authority recommends combining them with interviews and focus groups: "*we recommend in our guidelines that there are two steps. The first step is the questionnaire. And in the questionnaire you can identify problems, risks. You should make a second analysis, qualitative analysis with interviews. Interviews, individual interviews or interviews in groups. Group sessions.*" (ES_E2: 24b). On the INSHT website the sequence, advantages and disadvantages of methods such as group discussions and interviews are shown in greater detail.

The most frequently used instruments are FPSICO (Método de Evaluación de Factores Psicosociales) – an instrument developed by the national occupational safety and health institute INSHT – and the Spanish version of COPSOQ (ISTAS21), which was adapted for Spain in 2003 by ISTAS, a union-linked research institute. ISTAS21 is understood not only as an analysis instrument, but also as a participative process. Anyone who applies ISTAS21 is requested to undertake an obligation in the framework of an internal agreement to act in a participatory way,, i.e. to carry out the risk assessment in a steering group of management, worker representatives and workplace occupational health and safety experts, to guarantee anonymity in the framework of the survey, to use the instrument without changes and to combat inappropriate stresses at the source[47]. The results of the survey are compared with national reference data that are based on a representative survey (around 5000 persons were interviewed in 2010). Cross-sector comparative data are used with ISTAS21. According to the develop-

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[43] The first value (85% with positive attribute for work contents) was derived empirically from the epidemiological study Stress and Health at Work (SHAW), in which a (clearly) increased stress value was determined for 20% of the population. This value was to be reduced by 5%. The second value (65% with positive attribute for the context) was determined on the basis of internal discussions.
[44] http://www.hse.gov.uk/stress/resources.htm [as of 13.01.2016]
[45] http://www.hse.gov.uk/stress/pdfs/checklist.pdf [as of 10.07.2015]
[46] This means that the proportion has fallen in comparison with 2012, when it was still 30% (CIPD, 2012, p. 28).
[47] With this, some aspects were anticipated that are specified in a recent judgment of the National Court 01/2014 (Garvayo, 2014) (e.g. no change to the instrument)

ers, this is intended to prevent sector-specific or usual inappropriate stresses being justified with sector affiliation.

Recommendations with regard to these two instruments and a further free instrument (the INSL questionnaire from the Instituto Navarro de Salud Laboral) are expressed (Ministerio de Empleo y Seguridad Social, 2012, pp. 39 ff.) in the guidelines of the occupational safety and health authority – and on the INSHT website.

Use of instruments in the framework of the case studies

On the whole, a broad spectrum of methods is used in all case companies in order to identify and assess psychosocial stress.

In Spain and Great Britain, questionnaires are most frequently used that – following a recommendation of the occupational health and safety inspectorate – should be combined with interview or focus groups. In the case studies in Spain, this recommendation was realised in the hospital and in the hotel – the results were not reflected in depth with workers in the manufacturing plant, but an elected worker representative was involved in the development of measures. In the British hospital, focus groups met in the framework of stress risk assessments following questionnaire-based surveys, while this was not the case in the British manufacturing plant, where the focus at the time of the survey was exclusively on developing management competence.

In Denmark and Sweden the interviewed experts on the national level did not describe a clear preference for the use of methods and instruments. However, questionnaires were used at company level in the case studies in all examples, whereby the following discussion of the results with workers and the development of measures rated highly. In addition, in all enterprises there were regular worker surveys (but frequently non-specific with regard to subjects), whose results were used as an initial atmospheric picture.

In comparison with questionnaires and focus groups, observational interviews carried out by external experts are seldom held in the four countries in the survey – they played no part at all in the case studies.

The instruments for the analysis of psychosocial stress that are mainly used in the countries and in the case studies are based on similar theoretical considerations, in particular Karasek's theory of the demand-control support model (extended) by Johnson & Hall (1988) and Siegrist's model of gratification crises (1996)[48], as Formazin et al. (2014) have already ascertained for the analysis of psychosocial stress in national surveys (along with Denmark and Spain the Netherlands, Norway, Finland, Germany and an EU-wide questionnaire were examined). Accordingly, similar dimensions were recorded in all

[48] Further fundamentals are mentioned, depending on the instrument, e.g. 1. the job characteristics model (Hackman and Oldham); 2. the Michigan organizational stress model (Caplan et al.); 3. the demand-control (support) model (Karasek; Johnson); 4. the sociotechnical approach; 5. the action-theoretical approach; 6. the effort-reward imbalance model (Siegrist); 7. the vitamin model (Warr) with the COPSOQ. However, because the theoretical foundations were not available for all instruments and more in-depth research would have exceeded the project's resources, only the central common features of the approaches are discussed in the present study.

instruments: work requirements (in particular the quantity and the time available), scope for action and decision-making and social support (from supervisors and colleagues).

In spite of the great similarities, there are also still some differences in the focussing. For example, work requirements are recorded with different precision (e.g. broken down in accordance with the contents dimension - cognitive and emotional stress[49], partially taking account of the quantity, the available time, the expected quality).

The scope for action and decision-making is also recorded with different degrees. In the Spanish FPSICO, scope for action and decision-making, participation and control by management, for example, make up a large part, in the ISTAS21 instrument the idea of participation is also taken into account in the realisation of the process in the enterprise (e.g. through participation of worker representatives in the steering group). This focus is probably owed to the fact that in Spain there is considerable pent-up demand with regard to inclusion of workers, as national comparative studies suggest (Moncada et al., 2010, see chapters 4 and 5 as well). At company level there is an extended understanding of participation in some Scandinavian cases – away from a passive understanding of the worker as someone who "is" involved towards emphasis on the own responsibility of workers as persons who are encouraged to become active themselves. In Sweden, this aspect is covered by the term "fellow workers" (medarbetarskap); in Denmark (in particular in the case study in the hospital) the topic was reflected on with the concept of "followership" – both points are reflected as items in the respective instruments. Here, the concept of the own responsibility of employees in the Scandinavian case companies is anchored in a culture that is on the whole generally participative. In the British manufacturing plant as well, active participation of workers was called for in the "stress policy", but this point was not explicitly queried in the analysis instruments, and corporate culture has up to now not suggested a participative approach.

Recording support from managers and colleagues is also differentiated in the instruments. In the Spanish FPSICO, support is recorded beyond the team. In the framework of the British management standards there is an own survey instrument available to query the role of managers in the organisation of work conditions and support for workers on a differentiated basis (*stress management competency indicator tool*), and in the Danish questionnaire for public service both directions are recorded – including support for managers from staff - and in addition the relationships between different occupational groups are surveyed.

