Project OSCAR: Occupational Stress Consultation and Research

Report 2 Interventions to prevent and manage 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 2 Interventions to prevent and manage 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
AFR	African Region
AMR	Region of the Americas
BMA	British Medical Association
CIPD	Chartered Institute of Personnel and Development
DWP/DHSC	Department for Work and Pensions/ Department of Health and Social Care
EMR	Eastern Mediterranean Region
EU-OSHA	European Agency for Safety and Health at Work
EUR	European Region
GB	Great Britain
H&S	Health and Safety
HSE	Health and Safety Executive
IES	Institute for Employment Studies
IGLOO	Individual, group, leader, organisation and outside
IOM	Institute of Occupational Medicine
ISO	International Organisation for Standardisation
MHFA	Mental Health First Aid
NICE	National Institute for Health and Care Excellence

OH/OHPs	Occupational Health/Occupational Health Practitioners
OSCAR	Occupational Stress Consultation and Research
PAG	Project Advisory Group
PSG	Project Steering Group
RCT	Randomised Controlled Trials
SEAR	South-East Asia Region
SME	Small and Medium-sized Enterprise
SOM	Society of Occupational Medicine
WHO	World Health Organisation
WPR	Western Pacific Region
WRS	Work-related stress

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Key messages

Why the work was done

Work-related stress (WRS) remains a leading cause of work-related ill health in Great Britain (GB). Despite strong evidence on the working conditions (often called psychosocial hazards) that contribute to stress, practice is often inconsistent and reactive. Most evidence looks at outcomes (e.g., stress, wellbeing, burnout) rather than whether interventions reduce harmful working conditions, limiting hazard-led decisions. A clear, organised record of interventions and their evidence base to prevent and manage WRS is missing.

What we did

- Reviewed evidence submitted by the WRS research, policy and practice community.
- Conducted systematic searches of evidence on control measures and interventions for WRS, prioritising research since 2020.
- Ran workshops with stakeholders to check and explore findings.

What we found

- Organisations use **many interventions**, but the evidence is **fragmented.**
- This reflects the **complexity of WRS** and the **varied ways organisations respond**.
- **Most evidence focuses on outcomes** (e.g., stress, wellbeing), limiting its use for hazard-led stress risk management.
- **Evidence for preventative interventions is mixed** and depends on context and how interventions are implemented.
- **Context, implementation and worker involvement** are not consistently reported.
- **Routine evaluation is limited,** and learning is rarely shared.

What this means

The evidence does not provide clear answers about “what works” in all settings, but it does show what organisations are doing and the gaps in knowledge. Organisations must still take action. Stress risk assessment is a practical starting point. Using available evidence alongside professional judgement and local knowledge, and reviewing and sharing what works in practice, will help to strengthen the evidence base and support organisations with selecting targeted interventions.

Executive summary

Introduction

Work-related stress (WRS) is a leading cause of work-related ill health in Great Britain (GB). There is strong evidence on the working conditions that can contribute to stress, often referred to as psychosocial hazards, and a growing body of evidence on interventions that can improve mental health and wellbeing outcomes. Although many employers take steps to identify and reduce WRS, current practice is often inconsistent, reactive and largely focused on individual-level support rather than prevention. Many employers also say that they are unsure whether their current approaches are effective.

Several reviews and guidance documents already exist on workplace mental health, including those produced by international bodies such as the World Health Organisation (WHO) and the National Institute for Health and Care Excellence (NICE). These provide valuable evidence on interventions that can improve mental health and wellbeing outcomes. However, they are largely outcome-focused and place limited emphasis on whether interventions reduce exposure to the psychosocial hazards that give rise to WRS. We currently lack a systematically organised record of interventions and their efficacy to guide decision making in relation to WRS.

The Health and Safety Executive (HSE) commissioned this research to complement existing reviews and to support its strategic objective to reduce work-related ill health, with a specific focus on mental health and stress. This report focuses on preventing and managing WRS through psychosocial hazards, and examines how far the existing evidence base aligns with a hazard-led approach to stress risk management, in line with HSE's remit.

Methods

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

- **A call for evidence** with the WRS research, policy and practice community (80 submissions, 400+ registrations).
- **A systematic search and review of evidence** on control measures and interventions for WRS, prioritising research published since 2020.
- **Two stakeholder consultation workshops** to review and refine findings and explore implications for guidance and regulation.

Findings from these sources were synthesised to identify common themes, areas of convergence and divergence, and identify new insights.

Key findings

A wide range of interventions are used, but evidence is fragmented

The review identified a broad range of interventions aimed at preventing or managing WRS including job design, leadership and manager training, participatory approaches, interpersonal interventions, and changes to the physical work environment. This reflects the complexity of WRS and the different ways organisations attempt to address it in practice. However, the evidence base is fragmented, with substantial variation in how interventions are defined, delivered and evaluated, limiting comparison across studies.

