Project OSCAR: Occupational Stress Consultation and Research

Report 1 Defining and labelling work-related stress

Health and Safety Executive

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Research Report

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The purpose of this research was to build the evidence base on how work-related stress (WRS) is understood, identified and managed in practice across workplaces. This will be used to help support developments in preventing and reducing the effects of psychosocial hazards in the workplace.

Affinity Health at Work and partners, the Institute of Employment Studies and the Institute of Occupational Medicine, used a multi-method research approach combining evidence reviews, interviews, and stakeholder engagement.

The findings are published in an overarching summary report and three thematic reports addressing the programme's key research questions:

- Overarching summary report: brings together key findings from across the programme
- Report 1: How is WRS defined and labelled by organisations and medical professionals?
- Report 2: What interventions are effective for preventing and managing WRS?
- Report 3: What are the enablers and barriers to organisations effectively reducing the risks of WRS?

The reports will be of interest to employers, practitioners, policymakers, academics and researchers working to improve the prevention and management of psychosocial risks.

In summary, the research found that:

- there is no shared understanding of how work-related stress is defined and labelled

- organisational responses to work-related stress are often reactive rather than preventative
- effective prevention depends on linking interventions to identified psychosocial risks and involving workers in developing solutions
- stronger evaluation and sharing of learning would improve understanding of what works in practice
- the key challenge is how existing knowledge is translated into coordinated prevention activity

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Project OSCAR (Occupational Stress Consultation And Research)

Report 1 Defining and labelling work-related stress

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Research ethics statement

This study was reviewed by Reading Independent Ethics Committee (Reference: Occupational Stress Consultation and Research; 29.07.2024).

All research for HSE is expected to be carried out with rigour, responsibility and respect following the principles within the Universal Ethical Code for Scientists and, where applicable, the International Code of Ethics for Occupational Health Professionals. This programme of stress research implements these principles and also adheres to the British Psychological Society's code of conduct, Government Social Research professional guidance framework and Market Research Society code of conduct.

Abbreviations

Abbreviation	Definition
EU-OSHA	European Union – Occupational Safety and Health Agency
GP	General Practitioner
H&S	Health and Safety
HCPs	Healthcare Professionals
HR	Human Resources
HSE	Health and Safety Executive
IES	Institute for Employment Studies
IOM	Institute of Occupational Medicine
OH/OHPs	Occupational Health/Occupational Health Practitioners
OL	Organisational Leader
OSCAR	Occupational Stress Consultation and Research
PAG	Project Advisory Group
PSG	Project Steering Group
SME	Small and Medium-sized Enterprise
SOM	Society of Occupational Medicine
WHO	World Health Organisation
WRS	Work-related stress

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Key messages

Why the work was done

Work-related stress (WRS) is one of the most common causes of work-related ill health in Great Britain (GB). But there is no clear, shared understanding of what WRS means, how to assess it, or who is responsible for managing it. This creates confusion, delays in support, and missed opportunities for prevention. The Health and Safety Executive (HSE) commissioned this research to understand how WRS is defined and labelled in practice, and what can be done to reduce its impact.

What we did

- Reviewed UK and international research published between 2014 and 2024.
- Interviewed 39 professionals across healthcare, occupational health, and organisational leadership.
- Ran workshops with stakeholders to check and explore findings.

What we found

- **There is no shared definition of work-related stress.** People use different words, like stress, burnout, psychosocial risk, making joined-up action hard.
- **Employers and managers say they are unsure of their responsibilities** which means action is often inconsistent or limited.
- **GPs usually label WRS** but lack workplace context. This can medicalise work issues and delay employer action.
- **Occupational health professionals use evidence-based tools**, but impact of their input can be constrained by contractual arrangements, limited access to organisational data and resource pressures.
- **Employees often negotiate how their condition is described** and who is told, which adds pressure and may delay support.
- **Everyone we spoke to called for better tools, clearer roles, more joined-up working and accountability** to help people earlier and prevent harm.

What this means

A shared language, clearer expectations, and better coordination between health professionals, employers and regulators could support earlier intervention and prevent harm. Reducing medical labelling, strengthening organisational responsibility, and promoting preventative action are key opportunities to enable support to be provided earlier, more fairly and with a stronger focus on prevention.

Executive summary

Introduction

Work-related stress (WRS) is a leading cause of work-related ill health in Great Britain (GB). While the term is used widely, there is no clear or shared understanding, even among health and work professionals, of what it means, how to assess it, or who is responsible for tackling it. This can lead to confusion, delays in support, and missed chances to prevent harm. The Health and Safety Executive (HSE) commissioned this research to support its strategic objective to reduce work-related ill health, with a specific focus on mental health and stress. The research aims to understand how WRS is currently defined and labelled in practice, and what can be done differently to reduce its impact and improve support.

Methods

We used several sources of information to help us answer the research question:

- A **systematic review** of research published between 2014 and 2024.
- **In-depth qualitative interviews** with 39 participants across three professional groups: healthcare professionals (HCPs), occupational health professionals (OHPs), and organisational leaders (OLs).
- **Two stakeholder consultation workshops** to review and refine findings and explore implications for guidance and regulation.

We looked across the data to spot common themes, answer our research questions, and identify new insights.

Key findings

There is currently no widely agreed definition of WRS

People use different terms alongside stress — like “burnout” or “psychosocial risk”. Professionals in organisations often use the HSE definition, while healthcare professionals tend to use the Word Health Organisation (WHO) definition or National Health Service (NHS) frameworks. People seem to have different ideas about what stress is and these differences are likely, in part, to explain why interventions and support are so varied and piecemeal.

Many agree that it can be hard to tell whether stress is caused by work or by other things, like problems at home or personal issues, which can also affect your ability to work. Some say WRS can mean that work made things worse, even if it wasn’t the main cause. It is important to acknowledge this complexity when labelling and supporting people with WRS so that they get the right help at the right time.

Organisational leaders are unsure of their responsibilities

Leaders use individual and organisational stress risk assessments in different ways, depending on their level of knowledge, their influence in the organisation, and how clear they are about their legal duties. Many are unclear about their responsibilities as an employer and feel there is not much pressure from the regulator. As a result, stress risk assessments and action planning are not always prioritised.

GPs label WRS but lack tools, time, and workplace knowledge

GPs often label WRS when writing fit notes. But they face several challenges – short appointment times, little knowledge about the person's job or workplace, and few options to refer them elsewhere. This can lead to WRS being treated as a medical issue rather than a work-related one. Many stakeholders are concerned that this may increase stigma (negative judgements made on individuals affected by WRS) and delay action in the workplace.

Occupational health professionals give structured advice, but system and contract issues can limit their impact

OHPs often use evidence-based tools like the HSE Management Standards to guide their assessments. In doing so, they tend to describe WRS as "perceived" or "likely" to manage legal risk and avoid implying that the employer is liable for an individual's health condition. These tools are not well known among GPs or organisational leaders, who often do not have access to them or the training to use them properly. Despite their expertise, the impact of their input can be constrained by contractual arrangements, limited access to organisational data, and resource pressures.

Labelling WRS involves negotiation with the employee

Employees shape how WRS is described and who is told about it, as they must give their permission for information to be shared and influence the wording used. This often involves a negotiation between the employee and others – such as their manager or GP – and can affect both the type and timing of support.

The system may contribute to over-medicalisation

Many said the system, being the work and health systems, treats WRS like a medical condition, rather than a response to difficult working conditions. As a result, time off work is often the main support. Stakeholders worry this may unintentionally reinforce stigma and the idea that stress is a personal weakness, rather than a normal response to challenging work – and one that employers could help prevent or improve. This is not to say clinical support or time off are never needed – for some, they are essential. But a more balanced, joined-up approach that also tackles workplace causes would better support people and reduce harm.

Poor coordination between health and workplace systems limits early support

Healthcare, occupational health, and workplace systems rarely work together. Even though there is widespread agreement that work affects health, there is no shared definition, no consistent tools, or clear pathway to refer people for support. This lack of joined-up working makes it harder to spot WRS early, make better use of the data available or provide coordinated support.

Key considerations

This study highlights opportunities for all those with an interest to make responses to the potential for work-related stress (WRS) more consistent, timely, and effective:

- **Clarify roles and responsibilities** for employers, managers, and healthcare professionals by strengthening regulatory guidance.
- **Develop a shared understanding of WRS** that works across workplaces and healthcare settings. Without a shared understanding of what WRS is and what action is required by whom, intervention and support will remain piecemeal and uncoordinated.
- **Provide GPs, line managers, and other non-specialists, better access** to simple, evidence-based tools and training.
- **Promote prevention-first approaches** in organisations to reduce the reliance on medical diagnosis or time off work.
- **Strengthen coordination** between systems**,** with clearer referral routes and better communication between occupational health, primary care, and employers.
- **Strengthen integration with other relevant legislative requirements,** including the Equality Act 2010, employment law and disability accommodations.

Conclusion

Work-related stress is widely recognised as a serious workplace health issue. But unclear definitions, poor coordination, and confusion over responsibilities are getting in the way of effective support and delaying action. In many cases, work issues become medicalised before the employer is made aware of the problem – reducing the opportunity for early workplace intervention.

Improving guidance, expanding access to tools, enhancing regulatory interventions, and building better coordination between key roles can help make sure support is provided earlier, more fairly, and with a stronger focus on prevention.

This summary brings together findings from research, interviews, and stakeholder consultations. It outlines practical, evidence-informed ideas for improving how WRS is defined, labelled, and managed in GB workplaces.

1 Introduction

1.1 Background to Project OSCAR

Stress is one of the most significant occupational health challenges in Great Britain (GB). It accounts for almost half of all cases of work-related ill health and the number of working days lost due to illness (HSE, 2024). Prolonged exposure to work-related stress (WRS) is strongly linked to poor mental health outcomes, such as depression (e.g., Madsen et al., 2017), and can contribute to serious mood disorders, burnout, and suicide (Khamisa et al., 2015; Howard et al., 2021; Dunning et al., 2022; Teoh et al., 2024).

The impact of WRS goes beyond the individual. For employers, it means more sickness absence, presenteeism (coming to work while unwell), reduced performance, reduced productivity, job turnover and early retirement, and the associated costs (e.g., Knapp and Wong, 2020; Hassard et al., 2018; Kinman, 2019). At a national level, it is associated with increased healthcare costs (BMA, 2016) and lowers workforce participation (HSE, 2023).

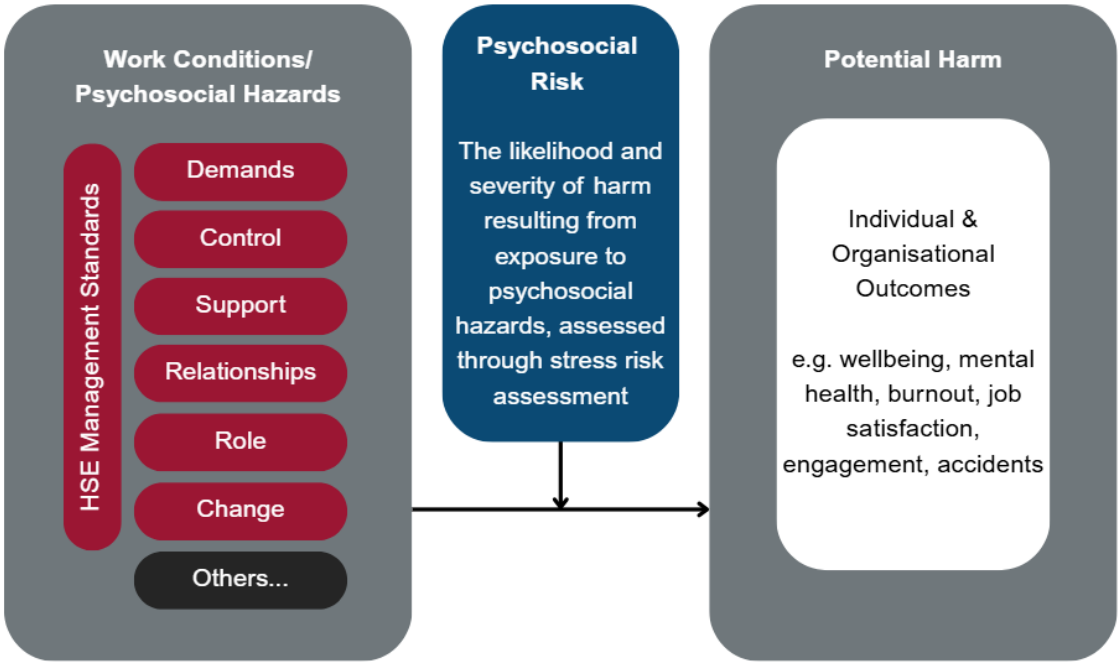
A strong and consistent body of research shows that specific working conditions (also called psychosocial hazards) are linked to WRS and poor health. These psychosocial hazards can include job demands, long working hours, poor leadership, low job control, low social support, poor work relationships, low work recognition, and high job insecurity as reflected in Figure 1 (Burman et al., 2018; van der Molen, 2020; Teoh et al., 2023). Many of these psychosocial hazards are reflected in HSE's Management Standards for WRS. The likelihood of these hazards causing harm and the severity of this potential outcome is referred to as psychosocial risk. It is this risk of psychosocial hazards potentially leading to harm which organisational and individual stress risk assessments seek to understand in order to put in place mitigations to reduce this risk.

Despite this evidence, many employers are not taking action to identify and reduce the risk of WRS. According to the CIPD Health and Wellbeing Report (2023) only 40% of the 726 organisations surveyed were taking steps to identify causes of stress using surveys, interviews or stress risk assessments/stress audits.

There is a perception that managing WRS is more complex than managing physical risks. The causes and impacts of stress are shaped by a mix of personal, organisational, and wider system factors. Unlike physical hazards – where the relationship between the hazard and outcome is more directly measurable and where controls are more commonly used (such as reducing the risk of falling from height with barriers and safety equipment) – WRS is generally perceived to be harder to identify, manage, and mitigate. Some organisations are also likely to have implemented measures such as good work design or management practices, which

they do not recognise as mitigations for WRS and so underestimate the action they have already taken.

Figure 1. Evidence on psychosocial hazards, risk, and their links to outcomes



It is important to recognise that many factors involved in managing WRS can sit outside the traditional scope of how organisations comply with health and safety legislation. For example, in sectors like education and healthcare, working conditions are often shaped by staffing levels, unpredictable/external work demands, funding models, trade union negotiations, professional regulation, and national policy. These factors may limit what individual employers are able to change. While the employing organisation is ultimately responsible for managing work-related stress under health and safety law, the actions taken often sit with human resource or occupational health teams. These teams may be less familiar with health and safety duties or may not work closely with those responsible for legal compliance within their organisation. HSE can take enforcement action, where appropriate, but identifying where and how poor management of stress and psychosocial hazards has created a risk of harm may be unclear.

At the same time, public and workplace conversations have changed. Terms such as “stress,” “mental health,” and “wellbeing” are used frequently and interchangeably. There has been a rapid growth of initiatives such as Mental Health First Aid and the Thrive at Work Standards. While these efforts have raised important awareness of and engagement with mental health, they can sometimes create ambiguity between individual-level wellbeing and systemic management of psychosocial risk. This may

lead to confusion around roles, responsibilities, expectations, and what counts as an employer's duty.

To address these issues, the HSE commissioned Affinity Health at Work, the Institute of Occupational Medicine, the Institute for Employment Studies, and the Society of Occupational Medicine through a competitive tender process to lead the Occupational Stress Consultation and Research Programme - Project OSCAR.

Project OSCAR is designed to provide the HSE with robust evidence to inform policy development and practical guidance for employers on preventing and managing work-related stress. The research addresses three priority questions identified by HSE:

1. How is work-related stress (WRS) assigned and/or labelled by (a) an organisation and (b) medical professionals?
2. What interventions are effective for preventing and reducing work-related stress?
3. What are the enablers and barriers to organisations effectively reducing the risks of work-related stress?

This report summarises study activity and presents the findings related to the first research question. Study activity and findings related to second and third research questions are reported separately (see report 2 and report 3)

1.2 Background to research question one

There is a long and well-documented history of the development of the term work-related stress (Cox et al., 2000), summarised in Appendix 1 on page 63. It is not clear from the scientific or practitioner literature the extent to which employers recognise that the spectrum of behavioural and physical signs and symptoms of mental health issues, such as social withdrawal at work, interpersonal conflict, and substance abuse, could be related to WRS (Teoh, 2023). There is recognition that even doctors need more training and support to recognise symptoms of mental ill-health and burnout (Spiers et al., 2022).

WRS often overlaps with other health conditions, adding to the complexity of identifying and reporting WRS and supporting people. For example, research by our team has uncovered how employees will comfortably report backpain, migraine or caring responsibilities as the reason for absence, but work-related stressors may be a contributing factor (Munir et al., 2007).

Despite being used as an 'umbrella' term for a wide range of conditions with varying presentation, severity and duration, employers typically record mental health absence with a single label in electronic systems, with the use of secondary labels varying in consistency and accuracy. Employers are then missing three pieces of

information needed to manage WRS effectively: i) they do not know whether absence is due to stress, mild anxiety and depression, or severe and enduring mental illnesses; ii) they can't tell if work has caused or made the condition worse; and iii) they can't use absence data to spot if certain teams or job roles are more at risk (Yarker et al., 2023).

While it can be difficult for employers to understand the prevalence of WRS, or what causes it, without carrying out a stress risk assessment, there is evidence that stigma (whether it is real or just perceived) around mental health is a barrier to employees disclosing such experiences, seeking help or utilising the (mental health) resources in their workplace (West et al., 2023). For example, employees may feel unable to discuss their experience of stress with line managers and others in their organisation due to a lack of support, perceived disinterest, or fear of appearing 'weak' or 'helpless' (Riley et al., 2021). This is compounded by a belief that in some settings (e.g., in healthcare and prison services), WRS is normalised and that taking time off is poorly tolerated. Furthermore, some workers internalise their experience of stress as a personal failure with regards to their ability to perform and function in their roles. This can make workers less likely to disclose and to seek support, with such concerns compounded where occupational health services are provided in-house (Kinman et al., 2020).

Nicholson (2018) suggests that for most UK employees, the main source of mental health support – whether or not it is work-related – is their General Practitioner (GP). Stress, depression, and anxiety are common reasons recorded on GP fit notes for long-term sick leave (NHS Digital, 2025). But it is unclear how often GPs explore whether a person's job is contributing to their symptoms. In many cases, patients may have several consultations relating to, for example, palpitations, odd aches and pains, and insomnia prior to presenting with more pronounced and severe signs of poor mental health requiring a fit note. Despréaux et al. (2017) suggest that medical professionals should carry out a 'quick risk assessment' to see if a person believes their job is contributing to their stress or mental health difficulties. Nonetheless, how medical professionals explore work as a contributing factor remains a significant gap in our knowledge.

Although good collaboration between employers, healthcare professionals, and employees is key to recognising and addressing WRS (Shemtob, 2022; Teoh, 2023), research shows this joined-up approach is rare (Nielsen et al., 2024). There is also evidence that people do not always want 'stress' on their record or fit note and would rather list a physical health condition instead – even doctors feel this way when they are patients themselves (Chew-Graham et al., 2003; Brower, 2021). The growing increase in young people not in work or on sick leave due to mental ill-health suggests this trend may be shifting (McCurdy and Murphy, 2024).

Research and practice to date indicates that different stakeholders are likely to hold different narratives about the causes and signs of WRS and often use different terms

to describe it. This can lead to inconsistencies across healthcare and within and between organisations. Adding to the complexity is the perception that WRS is "well understood". Unlike many other health issues, WRS does not require a medical diagnosis, which can give the impression that it does not need an explanation, investigation or a shared understanding. As a result, individuals, GPs, occupational health and allied health professionals, and employers are likely to all approach WRS based on their own assumptions, responsibilities, and priorities (Wezyk et al., 2023) – however relevant or incomplete these may be – influencing how WRS is identified, labelled and responded to.

1.3 Research aims

There is a need for a clearer understanding of how WRS is assigned or labelled – meaning how a choice is made to describe a situation or a person's experience as WRS – by organisations and medical professionals (e.g., GPs and occupational health providers), including any recommendations they make. It is envisaged that understanding issues at the interface between workers, employers, and medical professionals will identify the range of signs and symptoms associated with WRS and resulting ill-health experienced, as well as how issues are recognised and linked to the workplace, particularly by medical professionals.

This research aims to answer the question '**How is WRS assigned and/or labelled by (a) organisations and (b) medical professionals?**'

Sub-questions, agreed through a process of consultation with the HSE and the Project Advisory Group and Project Steering Group, were also examined. Additional areas of interest identified are summarised in **Table *1***.

Table 1. Additional areas of interest for labelling WRS

Labelling in organisations	Labelling by medical professionals
• Process followed and consistency of process • Links between individual and organisational processes for assessing risk	• Process followed and consistency of process • Use of other terms, e.g., burnout or moral injury • Typical symptoms considered • Links to HSE Management Standards • Sectors with highest prevalence • Sectors with greater impact • Other linked outcomes • Linked H&S issues, e.g., noise exposure • Advice given

2 Methodology

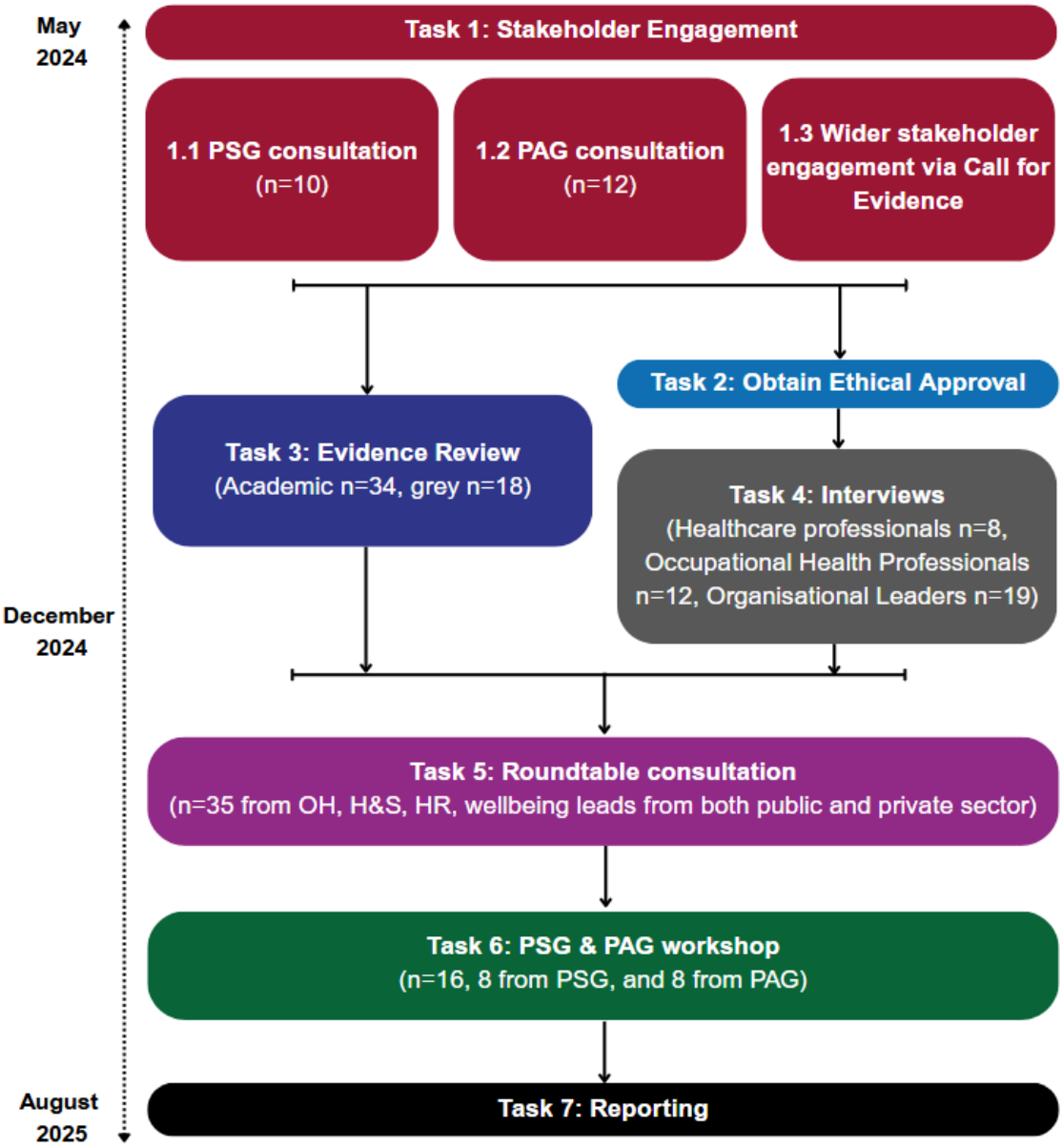
A multi-phase, mixed methods approach combined findings from: stakeholder engagement, a systematic literature review, stakeholder interviews, roundtable discussions, and consultation with the Project Steering Group (PSG) and Project Advisory Group (PAG). This was carried out as shown in the flow chart in Figure 2 below.