Social relations in the form of conflicts through to bullying are recorded in all instruments. Clear, unambiguous role requirements are also contained in all instruments as dimensions –instruments differ comparatively little here.

As far as career development possibilities and the rich variety of work are concerned, these points are anchored in law in Sweden (Hansen et al., 2015, p. 34). This point is covered correspondingly by

[49] In the indicator tool of the management standards emotional stresses are not queried separately but in combination with social support ("33. I am supported through emotionally demanding work").

questions in Swedish instruments. Even if there are no legal specifications in this respect in Denmark, there are enquiries about development possibilities here as well in the examined instruments – even in short checklists. The same applies to the Spanish instruments described here. In contrast, they are not contained in the British indicator tool, but are shown there as a target in the states to be achieved and are recorded as a factor in the hospital case study in the organisation-wide staff survey.

In the British management standards, dealing with organisational changes is surveyed as one of six focuses, and thus weighted correspondingly high. Other instruments also contain dimensions that ask for information on dealing with changes (e.g. DK1/hospital: "*Are you given prompt information on important decisions, changes, future plans that affect you?*"), or foreseeability (COPSOQ) or participation in the organisation of changes (FPSICO), but these points are not, as in the indicator tool, recorded in a joint heading "organisational changes" (change). The emphasis on this factor may also be connected in Great Britain with the situation that the management standards were initially employed intensively in five risk sectors with high sickness levels (among others hospital / nursing) that at the time were characterised mainly by regular organisational changes.

In addition, the differentiated survey of workplace uncertainty is apparent in the Spanish adaptation of COPSOQ. This point is possibly linked to the socio-economic situation in Spain, which is characterised by higher unemployment in comparison with Denmark, Sweden and Great Britain, and at the same time by lower social security in comparison with Denmark and Sweden, so that uncertainty represents a greater burden there[50].

In addition, the consistently positive wording is apparent in the Danish instrument (public service). This point, and the holistic embedding of risk assessments in the Scandinavian cases, was already shown in depth above in connection with occupational health and safety culture (chapter 7).

Partly sector-specific and partly sector-overlapping reference values are used in the instruments for the assessment of risks. The arguments are different in each case. In the Danish hospital, comparisons with the values of other hospitals are seen as helpful, even though they are regarded in part as too non-specific because of the differences between wards. In the Spanish COPSOQ / ISTAS21 sector-specific comparisons are deliberately done without – including where this would be possible because of the sample size. The use of sector-overlapping comparative values is justified there because sector-specific disadvantages would otherwise be cemented. Kompier, Cooper and Geurts (2000) also draw attention to the problem that high risk factors in the comparative values could play down the significance of existing problems: "*Let us, for example, suppose that 60% of the workers in company A reports ‚to be working under high time pressure', and that a common score in this branch of industry is 65%. Let us also suppose that this difference is statistically significant. Although workers in company A report less time pressure than in the comparison group, we would still argue that time pressure is a problem that should be dealt with in company A.*" (p. 383).

[50]However, there is a discussion at present on differentiating this factor as well in the newly agreed COPSOQ version (COPSOQ III) (personal conversation with a member of the COPSOQ network in July 2015).

9. Central action steps at company level

Motives for implementing psychosocial risk management were diversified and varied in dependence on the interview partners and enterprises. The legal basis was one reason (among others) for carrying out a risk assessment that was referred to by nearly all interviewed enterprises. In two Spanish cases and one Danish case it had to be enforced emphatically by the works council and (in Spain) by the occupational safety and health inspectorate and the union. In the other enterprises, implementation took place without explicit pressure from outside. Together with normative motives, instrumental and humanist motives also played a part (extended classification following Frick, 2011, p. 980)[51]. Sector- and country-related patterns were seen in the sample, but these are to be interpreted cautiously and exclusively in the context of the respective enterprises:

- Reactive motives were predominant (e.g. reducing the sickness rate) in the *manufacturing* establishments that were examined, while in the *service sectors* hospital and hotel numerous proactive motives were also referred to as triggers (e.g. improving worker satisfaction and image, increasing patient security).
- Normative reasons predominated in two *Spanish* establishments (at least from the management's point of view), mainly humanist motives were referred to as drivers in the *Scandinavian* establishments, the *British hospital* and the *Spanish hotel*.

If the case studies from Spain are compared as examples with those from Denmark, far-reaching measures were realised – from easy to realise information events and training courses through to more complicated changes (e.g. to work organisation and working hours). In this, the Spanish cases that were illustrated are not behind the Danish cases in the range of the measures, and in some cases go beyond them in part.

With regard to the initial conditions, in the two Spanish cases the limited structures for worker involvement at the commencement of the process are apparent. In both cases, extensive activities were necessary to anchor the inclusion of workers more strongly structurally as well, e.g. through regular department meetings or coordination of the management level with worker representatives on planned operational changes. Structures such as regular team meetings and coordination with worker representatives were already implemented in the Danish case companies.

In contrast, in the Danish case companies, stress inherent to work was in part less questioned. Promotion of the social dialogue and support by managers and colleagues were made the subject of discussion there in both cases as a solution strategy, to offset structural problems (e.g. personnel reductions). At the same time, there was greater focus on social relations and conflicts between workers in

[51] Frick differentiates two motives for introducing voluntary OSH systems, (a) relationship-oriented and (b) economic motives, each of which can be pursued in an (c) internal/proactive/seeking, or (d) external/reactive/avoiding manner. This results in 4 fields that identify different motive situations and are characterised by the following factors: 1) Ethics (a+c), 2) Poor reputation (a+d), 3) Resources (b+c), 4) Costs (b+d).

the two Danish establishments, whereas on the worker level in the two Spanish establishments they were not seen as a problem area and were therefore not processed.

The results of risk management (assessment of stress and issue of an action plan) were documented in the majority of the establishments. In contrast, a check of effectiveness was not carried out either systematically or throughout. Wherever worker surveys were carried out regularly they served as expressions of the mood. Follow-up surveys were planned in the Spanish establishments, but had not yet taken place at the time of the survey (case studies). There were no considerations as yet in this respect in the British manufacturing plant. At company level it can be seen what can be observed transnationally as well: check of effectiveness is minimised, the more it refers to the actual objectives (i.e. the quality of the realisations of the risk assessment) and does not just query facts. Up to now, systematic evaluation and use of the results for internal learning processes is comparatively rare. This is consistent with findings from the GDA survey (2011) in Germany, according to which 51% of establishments in the survey claimed to carry out a (general) risk assessment, but only 16% run through all steps up to "review of effectiveness" (Schmitt & Hammer, 2015, p. 2).