Across research and practice sources, approximately 80 distinct interventions were identified. These were consolidated into a structured catalogue of 40 interventions across 10 broad categories, spanning primary, secondary and tertiary approaches.

The evidence base is immature and uneven

Across intervention types, the quality of evidence is typically low to moderate, with limited quantities of robust evaluative research. Using the NESTA Standards of Evidence, much of the evidence sits at early stages of development, reflecting the challenges of evaluating complex organisational interventions in real-world settings rather than a lack of activity or innovation.

Most evidence focuses on outcomes, not psychosocial hazards

Across most reviews, interventions were evaluated primarily in relation to outcomes such as stress, burnout, wellbeing or mental health. Few studies explicitly assessed whether interventions led to changes in underlying psychosocial hazards, such as workload, control, role clarity or workplace relationships. As a result, it is often unclear whether reported improvements in outcomes reflect meaningful reductions in psychosocial risk. This makes it difficult for employers to know what action to take, and difficult for others to make recommendations to employers where hazards are identified.

This limitation also applies to many interventions that are not designed or labelled as stress interventions, but which may nonetheless influence psychosocial hazards. Examples include leadership and management capability development, change management, communication practices, and aspects of work and job design. These approaches are often implemented for broader organisational purposes and are rarely evaluated in relation to WRS or hazard reduction, meaning their potential contribution to preventing and managing WRS may be under-recognised.

Evidence for primary prevention is mixed and context-dependent

Evidence of effectiveness is mixed and highly dependent on organisational context and implementation. Leadership, interpersonal and mental health awareness interventions often improve knowledge, confidence or perceived support, but show limited evidence of sustained reductions in WRS when used in isolation.

Context, implementation and participation influence effectiveness

Both the evidence review and stakeholder consultation highlight that how interventions are implemented is as important as what is implemented. Organisational context, sector, workforce characteristics and worker involvement all influence effectiveness. Reviews commonly synthesise evidence across diverse settings, limiting their usefulness for guiding decisions in individual organisations.

Risk assessment remains central to prevention

Given the limitations of the evidence base, stress risk assessment plays a critical role in identifying suitable interventions to prevent and manage stress. Stress risk assessment enables organisations to identify relevant hazards, prioritise action and select interventions that are proportionate and appropriate. Evidence relating to interventions can inform this process, but it cannot replace a structured risk management approach.

Limited evaluation and shared learning from practice

The review found limited evidence of organisations evaluating interventions in relation to psychosocial hazards or sharing learning from implementation. Compared with some European initiatives, there is relatively little accessible documentation of sector-specific good practice, opportunities for shared learning.

Key considerations

This review highlights opportunities to strengthen research and practice by:

- **Strengthen the problem – solution – impact link**, by supporting employers to use stress risk assessments and indicator tools to diagnose problems, map appropriate interventions to those psychosocial risks, and evaluate whether the risks have reduced over time. This should be understood as a **cyclical process,** reviewed regularly and updated as business contexts change.
- **Promote a shared, hazard-led understanding of WRS**, centred on how work is organised and managed, rather than focusing primarily on individual symptoms or outcomes. Without this, prevention and management efforts are likely to remain reactive and fragmented.

- **Support organisations to take an integrated, systemic approach to intervention**, recognising that no single intervention is sufficient and that combinations of actions across organisational levels are often required.
- **Recognise the potential of interventions implemented for broader organisational purposes** (e.g., leadership development, change management, communication) in contributing to preventing and managing WRS where they address psychosocial hazards, even when this is not their primary aim.
- **Increase emphasis on participation and implementation**, recognising the role of worker involvement, context and delivery quality in determining whether interventions are effective in practice.
- **Embed evaluation and learning as a routine part of prevention**, encouraging organisations to define intended outcomes, monitor both process and impact, and adapt interventions as work and business contexts change.
- **Improve how evidence is generated, used and shared**, by valuing well-documented organisational practice alongside academic research, and supporting learning about what works, in what contexts, and why.

Conclusion

Preventing and managing WRS remains a complex challenge. While a wide range of interventions are currently in use, the evidence base is fragmented and often does not clearly demonstrate whether interventions reduce exposure to the psychosocial hazards that give rise to stress or other individual or organisational outcomes. Existing evidence, when used in isolation, is insufficient to support clear hazard-led decision-making.

This does not mean that organisations should delay action. Rather, it highlights the need to make better use of the evidence that is available, alongside stress risk assessment, professional judgement and contextual knowledge. A clearer alignment between identified risks and intervention choice, together with a greater attention to implementation, monitoring and evaluation, can support a more preventative and proportionate management of WRS.

This report brings together evidence from multiple sources. It provides a structured catalogue of interventions, examines their efficacy in relation to WRS, and highlights opportunities to strengthen learning by encouraging employers, practitioners and researchers to review, evaluate and share learning from real-world implementation in GB workplaces.

1 Introduction

1.1 Background to Project OSCAR

Stress is one of the most significant occupational health challenges in 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 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, and burnout (Dunning et al., 2022; Howard et al., 2021; Khamisa et al., 2015; 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 & 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, 2024).