This mixed-methods approach was selected to make sure that findings were both evidence-informed and grounded in the realities of practice. Each phase of the research was designed and delivered in line with scientific best practices. Full details of the methods used and supporting materials are provided in Appendix 2 on page 64.

Data from each phase was brought together using a narrative synthesis to address the research questions. A formal quality assessment was applied to the academic literature review, which included studies predominantly of low to moderate quality. The wider project prioritised the engagement of diverse stakeholders to gather new insight and identify implications for practice. As such, no overall rating of the quality of the evidence is provided.

The findings are intended to inform future work and discussions, rather than provide definitive conclusions. The strengths and limitations of the methodologies used in this research should be borne in mind when considering the findings and the implications of this research. For a further list of the strengths and limitations of this research please see Appendix 7 on page 113.

Figure 2. Flow chart showing methodology of research undertaken



3 Findings

This section presents a synthesis of evidence gathered through the multi-phased approach, drawing on the academic and practitioner literature reviews, and qualitative data from interviews and roundtable consultations. Detailed findings from each research phase are available in Appendices 3 to 5 starting on page 86. A map summarising how each data source contributed to the findings presented in this section can be found in Appendix 6 on page 111.

This narrative synthesis outlines current understanding of the way work-related stress (WRS) is defined and the process of labelling used by organisations and medical professionals, highlighting key challenges arising across different contexts. The mixed methods approach enabled integration of existing academic and practitioner literature alongside rich and in-depth practical perspectives gathered through the interviews and consultation, providing a novel layer of insight into current practice and experience.

The combination of evidence types provides a more holistic view than would be possible through a single method alone. However, the focus on qualitative synthesis and stakeholder engagement means that conclusions should be interpreted with caution and within the context of the data sources included. While the findings offer insights for research, policy, and practice, they are not intended to provide definitive or generalisable claims. For further detail on the strengths and limitations of the research, see Appendix 7 on page 113.

A note on terminology – The term “labelling” has been used throughout rather than “diagnosis” as WRS is not a formally defined medical condition. The research explores how and when the term WRS is assigned to a situation - whether it is used in conversation or written in official documents, such as a fit note or an OH report.

3.1 Defining work-related stress

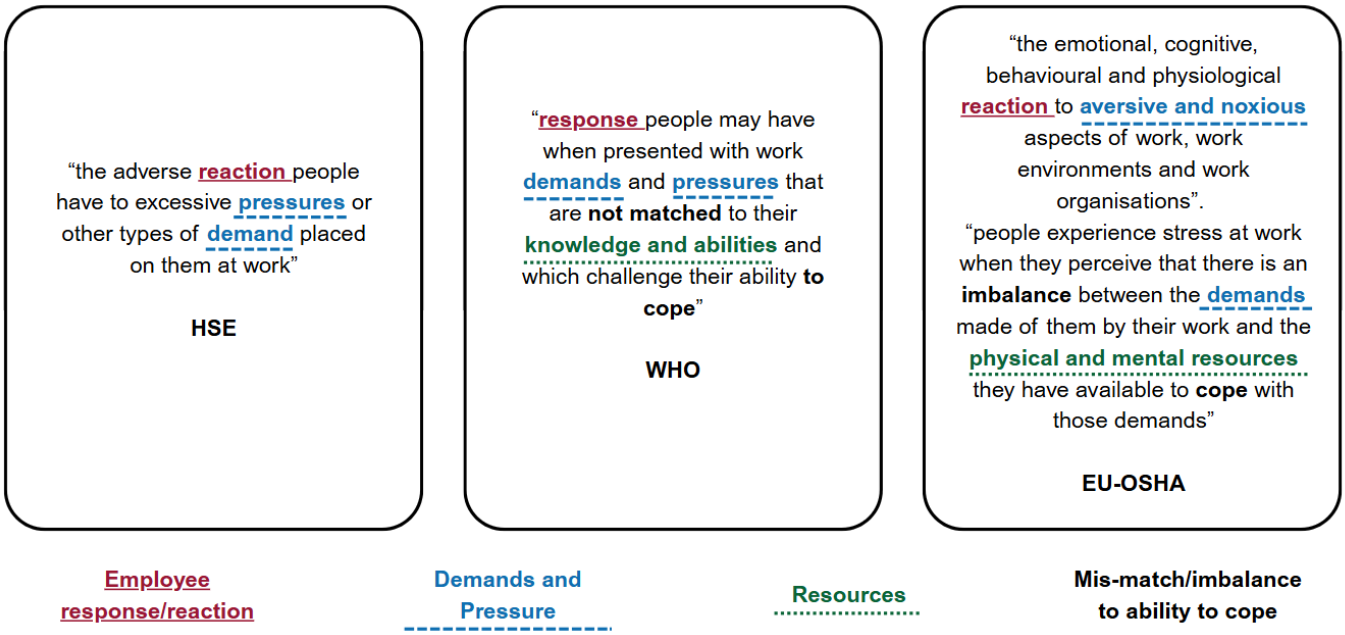
In examining the processes of assigning and labelling work-related stress in different contexts, the first key finding is that **WRS is defined in different ways depending on who is asked**. Across academic, clinical, and workplace settings, organisations, professions, and individuals use the term “stress” differently. Before looking at how WRS is labelled, it is important to recognise these variations and how they can affect how stress is understood and responded to.

3.1.1 Formal definitions, causes, and individual perceptions of WRS

Our literature review showed that there is no single agreed definition of WRS. Researchers, practitioners, and policy makers often use different definitions – or do

not define WRS at all. Analysis of the data showed the most frequently used definitions are those by the World Health Organisation (WHO), the HSE, and the European Union – Occupational Safety and Health Agency (EU-OSHA) (See Figure 3). All three definitions focus on the employee's **response/reaction to the demands and pressures of their work**. However, the WHO and EU-OSHA definitions also include references to an employee's **resources**, and the balance between these resources, their demands, and **their ability to cope**. Noteworthy, although not explicitly stated in the literature reviewed, the variations in definitions appears to reflect differing theoretical foundations. This suggests some of the inconsistencies in how WRS is understood may stem from a lack of shared theoretical grounding. See Appendix 1 on page 63 for a background to WRS and Appendix 3 on page 96 for a note on theory.

Figure 3. Comparison of content of definitions of WRS



In our interviews with organisational leaders (OLs), healthcare professionals (HCPs), and occupational health professionals (OHPs) we found clear differences in how they think about WRS and how they apply definitions in practice.

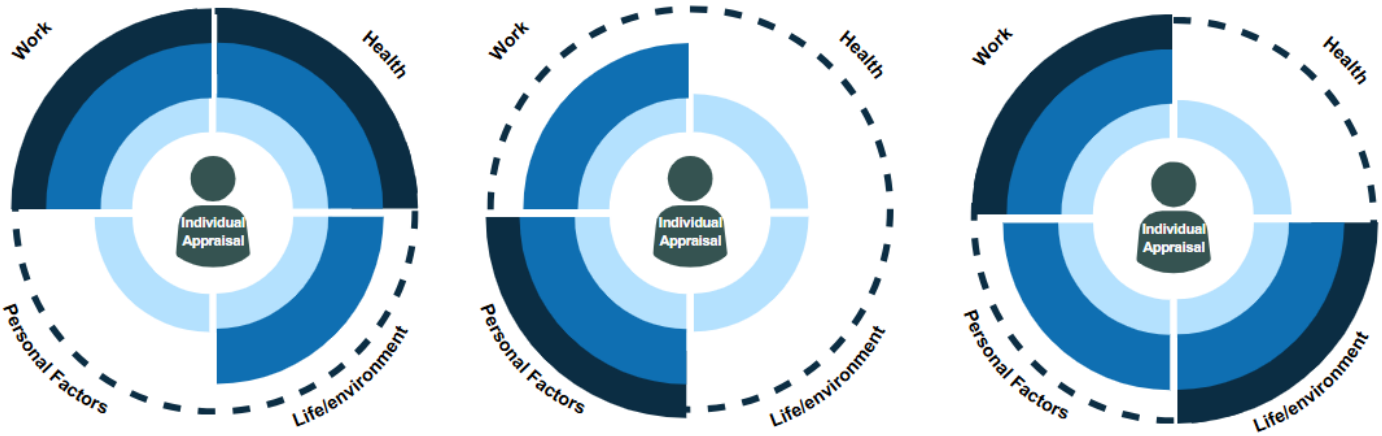
HCPs typically focus on the **source** of stress to determine whether it is work-related. They often use **tentative** language, describing stress as something the individual "perceives" or experiences, to avoid over-attributing responsibility to the workplace, especially when they only have access to one side of the story. This emphasis on **perception** aligns with theories of stress such as the dynamic/transactional theory, which argues that an individual's perception – or interpretation – of their work environment shapes their stress response (Cox, 1987). However, not all definitions or models of stress explicitly incorporate this appraisal component.

There was strong consensus across all data gathering activities that WRS is influenced by multiple, interconnected factors - both within and outside work -

shaped by individual and organisational circumstances. Factors outside of work can intensify WRS and how working conditions are experienced, just as WRS can spill over into other areas of life and heighten experience of external stressors such as relationship issues or health challenges. Interviewees noted that the term WRS was not limited to **stress caused directly by work** but also includes **stress exacerbated by work**. Moreover, based on the situations described, interviewees felt that in some circumstances **work can also alleviate stress**.

The complexity is illustrated in Figure 4 , which shows how people may experience different levels of stress across different areas of life. Each quadrant represents an area of life, with more bands indicating higher levels of stress perceived in the area. The individual is positioned at the centre, appraising and perceiving the stress across all areas. Because stress is shaped by a combination of personal, environmental, health, and work-related factors, attempts to separate 'work-related' and 'non-work-related' stress creates **a false dichotomy**. Many people, especially HCPs, felt that this separation is challenging, if not impossible, to achieve.

Figure 4. Visualisation of individual level perceptions of stress



Note: Additional bands per segment indicate more perceived stress in this area

Findings on the usefulness of existing WRS definitions were mixed. OLs expressed a **need for clearer definitions** to support effective action on WRS, but roundtable attendees felt that the precise definition of WRS itself was less important as long as it was simple and clear, to enable the enforcement of organisational stress risk assessment.

When presenting these findings to our PAG and roundtable attendees (see Appendix 5 page 108), participants emphasised the importance of **acknowledging the complexity** of stress and that stress involves a process of appraisal (i.e. how a person interprets and evaluates a situation as stressful), whilst also **focusing on those aspects that are work-related** and therefore **within an employer's control to manage**.

3.1.2 Stress and its related concepts

Roundtable participants highlighted the importance of clarifying how stress relates to other concepts (e.g., the difference between pressure and stress), while avoiding the over-medicalisation of stress. A tension emerged where participants were keen to avoid placing undue responsibility or blame on the individual for their experience of stress in the workplace, in part to reduce stigma; whilst at the same time, there was a recognition that stress should not be misused to justify or excuse performance issues**.** Thus, highlighting the **need for both accountability and understanding at individual and organisational levels**.

Stress vs pressure

OHPs mostly described that they took a threshold perspective of stress, where to some degree, it is a positive and motivating factor (i.e. “good”) until it exceeds an individual’s capacity to cope and has a prolonged negative impact. Similar themes were raised in the roundtable discussions and PSG and PAG workshop, where **the importance of language** was noted - recognising the difference between ‘pressure’, which can be a positive and motivational force, and ‘stress’ which relates to prolonged exposure to excessive pressure.

This distinction is reflected in well-known work design theories such as the Job Demands-Resources Model (Demerouti and Bakker, 2011) which draws on both the stress and motivation literatures. The model explains that the lack of sufficient resources and recovery time is what can cause job demands to act as a stressor, with resources themselves having a motivational effect, particularly in the face of higher demands (Demerouti and Bakker, 2011). Similarly, demands can either be considered as “Hindrance” or “Challenge” stressors. “Challenge” demands such as responsibility, can be linked to development and job satisfaction (Podsakoff et al., 2007).

Stress vs psychosocial risk

The use of the terms “psychosocial hazards” or “psychosocial risk” as an alternative framing for WRS is noteworthy as this was a theme identified, particularly in the grey literature and consultation findings. In the grey literature, this terminology was seen to be increasingly used as an alternative label, offering a broader, more practical way to define and discuss WRS (see Appendix 3 page 92 for further detail). Following the uptake of this approach by the EU and Australia, several consultation participants believed this framing could provide a clearer and more action-orientated way to address WRS in UK workplaces due to the emphasis placed on work-related factors that can be identified, assessed, and managed.

This framing also allows for a more nuanced understanding of the relationship between pressure and stress, recognising that pressure at work is not inherently harmful but healthy pressure at work can turn into stress when it exceeds an

individual's ability to cope. This highlights the importance of monitoring through both individual and organisational stress risk assessment.

- **Individual stress risk assessment**: Individual factors—like personal life events—can also impact how an employee experiences workplace stress (e.g., job demands). Individual-level assessments help identify how these various stressors/psychosocial hazards may affect an individual's ability to cope at work.
- **Organisational stress risk assessment:** Psychosocial hazards such as job demands, management, or organisational structure can affect staff more broadly. Increased risk can be monitored and mitigated at the organisational level through regular assessments and appropriate adjustments/interventions.

Stress vs burnout

Burnout was raised regularly throughout the process of the research because of its close links to stress and its recent addition as an occupational phenomenon in the International Classification of Diseases *(ICD-11)* (World Health Organization, 2019). Although burnout was excluded from the scope of the literature review (as it is a distinct construct from WRS) it is receiving increasing research attention. Burnout is defined by the WHO as "*a syndrome resulting from workplace stress that has not been successfully managed".* In this research, across sources, burnout was seen as **the longer-term impact of persistent and uncontrolled stress.**

The recognition of burnout in the ICD-11 has prompted an important reflection which was also raised by our roundtable attendees, that in the work setting, **by the time we label something as stress, it is often too late**, and the situation may have progressed to burnout.

Proactive monitoring, labelling, and managing workplace stressors – at both individual and organisational levels – is key to supporting recovery and preventing progression to burnout, and to preventing others from being harmed. The findings from Research question 2 aim to support organisations in selecting primary interventions to reduce stress at work (see report 2).

3.1.3 Towards a shared understanding of WRS

The findings from this research highlighted the value of developing a shared understanding of WRS and of using visual tools to explain the range of different factors that influence stress at work.

Considerations for a broader definition of WRS

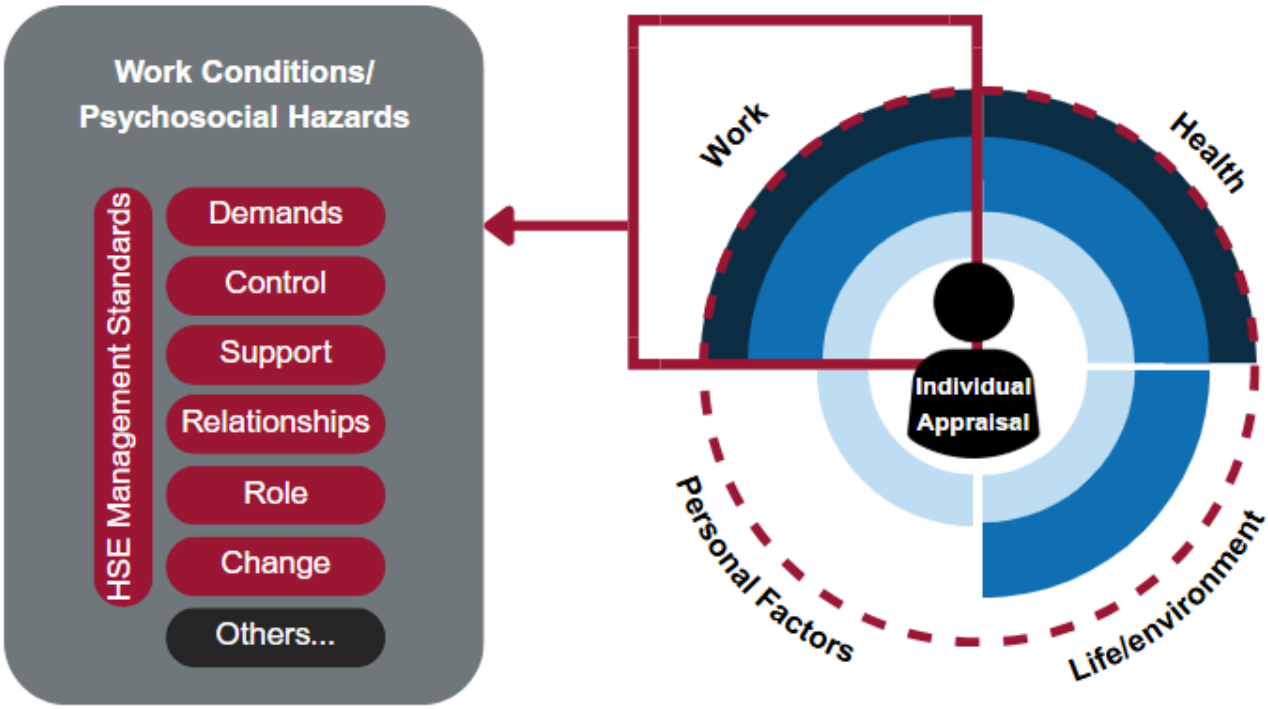
To bridge the gap between healthcare, occupational health, and organisational stakeholders, any working definition might benefit from the following characteristics:

- **Inclusive of multiple cases:** Recognising that WRS may be caused by work, be exacerbated by work, and involve external factors, and that the presence of "good work" can support recovery and help people stay well.
- **Recognition of complexity:** Acknowledging that stress can arise through a combination of many different factors, including work-related factors, and individual appraisal.
- **Using the language of psychosocial hazards and risk:** Recognising the work-related factors that contribute to stress and harm.
- **Clear about related concepts:** Providing context on how WRS relates to overlapping or adjacent terms such as pressure, burnout, moral injury, and mental health.
- **Focused on impact:** Emphasising the impact on a person's ability to function at work and the support or adjustments that may be needed.
- **Usable across settings:** Using clear, accessible language that can be applied in both health and work settings.

Example visual representation

During the consultation, attendees suggested it would be helpful to show an expanded view of stress, where the work-related component is shown alongside other factors that may influence an individual's experience of stress. Figure 5 presents an example of this. It shows how interconnected factors influence stress, while focusing on known work-related psychosocial hazards covered by tools such as the HSE Management Standards. For more information about the HSE Management Standards referred to in Figure 5, see the Management Standards page on the HSE website. A visual such as this aims to show where employers have a responsibility to monitor and manage risks and could be built upon to demonstrate to employers when to apply organisational and individual stress risk assessments.

Figure 5. Visualisation of WRS



Implications for research

- Explicitly documenting the definition and/or theory of stress used in studies would support comparison across research and improve practical application of findings.
- Exploring how varying definitions such as WRS, burnout, and psychosocial risk, influence the choice, design, delivery, and effectiveness of interventions could help us to understand whether more unified definitions would support greater consistency and impact.
- Examining how the use of psychosocial hazard terminology influences organisational behaviour, regulatory engagement, and employee outcomes would help to assess its value as a framing for workplace action.

Implications for practice

- Using an inclusive definition of stress that recognises the complexity of how stress can be caused, exacerbated or alleviated by work may be more helpful than trying to identify the primary cause.
- Providing training to all employees on the nature of stress and how it is shaped by work and life pressures could help people better voice their needs and seek timely support.
- Supporting line managers, occupational health, and healthcare professionals to distinguish between healthy pressure and harmful stress could help improve early identification and appropriate support, while reducing stigma and avoiding over-medicalisation.
- Using clear, visual tools may help organisations and individuals understand their shared responsibilities and promote a more consistent response to WRS.

3.2 The process of labelling work-related stress

A key aim of this research was to understand how the label of work-related stress (WRS) is assigned to individuals and situations in practice. Through interviews and consultations, we gathered perspectives of organisational leaders (OLs), healthcare professionals (HCPs), mainly GPs, and occupational health professionals (OHPs). A thematic analysis was used to identify commonalities and differences in the description of typical processes surrounding cases of WRS. There was limited academic or practitioner literature that described the process of labelling.