The workplace examples show that it is important for a successful design of the process of risk management to support the both players' preparedness for action and their capacity for action. For this purpose it is necessary to dismantle existing barriers to both knowledge and action.

- With regard to management and senior staff it is necessary to emphasise the benefits of risk management– on a normative, but also on an instrumental and humanistic level, whereby the players' currently dominant reference system (normative, instrumental or humanistic motives) is to be taken into account. Assumption of responsibility by management for the health of workers can be supported structurally, for example, by concretising it in appropriate guidelines and anchoring it as a management task (e.g. in incentive and assessment systems).
- Good and concrete examples from other establishments and a corresponding exchange of experience can help to make the way in which psychosocial stress works more understandable and graspable.
- One problem in an examination of psychosocial stress is the focus of company players on individual conditions under which it evolves. Where necessary, such "reduced" mental models[52] on the emergence of stress are to be supplemented by situational factors.
- In addition, specialist expertise and process competence are to be developed, in particular with regard to dealing with participative processes, possible expectation of workers and limits to the changeability of stress. How far stress inherent to work (e.g. emotional stress in dealing with cus-

[52] *"Mental models are deeply held internal images of how the world works, images that limit us to familiar ways of thinking and acting. Very often, we are not consciously aware of our mental models or the effects they have on our behavior"* (Senge, 1990, p. 8). Mental models determine how information, e.g. cause-and-effect relationships are organised mentally and function as a filter for new information from outside. Referencing Argyris and Schön, Senge differentiates here between *espoused theories*, which are communicated externally, and *theories-in-use*, which – on the basis of mental models – influence real action. If real behaviour is to be changed, it is important to make the mental models transparent.

tomers or patients) can be changed structurally – within limits - (e.g. through breaks and relaxation rooms for staff, as well as through sufficient personnel, functioning and transparent work processes that reduce experiences of frustration for customers, because they can estimate waiting times, for example, and can prevent aggression towards workers) can be made clear through good examples from other establishments. Good and concrete examples can also help to make the way in which psychosocial stress works more understandable and to break down the complexity and make it processable in workplace practice.

- Sufficient resources and decision-making competence (e.g. transferred by management) are decisive for senior staff in the middle and lower levels, as well as for worker representatives, in order to be able to (co-)design the process.

What is central is that participating players perceive the process as *controllable and work conditions as changeable* and that players see it as their task to participate in this process, and assume *responsibility* for this.

Discussion of central results

The objective of the study was to use a qualitative, explorative research approach to acquire knowledge of basic conditions, constellations of players and processes of risk assessments under different national conditions for action. In this way, a deeper understanding of this process was to be acquired than was permitted up to now by studies on a quantitative level. In the framework of this project, ten establishment case studies on the realisation of psychosocial risk management were carried out in four European countries and were supplemented by interviews with inter-company experts and document analyses. The "case" was defined at country level. Corresponding to the question, we selected Sweden, Denmark, Great Britain and Spain for the study.

Reconstruction of the framework conditions and of the process of risk management in the four countries took place on three levels – descriptive, comparative and evaluative-explanatory. Descriptions were provided extensively in the previous chapters, and will not be taken up in detail here. Rather, at this point the common features and differences and instrumental factors will be presented in a summary.

As a legal requirement for enterprises, and as a "central instrument of company occupational safety planning" (Faber, 2004, p. 502), psychosocial risk management is embedded in its system and design in (overlapping) occupational health and safety cultures and traditions and occupational safety priorities, in which the countries in the survey are on the one hand similar, but in other points differ from one another as well. What are the important commonalties and differences for the different countries?

Common starting situation on European level:

- European Occupational Safety and Health Framework Directive (1989) and its transposition into national law

- Participation in the SLIC focus action 2009 - 2012 on "psychosocial risks", for example

Commonalities above all with regard to:

- Cooperation of the most important occupational safety and health players: support for enterprises though information, training courses and advice from the occupational health and safety inspectorate, social partners and external consultants; in each country there are offers from various parties for strengthening realisation in establishments, but with different focuses and to different extents (see below)
- Recommendations of the countries with regard to process / structured method and contents of risk assessment, and process character of risk management (classification into stages, from analysis to evaluation of the measures)
- Theoretical foundations on which the instruments that are used are based and the superordinate stress factors that are recorded in the instruments, but with different focusses (see below)
- Broad involvement of workers in *identifying* problems[53] (with the exception of the British manufacturing plant)
- Type of and handling challenges in designing risk assessments at company level, for example, addressing and motivating special target groups (e.g. doctors), transition for risk analysis to the development and realisation of measures and the implementation of effectiveness analyses

Differences above all with regard to:

- Emphasis on and degree of detail of individual stress factors in the instruments (in particular the questionnaires): in Denmark and Sweden the proactive design role of workers is emphasised, in Great Britain (management standards) changes in the workplace are enquired about separately and in Spain participation opportunities for workers are recorded on a differentiated basis.
- Occupational safety and health culture with regard to notions and organisational practice (holistic nature and integration of the risk assessment): while the Scandinavian countries use neutral terms at *inter-company level* that emphasise conditions (working environment), in Spain and Great Britain the risk term is used, and Great Britain in addition the complete process is emphasised more (risk *management*); at *company level* there is a tendency to use positive terms, in particular in enterprises that have been occupied with the subject for a longer period.
- Instrument recommendations: while there is a great variety of instruments in the Scandinavian countries, in Spain there are recommendations both on regional level (ISTAS21) and on national level (FPSICO), and in Great Britain national recommendations (management standards for work-related stress).