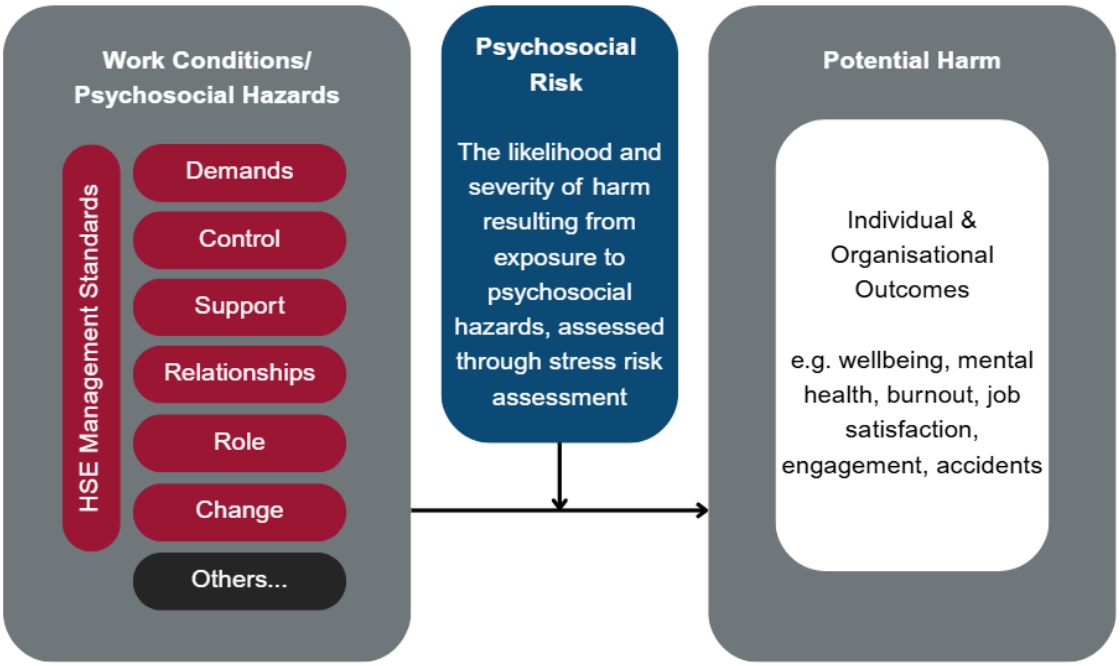
A strong and consistent body of research shows that specific working conditions (also called psychosocial hazards) are linked to WRS and poor health. These psychosocial hazards can include job demands, long working hours, poor leadership, low job control, low social support, poor work relationships, low work recognition, and high job insecurity as reflected in Figure 1 (Leka & Jain, 2024; Niedhammer et al., 2021) Many of these psychosocial hazards are reflected in HSE's Management Standards (which are shown in Figure 1) for WRS. The likelihood of these hazards causing harm and the severity of this potential outcome is referred to as psychosocial risk. Organisational and individual stress risk assessments aim to identify psychosocial hazards and implement measures to reduce the risk of harm.

Despite this evidence, many employers are not taking action to identify and reduce the risk of WRS. According to the Chartered Institute of Personnel and Development (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. This is because 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. Further detail concerning the history of WRS to frame the current position is provided within Appendix 1 – Background to WRS.

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



In the current report, we use the terms “prevent” and “manage” when referring to WRS. We use the term “prevent” to refer to reducing the causes and any factors that can make workplace hazards more likely to lead to stress. As a result, we are interested in considering predominantly primary interventions at work (defined within section 1.2). Health and Safety (H&S) professionals may also describe these as “controls” or “control measures”. We intentionally use the term “managing” rather than “eliminating” WRS. While employers have a duty to control work-related risks, total elimination is often neither feasible or proportionate, given the dynamic nature of work and the influence of personal, health-related, and environmental factors (see report 1 for detailed explanation).

It is important to recognise that many factors involved in managing WRS can sit outside the traditional scope of how organisations comply with H&S 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 influence what individual employers are able to change. While the employing organisation is ultimately responsible for managing WRS under H&S law, the actions taken often sit with human resource or occupational health teams. These teams may be less familiar with H&S 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 (MHFA) 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 risks. 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 (IOM), the Institute for Employment Studies (IES), and the Society of Occupational Medicine (SOM) 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 WRS. The research addresses three priority questions identified by the HSE:

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

This report summarises study activity and presents the findings related to the second research question. Study activity and findings related to first and third research questions are reported separately (see report 1,and report 3).