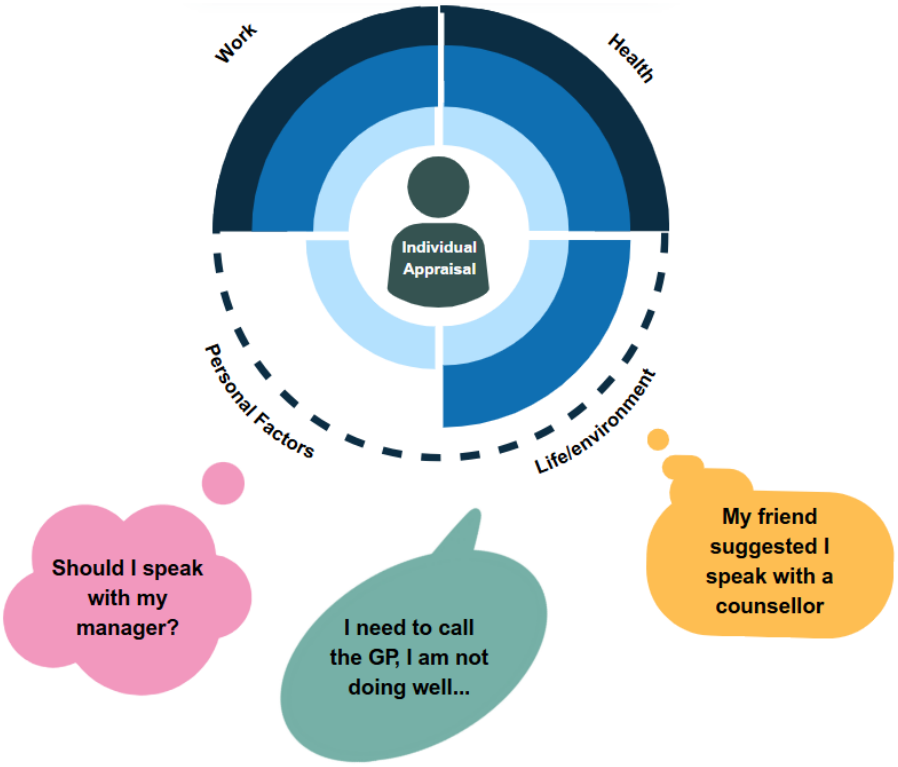
While experiences of WRS vary widely, and inconsistencies were noted between stakeholders and settings, several key themes were identified which help to build a clearer picture of current practice. The findings are summarised in this section, with further detail available in Appendices 2-5, starting page 64.

3.2.1 A range of pathways

Interviewees indicated that individuals experiencing WRS follow varied and often complex personal journeys. These inconsistencies can lead to delays, miscommunication, or missed opportunities for early intervention. This makes it important to understand the common touchpoints and features of the different pathways, and how they vary.

A key observation from the data was the range of disclosure patterns. Interviewees and roundtable participants noted that if an individual chooses to disclose their experience, they may speak to one person or to several people, depending on their circumstances. These may include healthcare professionals, colleagues, managers or others in their personal and professional lives (see Figure 6).

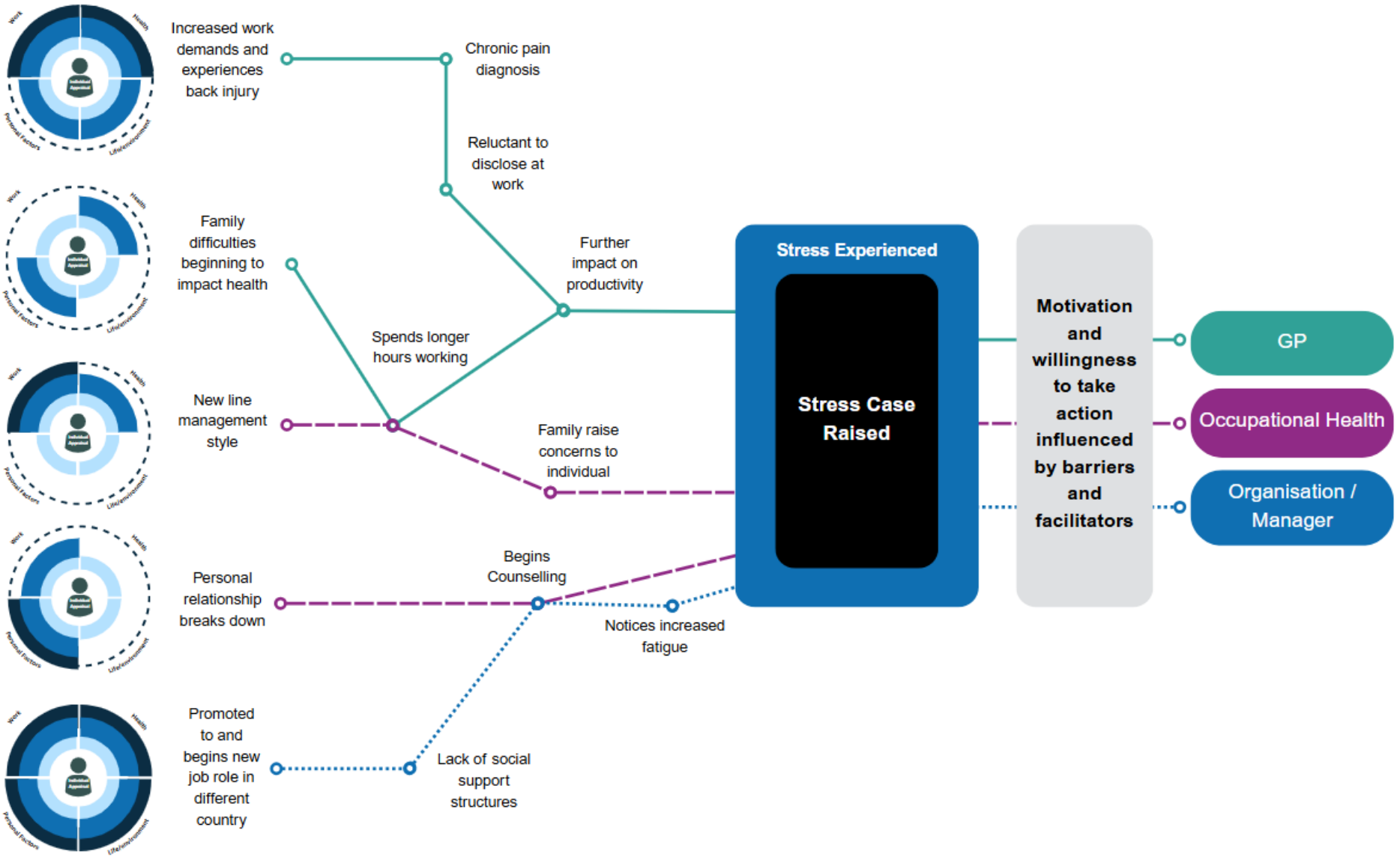
Figure 6. Individual appraisal of stress and following steps



It is therefore important to recognise this diversity, as well as the many individual choices that shape each person's experience (see Figure 7). These choices are shaped by individual factors including personality, coping strategies, help-seeking behaviours, relationships, socio-economic status, and the nature of their work.

This diversity means that there is no single or standardised pathway to labelling or managing WRS. However, for the purposes of this research, we focused on three settings where WRS is commonly discussed: the workplace, OH services, and in primary care settings, particularly general practice. We acknowledge that many others – including professionals such as counsellors, employee assistance programme (EAPs) practitioners, allied health professionals, and others in voluntary support roles such as mental health champions – also play important roles in identifying cases of WRS and managing its impact. We have focused on these three settings to explore the most common processes in depth.

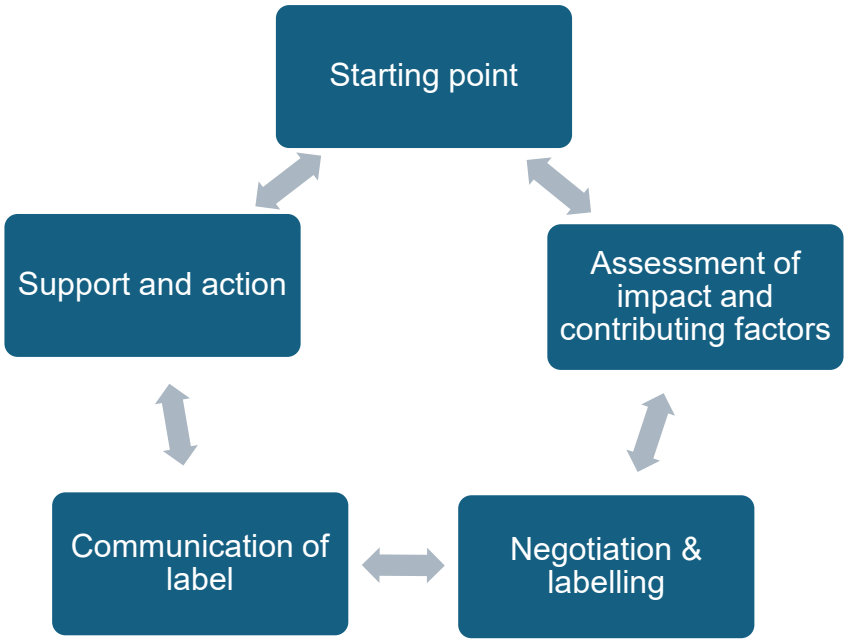
Figure 7. Example pathways of individuals before stress case is raised



3.2.2 Common aspects of the labelling process

Across the three key settings, the research identified five common stages that, at a high level, describe the process of labelling (see Figure 8):

Figure 8. Labelling process



- **Starting point** – When an individual first raises or discusses their experience.
- **Assessment of impact and contributing factors** – An exploration of what is causing the stress and how it is affecting their health and/or work.
- **Negotiation and labelling** – A two-way process where the term WRS is applied or agreed between the individual and the professional involved.
- **Communication of label** – Where the WRS label is shared with others such as HR, line manager or OH.
- **Support and action** – The steps taken following the labelling of WRS, including access to support services, sick leave, or workplace adjustments.

While this model provides a helpful structure for comparison across settings, it does not imply a linear or a clearly defined progression pathway. People may move back and forth between stages, skip some stages, or the process may be paused or stopped entirely. In practice, the process of labelling is highly inconsistent and fragmented.

3.2.3 How are WRS cases labelled by organisational leaders?

The views of OLs were analysed to identify commonalities and the processes used for labelling within organisations. Interviewees described how varied current practice is, a theme that also emerged during roundtable discussions.

The **starting point** for labelling WRS in an organisation typically involves someone raising a concern – this might be by an individual, their colleagues or their manager. These concerns may be based on observations of the individual's behaviour, including common signs and symptoms of stress, or they may arise from a direct conversation if an individual chooses to disclose their experiences.

Initial conversations in the work context generally include both the **impact of stress and the causes of stress**. Contributing factors discussed may include both work-related factors or working conditions and other factors, such as family responsibilities or a health condition. This initial conversation may, for example, be with a line manager, HR, or a mental health champion. Some organisations support these conversations with **individual stress risk assessments** or tools like the HSE's Talking Toolkit, to help structure discussions about the different causes of stress, but interviews indicate that knowledge about WRS, and awareness and use of the tools available is highly inconsistent.

The evidence indicates that the label WRS may be used in reference to, or in discussions with, an individual, but often without being underpinned by any definition or measurement. A key part of the conversation is the **negotiation** of the extent to which work contributes to their experience of stress, and whether workplace adjustments could help reduce their experience of stress – regardless of whether work is the primary cause.

The label WRS may not be formally recorded or **communicated** within an organisation. Instead, the term might be used informally, for example if a manager seeks advice from HR, or during the process of requesting workplace adjustments be made. More often than not, this happens on an ad hoc, case-by-case basis, rather than through a defined formal organisational process.

Support offered and action taken varies between organisations and might include adjustments such as flexible working arrangements, and signposting to external support services, particularly EAPs and OH where available. However, in some cases, no action is taken, particularly where access to such support services is limited. Delayed responses, which can exacerbate stress experienced and worsen the impact, were also reported.

Key points for labelling in organisations

Based on analysis of interviews with OLs, the following key points were identified:

- **Practice varies widely** between organisations and is influenced by differences in knowledge, familiarity with available tools, and organisational size.
- **Few organisations have a consistent process for labelling WRS.** Many organisations do not formally record stress-related cases. Sick leave related to WRS is generally coded as 'mental health' as the recording relies on HR systems and rigid codes based on what is most administratively convenient.

- **Some employers use individual stress risk assessments** to investigate cases where individuals report stress, but this practice is not widespread.
- **There is limited connection between individual conversations about WRS and organisational stress risk assessments**. While some OLs described this kind of process, including the involvement of OH and EAP providers, most organisations did not have a formal system in place to track and review trends in data.
- **Responsibilities for organisational stress risk assessments are unclear.** Many people are unsure how assessments should be carried out or used, and even within formal health and safety roles there may be limited confidence in how to carry out an organisational stress risk assessment and support the ongoing management of identified risks.
- **Labelling of WRS in organisations is mostly informal and reactive**, with labels being given only after an individual has experienced WRS. Even in organisations with more advanced stress management systems, further integration between organisational and individual approaches was seen as necessary.

It is noteworthy that those consulted were likely to be among the most interested and engaged employers – meaning that the challenges identified here may be even more pronounced across employers more generally.

Implications for research

- Identifying leading indicators of WRS that can support earlier identification and intervention, both at individual and organisational levels, would be helpful given the reactive nature of the approach reported.
- Evaluating the effectiveness of informal labelling processes and understanding how they influence outcomes for employees, such as access to work adjustments, support, and return to work could determine what changes should be prioritised to improve work and health outcomes.

Implications for practice

- Implementing an organisational stress risk assessment process will pivot stress management from reactive to preventative practice and ensure that legal duties are met.
- Integrating individual and organisational stress risk assessment processes could ensure that insight from individual cases informs wider organisational practices.
- Providing line managers with training and tools to be able to recognise signs and symptoms of WRS, and to identify and manage work-related factors that can impact on health, will help to increase consistency in support for individuals.
- Clarifying internal roles and responsibilities for carrying out and acting on stress risk assessments will improve the consistency and transparency of how WRS is labelled and managed.

3.2.4 How is WRS labelled by medical professionals

The views of HCPs and OHPs were analysed to identify commonalities and the processes used for labelling in healthcare settings. Given the differences between processes and perspectives between groups, this section is presented in two parts.

Labelling by GPs and primary care professionals

Due to variation in workplace practices and stigma associated with disclosure, the **starting point** for many individuals raising stress-related concerns is in a primary care setting. They may visit a GP or other HCP due to feeling stressed at work or with another health-related concern that is later found to be linked to, or exacerbated by, WRS. This is now a common experience given the scale of stress-related absence reported.

When individuals speak to HCPs, the primary focus is on **assessing** their overall health and **identifying contributing factors**. Stress may be explored as the primary condition being investigated, or it may emerge during discussions about other concerns, such as anxiety or depression, where work is identified as a contributing factor. In these cases, time off work may be recommended to support recovery, even if work is not seen as the root cause of the stress. This distinction is important. HCPs indicated that they are not trained to assess specific aspects of a person's job or to determine precisely which work-related factors may be causing stress. Instead, their role is to determine the best course of action to improve the individual's overall health.

It was noted that this process of issuing a fit note is not always led by a GP. The process varies considerably between practices as to who may assess an individual's request for a fit note, and in some cases, as primary care increasingly relies on digital systems, **digital requests are submitted and fit notes issued in the absence of an assessment by or conversation with a medical professional,** meaning the individual decides for themselves whether they are fit for work. Where a consultation does take place, the **assessment may be brief**, with an average of nine minutes per GP appointment.

If a HCP believes that time off work will be beneficial for the patient, the next phase of the process will involve **negotiating the content of the fit note**. HCPs described how some patients prefer not to have workplace issues (e.g., WRS) written on their fit note if it is going to be seen by their employer, while others shared that they use the term WRS as a simple and pragmatic way to reach agreement with a patient on what is recorded, providing enough information for the employer, while respecting the patient's right to privacy. In many cases, other diagnoses may be recorded elsewhere in the medical record and additional contributing factors may have been discussed during the consultation but omitted from the official document.

Some stakeholders expressed concern or frustration about HCPs issuing a fit note for stress as they perceive this as unhelpful. It is important to recognise that there are several reasons why the fit note cannot reflect the full content of a consultation, where such a conversation has occurred. These include the format of the fit note and space available for communicating information, training and confidence of HCPs in completing fit notes, knowledge of the patient's job and workplace, and time available during the consultation to make meaningful recommendations.

Typically, a full diagnosis and label will be shared with the patient, while the label of WRS will be **communicated to an organisation** via a fit note. Follow-on **support and action** are inconsistent. Some HCPs signposted patients to specific resources or services related to stress, while others lacked options to offer. As communication between primary care and employers is limited, for many HCPs this often marks the **end of their involvement.**

Time off work was described as the most common intervention for WRS. However, this raises important concerns. There is limited research evidence to support the effectiveness of time away from work in improving outcomes for WRS, or to determine under what conditions it may be helpful. HCPs reported that recommending time off was often the only available option, particularly when other forms of support were not accessible. This is especially noteworthy given the broader evidence that good work is generally beneficial for health (Waddel and Burton, 2006) and that the longer an individual remains away from work, the less likely they are to return (Office of National Statistics, 2021).

Labelling WRS in occupational health services

The **starting point** for labelling WRS by an OHP is typically through a manager referral. While some interviewees reported working in organisations that allowed individuals to self-refer, this was noted to be rare. It is also noteworthy that, in many cases, an individual may be referred to OH after they have already been signed off work by a GP. As such, this stage often follows the processes previously described in the section above.

OHPs consistently reported using **individual stress risk assessment** tools to identify **sources of stress** for an individual, drawing on a biopsychosocial approach. This holistic perspective considers physical health, mental health, relationships and social circumstances that may be influencing an individual's experience of stress. Where a patient is also experiencing mental ill health, OHPs may use additional tools to assess the **impact of stress**, such as measuring anxiety, sleep, substance use or depression. Unlike consultations with a GP, an OHP typically has more time available to work with a patient and explore their situation, in some cases supported by the completion of questionnaires prior to an appointment.

If an OHP identifies WRS as an issue, this label is usually included in their report. The report is then subject to a **consent and negotiation phase**, where the individual is asked if they agree to share it with their employer. Interviewees reported that this negotiation often involves discussions about the precise language used in the report, or also the recipient of the report, particularly if the individual's relationship with their line manager is a source of stress. In some cases, consent may not be obtained, in which case the report would not be shared. However, in general, a report will be shared following mutually agreed adaptations. The report would include the **communication of the label** WRS to the organisation. However, OHPs described being careful with their wording, ensuring they make clear that WRS is not the same as stress **caused** by work. This distinction is important, as OHPs typically only hear the individual's account of their work situation and may not have all the relevant information. As a result, OHPs generally felt confident stating that work contributed to, rather than directly caused, the individual's experiences of stress.

As part of an OH report, individuals were often signposted to various **sources of support,** alongside recommendations for **employer-led actions**. These recommendations were based on suggested adjustments to address the contributing factors identified during the assessment. For most OHPs interviewed, this marked the end of the process, as responsibility for implementing any actions was generally passed back to the line manager. In most cases, no follow up or further assessment was conducted.

Key points for medical professionals

Based on analysis of interviews with HCPs and OHPs, the following key points were identified:

- **Signs of WRS vary widely:** Medical professionals described a wide range of signs that may indicate WRS, including physical symptoms (e.g., sleep problems, fatigue) and social or behavioural changes (e.g., conflict at work, withdrawal).
- **Mental health and other conditions often overlap:** WRS was often found to co-occur with mental health conditions such as anxiety or depression. This overlap can complicate how WRS is recognised and managed.
- **Different assessment approaches and tools are used:** HCPs and OHPs use different approaches to assess WRS. HCPs rarely use specific tools, mainly due to a lack of awareness and time constraints. In contrast, OHPs are more likely to use structured tools such as the HSE Management Standards, Generalised Anxiety Disorder 7 (GAD7), and Patient Health Questionnaire 9 (PHQ9). Even so, OHPs focus on identifying links between work and stress rather than proving a direct cause, which they say is difficult to determine.
- **Management Standards are used by OHPs:** OHPs reported consistently using the HSE's Management Standards to explore potential work-related causes of stress and found it a helpful framework for assessing psychosocial risk.
- **Work context matters:** OHPs highlighted how the factors contributing to WRS can vary depending on the sector or role. For example, those working in the military or emergency services may face specific pressures. They often distinguished between *role stressors* (linked to the job itself) and *organisational stressors* (linked to workplace culture or management practices).
- **Time off work is the most common intervention, but often applied without considering the potential unintended consequences:** NICE guidelines support short absences with structured return-to work planning because short-term leave can be helpful to allow for recovery, taking time away from a stressful environment, and allows people to engage in therapy, medical appointments or self-care they might not manage while working. However, being away from work – particularly for periods of four weeks or more - has been found to reduce the chances of an individual returning to work, potentially leading to job loss (Office of National Statistics, 2021). HCPs did not appear aware of this unintended consequence.

- **Support offered varies:** People with WRS were usually signposted to wellbeing advice and support outside of work. Within the workplace, OHPs often recommended adjustments, such as changes to working hours duties, or improved conversations with line managers, but their input was often limited to making the recommendation – neither HCPs nor OHPs saw their role as providing ongoing support.
- **More proactive action is needed:** Both HCPs and OHPs described how system pressures mean that limited support is provided, and most support is given only once someone is already struggling – meaning that they are set up to be involved in reactive stress mitigation, rather than preventative action. There was strong agreement that employers could do more to take *early, proactive steps* to reduce stress before it becomes a health issue.

Implications for research

- Examining the short- and long-term effects of time away from work as a response to WRS is needed. This should include identifying when time away from work supports recovery, when it may have unintended consequences, and how it influences longer-term employment outcomes, such as return to work, job retention, and health.
- Evaluating the effectiveness of OH recommendations and how they are acted upon in organisations, including the barriers and enablers that influence whether adjustments are implemented and sustained.
- Identifying and testing novel approaches to improving effective communication between medical professionals, employers, and employees in relation to WRS labelling, support, and follow-up actions.