[53] This point was estimated on the basis of the company case studies, because there was no inter-company data available; however, it can be assumed that the worker perspective is recorded when questionnaires and focus groups are used; checklists and workplace observations were discussed with workers in the cases in the study or reported back to them

- Profile, resources and key activities of the occupational safety and health inspectorate: while the Danish occupational safety and health inspectorate pursues a proactive approach, the other three countries are (now) more reactive (whereby Sweden and Great Britain initially pursued a proactive approach and Great Britain is planning to attach more importance to the topic again).
- Participation culture, influence of the social partners, consensus *vs* dissent between the social partners at the national level regarding central aspects of occupational safety and health : while development in the Scandinavian countries was possible in a strong company participation culture and the social partners have drawn up coordinated recommendations jointly on an inter-company basis, coordinated activities in Spain have not (yet) been realised, and in Great Britain are not foreseeable at present.
- A strongly management-oriented approach is pursued in Great Britain, which is reflected in the terminology (risk management for work-related stress) and in the differentiated approach to managers on the HSE platform (e.g. through specific instruments for identifying management competences and working out business cases). In contrast to this, there is a very consensus-based approach in the Scandinavian countries, in which the responsibility of workers for designing the process and the support of senior staff is stressed as well. In Spain, where experience with strong (direct) worker participation is still at comparatively low level, but the rights of co-determination are on the whole stronger than in Great Britain, attempts are made in particular on the part of the unions to intensify indirect participation through worker representatives.
- Involvement of workers in the *development and realisation* of measures and in the evaluation of these measures[54]: in the Scandinavian case studies, workers were involved in all phases (up to direct evaluation, or evaluation via regular worker surveys, which enable at least a rough idea of the mood), in Great Britain in one of the two examples, and in Spain they were broadly involved in the hotel and in individual departments in the hospital, and in the manufacturing plant exclusively by worker representatives.
- Profile and quality orientation of external consultants: Denmark and Spain have requirements for the qualifications profile of external prevention services, and Denmark also has specifications for the advisory process.
- Relevant developments on country level: in the most advanced occupational safety and health cultures there are concrete initiatives (Sweden) and considerations (Denmark) for the specification or clarification of the legal framework for occupational health and safety with regard to prevention or psychosocial risks; in Spain, the country's supreme court has confirmed that guidelines of the government occupational health and safety institute or of the occupational

[54] This point was again estimated on the basis of the company case studies, because there was no inter-company data available.

health and safety inspectorate that are based on findings from occupational science research are valid as (binding) reference documents for identifying and assessing psychosocial risks. On the other hand, in Great Britain, the occupational health and safety inspectorate (HSE) was weakened by reductions in funding and has withdrawn from the active engagement with enterprises with regard to stress at work that was practised from 2004 with the introduction of the management standards; HSE has only recently planned to extend its activities again in this respect as a reaction to increasing problems with stress.

Psychosocial occupational safety and health cultures

The *psychosocial* occupational safety and health culture at national level is characterised by the following factors: the familiarity of company players with the applied notions and concepts, their width and connotation, the holistic nature (separation or combination of physical and mental factors) and the integration of the risk assessment in operational processes.

The prominence of concepts and notions and a positive connotation of psychological factors reduce the reservations and inhibitions of occupational safety and health players regarding the subject of psychosocial stress and facilitate initiation of a risk assessment of this. For example, less persuasion had to be applied (by management or worker representatives) in the Danish and Swedish enterprises than in the Spanish and British organisations.

In highly developed occupational health and safety cultures (Denmark, Sweden) the accent is on combining "traditional" and psychosocial factors for the purposes of "holistic" risk management. In the case studies in Spain and Great Britain, "traditional" and psychosocial risks are processed separately, whereby this separation also corresponds to a time sequence ("traditional" risks are generally dealt with first).

The arguments in favour of a separation or combination of "traditional" and "psychosocial" risk management put forward by (company and inter-company) occupational safety and health and safety players are in part on different levels: seen from the systematic of occupational safety and health and safety, the holistic arrangement of work conditions[55] required by law in these (Scandinavian) countries and the actual combination of different stress factors and risks (e.g. increased risk of an accident as a result of lack of attention or tiredness resulting from excessive working hours, pressure of time and pressure to perform) are indicative of practised *integration*. A clear demarcation between the fields of action risk management and health management is also more difficult to detect there and reflects the occupational safety and health culture in those countries. However, practical realisation of an integrated procedure at company level presupposes structures, experience and practical routines, which exist in Denmark and Sweden but tend not to be found (as yet) in Spain. Consequently, company players in Spain put forward pragmatic arguments for the *separation* of "traditional" and "psychosocial" risk management that correspond to the conditions for action obtaining there and their assessed possibili-

[55] This integrative understanding conforms as well to the "philosophy" of the framework EU Occupational Safety and Health Framework Directive.

ties for action: simplification of process control through a step-by-step approach (enabling gradual learning processes by means of successive visible successes) and thus avoiding excessive demands on company players, in particular management. One case company in Great Britain is considering breaking down the previous separation of "traditional" and "psychosocial" risk management in favour of integration. Integration in organisational processes is already practised there. The structural preconditions for this are in particular the priority of the subject and the (established) cooperation of internal occupational safety and health and the personnel department.

Participation culture

Participation of workers and their representatives, which is stipulated in Article 11 European Occupational Safety and Health and Safety Framework Directive, has already proved to be a success factor in Germany (Beck, Richter, Ertel & Morschhäuser, 2012; Langhoff & Satzer, 2010), in other European countries (Moncada et al., 2011) and internationally (Lenhardt & Ertel, 2012). The existence of workforce representations, and in particular the extent of their activity, is conducive especially for the operational implementation of the psychosocial risk management. However, characteristics and realisation differ in the individual countries at national and at company level: the European Participation Index (EPI) maps the extent of legally structured representative participation of workers. According to this, Denmark and Sweden have high values, Spain lies in the middle and Great Britain has the lowest value (see chapter 4). The actual weight of representative participation of workers in the psychosocial risk management in practice varies in dependence on national, sector-related and company framework conditions. The spectrum ranges from an initiating role, where management does not (at first) comply with its duty under occupational health and safety law to implement a psychosocial risk management, through to a more accompanying or subordinate role where risk assessment is embedded in a broad spectrum of prevention activities initiated or controlled by management.

Sweden and Denmark: the statutory framework that grants extensive rights to workers' representatives in companies is "implicitly" present (as it were in the background) in a participation culture that has evolved historically and is accepted everywhere as a democratic right of workers to participate. In the two Swedish case studies, the union representatives who were interviewed are conscious of their (legal) possibilities for action, but at the same time they make use of them selectively at most. Patterns of interaction between the players (management and worker representatives) are established, and this applies to psychosocial risk management as well. "Proactive" managers play an important role in handling problems.

Great Britain: few rights of participation for workers and a distinct socio-politically individualised attribution of responsibility for health are accompanied by prevention activities that are strongly dominated by management. Workers and their representatives are much more dependent than otherwise on the "benevolence" of management, above all in establishments in which unions are not recognised as representatives, or in which unionised workers are in a minority (e.g. UK2 / manufacturing). The individualised attribution of responsibility for stress problems represents an obstacle to the perception of

"stress" as a problem to be dealt with in the company. The situation in the NHS hospital that was examined is more differentiated. Under very difficult economic framework conditions ("*terrible financial climate*") and under external pressure (threats of further reductions in funding and of privatisation, little support from politicians), a great congruence of interests is becoming apparent between (top) management and staff representatives that fosters an engaged and joint approach in occupational safety and health and in particular as well in psychosocial risk management.