1.2 Background to research question two

In the two decades since the introduction of the HSE Management Standards (Cousins et al., 2004; Mackay et al., 2004), more organisations have introduced measures to reduce and manage WRS. This growth has been driven by stronger awareness of the personal and economic costs of poor mental health (Deloitte, 2022) and the emergence of international frameworks promoting proactive management of psychosocial risks at work. For example, ISO 45003 (International Organisation for Standardisation ISO, 2021) provides detailed guidance on psychosocial risk management, while the World Health Organisation Guidelines on Mental Health at Work (2022) encourage organisations to integrate mental-health protection within occupational safety and health systems. Despite this progress, there is still limited agreement on which interventions are most effective, how they operate in practice, and how they can best be built into existing H&S management systems.

In managing WRS, employers can apply the same prevention principles used for physical H&S risks: prioritising action to address hazards at source. Interventions for WRS can be commonly assigned as follows:

- **Primary interventions** aim to reduce or eliminate root causes of stress by addressing psychosocial hazards at source.
- **Secondary interventions** aim to target the reactive stage of stress, helping workers and managers to better identify and manage stressors and symptoms as they occur. This includes activities such as stress awareness training, resilience building, or mindfulness programmes.
- **Tertiary interventions** aim to treat the consequences of stress and supporting recovery and return to work. These include access to counselling, employee assistance programmes, and occupational health or rehabilitation services.

This tiered approach (primary, secondary tertiary) mirrors the prevention hierarchy used for physical H&S management. It emphasises the importance of taking action at source, while recognising the need for an integrated, systemic approach to manage risk and optimise individual and organisational health and performance (Lecours et al., 2023; Nielsen et al., 2023). It is important to note that categorising interventions within levels of control, may involve some overlap. Certain interventions may function as primary or secondary depending on the intent and implementation. As a result, the assignment of interventions should always be interpreted with contextual flexibility.

Recent data suggest that most UK employers are taking some form of action, but implementation and effectiveness remain uneven. In a survey of 1,101 UK employers, 64% of organisations report taking steps to identify or reduce stress in the workplace,

yet only 50% believe their approach is effective. Common interventions include access to counselling (43%) and employee assistance programmes (41%), while only 29% provide line-manager training to support mental health and just 14% use occupational-health services proactively (Sinclair & Suff, 2025). These figures illustrate some of the gaps in organisational control measures.

To direct effective action, numerous reviews of research and data have examined the types of interventions that aim to improve mental health and wellbeing at work, and the extent to which they are effective (e.g., Aust et al., 2023; Joyce et al., 2016; LaMontagne et al., 2007; Nielsen et al., 2010; van der Klink et al., 2001). There are several important observations from the existing evidence on WRS that must be considered when reviewing effective prevention and mitigation strategies:

- **A dominant focus on individual-level interventions**. The majority of existing studies, including economic analyses, evaluate individual-focused or secondary approaches such as stress-management training, cognitive-behavioural and relaxation-based programmes (van der Klink et al., 2001; Richardson & Rothstein, 2008; Joyce et al., 2016) and specific techniques such as mindfulness training (Donaldson-Feilder et al., 2019), cognitive-behavioural therapy (Yunus et al., 2018), and resilience training (Joyce et al., 2018). While there is a growing body of prevention-focused, organisational-level research, these remain under-represented and methodologically diverse (Aust et al., 2023; LaMontagne et al., 2007; Nielsen et al., 2010). Reviews highlight that organisational interventions often yield variable effects, depend heavily on context and implementation, and the reviews show limited evidence of sustained impact (Aust et al., 2023; Nielsen et al., 2010).
- **Variable quality of research.** Meta-analyses and syntheses informing the World Health Organisation's Guidelines for Mental Health at Work revealed that much of the evidence base is of low to medium quality. Similarly, a review of the evidence for reasonable adjustments for mental health, mapped against the NESTA Standards of Evidence (Puttick & Ludlow, 2013)**,** found that most studies sit at lower levels, with none at the highest levels, providing little opportunity to assert the effectiveness of even the most common interventions such as flexible working or adjustments to work tasks.
- **A growing recognition of the importance of context.** Recent research highlights the importance of contextual factors in understanding why interventions succeed, fail, or have unintended effects (Daniels et al., 2021; Lecours et al., 2023; Nielsen et al., 2023; Yarker et al., 2023). This work underscores the necessity of understanding the organisational, cultural, and implementation conditions that strengthen or weaken the efficacy of workplace mental-health interventions.

These limitations also have implications for policy and guideline development. Recent efforts to synthesise evidence for practice frameworks and guidelines - such as the World Health Organisation's Guidelines for Mental Health at Work (WHO, 2022) and the ISO, 45003 Standard on Psychosocial Risk Management (ISO, 2021) highlight the need for stronger evidence linking specific interventions to the psychosocial hazards they are intended to control. Guideline development exercises continue to emphasise the importance of primary prevention and organisational-level action.

As risk management within organisations begins with the consideration of specific psychosocial hazards, identified through stress risk assessment (as shown in Figure 2), it would be useful for employers and practitioners to understand which interventions are most appropriate for different hazards.