Implications for practice

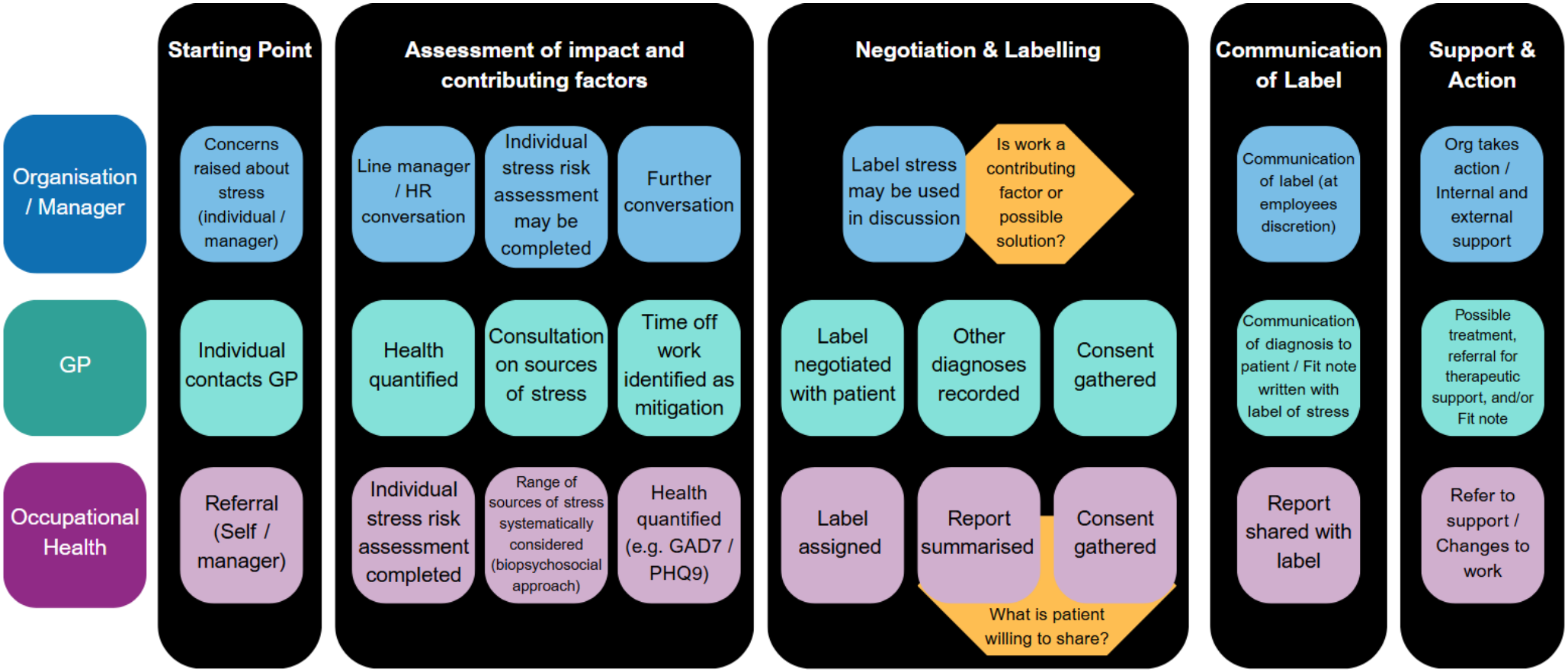
- Developing accessible, evidence-informed tools for use by HCPs, specifically GPs, would help to structure conversations about WRS and draw in helpful frameworks like the Management Standards.
- For HCPs completing fit notes, weighing the benefits and risks of time off work carefully is important, and ensuring these decisions are based on consultation with the patient will help to contribute to holistic decision making.
- For OH professionals, considering further ways to influence good practice by sharing knowledge and providing strategic insight could help improve the management of WRS.
- For organisations, engaging OH as a strategic partner not only for individual assessments but for informing organisational stress risk assessments and strategy reviews to allow identification of patterns early and targeted action to be taken.

3.2.5 The comparison of labelling processes

The pathways to labelling WRS vary depending on the professional involved, the system in place and the resources available. Figure 9 summarises the typical processes followed by organisations, OH professionals, and GPs when identifying WRS.

The labelling process across the different settings is presented visually in Figure 9.

Figure 9. Comparison of labelling process across organisations, GPs and occupational health



Drawing together the findings from across the different sources, several key points regarding the labelling of WRS were identified:

- **There are multiple, varied routes to labelling WRS**: People reach the point of receiving a WRS label through different pathways depending on who they speak to first, what support is available, and how their organisation or GP responds. These pathways are inconsistent, fragmented, and non-systematically applied.
- **Labelling involves negotiation**: Assigning the label of WRS often involves a negotiation between stakeholders with different responsibilities and priorities — including line managers, GPs and other primary care providers, OH professionals, and employees themselves. Disagreements can occur, particularly around the content of fit notes, but these reflect wider systemic and contextual challenges – such as time pressures, information gaps, or role boundaries - rather than any one individual's failing or error.
- **Labelling is complex, multi-faceted, and requires time to do well**: Understanding the causes of stress is complex, and a comprehensive assessment requires a full picture of what is contributing to someone's stress — at work and outside it. However, current systems often do not allow enough time or space for a thorough assessment, meaning it is difficult to get a complete understanding of a person's situation and determine the most appropriate label or support.
- **Structured tools are essential but underused**: There are tools available to assess causes of stress, such as individual stress risk assessments, but they are not used consistently across settings. Many health professionals, particularly GPs, lack the time, training or remit to carry out workplace assessments.
- **By the time we label something 'stress', it is often too late:** In many cases, the process of labelling begins only once someone's health has already been impacted — often through the issuing of a fit note. This is a reactive process and opportunities for early intervention are often missed.
- **A proactive approach is needed:** Interviewees consistently highlighted the value of early identification and action. Addressing potential sources of WRS before they escalate into or exacerbate ill health is preferable to waiting until an employee reaches a point of crisis.
- **Organisational responsibility must be central to the process of labelling WRS:** While labelling stress often focuses on the individual, the role of the organisation is just as important. When employers use data (e.g., surveys, absence trends, or case reports) to identify patterns and act early, this shifts the focus from individual responsibility to shared organisational accountability. This also reflects a known limitation of the Management Standards (MS) Stress Indicator Tool when used in isolation: when only a small number of employees are reporting exposure to potential stressors, their survey responses may appear as 'outliers' and be disregarded. This risks minimising their experience and may

lead to serious issues being missed. A more nuanced, proactive, and integrated approach is therefore required.

- **Better coordination across systems is needed**: To ensure people receive the right support at the right time, professionals across health, occupational health, and the workplace must have access to the right tools and be supported in using them. Greater alignment between these systems would improve the consistency, accuracy, timeliness, and impact of WRS labelling and subsequent action.

3.2.6 Factors influencing the process of labelling WRS

A wide range of factors were identified as contributing to the lack of consistency in how WRS is identified, labelled, and managed. These include factors related to the individuals involved (both the person experiencing WRS and the professionals), levels of knowledge and understanding of WRS, and the wider organisational and healthcare context.

Individual factors

Several factors were found to shape an individual's experience of WRS. One key factor is **comorbidity** – when other medical conditions are present at the same time. HCPs and OHPs referred to common mental health disorders, such as anxiety or depression, being particularly associated with experiences of WRS. An individual's **medical history** is also relevant; for example, those with a long-term health condition, or previous stress-related concerns, may respond to workplace changes differently, with adjustments having a disproportionate or specific impact on their level of stress.

The personal support available to an individual also matters. **Support from colleagues**, **line managers** or **family and friends** can influence an individual's perception of stressors and influence their ongoing recovery. While evidence on the topic is complex and shaped by context, research suggests that social support can play a protective role by buffering against the negative impacts of WRS (Jolly et al., 2021).

Knowledge-based factors

The level of knowledge and understanding among all those involved has strong influence throughout the labelling process. For example, differences in training and remit mean OHPs are likely to have more specialist conversations with individuals regarding WRS. Similarly, managers may vary in their understanding of stress and their ability to recognise signs and respond to it.

Familiarity with **frameworks and tools** also matters, and this is influenced by prior knowledge and experience. Those who were familiar with the different factors influencing WRS, as captured in the **HSE Management Standards**, were more likely to consider a broader range of possible sources of stress. During the consultation, it was also noted that while resources such as individual stress risk assessments and

toolkits published by the HSE are valuable for supporting managers and organisations, many managers were unaware that these tools exist.

Subjective views of stress also have a strong influence on how WRS is perceived and addressed, particularly among managers. There was an acknowledgement that among some managers, there is an acceptance that stress is justified and a natural outcome of high performance, reducing their likelihood to act on concerns. While participants shared that this view is becoming less common among managers, it was still expressed by several interviewees, noting that this varies by sector, where stress was considered an inevitable part of certain occupations, for example in construction.

Contextual factors

In organisational settings, several contextual factors were found to influence experiences of WRS. **Trust in the organisation** was a key factor affecting whether an individual was likely to discuss their experiences of stress. This was closely linked to the **opportunity to raise concerns** and speak up about stressful experiences. However, **stigma** about stress was still prevalent in some workplaces, where negative assumptions are made about individuals who experience stress or take time off for this or other mental health concerns.

Practical issues, such as the limitations in HR and OH **coding systems,** were also identified as barriers to gathering accurate data on the causes of WRS within organisations**.** As a result, organisations may lack a clear picture of where stress is occurring and why.

For HCPs, the **system pressures** were a major factor. Rising demand for services, time constraints, and limited resourcing made it difficult to assess stress thoroughly. While these system pressures are well recognised in primary care, OHPs reported that this is increasingly felt by occupational health providers too. It is also worth noting that a small portion of the UK workforce (45%) has access to OHPs (Commission for Healthier Working Lives, 2024). OHPs also reported challenges around the **supplier relationships** with many external providers, and the **policy and contractual terms** agreed. As previously mentioned, these OHPs also raised **concerns about liability.** This influenced how they described WRS, noting that some organisational clients had relayed concerns that there was a perception that any implication that stress was caused by work could lead to legal consequences.

In more complex or escalated cases, it was recognised that **formal processes or legal proceedings** can influence the process of labelling WRS and how it is recorded. For example, if an employee is pursuing an employment tribunal, any assessment of stress may be shaped by legal considerations. OHPs described being cautious in how they worded reports, making sure they carefully constructed it to account for potential liability, and negotiations with the individual may be influenced

by the perceived utility of the report in supporting their case. While these cases are relatively uncommon, they were highlighted by OHPs in different settings as an important consideration in how WRS is labelled.

Overall, a combination of individual, knowledge-based, and contextual factors contribute to the wide variation in how WRS is identified, labelled, and managed across different settings.

4 Conclusion

In examining perspectives of labelling WRS across organisations and medical professionals, several key differences as well as commonalities can be identified.

It is noteworthy that each stakeholder group approaches WRS with different priorities. For employers, there is a dual responsibility: a duty of care for their employees alongside a need to deliver their core business objectives. As a result, managing WRS involves balancing both health and performance considerations. For HCPs, their duty is to an individual patient and safeguarding their health. OHPs occupy a unique position, aiming to balance legal, organisational, and health perspectives, while maintaining a primary duty of care to the individual. These different agendas are by no means incompatible, but these inherent tensions help explain the variation in how WRS is identified, labelled, and managed in practice.

It is important to consider that no research is without strengths and limitations, and these should be kept in mind when reflecting on the conclusions of this report. The strengths and limitations of each of the methods used to gather the data in this research are discussed fully in Appendix 7.

This mixed methods approach has several notable strengths:

- Enabling a holistic synthesis of different types of evidence and captured insights from a wide range of stakeholders, including practitioners from occupational health, healthcare, and organisational leaders.
- Allowing us to capture the complexity of WRS labelling across different systems and professions.
- Iteratively validating and refining findings through PAG and PSG input.

The approach also has several limitations that must be considered when interpreting the conclusions:

- The quality of the available academic evidence based on WRS labelling is limited.
- The consultation sample may be more informed and engaged than the general population.
- Formal evaluation of effectiveness or outcomes was beyond the scope of this research.

Overall, this study represents a foundation for further testing and refinement and highlights key directions for future research, policy, and practice.

4.1 Defining work-related stress

Across all sources of evidence, there was consensus that there is not a binary distinction between stress related to work and stress outside of work. An individual's experience of WRS is shaped by a combination of factors – both within and outside of work – as well as the availability and suitability of resources, and their appraisal of their situation. Consequently, the process of labelling WRS in practice is often less about understanding when work has or has not caused stress and looking to assign blame (unless required for legal reasons), but more about looking for opportunities to alleviate stress through adaptations in the working environment.

While definitions of WRS vary, in practice processes focus more on the impact of stress rather than its cause – a shift also reflected in academic research, demonstrated by the growing research interest in burnout. To support practice, it is important that clear distinctions are made between stress, pressure, burnout, and other related concepts. Though this need not be the primary focus of activity on WRS, it is recognised that practical action is better informed by understanding the aspects of work that can impact health.

Our research suggests that identifying psychosocial hazards – the work-related factors that can create risk of WRS – and recognising the broad range of potential outcomes, both to mental and physical health, could help. For employers, this helps to clarify responsibilities and provides a basis for taking action on the factors they can influence. Focusing on defined hazards creates a clearer remit for employer activities in assessing risk and identifying effective interventions in the work environment.

In this context, further work to align language, regulatory expectations, and assessment tools between sectors could support greater consistency and reduce ambiguity for employers.

4.2 Labelling work-related stress

Labelling WRS often involves negotiation between individuals across different settings, yet the full nature of this negotiation is rarely captured in documentation. This suggests the need for open and ongoing dialogue between stakeholders to develop a full understanding of individual circumstances and identify responses that reflect the complexity of each case.

This research also found that with the increasing use of digital systems in primary care, more fit notes are being issued based on self-reported symptoms and requested outcomes, and in the absence of a consultation or conversation. Many participants described improvements they would recommend being made to the fit note system. It is acknowledged improving it will require significant engagement

between different stakeholders and a recognition of the constraints facing each party. Some pilot initiatives are already seeking to improve these processes (See Department of Health and Social Care et al., 2025).

The high level of variation in how WRS is labelled and addressed raises concerns about the consistency and adequacy of support provided. Many workers do not have access to supportive systems like OH or EAP services, or are supported by professionals (e.g., GPs, line managers) that do not have the knowledge, tools or time required to assess WRS holistically.

Even when WRS is recognised, the type and quality of support an individual receives varies significantly depending on who they have told, where they work, and the support services available to them. This differential access is likely to contribute to existing health inequalities as those in more unstable employment (such as gig workers), small and medium sized enterprises, and in lower paid work which is outsourced or managed on a self-employed basis are the most likely to lack access to additional support. This is a key area for further research to understand the links between WRS and health for particular groups of employees.

A related challenge is the lack of integration between individual-level identification and organisational-level stress risk management. Very few organisations systematically use insights from individual cases to inform systemic actions or stress prevention efforts. This disconnect limits opportunities for proactive, systemic improvement.

4.3 Supporting individuals and organisations

Various participants in this research recognised the benefits in existing tools and support for WRS – including individual stress risk assessments, HSE's Management Standards, HSE's Talking Toolkit, and the Management Competencies for Preventing and Reducing Work Stress. Participants felt that further communication of these tools, including building on the sector specific resources already available, and encouragement to use them would be a positive step in tackling WRS.

Many participants felt that further regulatory action from the HSE would help to incentivise organisational action on WRS, gaining the attention of senior leaders, and the consultation process revealed that further clarity is wanted on what form of enforcement action would be most effective. Participants felt that many organisations remained unaware of their responsibilities for managing stress at work and that clarity and advice on the need for, and how to conduct an organisational stress risk assessment would be helpful.

Line managers were consistently seen as critical to enabling supportive conversations about WRS, but participants noted wide variation in their confidence and capability to do so. While some managers are well-equipped to respond to early

signs and hold discussions about WRS enabling early action, others feel unsure how to respond to concerns. Increasing the focus on manager training, supported by accessible tools and guidance, was seen as essential to improving consistency and enabling earlier intervention.

4.4 Taking a joined-up approach to work-related stress

Participants emphasised the need for organisations to take a strategic and preventative approach to managing WRS. This includes having systems in place to understand psychosocial hazards present, gathering data to identify areas of elevated psychosocial risk, and enabling pre-emptive action to mitigate possible harm. Creating mechanisms for individuals to raise concerns confidentially and supporting managers to have capacity to create supportive environments, where these could be raised informally were seen as critical enablers.

Where individuals are then impacted by WRS, which will always be a possibility given the wider sources of pressure people face, creating clear links between individual processes (such as case management and individual stress risk assessments) and wider organisational safety management systems were seen as key. One aspect of this is ensuring that accurate and actionable data is captured. Another is securing good information from suppliers where any aspect of this system is outsourced.

Despite their expertise, OHPs are often underutilised in wider organisational strategies for WRS. Greater involvement of OH in routine workforce data analysis and system-level planning could strengthen early information. Participants reported experience of suppliers withholding information due to confidentiality concerns but were clear that trend data can and should be shared, and such data were key to allow organisations to take appropriate action to manage WRS. More broadly, the availability of big data within organisations remains a largely untapped resource. Data on working hours, technology use, sickness absence, and EAP utilisation are already collected in many organisations. Linking these data sources to identify leading indicators could help to create a more joined-up and evidence-based system for identifying and managing psychosocial risk.

Finally, participants emphasised that a preventative and system-wide approach must be underpinned by coordinated action across government, employers, occupational health, primary care, and regulators. Without this, individuals will continue to navigate fragmented systems and inconsistent support. A clearer, system-wide response could reduce harm and support healthier, more sustainable working lives.

5 Considerations

5.1 For research

Based on the evidence presented, the following areas are recommended for further investigation to strengthen the evidence base and improve the early identification, prevention, and management of WRS across settings:

- Investigate the impact of time off work as response to WRS, including when it is helpful, when it may be harmful and what alternatives may be more effective.
- Explore the unintended consequences of labelling WRS, including stigma, over-medicalisation, or impact on employment and support, and how these may influence work and health outcomes.
- Explore appropriate interventions in smaller organisations without access to OH or EAP services.
- Examine how health inequalities interact with lack of access to OH or EAP services (e.g., gig workers).
- Examine sector-specific variation in how WRS is labelled, managed, and addressed, and how this should shape future policy and intervention design.
- Examine how different regulatory approaches to WRS (for example, awareness campaigns, inspections or enforcement) could support compliance and prevention in a GB context.
- Develop linked, large-scale and longitudinal datasets on work and health to identify early indicators of risk, better understand trends over time, evaluate the impact of interventions on employee outcomes, and shape intervention activity.
- Investigate the impact of new and evolving work practices (e.g., hybrid work, digital surveillance, AI integration) on psychosocial risk, and how these risks can effectively be mitigated.

5.2 For organisations

We encourage organisations of all sizes to reflect on these findings and take the following steps to:

- Ensure that organisational stress policies, or their equivalent, use an inclusive definition of stress that recognises the impact that work adjustments can have on stress, even if the primary cause of stress is external to the workplace.
- Implement a robust organisational stress risk assessment to identify and addresses key sources of work-related stress. This may draw on the HSE Management Standards, but the priority is to identify the most significant psychosocial risks using available data and employee input, and to then

demonstrate how these are being managed. A robust assessment should map the highest-risk areas to the relevant Management Standards, even if the full framework is not used.

- Provide training to employees on what stress is, how to recognise signs and symptoms of stress in themselves, and to understand the work-related factors that can impact on health so they are better able to articulate their needs and feedback on any issues.
- Provide training to line managers on what stress is, how to recognise signs and symptoms of stress in themselves and others, and to identify and manage the work-related factors that can impact on health. Training should also equip line managers to take preventative action, including adjusting work demands and addressing organisational causes of stress. Managers should also have time to fulfil this role.
- Ensure there is a system in place to routinely link health and wellbeing data (e.g., From OH, HR, EAP or line managers) to organisational stress risk assessments. Use this data to inform decision-making, track trends, and evaluate interventions to enable more joined up and preventative action. OHPs could play a vital role as a strategic partner in these efforts.
- Regularly review multiple data sources (such as absence, staff surveys, working hours, performance concerns, and exit interviews) to identify early warning signs and priority psychosocial risks.

5.3 For health professionals and the services they work in

Our findings suggest that more consistent and effective responses to WRS could be supported by:

5.3.1 Primary health services to support GPs and other primary care professionals:

- Develop a consistent suite of tools or consultation prompts that could be used by GPs to ask relevant questions about the working environment to support meaningful conversations about work-related factors (e.g., a simplified version of the Management Standards).
- Weigh the benefits and risks of time off work carefully, particularly for longer-term absence, and ensure that decisions about time off are not made solely through digital or automated systems.
- Signpost people to organisational resources in the first instance, such as encouraging individuals to speak to line managers or HR professionals about their concerns or access available support from their employer.
- Explore opportunities for integration between healthcare and workplace systems, where consent allows.

5.3.2 Occupational health professionals:

- Consider how to use knowledge of good practices and tools to influence other stakeholders, encouraging employers to take more targeted and effective action.
- Offer strategic insight to organisations to feed into broader organisational stress risk assessments, helping employers to identify broader patterns and root causes of psychosocial risks, and encourage leaders to take action.

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7 Appendix 1 – Background to WRS

7.1 History of research into work-related stress

Understanding of work-related stress has developed over time as research evidence has been used to inform different ways of thinking about stress. The earliest concepts that underpin WRS come from broader psychological theories. Early theories of stress were informed by physiological and engineering approaches. Some of these were known as “stimulus based” approaches, which suggested stress was a set of causes (e.g., Symonds, 1947) – the things that happen to a person, and that this placed strain on an individual. Later “response based” theories used stress to describe the reaction of individuals to stressors (meaning the events or conditions which are seen to be putting pressure on an individual). This focuses on the biological response within an individual and the physical and emotional experience which follows. These early concepts informed early research in a workplace context, for example initial reviews of evidence by Cooper and Marshall (1976) and Beehr and Newman (1978), which collated job characteristics that could be seen as stressors in a work setting.

“Interactional approaches” built on these earlier theories, looking at the interaction between different factors such as job demands and control (Karasek, 1979) and effort and reward (Siegrist, 1996). These theories recognised that a combination of factors and their relationship to each other influenced how they contributed to stress. Later “transactional models” incorporated further factors such as the individual’s reaction to circumstances and their coping behaviour. A major addition was examining how individual thinking affected this process, looking at the dynamic interaction of how an individual makes sense of and responds to their environment (Lazarus and Folkman, 1984).

Theories further developed by considering how the resources available to an individual affected perceptions of stress (Hobfoll, 1989), and the balance of demands and resources and the relationship of these to motivation was brought together in the Job Demands Resources model (Bakker and Demerouti, 2007). Each of these theoretical approaches has been used to inform research into WRS, helping to identify the factors that contribute to individual responses to stress.