Spain: against the background of an on the whole adversarial occupational safety and health culture with work conditions that are unfavourable in a European comparison, the union institute ISTAS supports worker representatives in the framework of a comprehensive strategy. This is done through training sessions, empowerment, and provision of a validated and field-tested instrument that contains a structured approach for risk assessment to improve work conditions on the way to a (social) dialogue with management. Implementation of psychosocial risk management takes in part the form of enforcement (backed by law). At the same time, company participation culture is developed or intensified in the process of risk management.

National supervisory authorities – occupational safety and health inspectorates

At the level of national supervisory authorities, the priority of the subject (psychosocial stress or psychosocial working environment) a high supervision ratio, effective sanctioning options and incentives and content-related support of establishments are central success factors. The characteristics of these factors were already described in detail in chapter 3 and are summarised here in an overview:

Table 6: Important dimensions at the level of the occupational safety and health inspectorate

Dimensions	National characteristics
Priority of the subject "psychosocial stress"	• Sweden: initially proactive approach; budget reduction 2006, significant staff cutbacks / more reactive inspection, currently reform activities to upgrade the subject • Denmark: proactive approach; one of 3 focus subjects (Plan 2020); guidelines and sector-specific guidance tools for inspectors; training and mentoring programme, specialised inspectors as contact persons for colleagues; previously: funds for supporting prevention projects • Great Britain: initially proactive approach, development of management standards, calling on problem sectors; now reactive approach, but efforts to upgrade the subject again • Spain: reactive approach

Table 7: Important dimensions at the level of the occupational safety and health inspectorate

Dimensions	National characteristics
Higher supervision ratio	• Sweden: < ILO recommendation • Denmark: > ILO recommendation** • Great Britain: < ILO recommendation** • Spain: < ILO recommendation**; = ILO recommendation (Walters et al., 2012, p. 84) (whereby the Spanish union expert estimates that the ratio is even lower)
Possible sanctions and incentives	• Sweden: fines of up to €11,000*; (general) occupational safety and health inspection in the last 3 years: approx. 42% of establishments (ESENER; Rial González, 2010, p. 33) • Denmark: infringements may be prosecuted, imprisonment up to 1 year; smiley/traffic light system – can be seen on the website of the occupational safety and health authority; screening programme; certification system for enterprises; inclusion of "authorised" / audited external consultants, (general) occupational safety and health inspection in the last 3 years: approx. 71% • Great Britain: fines of up to GBP20,000; (general) occupational safety and health inspection in the last 3 years: approx. 56% • Spain: fines of up to €40,000 (general) occupational safety and health inspection in the last 3 years: approx. 45%

Notes: *not specifically for psychosocial risks; ** data refer to 2009 (EPSU, 2012, pp. 9 f.)

How do these factors work? High priority for the subject "psychosocial stress" is expressed by the fact that corresponding (in part sector-specific) focuses are set and resources flow into the subject area. For example, in the framework of national strategies and focus programmes 2005 - 2010 and 2012 - 2020 in Denmark training courses for inspectors were extended and information campaigns in establishments were increased. In Great Britain, the management standards were developed in 2004, and enterprises were provided with active guidance in the first few years - in five focus areas in particular: "*I think our experience is that when you can positively engage with organizations, like we did with these five sectors, the priority sectors, I think the data seemed to show that they improve more than when you don't, when just have a passive (E1: Yeah.) or not so well engaged situation*" (UK_E2: 4). Offers such as information material, telephone and online guidance support establishments in questions that arise before and during psychosocial risk management and contribute (or contributed) to increased certainty in action.

The ESENER data from 2009 show that information on (general) occupational safety and health subjects from the health and safety inspectorate is very important. In Denmark, Sweden and Great Britain it was used by approx. three quarters of enterprises and in Spain by at least half of the interviewed enterprises (Rial-González et al., 2010, p. 35).

If resources for occupational safety and health and inspections are reduced, "*risk-based approaches to inspection and enforcement*" tend to be pursued, i.e. supervision is concentrated on problematic sectors and establishments. Selection criteria are in general accidents and sickness rates, which encourages the focus on traditional risks (Walters et al., 2012, p. 50).

In contrast, a higher supervision ratio facilitates a proactive procedure, because occupational safety and health inspectors then have more time available to examine implementation on site in establishments and on the whole to take on not just a controlling but also an advisory role.

Social partners / unions and employers' associations

For the social partners (unions and employer' associations) the priority of the subject, the strength of the institution, the content-related support of establishments and the quality of the cooperation are important positive determinants for the company implementation of psychosocial risk management r. The characteristics are summarised here in the overview, see chapter 4 for a broader view.

Table 8: Important dimensions with regard to the social partners

Dimensions	**National characteristics** **Unions**	**Employers' association**
Priority of the subject	• Sweden: high • Denmark: high • Great Britain: high • Spain: high	• Sweden: high • Denmark: high • Great Britain: low / medium • Spain: low for the employers' association for large enterprises; more distinct for the SME employers' association
Significance of the institutions at company level	• Sweden: high (high level of union membership) (70%[1])[56] • Denmark: high (67%) • Great Britain: medium (26%) • Spain: low (19%)	• Sweden: very high (high collective bargaining cover) (88%[1]) • Denmark: very high (80%) • Great Britain: medium (29%) • Spain: high (70%)
Quality of cooperation	• Sweden: good (joint agreements and guidelines) • Denmark: good (joint agreements and guidelines) • Great Britain: low (no joint agreements) • Spain: low/medium (joint agreements planned but not yet implemented)	

[56] http://de.worker-participation.eu/Nationale-Arbeitsbeziehungen/Quer-durch-Europa/Gewerkschaften [as of 30.07.2015]

Table 9: Important dimensions with regard to the social partners

Dimensions	National characteristics Unions	Employers' association
Company support	• Sweden: case studies high / ESENER high • Denmark: case studies* high / ESENER** medium[1] • Great Britain: case studies low / ESENER low • Spain: case studies high / ESENER medium	• Sweden: case studies low / ESENER high • Denmark: case studies low / ESENER* medium[1] • Great Britain: case studies medium / ESENER medium • Spain: case studies low / ESENER medium

Notes: *Information, guidance; **provision of information; [1](very high > 75%), high ≤ 75%, > 50%; medium ≤ 50%, > 25%; low ≤ 25%

How do these factors develop that effect at the company level? Analogous to the government level, high priority for the subject of psychosocial stress leads among social partners as well to more intensive engagement with the contents and greater allocation of resources, which is then reflected in increased development of information material and training courses and thus to higher qualifications for company players, and to stronger company support as well.