Figure 2 HSE Risk Management Cycle



Previous reviews have largely focused on the relationship between interventions and a broad range of individual and organisational outcomes. There has been less emphasis on the links between work conditions/psychosocial hazards and the interventions used to address them. Better understanding this link would support more targeted and effective action.

Taken together, this evidence highlights a clear gap between existing research evidence and the needs of occupational health & safety practitioners. Previous reviews have provided useful insights into the effectiveness of broad categories of workplace mental health interventions, but they are not structured to support hazard-led stress risk assessment or the selection of control measures. Interventions are rarely mapped to specific psychosocial hazards, making it difficult for organisations to identify targeted solutions. Moreover, many reviews do not always explain why interventions succeed or fail, overlooking contextual and implementation factors that strongly influence outcomes. As a result, few reviews provide findings that translate into actionable guidance.

There is need for a more systematic, hazard-focused and practice-relevant approach, including an organised record of interventions and their evidence-base to support decision making on WRS.

1.3 Research aims

HSE required an up-to-date review of the evidence in relation to practical control measures/interventions at various levels – primary (preventative), secondary (protective), and tertiary (rehabilitative) – with a focus on preventative measures, to inform future guidance and judgements on intervention suitability for WRS. Given the HSE's prevention-led focus, the primary emphasis of this research is on preventative approaches, incorporating considerations of mitigation and recovery. While priority has been given to evidence from the UK, learnings from relevant organisations around the world have also been considered.

This research aims to answer the question '**What control measures/interventions show efficacy for preventing and managing WRS?'**

Specifically, this review aimed to address gaps in the existing literature in three ways, by:

- Placing a specific focus on WRS, rather than broader mental health outcomes.
- Identifying the types of control measures and interventions implemented in workplace settings by UK employers and practitioners, with focus on WRS prevention.
- Examining the extent to which interventions can be linked to the psychosocial hazards they are intending to control.

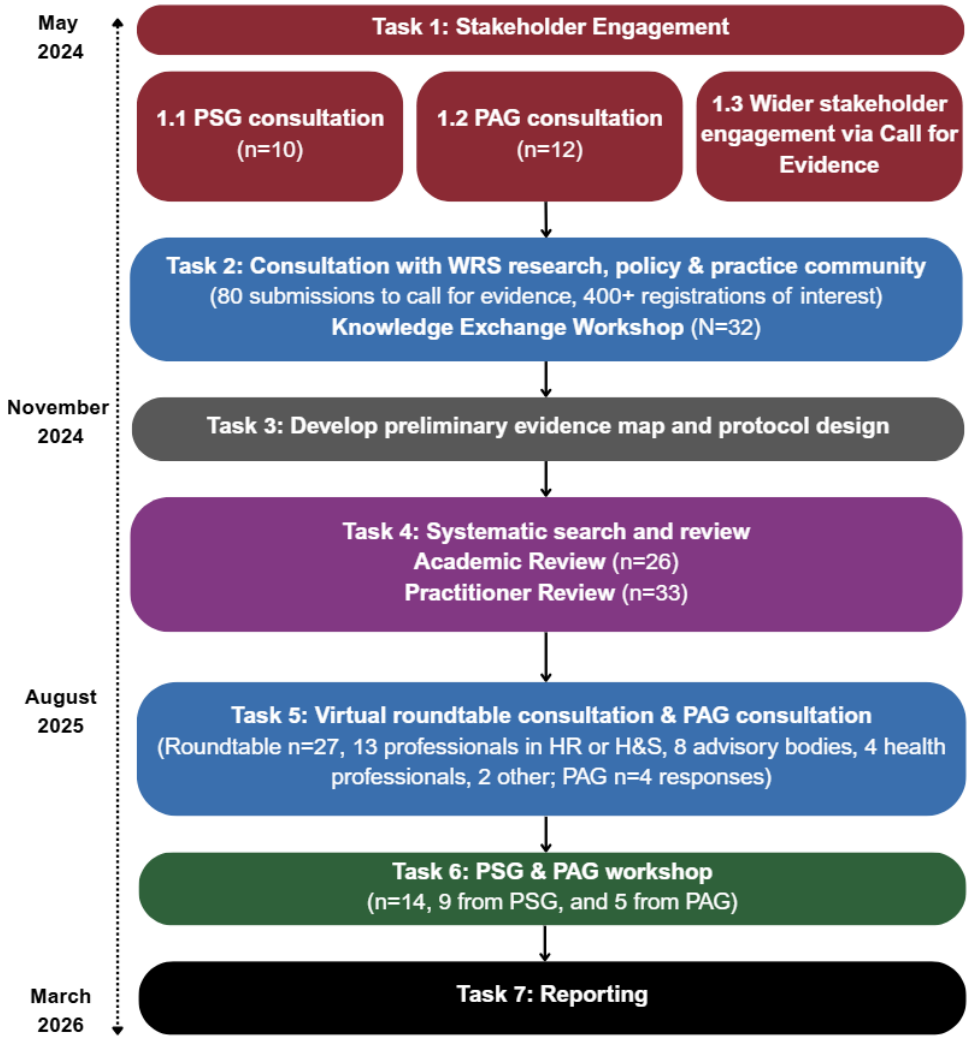
Sub-questions, guided by the tender document and agreed through a process of consultation with the HSE and the Project Advisory Group (PAG) and Project Steering Group (PSG), were also examined:

- When considering interventions (control measures and mitigation) for WRS, which show efficacy? What is the strength of the evidence? And are there any known issues/limitations?
- Is efficacy limited to certain contexts/sectors/organisational sizes?
- Can controls be mapped to ‘primary’ (preventative), ‘secondary’ and ‘tertiary’ interventions?
- Do some control measures offer greater utility, for example, mapping to multiple HSE Management Standards Factors? Or impacting on WRS factors considered more damaging/harmful to employees/workers?
- Are there any commonly applied interventions that have limited evidence, or appear not to work?
- Are there any commonly used interventions that may exacerbate issues/harm?
- Are there any common ‘interventions’ that would not fit the definition of a control/intervention in terms of a WRS risk assessment (i.e., something that would more broadly fit as a ‘wellbeing’ intervention, not necessarily WRS)?
- Do duty holders evaluate the effectiveness of their control measures/ interventions for WRS? If so, how?

2 Methodology

A multi-phase, mixed methods approach combined findings from: stakeholder engagement, a systematic search and review, 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 3 below.

Figure 3 Flow chart showing methodology of research undertaken



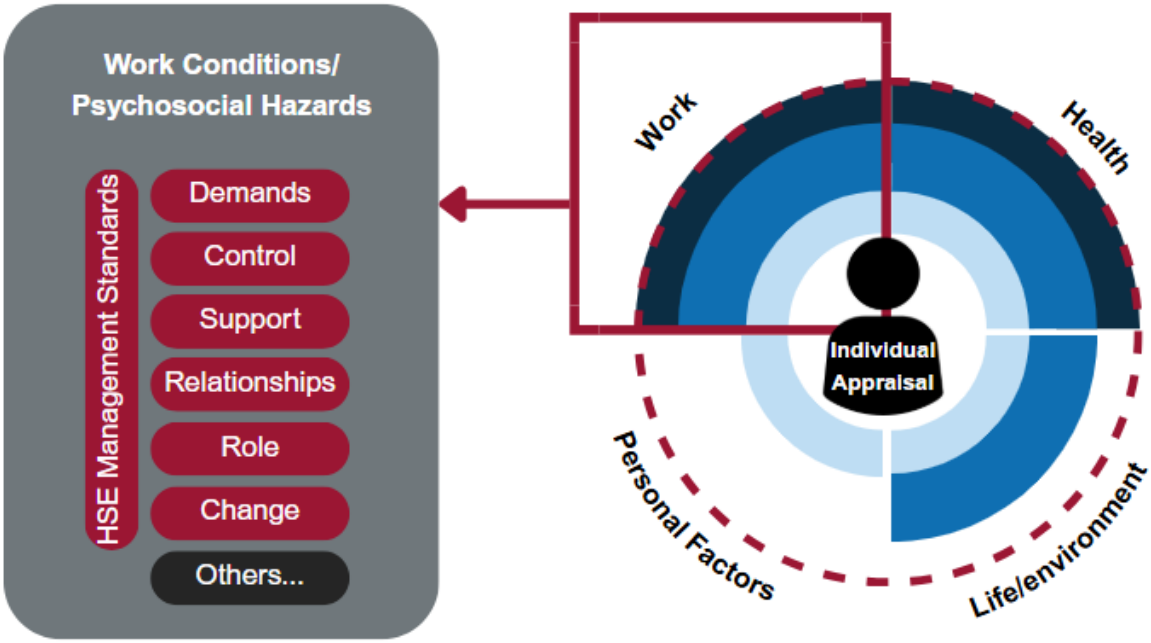
This mixed-methods approach was selected to make sure that findings were both evidence-informed and grounded in the realities of practice. Each phase of the research was designed and delivered in line with scientific best practices and involved an iterative approach to navigate the complexity and size of the evidence base. Full details of the methods used and supporting materials are provided in Appendix 2 – Methodology.

Data from each phase was brought together to address the research questions.

2.1 Focusing on work-related stress

Through the research carried out as part of the Define and Label stream (see report 1) of the wider OSCAR project, consensus was seen that there is not a binary distinction between stress related to work and stress outside of work. Therefore, it is recognised that an individual's experience of WRS is shaped by (i) a combination of factors – both within and outside of work, including health conditions that impact work; (ii) the availability and suitability of resources; and (iii) their appraisal of their situation (see Figure 4). Consequently, in practice, the process of labelling WRS is often less about understanding whether work has caused stress (or not) but instead is more about assessing its impact and looking for opportunities to alleviate stress through adaptations in the working environment.

Figure 4 Conceptualisation of stress based on Define and Label Report.