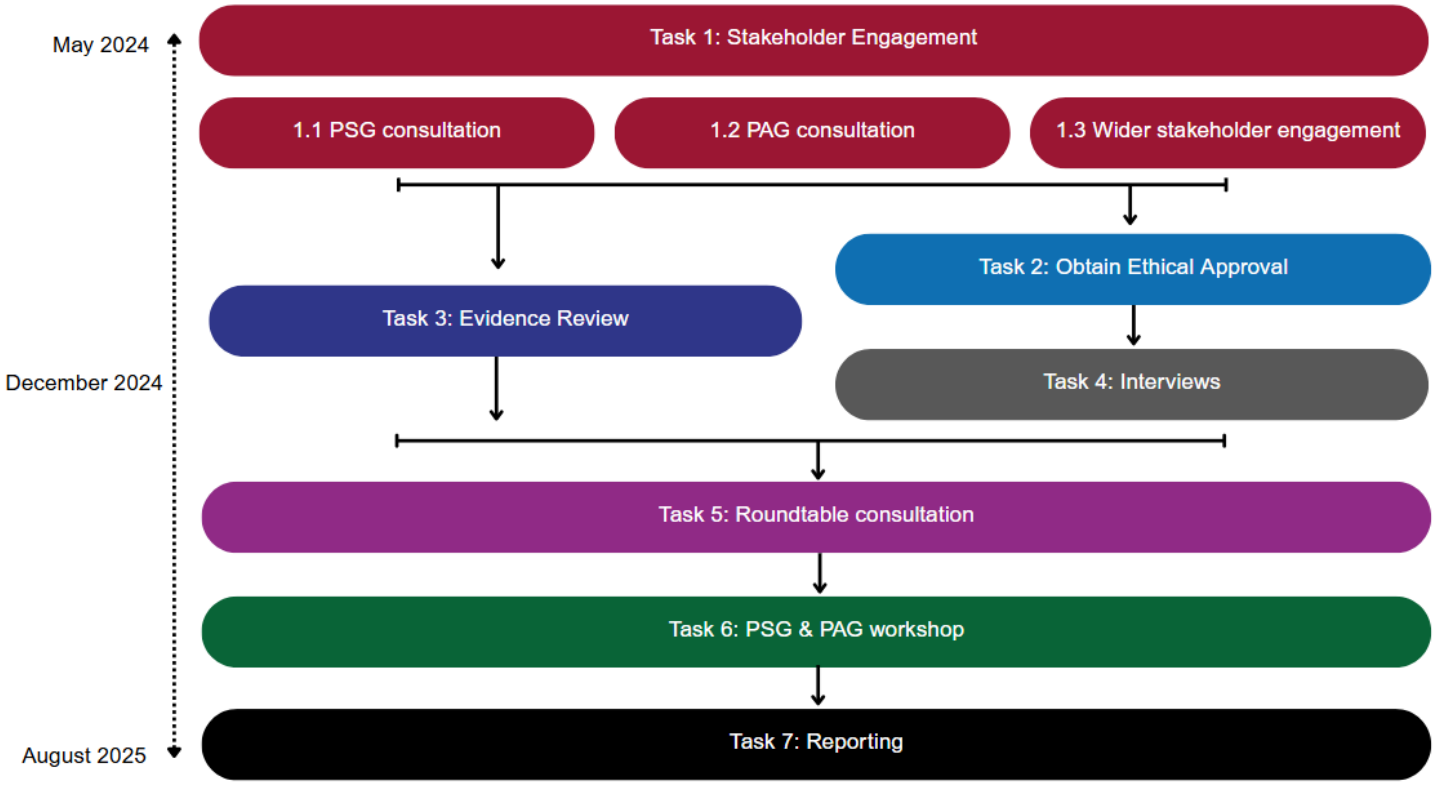
The complexity of WRS is also shown by the range of signs and symptoms that are associated with it. Individuals who are experiencing stress at work display a range of symptoms, including physical, mental, cognitive and social impacts. Early signals of stress can therefore range from headaches and pain to withdrawing from contact with colleagues. This has presented a challenge in the workplace for managers and others to clearly identify WRS at an early stage.

8 Appendix 2 – Methodology

8.1 Approach

A multi-phase, mixed methods approach combined findings from: stakeholder engagement, a systematic literature review, stakeholder interviews, roundtable discussions and consultation with Project Advisory and Steering Groups. Throughout, the project was overseen by several groups to ensure project governance and integrate a wide range of expertise.

Figure 10. Flow chart of research approach



8.2 Project governance

8.2.1 Project Steering Group

The Project Steering Group (PSG), set up by the HSE, consisted of 10 members, including representation from the science division, the policy team, and senior leadership within the HSE, the Department of Work and Pensions, and members of the project team. Chaired by Professor Andrew Curran, Chief Scientific Adviser and Director of Research at HSE, the PSG met approximately every 3 months throughout the project to review deliverables and obtain early insights.

8.2.2 Project Advisory Group

The Project Advisory Group (PAG), set up by the research team, consisted of 12 experts in the field of WRS, including representation from advisory agencies, industry representatives, academics and members of the project team. Chaired by Professor Jo Yarker, the PAG met throughout the project with the aim to:

- Gain advice on emerging policy, practice and research that is relevant to the research questions.
- Share learnings from the research with those who are advocating, researching and consulting in the area of work-related stress to promote a coordinated approach.
- Gain a critical eye and sense-check approach to ensure the most robust and appropriate approaches available were used, optimizing the contribution of the work.
- Identify avenues for dissemination of learnings for research, policy and practice.

PAG members were offered various ways to engage as their expertise, preference and time allowed. The following arrangements were made:

- Meetings were held quarterly for 1 hour via Teams.
- Relevant material was shared ahead of meetings; meeting notes and actions circulated following.
- Specific documents relating to review protocols and draft outputs were circulated for comment.
- Members were invited to complete the calls for evidence and attend roundtable events run throughout the project to share experiences and recommendations along with other multidisciplinary work and health professionals.

8.2.3 HSE Project Team

Members of the HSE Science Division and Engagement and Policy Division met with Professor Jo Yarker and Nathan Palmer monthly to review research materials and deliverables, discuss early findings, seek clarification on HSE policy on WRS and provide oversight of contracting arrangements.

8.2.4 Consortium Project Team

The main project team undertaking the research for the HSE was Affinity Health at Work in conjunction with its partners, the Institute of Occupational Medicine (IOM), the Institute for Employment Studies (IES), and the Society of Occupational Medicine (SOM). The Consortium Project Team met at regular intervals to discuss project activities, report on progress, and identify and mitigate risks to delivery. The team also used Teams channels to maintain regular communication.

8.3 Initial stakeholder engagement

In the early stages of the Project OSCAR research, a wide consultation and stakeholder engagement phase was conducted to help clarify the research approach and questions and identify ongoing activities in research and practice. This consultation was carried out between May – October 2024 and consisted of:

- An online call for evidence via the OSCAR webpage where members of the community could upload files, share evidence, thoughts, references and documents pertaining to the three research questions (of which this current report addresses one).
- Initial meeting with the PSG to further develop and understand project context and aims.
- Initial meeting with the newly formed PAG to further refine and define research questions and protocol for the evidence reviews.

Evidence submitted through the call for evidence were tagged to be considered in the evidence review.

8.4 Wider stakeholder engagement

A Knowledge Exchange Workshop (KEW) was facilitated virtually to engage stakeholders. Attendees included academics, researchers, consultants, health professionals and practitioners, and experts in the field of WRS. The KEW enabled experts to share their knowledge and insights on WRS across the three RQs of interest and signpost the study team to relevant information sources for inclusion in the evidence reviews. The input provided during this session was helpful to refine and further target our approach to reviewing the evidence base and data collection methods to consult with relevant stakeholders as part of research for this question and more widely across Project OSCAR on the topic of WRS.

8.5 Systematic literature review

A systematic review of academic and grey literature in the field of WRS examined the question **"How is work-related stress assessed, assigned, labelled and defined by organisations and medical/healthcare professionals?"**. We also aimed to answer sub-questions:

- What definitions of work-related stress are used and by whom?
- What assessment criteria/processes or information are used to assign a label of WRS and what is the source?
- What other labels are used to describe WRS, e.g., burnout, moral injury?

- How is WRS distinguished from other forms of mental ill-health and what are the difficulties in doing this?

8.5.1 Academic literature search and sift

Protocol and eligibility criteria

A protocol with the review was developed and registered on PROSPERO (CRD42024599357) on the 14/10/2024. Prior to registration both the PAG and PSG were consulted to ensure agreement and to gain expert opinion on inclusion and exclusion criteria. For the full search criteria, see **Table *2***.

Table 2. Inclusion and exclusion search criteria

Category	Inclusion	Exclusion:
Participants/ population	• Employees, including individuals experiencing WRS, managers and colleagues	• non work samples, student samples
	• Organisational stakeholders, including Human Resource professionals, trade unions, professional bodies, occupational health professionals, those responsible for health and safety	• Researchers/academics measuring WRS for academic research purposes only. This review is only interested in applied use of measures of WRS in organisational or clinical settings with the aim of diagnosing individuals/employees
	• Medical and healthcare professionals, including GPs, psychiatrists	• Employees self-reported definitions or reflections on lived experience of work-related stress
Outcomes	• Work-related stress and specifically the ways in which it is assigned and/or labelled by individuals, organisations and medical professionals. This will include clinical definitions of stress which is attributed to work	

Study Design	• All types of research such as reviews, qualitative studies, quantitative studies, mixed methods, case studies and case reports. We will include research from all countries as long as it is published in English	• Where stress or mental health is not related to work
	• Published in the last 10 years (from 2014) to capture contemporary and currently applied definitions	• Thought and opinion pieces

Searches

Eight databases were searched on the following dates via EBSCO Host: Academic Search Ultimate (21/10/24), APA PsycArticles (21/10/24), APA PsycBooks (21/10/24), APA PsycExtra (21/10/24), APA PsycInfo (21/10/24), Business Source Ultimate (22/10/24), CINAHL Ultimate (22/10/24), Health Policy Reference Center (22/10/24), MEDLINE Complete (22/10/24). Web of Science was searched separately (23/10/24). Additional relevant studies were identified via pearl gathering though screening papers as well as via the evidence mapping exercise completed for the wider project.

An example of the main search string is:

TI (stress OR anxiety OR depression OR mental health OR 'mental health condition' OR 'common mental disorder' OR mental distress OR 'psychological distress' OR PTS* OR suicid* OR burnout) AND AB (work OR occup* OR organi* OR work-related OR job-related) AND TI (identif* OR diagnos* OR screen* OR detect* OR label* OR assign OR defin* OR assess OR present OR measure)

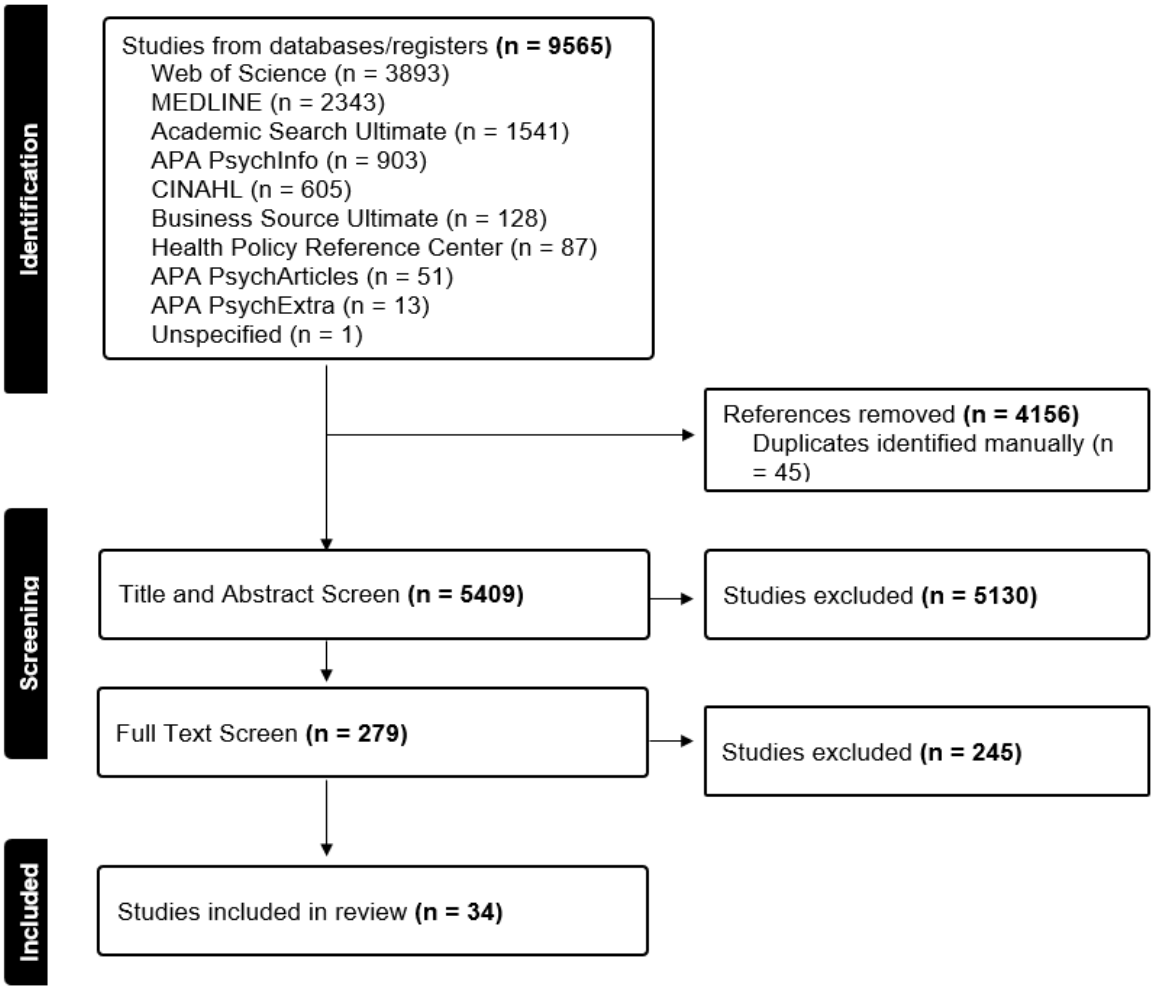
Reference lists were imported into the review platform Covidence where title, abstract and full text screening and extraction were completed (21/10/2024 - 18/11/2024).

A note on burnout

The academic review highlighted how a large proportion of research in the area of WRS is focused on burnout. Burn-out is included in the 11th Revision of the International Classification of Diseases (ICD-11, World Health Organisation) as an occupational phenomenon. It is not classified as a medical condition (Jacobs, 2024). According to WHO's diagnostic criteria, burnout is a syndrome resulting from workplace stress that has not been successfully managed. It is characterized by

three dimensions: "*feelings of energy depletion or exhaustion, increased mental distance from one's job or feelings of negativism or cynicism related to one's job, and reduced professional efficacy*". Mind defines burnout as "*a term used to describe a collection of experiences caused by long-term, unmanageable stress at work*" (Mind, 2022). Due to burnout being recognized by the ICD-11 in this way, it has generated much research interest and therefore there is larger consensus on how to define and assess this construct with the most frequent measure being Maslach's Burnout Inventory (Maslach et al., 1997). As the current review is seeking to answer the research question of "how WRS is defined and labelled", studies related only to burnout were excluded to (1) more clearly identify the findings for WRS and (2) contain the scope of this review given the resource available. However, it is worth noting the importance and relevance of the burnout literature to this discussion.

Figure 11. PRISMA flow diagram of searches and retained studies for academic literature



Study selection and extraction

At each screening stage, 20% of the screen was moderated by a second or third reviewer. At each stage any disagreements were discussed with the wider team prior

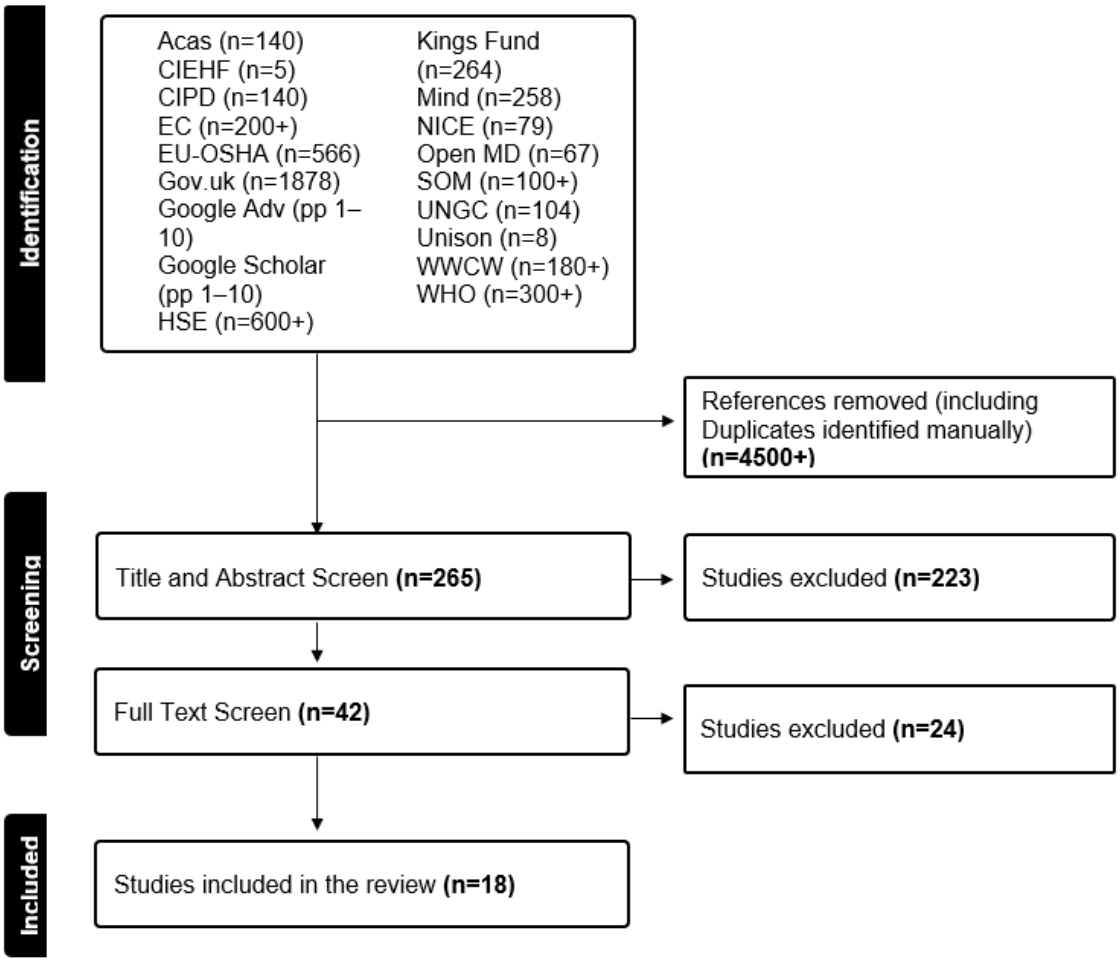
to moving to the next phase of screening. As detailed in Figure 11, our search identified 34 studies which were then extracted.

Grey literature search and sift

To identify relevant grey literature, a search protocol was developed which incorporated three complementary strategies to capture the relevant evidence:

1. A search of targeted websites of prominent public, private and third sector institutions, including governmental and intergovernmental organisations[1]
2. Searches of grey literature databases relevant to the review
3. Advanced Google search

Figure 12. PRISMA flow diagram of searches and retained studies for grey literature



[1] Consensus on authoritative sources as recommended by experts across the consortium and the PAG

The search of targeted websites included European agencies, such as the European Commission, the European Agency for Safety and Health at Work (EU-OSHA) and Eurofound; Global agencies, such as the International Labour Organization (ILO); United Nations Global Compact and World Health Organisation (WHO); and UK bodies, such as the Advisory, Conciliation and Arbitration Service (Acas), Chartered Institute of Ergonomics and Human Factors (CIEHF), Chartered Institute of Personnel and Development (CIPD), Health and Safety Executive (HSE), Institution of Occupational Safety and Health (IOSH), Mind, National Institute for Health and Care Excellence (NICE), Society of Occupational Medicine (SOM), Unison and the What Works Centre for Wellbeing.

The interrogated grey literature databases included three general databases: Gov.uk; Google Scholar; and Opengrey.eu; and two sources of grey literature on health: OpenMD and the Kings Fund Database. The advanced Google searches were conducted with results ordered by relevancy and we screened the first ten pages of results from each search, as it is not feasible to screen all retrieved results from Google.

There was significant variance in the search functions and limiters available in each of the three main search strategies and search terms were adapted to fit each search source (with Boolean operators and truncation commands applied where the search functionality allowed). Our search terms mostly reflected the key terms used in the adjacent academic review, including: mental health terms (stress OR anxiety OR depression OR mental health OR mental disorder OR mental distress OR psychological distress OR PTS OR suicide OR burnout); work terms (work OR occupation OR organisation OR work-related OR job-related); labelling terms (identify OR diagnose OR diagnosis OR screen OR detect OR label OR assign OR define OR assess OR present OR measure); and additional terms identified as relevant to this review (psychosocial risk OR psychosocial hazard).

Our inclusion criteria was set at relevance to any of the key research questions; population samples including employees, medical and healthcare professionals or organisational stakeholders; publications from 2014 onwards; UK and international evidence; full text access availability; and literature possessing a robust scientific quality e.g., literature reviews, policy, practical or clinical guidance informed by subject matter experts or surveys with acceptable samples. We excluded: any content where stress or mental health was not related to the work context; non-work populations; employees self-reported definitions or reflections on lived experiences of work-related stress; documents published in academic sources; thought or opinion pieces; and any non-English language publications.

The searches were conducted in November 2024. Grey literature titles (and abstracts or other descriptive text where available) were initially screened and in case of doubt or lack of information, the document or web page was included. The targeted website searches generated 273 potentially relevant documents or web

pages; the grey database searches identified 32 potential sources; and finally the Google searches obtained 24 potential sources, totalling some 329 records overall. Once all duplicates were removed, across the three search strategies, an initial selection of 265 potentially relevant documents/web pages were obtained. Full text screening reduced the final selection of documents to 42 documents/web pages. The main findings relevant to the review were extracted from each source and then synthesised into themes, which form the basis of the structure of this review.

8.6 Interviews

Semi-structured interviews were conducted virtually via Teams. Informed consent was obtained prior to commencement, with each interview lasting a maximum of 45 minutes and recorded (with expressed permission) for quality and transcription purposes.

8.6.1 Recruitment

Interview participants were recruited for all three Project OSCAR research questions at the same time using a variety of methods such as:

- **Expert Input:** Affinity, IOM and IES drew upon our respective connections to generate interest amongst wider stakeholders (in the form of independent experts or representatives with relevant organisations) to register with the study webpage and contribute their professional expertise. This included occupational health practitioners and medical professionals in particular, who were part of the professional network of the research partners.
- **Intermediaries:** Collaboration with professional bodies, unions and member organisations such as SOM, as well as support from our PAG and professional networks raised awareness of the study. Promotional materials and email templates with QR codes for individuals to register their interest were shared and PAG and collaborating members who were encouraged to share with their networks.
- **Social Media**: The project team leveraged their respective social media platforms, to create and repost materials with encouragement for intermediaries to share/repost these where possible.
- **Direct Outreach to Organisations:** Potential participants and relevant organisations were approached via email.

8.6.2 Sampling strategy

The primary sampling strategy was opportunity sampling, as the recruitment methods led to a voluntary approach to participants offering to take part in the study. Pre-screening was used to identify the coverage of relevant factors, as well as gathering further information from participants during interviews to describe the sample and compare their experiences. The project was not aiming to reach

saturation for each participant group, due to the individual nature of WRS and contextual factors that impact this (e.g., size of enterprise, sector/industry, geographic location, demographic characteristics, etc.). Therefore, the sample group size is appropriate to provide initial insight into the experience of each group rather than drawing firm or transferable conclusions at this stage. This included:

- **Demographic information:** Participant's demographics including age, gender and ethnicity were captured prior to interview, to allow for accurate description of the sample and to identify potential bias in the results. We did not propose to conduct purposive sampling on a demographic basis given the small size of the sample.
- **Industrial sector:** Interviews with organisational leaders were prioritised to provide a range of representation from various sectors.