The strength of the union has an effect on the one hand at the political level, for example, in that the subject is brought into the public discussion, or laws and regulations are influenced. This point became a subject for discussion for example in the case study in the Swedish hospital in connection with the issue of staff shortages in the nursing area. The unions attempt here to exert an influence at the political level, in order to reduce staff shortages at a superordinate level. On the other hand, unions also have a direct influence at the company level, in that they strengthen the negotiating position of safety representatives (Menéndez, Benach & Vogel, 2009, p. 11)[57] or offer training courses and provide advice by phone or locally on technical, operative, legal and strategic questions on the implementation of risk management.

The role of employers' associations was on the whole less clearly felt in the case studies. While there were approaches at inter-company level and in part guidelines and surveys coordinated with the unions (e.g. staff surveys in the public sector / case example hospital Denmark), direct influence is probably comparatively lower, because management has more influence in the establishment anyway than worker representatives. Insofar, strengthening the own interest group through employers' associations in the establishment probably plays a subordinate role. It is to be suspected here as well that a higher degree of organisation increases the influence of employers' associations at company level.

The ESENER survey makes it clear that support at company level through the provision by unions of information (on general occupational safety and health subjects) made up the greater part in Sweden

[57] With a high level of union membership within the establishment and greater acceptance of the union

(63%) and was still a good third in Denmark and Spain (38% and 36% respectively), while unions in Great Britain did not play a prominent role in this respect (14%) (Rial-González et al., 2010, p. 35). Information from employers' associations was also found to the greatest extent in Sweden (52%), in Denmark and Spain it was slightly higher than from unions (39% and 42% respectively) and in Great Britain significantly higher than the union influence (37%). These ESENER data indicate that, as far as (general) information on occupational safety and health subjects is concerned, employers' associations in three countries play a comparatively greater role – whereby the data are based on statements from management representatives.

With the Swedish background in mind, referencing Huzzard et al. (2004) Frick describes the cooperation between the social partners as a central factor for involvement with subjects such as work organisation – in trusting relations with a lower power imbalance readiness to deal with such subjects is greater (dancing). In adversarial relations, traditional subjects tend to be dealt with (boxing): "*When unions are relatively strong and there are some levels of trust between the social partners, they can promote their members' interests in cooperation with the employers (in combination with traditional negotiations). However, when unions are weaker and the industrial relations are more adversarial, unions keep a distance and mainly interact with the employers through boxing/negotiations.*" (Frick, 2011, p. 985). Constructive cooperation between unions and employer' associations enables harmonised rules and guidelines and in this way can increase the preparedness for action and confidence of company players. The preconditions for this are significantly more distinct in the Scandinavian countries than in Great Britain and Spain. In Denmark, close cooperation between unions and employers' associations has led to jointly agreed (sector-specific) information material. In Spain, from the point of view of the occupational safety and health expert the public position of employers' associations has up to now been much more noncommittal and cooperation with the unions is more limited. Accordingly, it has not been possible as yet to develop jointly agreed rules and agreements and thus greater binding character for the company level, even if this is at least planned, in contrast to Great Britain.

External advice

External advice (e.g. from private providers or scientific institutions) is particularly instrumental to the initiation and implementation of psychosocial risk management if the consultants have substantiated content-wise and process-related expertise, e.g. with regard to group dynamics, micro-politics and moderating internal processes, and place the focus on process quality in comparison with purely time-effective considerations. It is also important to impart to company players that they take into account the interests of management and worker (representatives) equally without bias. The characteristics of these factors are summarised here briefly in an overview, see chapter 6 for a broader view.

Table 10: Important dimensions at the level of external advice

Dimensions	National characteristics
Technical expertise (content-wise and process organisation)	• Sweden: no specifications for external consultants; (internal and external) employment of psychologists 65% (ESENER; Rial González, 2010, p. 31) • Denmark: prevention services must employ specialists from at least five different specialist areas. Physics, chemistry, biology, ergonomics and psychology; (internal and external) employment of psychologists 48% • Great Britain: no specifications for external consultants; (internal and external) employment of psychologists 9% • Spain: prevention services must employ at least one expert for each of the following disciplines: occupational medicine, safety at work, occupational hygiene, ergonomics and applied psychology; (internal and external) employment of psychologists 27%
Quality orientation	• Sweden: no certification; enterprises are requested by the occupational safety and health inspectorate to make use of external services if they lack internal competence; no evaluation of the work of external prevention services required • Denmark: *certification or accreditation system* for external prevention services; enterprises are requested by the occupational safety and health inspectorate to make use of external services if they lack internal competence; consultancy companies must document and evaluate the process and the results and report back on an inspection; the "Danish Accreditation (DANAK)" checks whether this specification was complied with • Great Britain: no certification, discussion on voluntary quality assurance: "*a voluntary Occupational Safety and Health Consultants Register (OSHCR)*" containing qualified consultants "*properly accredited to one of the professional bodies in the industry*" (EU-OSHA, 2013, p. 10); no evaluation of the work of external prevention services required • Spain: *certification or accreditation system* for external prevention services by regional authorities – however, no uniform specifications; enterprises must satisfy lower specifications when using external experts; employer's own task to evaluate the work of external prevention services

How do these factors work? In the cases that were examined, high specialist expertise of the external consultants played a central role in particular where internal structures and processes were lacking or not sufficiently developed. External consultants contributed to initiation, problem analysis and the development and implementation of measures. In doing this, their role consisted on the whole not only in imparting specialist knowledge and taking over operative implementation (e.g. implementation of the survey), but also in supporting the process (e.g. through moderation, detecting differences in interests, planning workshops, advice on project management). In enterprises that had already been engaged in depth with the subject of psychosocial stress and had appropriate process competence, exter-

nal experts tended to be brought in ad hoc for specific focus subjects, which conforms to the EU's legal specification of the subsidiary use of external expertise.

On the whole, management and worker representatives were able to get involved better with the process if consultants conveyed the message that they were acting impartially and not in the interests of a single stakeholder group.