Academic research shows a similar shift towards the consideration of impact and outcomes, demonstrated by the growing research interest in burnout (Edu-Valsania et al., 2022). For the purpose of this review however, the focus established was on WRS specifically rather than its possible outcomes. This was to ensure that research on interventions was assessed for its efficacy in addressing the work-related factors that can create risk of WRS, rather than the broader topic of interventions that have positive impact on mental and physical health. From a practical perspective, this allows employers to focus on their direct responsibilities and provides a basis for taking action on the factors they can influence.

2.2 The quality and standard of evidence

As part of this review, both the quality of evidence and the standard of evidence are assessed. Further details on the decision-making process for the ratings of quality and standards are provided in Appendix 2 – Methodology.

Quality of evidence: These markers help us understand how much confidence we can have in the findings. These ratings consider whether the methods used were sound, how reliable the findings are, and how consistent the findings across studies are. The research team made judgements of quality based on the review authors statements of quality. Where this was not present, research team's expert opinion was applied. Studies were rated as having quality ratings of low, moderate or high. Studies were also rated on the Nesta Standards of Evidence (Nesta, 2013) to help understand how well and extensively an intervention has been tested, and how far it has progressed along the evaluation journey.

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 - Strengths and limitations.

3 Findings

This section presents a synthesis of evidence gathered through the multi-phased approach, drawing on the academic and grey literature reviews and consultation. Detailed findings from each research phase are available in the appendices from Appendix 3 - Evidence map findings. A tabulation of how each data source contributed to the findings presented in this section can be found in Appendix 6 – Evidence Map.

A note on terminology – This review focuses specifically on WRS, rather than broader mental health outcomes. Please see the full rationale for this decision in section 1.1, Background to Project OSCAR.

3.1 Interventions used to address WRS

The breadth of items submitted by the research and practice community to the Call for Evidence revealed that a wide range of interventions are in use. Items ranged from documents describing how WRS is addressed in practice, research evidence, and example materials. Across the circa 100 submissions and additions made through scoping searches from the research team, around 80 different interventions were identified. From this, a catalogue of interventions related to WRS was created and refined through consultation and discussion. This catalogue is made up of 40 interventions, which collate under 10 intervention categories.

The catalogue shown in Table 1 provides, for the first time, a structured and quick overview of the intervention types that practitioners, employers, and researchers report using for WRS. These have broadly been organised by primary, secondary and tertiary intervention types, though there is recognition of overlap in these depending on how the intervention is implemented. The purpose of the catalogue is to show the range of existing approaches rather than to assess their effectiveness. Although a high-level review of the extent of evidence available for each area is shown here, it is important to note that this catalogue does not draw conclusions about effectiveness of the interventions presented.

3.1.1 Good practice in selecting and combining interventions

Preventing or reducing psychosocial risk and WRS should be the primary aim of any organisational approach, with interventions focused on reducing exposure to psychosocial hazards at source.

It is important to emphasise that no single intervention is sufficient to prevent or reduce WRS or associated outcomes. As shared in other large reports, such as the WHO Guidelines (2022), and emphasised through our consultation and PAG discussions, a systemic and integrated approach is needed, choosing interventions that operate at different levels of control (Nielsen et al., 2024).

Consistent with HSE guidance (Step 3: Evaluate the risks - explore problems and develop solutions), interventions are typically assigned as primary (preventing harm at source), secondary (mitigating risk and supporting coping), or tertiary (managing and responding to harm once it has occurred).

Levels of control

Note. *Some interventions can be assigned in multiple ways depending on the context and intention of their implementation. Interventions may also operate across multiple levels simultaneously.*

- **Prevention/Primary interventions** aim to reduce or eliminate organisational causes of stress by addressing work-related hazards at source.
- **Development/Secondary interventions** aim to target the reactive stage of stress, helping workers and managers to better identify and manage stressors and symptoms as they occur. This includes activities such as stress awareness training, resilience building, or mindfulness programmes.
- **Support/Tertiary interventions** aim to treat the consequences of stress and support recovery and return to work. These include access to counselling, employee assistance programmes, and occupational health or rehabilitation services.

However, our findings indicate that this assignment is not fixed, but contingent on both the core ingredients of the intervention and the intent and quality of its implementation. The same intervention may operate at different levels of control depending on its design and delivery.

For example, line manager training focused only on awareness or signposting is likely to function as a secondary intervention, supporting recognition and response. In contrast, training that equips managers with the skills, authority, and expectations to proactively identify psychosocial hazards, conduct risk assessments, and implement changes to work design operates as a primary intervention.

Some interventions may operate at more than one level at the same time. For example, organisational policies, tools, or frameworks can include preventative elements while also providing opportunities for early identification and response. In addition, some interventions may not appear to be preventative in isolation but form part of a wider preventative strategy. See section 5 for guidance on what can be deemed as a preventative intervention.

This highlights the need to select interventions not only by what they are, but how they work, what they aim to achieve and how they fit within a broader system of risk management. Categorising risks in a fixed way can oversimplify practice and may obscure whether interventions are genuinely addressing root causes or responding to their consequences.