8.6.3 Participants

We interviewed three main groups of participants:

- **Healthcare professionals (HCPs)** - The majority (5/8) of this participant group were General Practitioners, either currently practising or recently retired. GPs were asked to draw on the experience of their practice to comment on how they define and label the issue of work-related-stress. Given the time pressures for this occupation, there was some difficulty in recruiting from this group.
- **Occupational health professionals (OHPs)** – The participants in this group were drawn from a range of backgrounds, including governmental roles (3), emergency services (1), transport (1) and private sector organisations (4), as well as those employed directly by healthcare providers (3). The participants also held a range of roles, from internal providers of occupational health and wellbeing services to external providers of screening and assessment services. Most internal providers managed small teams and worked with external suppliers to meet their requirements for support. All participants shared their experiences of labelling work-related stress and supporting employees, whether in the pre-employment stage, as part of an occupational health referral of existing employees or at a strategic level looking at health and wellbeing strategy within an organisation.
- **Organisational leaders (OLs)** – The participants from this group were leaders from a variety of sectors, including: public sector (5), healthcare (3), construction (3), emergency services (3) education (2), care (2), transport (1), and one classified as 'other'. During their one-hour virtual interview, participants were asked to reflect on work-related stress laws and rules; identification, classification and labelling; causes and risks of work-related stress; information sharing and trusted sources; resources, support, and interventions; enablers and barriers to managing work-related stress; responsibilities for workplace stress and future improvements and knowledge gaps.

8.6.4 Participant information sheet

Study Title: Occupational Stress Consultation and Research (OSCAR)

Research Team:

- Affinity Health at Work: Professor Jo Yarker, Dr Rachel Lewis, Dr Kevin Teoh, Professor Gail Kinman, Fehmidah Munir, Nathan Palmer, Sophie Walker
- Institute of Occupational Medicine (IOM): Rebecca Canham, Katie Clabon, Emily Christopher, Dr Amanda McNamee
- Institute for Employment Studies (IES): Dan Lucy, Dr Sally Wilson, Dr Zofia Bajorek, Arundhati Dave

Sponsor: Health and Safety Executive (HSE)

Ethical Committee reviewing and providing approval: Reading Independent Ethics Committee

Background: Work-related stress caused the loss of 17.1 million workdays in 2023. It leads to poor mental health, mood disorders, burnout, and even suicide. Stress impacts employers through absenteeism, reduced performance, and increased turnover of staff. Despite evidence linking work conditions to stress, only 40% of organisations actively address its causes. to explore work-related stress.

Project Objective: OSCAR aims to gather evidence to help the HSE develop policies and guidelines for preventing and managing work-related stress. The study has three areas of focus:

1. Prevention and Mitigation: Effective measures to prevent and reduce work-related stress.
2. Definition and Labelling: How work-related stress is identified and classified.
3. Implementation: Barriers and enablers for organisations managing work-related stress.

Who Can Participate? We are seeking individuals from the following groups to take part in semi-structured interviews:

- Employees: experiencing or having experienced work-related stress.
- Organisations/employers: Leaders, business owners, HR representatives.
- Occupational health professionals: Physicians, nurses, vocational rehabilitation professionals, occupational therapists.
- Healthcare representatives: GPs, psychiatrists, allied health professionals.

Participants must be over 18 and able to give informed consent.

Participation Details: You are invited to a one-time, 45-minute interview via phone or MS Teams. If interested, contact us at oscar@affinityhealthatwork.com to schedule a convenient time for your interview and receive a consent form (which you will be given a copy of') to sign and return. You can expect questions to ask about how you recognise work-related stress, the resources and support your organisation offers,

and how you measure their effectiveness. We'll discuss what makes managing stress easier or harder, and where there might be gaps in knowledge or support. This interview will be recorded and after this session will be transcribed and anonymized.

Risks and Benefits to Participation:

- Risks: No anticipated risks. You may stop the interview at any time without needing to give a reason.
- Benefits: Your participation will help to shape HSE guidelines and support for businesses to prevent and manage work-related stress.

Confidentiality: Your interview answers (research data) will remain confidential and stored securely. Data will be fully anonymised with no reference made to identify you as an individual or your organisation. We acknowledge that discussing work-related stress may cause discomfort. In which case we would like to remind you that you are free to cease participation and withdraw your data.

Voluntary Participation: Participation is entirely voluntary. You can cease participation and withdraw your data within two weeks following interview conduct without penalty. After two weeks, data analysis may make withdrawal impossible.

Consent and Accessibility: If you choose to participate, you will be asked to sign a consent form (which you will be given a copy of) detailing your rights before your interview. Let us know if you need any accessibility accommodations.

Contact Information: For questions or concerns, contact our project team at oscar@affinityhealthatwork.com.

Principal Investigator: Professor Jo Yarker, Chartered Psychologist, Managing Partner, Affinity Health at Work Jo.Yarker@affinityhealthatwork.com

Further details can be found at www.affinityhealthatwork.com/oscar

Please keep this information sheet for your records.

8.6.5 Participant consent form

Health and Safety Executive Programme of Research on Work-Related Stress

Participant Consent Form

Please complete, sign and return this consent form to our project team at oscar@affinityhealthatwork.com in advance of your interview. We will also provide you with a copy of the signed consent form. Alternatively, your interviewer will need to talk through this consent form with you prior to your interview starting, extending your interview time by approximately 5 minutes.

Activities:

1. I confirm that I have read the attached Participant Information Sheet for this research, I have had the opportunity to consider the information, ask questions, and had these answered satisfactorily.
2. I understand that my participation in the study is voluntary and that I am free to withdraw up to two weeks following my interview completion without giving a reason and without detriment to myself. I understand that it will not be possible to remove my data from the project any later than 2 weeks following completion of my interview, once this forms part of the data set for analysis.
3. I agree to the interview being recorded for quality assurance purposes. I understand that I can choose between audio recording or having a scribe present to take notes. Please inform interviewer in advance if you do not wish to have audio recording so that we can arrange a scribe to make notes during your discussion.
4. I agree that any data collected may be published in anonymous form in academic books, reports or journals. It will not be possible to identify me personally or my company from any published study material.
5. I understand that data collected during the study may be looked at by individuals from Affinity Health at Work, the Institute of Occupational Medicine and the Institute for Employment Studies, where it is relevant to my taking part in this research. I give permission for these parties to have access to my data.

I agree to take part in this study.

Study findings will be made publicly available on the study webpage www.affinityhealthatwork.com/oscar

Participant name: _____ Participant electronic signature:

The personal information we collect and use to conduct this research will be processed in accordance with data protection law as explained in the Participant Information Sheet and the IOM Privacy Notice for Research Participants

8.6.6 Data collection

A core interview schedule was developed with a set of different questions for each of the specialist groups. Interview proformas were also informed by consultation and agreed with the PSG. Questions followed the structure below and as displayed in Table *3* and Table *4*:

- Introductory question to gather context.
- Work background and Services provided.
- Definitions of WRS.
- Presentation of WRS.
- Causes of WRS.
- Labelling/Identification.

- Information sharing during labelling/identification process.
- Support and Interventions offered.
- Responsibilities for WRS.
- Future ideals for how this is managed.

Table 3. Interview schedule occupational health and healthcare professionals

Topic	Questions and prompts
Introduction	Could you please start by telling me about your current role or employment status?
Work background	Can you describe your role and the types of services you provide/main focus of your work?
Definitions	How would you define 'work-related stress'?
Presentation	How does work-related stress typically present itself? (e.g., physical signs, emotional, behavioral, cognitive, co-morbidity) How do you determine whether stress is work-related? • What factors go into this consideration? What are the challenges you face in making a labelling/ identifying WRS? • Practical (e.g., time). • Patient-related (e.g., lack of accurate disclosure, comorbidity). Are there occupational/health frameworks that influence these decisions?
Causes	• In your opinion and experience, what are the most common work-related causes of stress? • Do you specify this in medical documentation? How easily can you distinguish between work and other causal factors?
Labelling/Identification	What disorders do you typically see that have been caused or exacerbated by work-related stress? Which of these are most common? What informs your labelling/identification of WRS?

Topic	Questions and prompts
	What are the common obstacles you experience? How could these be overcome? Have you ever experienced situations where you have either felt inclined not to label a patient's stress as work-related, or even to avoid labelling their condition as stress altogether? If so, what factors or concerns influenced your approach in these cases?
Information sharing	Following a conversation with someone experiencing work-related stress, what information do you share with them? …and with others? Can you tell me about the process involved?
Support and Intervention	What support or intervention do you offer to an individual who is experiencing WRS? • What do you recommend? • Does this include anything for the employer? (if internal) Do you feedback information about WRS issues or trends to the organisation? Are you able to influence interventions that the organisation has in place at the primary and secondary level to prevent and manage WRS? What specifically are you able to influence? How do you monitor the impact of the support provided? If you are responsible for writing fit-notes, what information do you typically include here?
Responsibilities	Who do you think should be responsible/accountable for stress in the workplace? • Individuals themselves. • Line managers. • HR.

Topic	Questions and prompts
	• Health professionals. • Health and safety team/professionals. • Others. What they should be accountable for? Why?
Future Ideals	Thinking about the way that work-related stress is currently identified/labelled, what could be done differently? What information would be helpful to make labelling clearer, and access to support easier?

Table 4. Interview schedule organisational leaders (combined with Research Question 3)

Topic	Questions and prompts
Introduction	Brief introduction, explanation of the interview purpose, and confirming consent.
Role and Responsibilities	Can you provide an overview of your role and your involvement in managing or preventing work-related stress (WRS)? Note: Combines role overview and specific involvement in WRS, setting the context for the interview.
Understanding of WRS Laws and Rules	How well do you know the laws and rules with respect to controlling WRS in your sector/industry? What steps do you take to ensure your organisation follows them? How do you monitor and review this, how regularly and does this integrate with your health and safety system? Possible probes - *What does this mean in practice? How do you monitor and review this, how regularly and does this integrate with your health and safety system?* Note: Focuses on awareness and compliance with legal requirements.

Topic	Questions and prompts
Identification, Classification, and Labelling of WRS	How do you identify and classify cases of WRS in your organisation, and are there any frameworks that influence these decisions? (e.g., staff survey, line managers, sickness absence). What factors (e.g., work environment, sector, industry) influence these decisions and their outcomes? If an employee shares that they are experiencing work-related stress, what is the response to this information within your organisation? (across different teams, from the interviewee). Note: Merges identification, classification, and exploration of factors influencing labelling and outcomes.
Causes and Risks of WRS	What are the main causes of work-related stress in your experience, and how do you monitor these risks? Possible probes – *how do you use risk assessments for monitoring and how do you do this (level/regularity)?* Note: Combines cause identification with risk monitoring.
Information Sharing and Trusted Sources	What sources of guidance, information, and support do you trust to help manage WRS within your organisation? Note: Covers information sharing actions and trusted sources of support.
Resources, Support, and Interventions	What resources and support does your organisation provide to prevent and manage WRS (e.g., Clinical/Therapeutic intervention, Time off work, Work adjustments, risk assessments, training)? How do you measure their effectiveness? What advice do you provide to individuals suffering from WRS, and how is information shared between different stakeholders (e.g., employees, HR, health professionals, line managers)? Are there any common misunderstandings or misapplications of WRS measures? Note: Merges resource provision, effectiveness measurement, and advice given with information sharing practices.

Topic	Questions and prompts
Enablers and Barriers to Controlling WRS	What are the main enablers and barriers for your organisation in effectively preventing and managing WRS? *What effects do these have? How have they impacted your approach?* *(If participant does not touch on relationships/support)* Have you noticed any enablers and barriers in terms of enablers and barriers in terms of relationships or support. Are you aware of particular barriers and enablers specific to the use of current HSE guidance and tools to control WRS? *Do you use them? If not, why not?* Note: Directly combines enablers and barriers to address organisational challenges and success factors.
Responsibilities for Workplace Stress	Who should be responsible/accountable for stress in the workplace, and why? Which aspects should people be responsible/accountable for? Does this reflect current practice in your organisation (explore)? Note: Discusses the distribution of responsibility within the organisation.
Future Improvements and Knowledge Gaps	What could be done differently in the way that work-related stress is currently: A) identified/ labelled? B) prevented/managed? Where are your knowledge gaps in preventing and managing WRS within your organisation? *Are you aware of evidence on the effectiveness of different approaches?* Note: Combines future improvements with identification of gaps to inform potential changes.
Conclusion and Wrap-Up	Is there anything I didn't ask that you would like to share? Thank the interviewee, offer to share the final report, and provide any final clarifications or answer their questions.

8.6.7 Data analysis

Interview transcripts were analysed thematically, following the approach set out by Braun and Clarke (2006, 2022), and drawing on Framework Analysis (Gale et al.,

2013). The analysis was conducted by experienced qualitative researchers in the project team. A deductive analysis approach was used to organise data around the research questions. Inductive analysis was used to identify patterns within the data corpus offering further value to the topic under study.

The research team met regularly during data collection and analysis to compare reflections on the data. In the final phase of analysis, a collective workshop was held to identify and refine themes. Following the agreed definition of the themes, each researcher revisited the original transcripts to examine the fit of the coding structure, and to identify the level of evidence in each participant group. The research team then met again to discuss resultant body of data within and across the themes and collectively agree and synthesize the findings. Open discussion was maintained during the report writing process to ensure a shared approach and use of terms.

All members of the research team had a social science background within psychology and human factors. Together, they brought diverse experience of working within research and practice across sectors, including healthcare.

Throughout the process the researchers reflected on their own frames of reference, and the HSE framework of work-related stress, to shape interpretation of the findings.

8.7 Stakeholder consultation: roundtables

Once the interviews and literature reviews were complete, virtual roundtables were carried out. The roundtables aimed to:

- Gather feedback on the evolving model of WRS labelling.
- Consider the extent to which the model holds in different contexts.
- Explore how employers and health professionals can improve on current practices and what needs to be in place for this to happen.

Roundtables were held on the Tuesday 25th March 2025 14:30 – 16:00 and Thursday 27th March 11:00 – 12:30. Two dates were offered to maximise attendance around differing schedules. Participants were sourced from people who had registered their interest in the project and expressed an interest in roundtables. Participants who were from the groups which mirrored representation of our interview groups were prioritised and selected based on roles provided in the interest form. Invitations were sent in 3 rounds to gradually build up attendance. In addition, the PAG members were invited to the session.

The sessions were dual facilitated to enable capture of detailed notes for later analysis. Before the session a pre-read was provided summarizing the project work to date, and the main findings from the interview and evidence reviews for RQ2. A

total of 35 people attended covering OH, H&S, HR, wellbeing leads from both public and private sector. Agenda for the session can be seen below.

Table 5. Agenda for stakeholder consultation

Timing	Topics
5 mins	Welcome and Introduction
25 mins	Sharing of results
Collapsed into sharing of results	Sensemaking - Definitions • Would an updated definition of WRS be helpful? • What could an updated definition incorporate? • How would this be helpful in practice?
15 mins	Sensemaking (Breakout activity) - Labelling • How relevant do the findings feel to your context? • How well do they represent your experience of the process of labelling? • Are there any factors missing you feel are important?
20 mins	Implications (Breakout activity) • How could we use these findings practically? • How can we improve on current practices? • What would be the enablers to change?
15 mins	Feedback (plenary session)
5 mins	Summary and close

Notes from the roundtables were then analysed thematically to add to the overall synthesis of the project.

8.8 Stakeholder consultation: Project Steering and Project Advisory joint workshop

After initial synthesis of the project findings, a PSG and PAG joint workshop was held to present and discuss planned outputs. This session aimed to help ensure project outputs achieve intended impact with respect to:

- Justifying strategic planning and informing policy decisions.
- Shaping HSE guidance on WRS to support duty holders to implement suitable controls and interventions to prevent and mitigate WRS amongst their workforces.
- Informing and supporting HSE inspectors to perform compliance audits and inspections of duty holders to constructively improve their management of WRS.
- Ensuring findings are fit for purpose, accessible, and valued across different stakeholder groups directly (HSE inspectors) and indirectly (e.g., duty holders, policy experts, support organisations) utilising them.

In order to ensure time in the session was used for feedback, a pre-watch was recorded covering findings and initial synthesis of stress and the process of labelling.

The session took place on Wednesday 11th June 2025**,** at 9:30 – 11:00 and the main questions which were asked of the group for each section were:

- What are the key implications for these research findings?
- How can we best convey these findings to practitioners in relevant fields?
- Are there any specific implications for professional body/ policy stakeholders that we should be mindful of as we convey findings? (See Figure 13).
- What challenges could be raised about the findings / what limitations of the research should we proactively raise and explain (over and above typical limitations of specific methodologies)?

Eight members from the PAG and PSG attended respectively, totalling 16 participants.

Feedback provided by attendees was used during the report writing phase to iterate and co-design the final format and structure of project outputs to maximise impact for all relevant stakeholders. Written feedback was encouraged from members from the PAG and PSG who were unable to attend.

Figure 13. Key stakeholders for consideration



9 Appendix 3 - Findings – Systematic Literature Review

The search of databases retrieved 5,674 papers to answer the question: 'How is work-related stress assessed, assigned, labelled and defined by organisations and medical/healthcare professionals?'. Table 6 and Table 7 provide summaries of study characteristics and key findings included in this review.

9.1 Summary study characteristics

Table 6. Summary study characteristics for literature review

Academic	Grey
• 5,409 papers at title and abstract screen • 34 papers identified Countries covered: • UK = 3 • USA = 1 • Australia = 3 • Sweden = 3 • Italy= 4 • Netherlands = 2 • Japan= 5 • India = 2 • China = 1 • Indonesia = 1 • Jordan = 1 • Korea = 1 • Canada = 2 • South Africa = 1 • New Zealand = 2	• 265 papers at title and abstract screen • 18 papers identified Countries covered: • UK = 6 • USA = 2 • Australia = 1 • EU = 5 • Ireland = 2 • International = 1

Table 7. Summary of academic evidence extraction

Study	Grey or Academic	Country	Type of Study Design	Sector	Role of Labeller (Academic)/target audience (grey)	Assessment criteria/conceptual framework/process used to assign label of WRS	Where is the criteria/information sourced from? (Regulatory or not?)	How is criteria administered? Survey taken independantly, someone assesses based on measure, or through discussion/clinical judgement.	What is ACTUALLY being captured? E.g. experience of work, experience of outcome...
Adi 2022	Academic	Indonesia	Cross sectional study	Energy and mining	Academic	SV-NBJSQ (short version of the New Brief Job Stress	Japanese Government Stress	Self report	Mixture
AlHadid 2020	Academic	Jordan	Cross sectional study	Public service, utilities and health	Academic	The De Villers, Carson and Leary (DCL) Scale. Specifically	Not Regulatory: Academics	Self report	Inputs: Both individual factors and organisational
Arapovic-Johansson 2017	Academic	Sweden	Non-randomised experimental st	Public service, utilities and health	Academic	Single-item stress question (SISQ)	Not Regulatory: From	Self report	Outcome: Individual WRS or Mental Health
Barbaranelli 2018	Academic	Italy	Cross sectional study	Mixed/various	Organisation	I-Check (European Trade Union Congress, 2004)	Using UK Management	Combination of Observed and Self	Mixture
Bjerkeli 2020	Academic	Sweden	Randomised controlled trial	Public service, utilities and health	Medical	Work Stress Questionnaire (WSQ)	Not Regulatory.	Combination of Observed and Self	Mixture
Boschman 2017	Academic	Netherlands	Randomised controlled trial	Public service, utilities and health	Medical	6 step approach to reporting work related stress using	Netherlands Centre for	Discussion/clinical judgement	Mixture
Chakraborty 2020	Academic	Australia	Qualitative research	Public service, utilities and health	Medical	Various.	Not Regulatory.	Discussion/clinical judgement	Outcome: Individual WRS or Mental Health
Connolly 2024	Academic	Multiple	Systematic review	Public service, utilities and health		Review found that Since 2014 the following tools were used	Not Regulatory.	Self report	Outcome: Individual WRS or Mental Health
DeSio 2020	Academic	Unknown	Non-randomised experimental study		Academic	Work-Related Stress Questionnaire (WRSQ)	Not Regulatory.	Self report	Input: Organisational e.g. psychosocial hazards
DiGennaro 2022	Academic	Italy	Tool validation	Public service, utilities and health	Academic	StressCoping Empathy (SCOPE)	Developed scale based on	Self report	Outcome: Individual WRS or Mental Health
Harmsen 2019	Academic	Netherlands	Tool validation	Public service, utilities and health	Academic	Questionnaire on the Experience and Evaluation of Work	Not regulatory.	Self report	Mixture
Houdmont 2021	Academic	UK and Norther Ireland	Cross sectional study	Mixed/various	Academic	Single-item job stressfulness measure (SIJSM) developed	HSE commissioned Bristol	Self report	Outcome: Individual WRS or Mental Health
Hultén 2023	Academic	Sweden	Observational Study	Public service, utilities and health	Academic	Work Stress Questionnaire (WSQ)	Not Regulatory.	Combination of Observed and Self	Mixture
Inoue 2014	Academic	Japan	Multi Study Tool validation	Mixed/various	Medical	New Brief Job Stress Questionnaire (New BJSQ)	Japanese Government Stress	Self report	Mixture
Johnson 2018	Academic	UK	Cross sectional study	Public service, utilities and health	Academic	ASSET Pulse (A Shortened Stress Evaluation Tool)	Not regulatory.	Self report	Input: Organisational e.g. psychosocial hazards
Kawakami 2016	Academic	Japan	Narrative commentary	Mixed/various	Medical	Brief Job Stress Questionnaire (BJSQ)	Japanese Government Stress	Self report	Mixture
King 2019	Academic	USA	Cross sectional study	Private services sectors	Academic	Revised Musician Occupational Stress Scale (MOSS)	Not regulatory.	Self report	Mixture
Kurioka 2024	Academic	Japan	Cross sectional study	Mixed/various	Organisation	Occupational Stress Scale for Small and Medium-sized	questionnaire developed	Self report	Mixture
Marcatto 2022	Academic	Italy	Multi Study Tool validation	Mixed/various	Academic	Perceived Occupational Stress Scale (POS)	Not regulatory.	Self report	Outcome: Individual WRS or Mental Health
Marcatto 2023	Academic	Italy	Cross sectional study	Mixed/various	Academic	Perceived Occupational Stress scale (POS)	Marcatto, F., Di Blas, L., Luis,	Self report	Outcome: Individual WRS or Mental Health
Mazza 2019	Academic	Australia	Evidence based guidance	Public service, utilities and health	Medical	For workers with symptoms of mental health conditions, a	The guideline was developed	Discussion/clinical judgement	Mixture
McBride 2015	Academic	New Zealand	Cross sectional study	Public service, utilities and health	Academic	Hospital Anxiety and Depression Scale (HADS)	Does not reference in paper	Self report	Outcome: Individual WRS or Mental Health
McCreary 2017	Academic	Canada	Cross sectional study	Public service, utilities and health	Academic	Operational and Organizational Police Stress	Developed by McCreary and	Self report	Input: Organisational e.g. psychosocial hazards
Park 2020	Academic	Korea	Multi Study Tool validation	Public service, utilities and health	Academic	Scale to assess the stress of nurses caring for terminally ill	Literature review	Self report	Mixture
Roy 2023	Academic	India	Cross sectional study	Private services sectors	Employee	Tool to assess and classify work-stress (TAWS 16)	Not regulatory. Developed at	Self report	Mixture
Shahidi 2021	Academic	Canada	Latent Profiling	Mixed/various	Academic	Copenhagen Psychosocial Questionnaire (COPSOQ) &	Not regulatory.	Self report	Mixture
Stewart 2015	Academic	New Zealand	Multi Study Tool validation	Public service, utilities and health	Academic	Mahi Oranga: Culturally Responsive Measure of Māori	Not Regulatory.	Self report	Mixture
Sukumar 2023	Academic	India	Observational Study	Private services sectors	Employee	Tool to assess and classify work-stress (TAWS 16)	Not regulatory. Developed at	Self report	Mixture
Sun 2022	Academic	China	Cross sectional study	Public service, utilities and health	Academic	Depression, Anxiety and Stress Scale (DASS-21)	DASS developed by Lovibond	Self report	Mixture
Sweetman 2022	Academic	UK	Cross sectional study	Education and research	Academic	Work Stress Screener WOSS-13	Developed based on:	Self report	Outcome: Individual WRS or Mental Health
Kawamura & Kobayashi 2024	Academic	Japan	Case Control Study	Education and research	Academic	Brief Job Stress Questionnaire (BJSQ)	Japanese Government Stress	Self report	Mixture
Tsutsumi 2018	Academic	Japan	Prospective Cohort Study	Private services sectors	Academic	Stress Check Program manual recommends using	Japanese Government Stress	Self report	Mixture
VanWijk 2022	Academic	South Africa	Cross sectional study	Mixed/various	Medical	composite mental health screener	10- item Stress Overload	Combination of Observed and Self	Mixture
Yong 2021	Academic	Australia	Systematic review	Public service, utilities and health	Academic	Multiple Psychological Strain instruments:	Not regulatory.	Self report	Outcome: Individual WRS or Mental Health

9.1.1 Academic

A large variety of tools and measures for WRS were seen to be used, with no consistency of use identified. This is likely to be due to the studies included covering many countries.