If external advice is drawn on, a success factor is a distinct quality orientation of the external consultants who focus on the success of the overall process and take over (co-)responsibility for the implementation of the measures. If methods, instruments and speed are not adapted to the expectations of enterprises and, in particular, to their requirements for development over time, this can lead to conflicts that impede the process (see case study Spain / manufacturing; hotel).

Vague requirements for the qualifications of the implementing persons and the quality assurance of the process can impede quality orientation, in particular if there is little openness with regard to problems in the enterprise. This can lead to external consultants being commissioned who carry out "*lengthy risk assessments*" but who hardly support risk *management* at all and do not contribute to actually reducing existing psychosocial risks (EU-OSHA, 2013, p. 7). There was speculation in the experts interview that there is a close connection between the competence and interest of the employer and the benefits of external advice (and its quality), insofar as a management that is engaged in occupational safety and health with clear concepts offers more leeway to consultants to provide good advice, and is at the same time more open to their suggestions.

In general, the interviewed experts from occupational safety and health inspectorates regard the long-term outsourcing of internal occupational safety and health as a problem. What Nielsen (2013) postulates as a success factor at company level for management, the balance between "driving the process" and "enabling true participation" (pp. 1041 f.), applies to external consultants as well: on the whole, it is important in the long term to move increasingly from external support to activating existing resources.

Evaluation of the research approach

The aim of this study was to describe approaches to the psychosocial risk management in selected countries, to work out common features and differences and to derive success factors from this. For this purpose, in each country company case studies were combined with expert interviews at inter-company level and with document analyses: documents (e.g. statistical reports) that were available in the national language only were translated and thus made accessible for the analysis.

Overall, different action levels were examined in this way in their interplay and a broad spectrum of workplace practices was surveyed. Previous systematisations of success factors generally take account of either the inter-company or the company level and do not differentiate on the basis of players and process. This viewpoint is extended in the present study.

The company case studies are concentrated on two service areas (hospital, hotel) and on selected enterprises in different manufacturing areas, in order not to impair comparisons between the countries

through too great a variance between sectors. However, the disadvantage of this procedure is that in this way sectoral specifics are given special weighting – e.g. in some countries healthcare is identified as a problem sector with regard to the characterisation of psychosocial stress (e.g. in Great Britain) and special attention is paid to it. However, because the company case studies serve in particular to make the concrete procedure (of psychosocial risk management) clear (how?) and less the frequency of occurrence (how often?), this point probably carried less weight.

The advantage of gaining access to the company case studies via national contact partners was that contact could be made quickly and selection criteria could be formulated that related to the company process (e.g. on the use of instruments / COPSOQ in Denmark). However, the disadvantage is that an unintended selection takes place through the contact partners – in dependence on their background (e.g. union research institute, occupational safety and health inspectorate, external consultants). When the case studies were evaluated, the issue of access was therefore thematised in each case and the results were subsequently reflected critically.

In Spain, as a result of access via the union research institute (ISTAS), only examples from Catalonia were examined and, in addition, only those that had employed the ISTAS21 instrument. As described in chapter 8, there are other free instruments in Spain and, apart from this, a series of procedures subject to a charge (see, e.g. INSHT, 2009, for a description of individual procedures in the form of case studies). In addition, with access via a union research institute, particular emphasis is given to the role of unions and worker representatives in the *company case* studies. This was already referred to in chapters 4 and 5. Furthermore, it must be kept in mind that the company case studies are not intended to provide statements on frequency distributions and in this respect do not (have to) claim to be representative. Quantitative weightings are secured at the inter-company level. The company case studies serve rather to help understanding of the process in its individual steps and the interplay of the players and the different levels.

It might appear that the role of external advisers in the case studies with access via a management consultant (Denmark) was overemphasized. However, this was not the case with our Danish case studies.

In Great Britain the contact with an enterprise was set up through the occupational health and safety authority. Correspondingly, in the evaluation the role of the occupational safety and health inspectorate is to be reflected critically (for possible distortions) and compared with its role in the other British case, which came about through a consultant for the employers' association.

In Sweden contact with an enterprise (hospital) came about via a scientific network. Projects that are implemented in the context of scientific studies are to be scrutinised in particular with regard to their transferability, because special resources are available here that cannot be accessed in traditional everyday enterprise work. However, because the participation of the scientific team was already some time in the past and the approaches had had to prove their worth for a longer period without additional

support in everyday enterprise work, the case can still provide important suggestions for other enterprises.

Prerequisite for including case studies in the study was that the enterprises were already in the implementation phase of psychosocial risk management, or that initial measures were at least planned. The reason for this restriction was that positive impulses were to be derived from the case studies. This meant that a positive case selection was already inherent in the design of the study. At the same time, the, on the whole, positive case selection is caused by the fact that the readiness of enterprises to provide information in less successful projects is lower overall, as shown by experience. In the same way, the specification for the contact partners not to seek out distinctly positive cases but typical cases in which typical internal conflicts are clear, was realised to some extent only.

Apart from this, it must be taken into account that – as a result of the countries' different traditions with regard to dealing with the subject – the (time-based) implementation status of psychosocial risk management differed in the case studies. In all three Spanish enterprises and one British enterprise risk management had just been carried out for the first time; in contrast, in the Scandinavian enterprises the introduction was already some time in the past (different level of maturity).

On the whole, in our opinion the result is a possibly incomplete but vivid picture of the implementation of psychosocial risk management at company level, embedded in the respective context. This means that an interpretation of the illustrated company cases in isolation from this as "best practice" is not appropriate, and a simple transfer of individual case studies from one country to another is insofar not possible, because in each case embedding in the broader national context has to be taken into account.

Consequences and suggestions for practical use

The basic idea behind this project, which was sponsored by the Hans-Böckler-Stiftung, was to improve understanding of company practice in its process determining factors and in its interplay with the superordinate national context. Finally, it should be possible to derive impulses for occupational safety and health practice in Germany from the comparison of "good practice" of risk assessments of psychosocial stress.

In doing this, the following characteristics in particular are to be taken into account in Germany in the comparison with the countries included in the project:

- The dual occupational safety and health system, i.e. the parallel structure of accident insurance providers (employers' liability insurance associations and accident insurance funds) and the occupational health and safety inspectorates of the German federal states is specific to Germany. The necessary coordination of the two pillars of the occupational safety and health system in monitoring establishments has been anchored in the joint German occupational health and safety strategy (GDA) since 2008.
- At company level, workers' representatives (works or staff council) have extensive co-determination rights in occupational health and safety – comparable with legislation in Swe-

den for union representatives there at company level, which are much more pronounced than in Great Britain, for example. In contrast, workers' representatives at company level in Germany do not have the right to strike (unlike in Spain, for example).

- In the discussions on German occupational safety and health players a clearer difference is made between risk management(here with regard to psychosocial stress) as an obligation under occupational health and safety legislation, and workplace health promotion anchored in Social Code Book V (SGB V) than is the case in some of the countries in the study. In Great Britain, but also in Sweden and Denmark, risk reducing and health promoting (resource-oriented) measures are often closely linked at company level. Where the legal form of the company procedure for the implementation of risk management is more strongly emphasised (for example in Spain), the "independence" of risk management is also more strongly emphasised – whereby here as well on the whole fewer parallel activities for health promotion were observed.

The findings that were acquired in the project from four European countries draw attention to the following issues, fields of action and problem areas:

A European ranking requires a differentiated set of indicators: a European ranking of countries with regard to psychosocial risk management based on two quantitative indicators, such as the EU Commission submitted in its evaluation report on the social partners agreement on work-related stress[58], is not sufficient to map company occupational safety and health reality adequately. Preliminary ranking of this type requires classification by taking essential framework conditions into account, such as the respective rights and duties of workers' representatives as well as those of social partners at inter-company level (industrial relations), and should also include government occupational safety and health policies.

Consensus building at national level supports operational practice: consensus building between occupational health and safety players (in particular at national level as a result of a social dialogue between government players and unions and employers' associations) on targets, priorities and procedures with regard to psychosocial stress supports occupational safety and health practices at company level based on this. Our findings have made clear that Denmark and Sweden are much more advanced in this respect than Great Britain and Spain. Support for this type of consensus building is primarily a labour policy, i.e. a government, task at national level, but could be considerably advanced by an up to now hardly existing interlinking of the company-based, , inter-company and European levels and a corresponding exchange of experiences between unions, employers' associations and, for example, the Senior Labour Inspectors' Committee (SLIC). The structures and experiences of the European Social Dialogue can also be used for this purpose.

[58] http://www.europarl.europa.eu/registre/docs_autres_institutions/commission_europeenne/sec/2011/0241/COM_SEC%282011%290241_EN.pdf (pp. 88 f.) [as of 02.02.2016]

Precise statutory regulations are a necessary but not a sufficient motive for action for the implementation of psychosocial risk management: our study supplies clear indications of the importance of the underlying motivation and of the type of existing barriers on the part of employers as important determinants for the implementation of psychosocial risk management. In order to prevent a procedure that is "followed to the letter" but is not sustainable ("paper compliance"), different strategies are required primarily at company level, but also at inter-company level (on the part of the occupational safety and health inspectorate) for the creation of capacity for action as well as preparedness for action (e.g. dismantling knowledge barriers through targeted offers of training sessions and advice; dismantling barriers to action by clarifying and enforcing legal specifications and strengthening the culture of participation). On the whole, it must be taken into account to an even greater extent that rules and practical routines must be anchored in the culture (i.e. established occupational safety and health practice) in order to be effective (e.g. a health policy is effective in particular if it is supported by management, if the priority of the subject is emphasised and if the most concrete references possible are provided, processes and responsibilities are clearly defined and existing instruments and methods are indicated).

Using existing structures and linking psychosocial risk management with existing organisational processes is expedient: in order to promote acceptance and sustainability it is expedient to integrate the process of risk management more strongly in existing operational support structures. Close coordination with personnel development, e.g. to develop offers of support for senior staff, and with organisation development, in order to take account preventively of psychosocial factors on organisational changes, and in order to improve the work organisation, can supplement risk management usefully. Integration into strategic planning can prevent the subject slipping into the background because of other priorities. Reconciliation with an already existing workplace health management system can prevent multiple surveys and parallel developments. In addition, showing already existing positive approaches can motivate the workforce and make the process more tangible for them.

The use of concepts is to be scrutinised: with the different terms that are employed in the context of risk management the emphasis is on different features, e.g. 1) on the *assessment* (as in Spain and in Germany as well) or on the *management* of the overall process (as in Great Britain); 2) risk (as in Spain / *riesgos*, Great Britain / risks and also in Germany / *Gefährdungsbeurteilung*), on the conditions (or on the working environment - as in the Scandinavian countries / Arbetsmiljö) or – more frequently practised at least at company level – on the chances (well-being; trivsel). The (psychosocial) stress definition, which in accordance with DIN EN ISO 10075 is meant neutrally in Germany, but is not generally understood as such, should be reconsidered with regard to whether it is suitable for creating acceptance at the company level, emphasising the process and adequately highlighting the significance of work *conditions* in a comparison with individual shares.

Focussing psychosocial risk management on taking stock is to be extended by a stronger process view: the interviewed representatives of the occupational safety and health inspectorates unanimously

referred to focussing on *taking stock* of stress instead of on *developing and realising measures* that is frequently observed in the operational practice of risk management as a major problem. This critical assessment is accompanied by a plea by the occupational safety and health and safety experts for a focus on the *process* of risk management rather than on an accentuation of the selection of methods. At the same time, greater account must be taken of the situation that this is not only a matter of the purely technical realisation of guidelines for action, but of negotiating and learning processes in the workplace, which in part demand wide-reaching changes of attitude, and therefore can only be dealt with in stages. In addition, checks on the effectiveness of risk management are scarcely carried out systematically and understood as a learning opportunity. How the evaluation can support organisational learning, which approaches for this are to be selected in dependence on the existing (occupational safety and health) culture, and which instruments and recommendations for action can be used to support this process, must be explored in greater depth.

Taking account of priority for the use of practical "local" knowledge: in the four countries included in the project external experts seldom use so-called objective methods (e.g. observation interviews / work analysis methods) for psychosocial risk management, and they are not used at all in the case studies. The reasons for this put forward by players were, among others, interest in the use of "local" (operational) knowledge – for example by specific surveys of workers - and interest in being able to determine the process of risk management autonomously, even if external expertise was certainly used selectively. Prerequisite for productive use of external expertise was that the company players perceived it to be competent and impartial. There will have to be even more examinations of what successful integration of external experts can look like under different framework conditions, how it can be advanced, e.g. through the development of quality criteria, and how external experts can promote own responsibility for the process in the establishment in the long term.

Create preconditions for the effective participation of workers: participation of workers in the improvement of their work conditions in general and in particular in psychosocial risk management is not only bound up with legal preconditions – no matter how important these are. Evolving effective participation requires in particular a credible participation culture that can contribute to overcoming passive behaviour on the part of workers, where necessary, by imparting the experience that their participation can in fact be effective.

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