Who: Seven studies discussed WRS being defined by medical professionals, and only two with organisations being the labeller. The remaining 25 were studies focused on the development or validation of tools designed to be used to label WRS in workplace settings, in these instances the labellers were academics.

In studies where **medical professionals** were labelling WRS, the extent to which the stress was deemed to be work-related was based on their clinical judgement. More generic tools to measure mental health outcomes were used (e.g., DSM criteria or Generalized Anxiety Disorder 7-items) in combination with clinical assessment and judgement on work factors which could be contributing to this.

In studies where **academics and organisations** were seeking ways to assess and label WRS, the majority referred to self-report surveys. These surveys were designed to measure the work-relatedness of stress (e.g., role, job demand, job control, peer and managers' support), and in many cases, the outcome itself to some degree (e.g., psychological difficulties, anxiety).

9.1.2 Grey

The reviewed grey literature provides a multiplicity of definitions of WRS and provides insight on how WRS is viewed by whom. Information on assessment and assignation of WRS within this literature is more limited because relevant sources originate from jurisdictions where there is a statutory requirement to do so (for example establishing the presence of psychological injury for the purpose of worker compensation in Australia). Assessment and assignation of burnout is more widely covered because of its recognition by the World Health Organization (WHO) as an occupational phenomenon in the 11th Revision of the International Classification of Diseases (ICD-11).

9.2 What definitions of work-related stress are used and by whom?

9.2.1 Academic

From the 34 identified studies in the academic review, 12 studies did not take a stance on how they were defining WRS (Adi et al., 2022; Al Hadid et al., 2020; Barbaranelli et al., 2018; Connolly et al., 2024; DeSio et al., 2020; Johnson et al., 2018; King et al., 2019; Kurioka et al., 2024; Mazza et al., 2019; McBride et al., 2015; Park et al., 2020; Stewart et al.,2015; VanWijk et al., 2022).

Those who did provide a definition used a variety of sources such as European Commission guidance, European Agency for Safety and Health at Work, National Institute for Occupational Safety and Health, with the most frequently referenced one being the World Health Organisation's definition (see definition below).

- WHO Definition “response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope” (referenced by: Bjerkeli 2020; Chakraborty 2020; Hultén 2023; Roy 2023; Sukumar 2023).
- “Work-related stress can be defined as a negative reaction to work conditions accompanied by high levels of distress and arousal (European Commission Guidance, 2000)” (Arapovic-Johansson et al., 2017).
- “a psychological state which is part of and reflects a wider process of interaction between the person and their work environment” (European Agency for Safety and Health at Work definition Via DiGennaro et al., 2022).
- “Teacher stress is divided into: (i) stress causes: collection of aspects of the work content and the work situation that influence employees at a cognitive, motivational and emotional level, for example student misbehaviour. (ii) stress responses: the employees mental interpretation when experiencing stress causes, for example feeling tension, (iii) stress outcomes: result from persistent stress causes and responses, for example leaving the teaching profession (attrition)” (Harmsen et al., 2019).
- “Occupational stress is defined as harmful physical and emotional responses that occur when the requirements of a job do not match the capabilities, resources or needs of the worker (National Institute for Occupational Safety and Health 1999)” (Sun et al., 2022).
- “Here, “work stress” denotes a stressor and “stress” denotes the subjective internal state.” (Sweetman et al., 2022).
- “Role stress (role stress types of role ambiguity, conflict, incongruity, over/underload, and over/under-qualification are differentiated from the concept of psychological distress)” (Yong et al., 2021).

There was also a collection of studies which, though not providing an explicit definition of WRS, did provide cut off scores which could be used as part of analysing responses to the measure in question to support with determining individuals with elevated WRS (Houdmont et al., 2021; Kawakami et al., 2016; Marcatto et al., 2022; 2023; McCreary et al., 2017; Roy et al., 2023; Shahidi et al., 2021, Kawamura and Kobayashi, 2024; Yong et al., 2021).

9.2.2 Grey literature review

Of the 18 documents reviewed, representing 14 organisations, five organisations described their own definitions of WRS. Nine Organisations cited single or multiple definitions from other organisations.

Government and Occupational Safety and Health (OSH) practitioner definitions

In GB, HSE defines work-related stress as “*the adverse reaction people have to excessive pressures or other types of demand placed on them at work*”. Reviewed sources indicate the adoption of this by key UK NGOs, (eg CIPD, 2024; TUC 2021; Mind 2022; Acas, (cited in CIPD, 2024); (Unison 2022) and the Society of Occupational Medicine (Kinman, 2018). A Public Health England/Leeds Beckett University review (2016) uses a slightly different

definition: work-related stress is defined as "*a harmful reaction to undue pressures and demands placed on employees at work.*"

In government organisations **outside GB** there is an apparent tendency for definitions to have an explicit focus on the job-person interface or 'fit'. EU-OSHA guidance (EU-OSHA, 2024) describes WRS as: "*the emotional, cognitive, behavioural and physiological reaction to aversive and noxious aspects of work, work environments and work organisations". T*he job-person fit is also acknowledged: "*people experience stress at work when they perceive that there is an imbalance between the demands made of them by their work and the physical and mental resources they have available to cope with those demands*". Similarly, EU-OSHA's Framework Agreement on Work-related Stress (2023a) states WRS results from "*individuals feeling unable to bridge a gap with the requirements or expectations placed on them*".

In Ireland, a Health and Safety Authority guidance document for employers (HSA, 2022) describes that work-related stress occurs "*when a person perceives the work environment in such a way that his or her reaction involves feelings of an inability to cope".* Similarly, in a policy document the Health Services Executive in Ireland (HSE, 2023) references the subjective nature of stress: "*Work-related stress is the development of a stress response that the worker believes is as a consequence of their work and what they have been exposed to at work.*"

In the US, the National Institute for Occupational Safety and Health (NIOSH; cited in Jacobs, 2024) defines occupational stress as "*the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker*" (again a job-person fit emphasis).

As an international NGO, the International Labour Organisation (ILO, 2016) provides a lengthy definition of stress which combines many features of the above definitions but also explicitly mentions organisational culture, i.e. stress can occur when the "*knowledge or abilities of an individual worker or group to cope are not matched with the expectations of the organizational culture of an enterprise*".

Health practitioner definitions

The **World Health Organisation** (cited in HSE, 2023) has described work-related stress as the "response people may have when presented with work demands and pressures that are not matched to their knowledge and abilities and which challenge their ability to cope". Stress is recognised as a response, not as a medical condition.

A description of WRS is present in guidance for **Australian OH professionals** (Way 2020) i.e.: "*when demands exceed (a worker's) resources e.g., skills, time, support and/or abilities to cope with the work".* However, it is also explicit that stress is "*a physiological and psychological stress response.*" Worker perception forms part of the definition: i.e. stress response occurs when "*responses of workers who perceive that their work demands exceed their resources and/or abilities to cope with the work*."

Likewise, the **American Psychological Association** (APA, 2018) states that 'occupational stress' is “a physiological and psychological response to events or conditions in the workplace that is detrimental to health and well-being”.

9.3 What assessment criteria/processes or information are used to assign a label of WRS and what is the source?

9.3.1 Academic

Though there was a variety of tools mentioned, those which were seen to be used more than once in the academic literature were:

- Brief Job Stress Questionnaire (BJSQ)
- Depression, Anxiety and Stress Scale (DASS-21)
- Patient Health Questionnaire-9 (PHQ-9)
- Perceived Occupational Stress scale (POS)
- Hospital Anxiety and Depression Scale (HADS) questionnaire
- Tool to assess and classify work-stress (TAWS 16)
- Work Stress Questionnaire (WSQ)

Specifically, Australian clinical guidance (Mazza et al., 2019) highlights tools that have been validated for use by GPs for the assessment of both depression and anxiety disorders in a work-context. Tools that have been validated for use by GPs for the assessment of depression and/or anxiety in a work-context are:

- Patient Health Questionnaire (PHQ-9)
- Depression Anxiety Stress Scale (DASS)
- Dimensional Symptom Questionnaire (4DSQ)

Across all the tools identified, the majority of the studies were measuring a combination of inputs (e.g., psychosocial hazards) and outputs (e.g., experience of stress) of WRS (20 studies). Very few measured organisational level outcomes related to WRS such as turnover, with most studies measuring WRS at the individual level.

16 of the studies which discussed tools/measures for WRS did not provide detail on cut off scores required to determine individuals with high WRS. This suggests that though these tools may be useful for understanding the level of employee stress, they may have limited diagnostic utility.

9.3.2 Grey

In their workforce policy The **Irish** Health Service Executive (2023) point to the basic problem of signs and symptoms of work-related stress vary from one individual to another and provide a detailed list signs and symptoms.

Australian clinical guidance (Mazza et al, 2019) provides a consensus-based recommendation that "The assessment of whether a diagnosed mental health condition has arisen as a result of work should be made on the basis of:

- a comprehensive clinical assessment.
- consideration of factors such as pressures, events, and/or changes in the workplace and the temporal relationship between these factors and symptom onset.
- consideration of whether the mental health condition is consistent with the description of how the condition arose.

9.4 What other labels are used to describe WRS?

9.4.1 Academic

During the screening stages in the systematic search several other research areas were identified which though linked to WRS were not explicitly measuring WRS. For the scope of this review, these were excluded, however these bodies of evidence may warrant further exploration as they are related but different forms of WRS, and measure related concepts in a different way. These were:

- **Burnout:** 32 studies were excluded as they were measuring burnout instead of WRS. This highlights a large literature base which may show how WRS is potentially conflated with the longer-term outcomes.
- **Post Traumatic Stress Disorder (PTSD) in Military Personnel**: Nine tudies considered how to measure PTSD in military personnel. This is a context specific form of long term adverse mental health outcome which may be more relevant to measure than WRS in this population.
- **Technostress:** there were a small handful of studies (four) which considered the specific form of stress which is induced in the workplace by increasing use of technology.
- **Biomarkers of stress**: There was an increasing number of studies in the last five years which considered how to measure biomarkers of stress (e.g., Hair samples, heart rate) in work contexts. Though this shows an interesting future direction research may be taking, it is still in its infancy with the majority of studies still testing out this technology in lab settings with simulated work environments.

9.4.2 Grey

Psychosocial risk: The ILO has noted that the term ‘workplace stress’ has evolved over the years, from stressors and stress factors to psychosocial factors, psychosocial hazards or psychosocial risks, and remarks that the latter is increasingly used (ILO, 2016 ; cited in HSE, 2023). They highlight that the terminology ‘psychosocial risk’ is broader than workplace stress or work-related stress and concerns “*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 define psychosocial factors as “*interactions between and among work environment, job content, organisational conditions and workers’ capacities, needs, culture, personal extra-job considerations*”. It is notable that

those factors have relevance to diverse aspects of working life, such as job design, working conditions, worker capabilities, and work-life balance.

In outputs from EU sources such as EU-OSHA and the European Commission definitions of stress tend to feature alongside definitions of psychosocial risks. These risks are interesting to consider because (i) an overlap can be seen with elements of the Management Standards and also (ii) hazards are featured linked to factors arguably not directly within HSE's remit including job security and worker involvement.

According to EU-OSHA (2024) and Eurofound & EU-OSHA (2014), psychosocial risks arise from "*poor work design, organisation and management, as well as from poor social context of work*". EU-OSHA provide ten examples of "*working conditions leading to psychosocial risks"*.

Burnout is included in the 11th Revision of the International Classification of Diseases (ICD-11, World Health Organisation) as an occupational phenomenon. It is not classified as a medical condition (Jacobs 2024). According to the WHO's diagnostic criteria, burnout is a syndrome resulting from workplace stress that has not been successfully managed. It is characterized by three dimensions: "*feelings of energy depletion or exhaustion, increased mental distance from one's job or feelings of negativism or cynicism related to one's job, and reduced professional efficacy*".

The charity Mind defines burnout as "*a term used to describe a collection of experiences caused by long-term, unmanageable stress at work"* (Mind, 2022). The layperson's language used to describe how it manifests is consistent with the ICD-11 diagnostic criteria. It is described in similar terms by the CIPD (CIPD, 2022).

A Eurofound report (Eurofound et al., 2018) discusses whether burnout is a disease or a syndrome and concludes that "*it appears to be both".* Media and public use of the term as a catch-all for ill-health brought on by work is felt to be a complicating factor.

9.5 How is WRS distinguished from other forms of mental health and what are the difficulties in doing this?

9.5.1 Academic

There was little active discussion of ways and challenges of distinguishing other forms of mental health outcomes from WRS within the academic literature. In the case of medical professionals, Mazza et al., (2019) explained that, to determine if the mental health condition is due to work, a full clinical assessment should be made considering elements of pressure, workplace changes, and the "temporal relationship" of these, however the mental health outcomes themselves were measured using generic surveys (e.g., PHQ-9, GAD-7 & DASS). In essence the distinguishing factor becomes the cause of the mental health outcome, rather than the outcome itself.

Alternatively, many of the tools being assessed were more explicitly measuring WRS rather than other mental health outcomes. For example, the POS scale (4-items) asked about work stress specifically, therefore distinguishing it from other mental health outcomes. Items were:

- My work is stressful.
- Thinking about my work makes me feel tense.
- At work I feel under pressure.
- My work has negative effects on my health.

The WSQ, was a longer scale with 21 items across four dimensions (influence at work, perceived stress due to indistinct organisation and conflicts, perceived stress to due individual demands and commitment, work to leisure time interference) and like the POS scale was asking explicitly about stress experiences in the work context.

The TAWS-16 took a dual approach where one part of the measure asked explicitly about work factors, and the second section asked more generally about health/psychosomatic outcomes (e.g., Disturbed sleep, Headache, Backaches), though it does not discuss how to distinguish the causes of those psychosomatic outcomes which may not be related to work stress from those that are.

Australian clinical guidance (Mazza et al., 2019) refers to "work-related mental health conditions", (as distinct from other mental health conditions) which it defines as:

- those mental health conditions that developed as a direct result of a work-related stressor, or
- mental health conditions that developed concurrently or as a consequence of a primary (physical or psychological) work-related injury, or
- a pre-existing mental health condition that was exacerbated by a workplace stressor.

GPs have reported challenges in distinguishing between mental health conditions that developed as a result of work-related stress and those that are related to a pre-existing mental illness.

9.5.2 Grey

In a guidance document the Irish Health and Safety Authority (HSA, 2022) comment on the **difficulty of establishing the degree to which the work environment and factors outside of work contribute** to an individual's stress level. "*Someone who is experiencing stressful life events may find that he or she is less able to cope with demands and deadlines at work, even though work is not the cause and had never been a problem before*".

Public Health England and Leeds Beckett University (2016) conclude there is **no valid differential diagnostic instrument for burnout** for that reason burnout and stress is used interchangeably in their evidence review with work-related stress.

9.6 Key Summary highlights:

9.6.1 Academic

- 34 relevant studies identified of which seven were considering the labelling carried out by medical professionals, two by organisations, and the remaining by academics who were designing or validating tools to be used in the work context.
- Research covered 15 countries with only three from GB.
- Large number of self-report surveys identified (e.g., Brief Job Stress Questionnaire (BJSQ), Perceived Occupational Stress scale (POS), Tool to assess and classify work-stress (TAWS 16), Work Stress Questionnaire (WSQ)).
- Most frequently used definition of WRS came from the WHO, however this was mentioned by five studies out of 34. The remaining studies either did not explicitly define WRS or used various definitions from both academic and regulatory sources.
- There is a notable lack of academic insight available from GB populations. Given the high proportion of sickness absence and economic inactivity due to stress and other mental health conditions in GB, this is concerning and highlights the need to prioritize further research in this area.

9.6.2 Grey

The reviewed literature showed the HSE definition of WRS to be widely accepted among NGOs and non-clinical organisations in GB.

- Definitions of WRS outside GB contain common elements to the HSE definition but differ primarily in their emphasis among on job-person fit and subjective experiences of stress.
- Within GB no sources were identified providing formal definitions of stress or assessment criteria for use by HCPs.
- European Union grey sources provide some definitions of stress but tend to use the term “psychosocial risks” when discussing the topic. This term encompasses factors such as work-life balance, worker involvement, and job security; these factors are wide in scope and go beyond the areas covered by the Management Standards.
- Burnout predominates in the international literature in relation to the mental health effects of stress, it is seen as a health outcome when stress is not successfully managed.
- However, there was no evidence in the reviewed sources that any of the instruments to measure WRS identified in this study are in common usage in GB.
- A small number of sources use the terms mental injury or moral injury to describe the effects of workplace demands.
- In Australia the diagnosis of mental injury is important, as compensation is available if the injury was caused by or arose out of employment, and the employment was a significant contributing factor.
- As a consequence, detailed guidance is available for Australian HCPs to enable them to make a distinction between mental health conditions arising from work vs more general causes.

9.7 A Note on Theory

Throughout the process of conducting both academic and grey literature reviews and considering the definitions of WRS used, it became clear that the theoretical foundations upon which definitions were based were mixed (see Appendix 1 on page 63 for background on theory). While the theoretical lens is not explicitly discussed, nor the main aim of this systematic review, it is worth considering the theoretical stance taken by the researchers. In the academic review, where naturally researchers were more likely to mention a theoretical stance on WRS, two papers adopt a stimulus-based approach, one a response-based approach, 15 an Interactional approach, 12 a Dynamic/Transactional approach, and two a Whole System approach. As the HSE Stress Risk Assessment tool and similar approaches used around the world are based on an interactional approach to understanding and tackling work-related stress, the implications of any differences in theoretical foundations may require further consideration. This variation in conceptualisation of WRS has implications for both how WRS is identified, and the interventions selected (as considered in the report for research question 2 (see report 2).

10 Appendix 4 - Findings - Interviews

10.1 Themes identified from interviews

Several themes were identified within each of the participant groups. Themes are summarised in the table below by participant groups' responses. **(S)** indicating strong evidence for each theme (based on frequency of coverage and valence/strength of coverage), **(M)** a moderate level of evidence, and **(L)** limited/no evidence:

Table 8. Interview themes

Theme	Subtheme heading	Subtheme detail	Healthcare Professionals	Occupational Health	Organisational leaders
1. Definitions, language and understanding	1.1 Definitions	- Growing acceptance of stress as a workplace issue	M	S	S
		- Concerns about definitions and terminology	M	S	M
		- Impact of subjectivity on views of stress	L	S	M
	1.2 Causes	- Recognition of a range of causes of stress	S	S	S
		- Role stress vs organisational stress	L	M	S
		- Intertwining of work and home	S	S	S

Theme	Subtheme heading	Subtheme detail	Healthcare Professionals	Occupational Health	Organisational leaders
	1.3 Presentation	- Variety of presentation and comorbidity	S	S	L
2. Process issues in labelling	2.1 Overall factors	- Consent and information	S	S	L
		- Liability concerns	S	S	L
		- Knowledge of tools and frameworks	L	S	S
	2.2 Organisational factors	- Influence of stigma	M	M	S
		- Skills / training to discuss WRS	L	S	S
		Influence of regulation	L	M	S
	2.3 Healthcare factors	- Impact of greater openness	M	M	L
		- Different healthcare approaches	S	M	L
	2.4 Providing a solution	Signposting and referrals	S	S	L

Theme	Subtheme heading	Subtheme detail	Healthcare Professionals	Occupational Health	Organisational leaders
		Time off work	S	S	L
		Workplace adjustment	S	S	L

10.2 Definitions, language and understanding

The interviews revealed differences in how the three participant groups understood work-related stress, and the internal and external factors perceived to influence WRS. Specifically, issues of definition and choice of language were differentiated across groups, all of which underpin the process to identify and label stress in the workplace.

10.2.1 Definitions

Growing acceptance of stress as a workplace issue

Healthcare professionals (HCPs) discussed a growing acceptance of stress as a workplace issue over time, mainly shown through greater openness about stress experienced (see 2.3).

Occupational health professionals (OHPs) reported an increased level of acceptance of stress as a workplace issue and consequent stakeholder engagement with dealing with problems arising from this. Those who had been in the profession for some time suggested that this had grown over time, normalising consideration of stress at work.

Similarly, interviews with organisational leaders (OLs) suggested that there appears to be a growing acceptance and understanding of stress at work within organisations. Many leaders reported taking proactive measures to support employee wellbeing. One emphasised the prevention of absence due to stress among staff, reflecting a commitment to early intervention. Another observed an increased awareness and understanding among their senior leaders, indicating a positive shift in organisational attitudes towards supporting staff mental health and tackling stress. Other participants reported their organisation being less willing to make accommodations (e.g., not permitting flexible working) amongst their staff.

Concerns regarding definitions and terminology

HCPs we spoke to differed slightly in their definition of WRS. However, most of them based their definition on the source of the stress; when this was clearly work-related, this was termed as WRS. Amongst GPs there was also uncertainty on how this is defined. There was also concern that a patient could have a number of other issues or stressors, so there may be difficulty in isolating WRS as an issue.

For OHPs, many were careful in their choice of words and preferred to talk about “perceived” WRS, “stress exacerbated by work” or simply to clarify that WRS was distinct from work-caused stress. This care around terminology was driven by two things – firstly a recognition that individuals may lack insight on the primary cause of their stress, and therefore even when they perceive stress to be work-related this may not be the case, and secondly that they often only receive the perspective of one party, and therefore cannot make an objective assessment of whether work is causing stress, or whether another factor or explanation could be more valid.

For OLs, a need for clearer definitions and simpler terminology was consistently highlighted by over half of leaders. Inconsistent interpretations of stress at present appear to hinder comprehensive action. One participant suggested that clearer definitions of WRS are needed, and education on symptoms and appropriate labelling would be beneficial, advocating for standardisation. Another emphasised adapting language to be culturally appropriate can encourage openness, which could facilitate better communication and understanding.

Impact of subjectivity on views of stress

Subjectivity in perceiving stress contributes to challenges in assigning and labelling WRS. This theme was not raised by HCPs, but amongst OHPs, subjectivity was apparent in differing perspectives. For example, while some participants delineated between pressure and stress, and therefore viewed stress as entirely negative, others referred to “good stress” and the idea of stress as a motivating force, that only becomes negative if it has a prolonged detrimental impact on individuals. For some this was a theoretically informed question, while for others this depended on context.

Notably, one participant operated in a high-stress environment where individuals were placed in stressful situations as part of training. Therefore, it was recognised that experiences of stress were normal in these circumstances and stress per se was not problematic, only if this exceeded the individual’s capacity to cope. On a related note, it was suggested that as stress is talked about more frequently in the workplace, this made it harder to disentangle those experiencing acute stress from those experiencing a normal response to a temporary stressful situation.

For OLs, over half of participants acknowledged that individual experiences and interpretations of stress vary widely. One noted the varied interpretations of what constitutes stress and the lack of a common understanding, which complicates organisational responses. Another added that stress manifests differently, underscoring the necessity for personalised approaches and acknowledging individual differences.

10.2.2 Causes

Recognition of a range of causes of stress

Interviewees felt that several factors can affect an individual’s stress levels and work is simply one of them. HCPs adopted a holistic approach in looking at the issue of stress, looking at all possible causes. Causes of stress mentioned by interviewees included relationship breakdown with managers, shift work, and other disruptions to routine.

Similarly, OHPs identified a range of causes of WRS, generally organising these according to the HSE’s Management Standards. Opinions differed on the most common causes of stress in the workplace, but relationships were raised most consistently as one of the top causes.

OLs reflected this pattern. OLs widely (more than half) acknowledge that stress arises from a multitude of factors, both intrinsic and extrinsic to the workplace. A significant theme is the recognition of various causes of stress, mirroring the Management Standards

factors. For example, one leader remarked on the high demands and emotional labour from dealing with complex clients, along with a lack of role clarity and control, underscoring how job demands and role ambiguity contribute to stress. Another leader identified excessive and unachievable workloads and unrealistic organisational targets as primary stressors impacting employees.

Role stress vs organisational stress

There is a clear distinction made between stress inherent to specific roles and stress stemming from organisational factors. This differentiation was not raised by HCPs, but OHPs made this distinction, and those working in high-risk sectors planned interventions for WRS accordingly. Some participants in this group elaborated further to highlight the links between individual expectations and role stress. For example, if an individual chooses to take on a role with minimal control, this was not seen as problematic in its own right, more that if the level of control in a role is reduced beyond their original expectations and experience, that this then would be a source of stress.

For OLs, more than half of the 20 leaders noted that certain stressors are intrinsic to the nature of the job, however, one participant highlighted that this shouldn't be used as an excuse for accepting WRS. For example, exposure to traumatic incidents like fatalities is an inherent job stressor, especially pertinent in high hazard sectors (e.g., healthcare, construction). Another participant discussed the concept of 'moral injury' (a psychological response to events that are contrary to a person's beliefs) from an inability to provide effective care and exposure to traumatic experiences. This indicates the emotional toll certain professions can have on the individuals in post.

Intertwining of work and home

The blurring lines between work and personal life emerged as a significant theme. For HCPs, this related to the holistic examination of causes of stress (see 1.2) and an individual's wider circumstances.

For OHPs, the examination of work and home related factors was a significant part of all assessment processes, which related to the care taken around using the phrase WRS. The participants reported taking a more holistic approach to understanding an individual's experience of stress, albeit that practically they would focus recommendations on steps that could be taken in the workplace to support the individual. As noted earlier on terminology, many argued that it can be impossible to unpick the relationships between work-related and non-work-related stressors and therefore it was better to think more about mental ill-health, and what could be done in the workplace to support wellbeing in general.

Almost half of OLs recognised that personal circumstances often interplay with WRS. One leader mentioned that home working challenges and eco-anxiety (anxiety centred around changing climate and environment) affect staff well-being, illustrating how external factors exacerbate WRS. Another observed that existing mental health issues of employees' impact work stress, suggesting personal health directly influences how stress is experienced at work.

10.2.3 Presentation of stress

Variety of presentation and comorbidity

HCPs and OHPs agreed that stress can present in a myriad of different ways including both mental and physical symptoms. Common presentations included depression and anxiety. Physical manifestations of stress were also common. This could result in many different symptoms or ailments, but common ones listed included back pain, trouble sleeping, digestive issues, or worsening of a pre-existing condition.

In the occupational context, referrals to OH were reported to be related to a range of possible presentations, including difficulties with performing the requirements of a role, breakdown in relationships or absence, as well as physical impacts as related by GPs.

10.3 Process issues in labelling

10.3.1 Overall factors

Consent and information

OHPs frequently spoke of issues related to consent, particularly around information sharing. While processes for referrals differed between organisations (for example on whether individuals could self-refer or referrals were only taken from managers), each subsequent step in the process consistently required consent from the employee for an assessment to be undertaken and for reports to be shared with other parties, including managers, HR, senior stakeholders, or their GP. OHPs reported experience of this sometimes becoming a problem in gathering trend data to inform organisational strategy, however, this was largely described as a past issue with most organisations being able to access anonymised data to spot patterns in experiences of stress or the requirement for mental health support.

For HCPs, approaches to fit notes differed amongst interviewees, but included a similar element of gaining consent to content. Most commonly, HCPs drafted the document in consultation with the patient. Interviewees reported checking to see if the patient was happy with the contents of the fit notes before sending this to the employer. One interviewee highlighted the risk of backlash for the employee if they mentioned a work-related stressor that the employee did not want to disclose (e.g., for fear of being seen as lacking competency or resilience). The co-design approach was important to mitigate this risk in their opinion. Other practitioners described co-designing fit notes with patients and employers to ensure an appropriate resolution was reached.

Liability concerns

OHPs reported managing issues of liability around their labelling and reporting of WRS. Concerns noted above on terminology used were driven by a reluctance to ensure that nothing was committed to writing in a report that could later be problematic in an employment tribunal for example, by implying that the organisation was responsible for adverse outcomes for the employee. While some internal OHPs did not share these concerns, overall, the majority of participants reported the need to use language carefully,

emphasising the role of perception and reporting the employee's views rather than being seen to give their own judgement on the situation and likely cause of stress. Some argued that there were cases where this was clearer, for example exposure to trauma, but in general care was taken to remain neutral. Participants reported that this was a point of tension with some employees, where they were looking for a label of WRS or acknowledgement of a particular stressor in order to contribute to legal proceedings.

Knowledge of tools and frameworks

Among OHPs there was consistent awareness and use of existing tools, with the HSE Managements Standards, Stress Risk Assessment tools, and Talking Toolkits being consistently referenced. However, they did also report that they found managers were not aware of these tools and many argued for more accessible tools or spaces for curated resources that would make it easier for managers to engage with the topic and support individuals.

In contrast, despite the availability of tools and frameworks designed to support the identification and management of WRS, there is variability in their application across organisations. While some OLs actively engage with guidelines like the HSE Management Standards and ISO 45003, others are less familiar or chose not to utilise these. One leader stated they apply frameworks and principles from recognised standards, demonstrating proactive engagement. In contrast, another admitted not currently being familiar with HSE guidelines but recognised the need to refresh knowledge, highlighting gaps in awareness. Additionally, the number of guidelines and tools available was acknowledged as a point of confusion, as well of lack of relevance to specific sectors.

10.3.2 Organisational factors

Influence of stigma

For HCPs, the evolution of reduced stigma around mental health has changed how GPs see stress presented. One interviewee described how earlier in their practice, individuals would be hesitant to attribute their symptoms to stress and would prefer to focus on physical symptoms. Over time, as stigma in the area of mental health has lessened, patients are more likely to say that they are struggling with stress.

For OHPs this depended on organisational context, as some reported still working in a culture where it was more acceptable to discuss physical injuries than ask for help with stress.

For OLs, stigma surrounding mental health and stress remains a barrier to action in many organisational cultures. Most leaders noted that both macro and micro cultures influence employees' willingness to discuss stress openly. One observed cultural factors that discourage open discussion of stress in a male-dominated environment, highlighting the impact of societal norms on workplace dynamics. Others mentioned that WRS is still seen as a mental health issue, indicating that misconceptions about stress contribute to underreporting and lack of support.

Skills / training to discuss WRS

OHPs recognised that upskilling line managers in conversations regarding stress was an important intervention for providing support, and that good line management skills were also a preventative measure.

For OLs, training is identified to be crucial for organisations to effectively address WRS by all 20 leaders that we spoke to. Organisations are investing in upskilling managers and staff to recognise and respond to stress indicators. Multiple leaders highlighted internal practices of promoting staff into supervisory/leadership positions based on technical competence, as opposed to non-technical skill. One leader specifically acknowledged this shortfall to be ongoing as staff are often not provided with leadership training opportunities to help address this skill gap. One participant emphasised the value of line manager training, providing guidance on holding well-being conversations, educating managers to recognise stress indicators, and underscoring the role of leadership in fostering a supportive environment. Another emphasised the importance of collective responsibility, seeking to embed stress risk assessments and emphasising that wellbeing is everyone's responsibility.

Influence of regulation

OLs in particular highlighted the impact of regulation on organisational action on WRS. It was argued that organisations were not entirely clear on their responsibilities for mitigating and preventing WRS and that this made it difficult to secure buy-in to act in some organisations. Some OLs stated that more active regulation would encourage the prioritisation of WRS activities, particularly the threat of enforcement action and its potential cost.

Some OHPs argued that processes were influenced by similar factors, as they felt organisations were more engaged in dealing with physical health and safety as they were clear on both the consequences of not acting and the potential solutions for dealing with risks.

10.3.3 Healthcare factors

Impact of greater openness

For some HCPs, reduction in stigma around mental health has meant an uptick in the number of cases of stress and other mental health issues they see. One interviewee stated that doctors were acting as the first point of contact for WRS, when in reality this needs to be the line manager. Some interviewees also described difficulty in knowing when stress was reaching dangerous levels.

Similarly, one OHP reported similar concerns, arguing that as mental health services were under pressure, OH providers were increasingly becoming the front line for mental health provision, including dealing with the impacts of trauma and suicidal ideation. In both cases therefore, these groups reported experiencing increased demand with a lack of preparedness for this.

Different healthcare approaches

OHPs reported feeling there was a difference between how labelling WRS was undertaken between different professionals. Some argued that for GPs these processes had become transactional due to the wider pressures of work, and therefore they felt that OH assessments offered a more in-depth assessment using the biopsychosocial model.

HCPs viewed this differently. While the interviews did not identify a generic approach taken by all or some HCPs to labelling or diagnosing WRS, the majority of GPs we spoke to reported taking a person-centric approach to stress. This involved listening to the patient and allowing them to guide them to the source of their stress.

In some cases, this process can take several appointments before they are able to get to the root of the issue. However, this can prove to be difficult in the context of the severe time pressures GPs are under. Time constraints on consultations mean that GPs are often not able to spend the time they would like on the issue. One interviewee also described difficulty in assessment with online consultations.

Factors that influenced decision making included the severity of symptoms and whether these were limited to the workplace. Some GPs were hesitant to medicalise the issue and would provide reasonable adjustments to help in the short term before an individual would return to work.

It is notable that the perspectives of OHPs and HCPs contrast on this issue, but this could be influenced by the sample of GPs who volunteered to be interviewed for this study as they were likely to have more of an interest in occupational support.

10.3.4 Providing a solution

Signposting and referrals

OHPs described a range of support offered by different organisations, including information provided through internal communications, employee assistance programmes, counselling provision, and other signposting to relevant services.

For HCPs, our interviewees were able to provide limited information on the information sharing practice around WRS. They most often did not have any stress specific guidance for patients. In some cases, information sheets were provided, or more often, patients were signposted to other services. Wellbeing coordinators at practices were reported to be responsible for signposting individuals to the relevant services and resources (for example specialist NHS mental support, or charities such as the Samaritans).

Time off work

Some OHPs reported instances of frustration at the current system of fit notes issued by GPs. They felt that some people can be signed off work for stress by GPs, as this is the only practical solution they can offer, particularly if other stressors are non-work-related and cannot be changed. However, in contrast, HCPs referenced time off work as a common form of support. Opinions on providing time off work differed within our sample,

with some GPs offering this readily and seeing it as a key form of support to recuperate. Others saw this as only being appropriate in more severe cases and presentations.

Workplace adjustment

OHPs described supervision processes and work adjustments, using frameworks such as the HSE Management Standards to take a holistic approach to identifying possible solutions to individual issues.

For HCPs, some identified flexible work arrangements, and adjustments to work as solutions, with GPs suggesting reduced hours, remote and flexible work options to combat WRS. Some interviewees felt that it was not within their remit to comment on workplace conditions. Separately, the role of the OH specialism was highlighted as being key to the issue and playing an important role in addressing the issues within the workplace outside of HCPs remit.

Time constraints on HCPs also meant that they did not have the time or opportunity to follow up with patients once support was provided or adjustments were made. Interviewees also described instances where they knew of difficult workplaces or environments that were causing stress and harm, but patients were unable to leave this work due to financial constraints. HCPs were limited in the support they could provide in these instances.

11 Appendix 5 - Findings – Consultation

The draft findings from the research were shared at a roundtable event with stakeholders and a workshop with the Project Steering Group and Project Advisory Group. The results of the consultation were used to shape the final reporting of the research and inform the priority considerations for policy, research, and practice. The consultation focused on the key outputs from the research and the discussions are summarised below.

11.1 Definitions of work-related stress

The project team presented the findings from the research on the range of definitions used in the academic and grey literature and the more holistic view of stress that informed the practice of those interviewed.

On this topic, the consultation revealed broad consensus on several areas:

- **The definition of work-related stress was not an issue** in current practice, but that it was important any update to the definition did not make it become too broad, as this may lessen the responsibility taken by organisations.
- **Simple definitions are needed** to make sure that it is easy to understand, and applicable across different types of organisations and job roles. The definition should focus on the impact of stress and its relationship with health, including the signs and symptoms that help to identify those who need support.
- **Clarification on the relationship between different concepts is needed**, such as the relationship between stress and burnout and accounting for pressure and motivational or challenge demands.
- **WRS should not be over-medicalised**. The distinction between clinical mental health conditions and more general experiences of stress, discomfort or malaise has become blurred. The current system, which often relies on GPs to identify and label WRS, was seen as contributing to this risk. While views varied on how to address the issue, there was a shared concern that medicalising WRS may reinforce stigma — particularly if it is perceived as a sign of individual weakness or an inability to cope, rather than a response to workplace factors.

Some participants suggested that the way work-related stress is currently understood and regulated may be contributing to inaction in workplaces. Rather than concerns about the definition of stress itself, the challenge was seen to lie in the lack of clarity around where responsibility lies — particularly in distinguishing between individual and organisational factors. Participants highlighted that the absence of clear regulatory expectations for employers may be limiting action. Alternative frameworks, such as those focused on identifying and managing psychosocial hazards (used in jurisdictions like Australia through Safe Work Australia and in the EU under EU-OSHA guidance), were seen as offering clearer routes for accountability and evidence-based intervention.

11.2 Process of identifying and labelling work-related stress

The project team presented a summary of the processes identified through interviews with GPs, OHPs, and OLs, representing some of the journeys taken by individuals who are impacted by WRS. The consultation raised several points for consideration:

- While it was recognised that there was considerable diversity between individual journeys, participants also noted:
  - that there are many other pathways and other health services involved, including Employee Assistance Programme (EAP) providers. Reflecting this in visual presentations may be beneficial.
  - that this is related to a disparity in access to support for employees, as many work in organisations that do not have occupational health provision or an EAP, creating both inequality in provision and differences in likely outcomes.
- In considering the process for GPs, it was recognised that this was complex as GPs work in different ways, and due to wider pressures, lack of time to engage with individual's work context or to access education on this topic. Therefore, more research is needed on how to address current issues with the use of time off work as a mitigation for WRS.
- By mapping the process from an individual perspective, participants argued that the initial presentation obscured the need for action by a range of stakeholders, including HR, managers and organisational leaders (for example by analysing trends in activity, gathering feedback from OH and EAP providers) and therefore might hinder them from being able to take a more preventative approach. Most importantly, participants felt that the role of stress risk assessments and the ongoing monitoring of stress was key, and this should minimise the need for reactive support.
- Overall, it was raised that by the point a case has been labelled as work-related stress it is too late to avoid harm – therefore it is more important for organisations to understand and prevent stress, rather than label and support individuals who are already impacted.

11.3 Implications and other considerations

As part of the consultation, participants were invited to comment on the practical implications of the findings, and any further considerations. In addition to some of the implications highlighted above, they said they thought there was a need for:

- **More information sharing to build a common understanding** across the different stakeholder groups identified. For example, providing managers and GPs with more information on the tools available and key concepts in managing stress.
- **Clarification of employer responsibilities at an organisational level**. It was argued that many organisational leaders did not understand their current responsibilities, or what good actions would look like. Therefore, it was suggested that using real world examples of activity would be helpful, along with demonstrating

the return on investment for these activities and support for organisations to measure their own impact.

- **Greater and visible regulation (including enforcement)** was stated by participants as an encouragement for organisational action. For example, holding organisations to account for their duty to protect employees from the impact of stress at work, or collecting data on whether stress risk assessments had been completed. It was argued that increased enforcement action would help to build support within organisations, allowing for greater priority and resource to be allocated to prevention efforts.

12 Appendix 6 - Evidence map

The conclusions above are drawn from the variety of evidence gathered by this project. The sources of evidence for each point are mapped in **Table** with a Y (yes) or N (not found) to allow readers to explore the relevant appendices more efficiently.

Table 9. Mapping of sources of evidence contributing to findings

Topic	Conclusion	Academic literature	Grey literature	Interviews	Consultation
Definitions	Varied definitions in use	Y	Y	Y	Y
	No binary distinction - Intertwine of work / life stress	N	N	Y	Y
	Using psychosocial hazards to specify workplace remit	N	Y	Y	Y
Labelling WRS	Inconsistent use of tools	Y	Y	Y	Y
	Lack of time / difference in length of time	N	N	Y	Y
	Individual variation in process	N	N	Y	Y
	Lack of access to OH	N	N	N	Y
	Negotiation as a key part of process	N	N	Y	N

Topic	Conclusion	Academic literature	Grey literature	Interviews	Consultation
Further support needed	Communication of existing tools	N	N	Y	Y
	Argument for regulation	N	N	Y	Y
Joined up approach	Opportunity to take a preventative approach	N	N	Y	Y
	Stress risk assessments for individuals and organisations	N	N	Y	Y

13 Appendix 7 - Strengths and limitations

This research draws on multiple sources of data to explore how WRS is defined and labelled in practice. As with any study, there are several strengths and limitations of this work.

Strengths

- **Multi-stakeholder perspective:** Interviews with organisational leaders, healthcare professionals, and occupational health professionals, provide a rarely presented triangulated view across work and health systems.
- **Mixed methods approach:** The integration of the evidence review (across both academic and grey sources), deep insights gathered through interviews, and the extensive consultation from diverse stakeholder groups allows a richer understanding of how WRS is defined and labelled in practice.
- **Cross-sector perspective:** Our stakeholder engagement and sampling approach aimed to draw insights from diverse sectors to understand common challenges and capture salient points of differentiation.
- **Practice- and policy- oriented:** The research aimed to bring together existing knowledge, and advance understanding, with a specific focus on developing practical insights to inform employers, health service provision, and policy.

Limitations

- **Engaged sample:** While we used several channels to recruit participants for this study, those who chose to take part in the interviews and workshops were likely to be more informed, engaged, or concerned about WRS than the wider professional population. This may have introduced a degree of positive bias in terms of knowledge or willingness to act.
- **Limited representation of some groups:** While we sought input from diverse stakeholders, including key professional groups, perspectives from smaller employers, gig workers, and employers without access to occupational health services were underrepresented. The study design allowed for discussion on how WRS may affect workers from different groups, including minority ethnic groups, neurodivergent individuals, women, and people with disabilities, and no specific issues were strongly raised by participants. How WRS labelling may intersect with other aspects of identity and experience may require further dedicated research.
- **Focus on professional views:** The study focused on those responsible for defining, labelling, or responding to WRS, rather than those experiencing it. As such, the findings may not fully capture how individuals with lived experience of WRS interpret or navigate these systems.
- **Lack of quantitative outcome data:** While qualitative insights are strong, the study does not include quantitative analysis of the prevalence or outcomes associated with

different WRS labelling or management practices. This limits the ability to draw conclusions about the relative effectiveness of specific approaches.

These strengths and limitations should be kept in mind when considering the findings of this research and the conclusions presented.

The purpose of this research was to build the evidence base on how work-related stress (WRS) is understood, identified and managed in practice across workplaces. This will be used to help support developments in preventing and reducing the effects of psychosocial hazards in the workplace.

Affinity Health at Work and partners, the Institute of Employment Studies and the Institute of Occupational Medicine, used a multi-method research approach combining evidence reviews, interviews, and stakeholder engagement.

The findings are published in an overarching summary report and three thematic reports addressing the programme's key research questions:

- Overarching summary report: brings together key findings from across the programme
- Report 1: How is WRS defined and labelled by organisations and medical professionals?
- Report 2: What interventions are effective for preventing and managing WRS?
- Report 3: What are the enablers and barriers to organisations effectively reducing the risks of WRS?

The reports will be of interest to employers, practitioners, policymakers, academics and researchers working to improve the prevention and management of psychosocial risks.

In summary, the research found that:

- there is no shared understanding of how work-related stress is defined and labelled
- organisational responses to work-related stress are often reactive rather than preventative
- effective prevention depends on linking interventions to identified psychosocial risks and involving workers in developing solutions
- stronger evaluation and sharing of learning would improve understanding of what works in practice
- the key challenge is how existing knowledge is translated into coordinated prevention activity

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