Research emphasises the importance of combining these approaches within a coherent strategy aligned to organisational priorities, developed with strong stakeholder involvement and supported by a careful implementation process. For further information about the barriers and enablers to effectively managing WRS see report 3.

3.1.2 How this catalogue differs from existing guidance on mental health at work

There have been recent systematic reviews carried out to support guideline development, for example, those carried out by the NICE (2022) and WHO (2022). The WHO Guidelines on mental health at work have a broader research area/outcome than WRS, that being mental health, which they conceptualise as “a state of mental well-being that enables people to cope with the stresses of life, to realise their abilities, to learn well and work well, and to contribute to their communities” (WHO, 2022). Similarly to the conclusions of our Define and Label Report (see report 1) they also note that mental health conditions occur regardless of the impact of work through a variety of other causes. The NICE mental wellbeing at work guidelines (2022), provide a series of recommendations which are supported by a series of reviews carried out for their research areas. Like the WHO Report, the NICE Reports take a much broader consideration of outcomes and also consider individual level interventions.

The current research examines which interventions are effective in preventing and reducing WRS specifically, recognising this as distinct from general mental health, and with greater focus on preventative/primary interventions. The WHO and NICE Reports were considered to support the development of the catalogue of interventions and their findings, where specific to WRS, were also considered alongside other research. Where relevant, comparisons to the WHO guidelines on mental health at work (2022) and the NICE guideline on mental wellbeing at work (2022) are made.

Table 1 shows the catalogue of interventions which were collated through the evidence mapping process with their definitions.

Table 1 Catalogue of interventions and their descriptions

Category	Intervention Strategy	Intervention Description
Work design	Changing break structure & form	Breaks used to provide workers with a period of recovery. Can include both regular and micro breaks.
	Flexible, remote & home working	Changes in work time and flexibility of where work is completed.
	Job design	Altering the design of work tasks and the demands and resources available to workers. This includes changes to the scheduling pattern of work and approaches which attempt to reduce workload of workers.
	Physical work/built environment	Changes to the physical work environment such as interior space, biophilic design, lighting etc.
Participatory interventions	Participatory interventions	Interventions which are designed with participation from workers and may involve a variety of intervention activities. The participation of workers in the design process is key.
Leadership training	Leadership training interventions - to support others' mental health	Training for leaders which focuses on leaders' capability to support their workers' mental health (e.g., may focus on interaction between leaders and workers, improving leadership style, ability to design healthy work environments).
	Leadership training interventions - manager training - own mental health	Training for leaders to support and take accountability for their own mental health and wellbeing (e.g., leader stress management).
Interpersonal interventions	Anti-bullying & incivility	Programmes which promote positive behaviours and aim to prevent workplace violence.

Category	Intervention Strategy	Intervention Description
	Coaching	Executive coaching as a learning and development intervention to improve individual capability.
	Mental health awareness training/literacy & mental health first aid (MHFA)	Programme providing education on various mental health conditions to increase knowledge, reduce stigma and increase confidence in supporting others with identifying poor mental health.
	Mental health champions	Workplace champions of mental health trained to support their colleagues.
	Social/peer support	Where workers can support each other with their mental health concerns, commonly in roles which have frequent stress or trauma exposure.
	Teamwork (interprofessional)	Interventions which seek to increase the capability of a team to work together effectively. Seek to improve communication and performance outcomes (e.g., patient care in healthcare).
Skills training	Skills training	Includes a variety of skills training approaches which provide workers with the information and ability to carry out certain tasks for their roles. Examples may be skills training for situations people may experience in their role (through imagery, simulation) or explicit tasks such as IT training.
	Selection, Optimisation, and Compensation (SOC)	A life management/goals training focussing on considered Selection of goals, Optimisation through improving ways to reach these, and Compensation through finding ways to restore any losses experienced in pursuit of these.
Staying well	Health promotion	Materials and trainings to increase knowledge and healthy lifestyle behaviours (e.g., fatigue education).
	Physical activity, lifestyle	Increasing, encouraging or including physical activity and exercise.
	Volunteering/charity work	Being given time through work to take part in charity work and volunteering activities.
	Sleep interventions	Apps, trainings and programmes provided to support healthy sleep.

Category	Intervention Strategy	Intervention Description
Psychological resources	Mindfulness & meditation	Programmes or brief trainings seeking to increase present moment awareness and other mindfulness skills through increasing noticing abilities.
	Acceptance and Commitment Training (ACT)	Intervention programmes which seek to target and improve psychological flexibility subprocesses.
	Digital interventions	Approaches which may seek to provide any psychological resource or training to workers, but primarily through providing access to online app formats. Examples can include guided meditation apps.
	Cognitive Behavioural Therapy (CBT)	Facilitated approaches focusing on which supports the change of behaviours and thought patterns to reduce unhelpful patterns.
	Positive psychology & Psychological Capital	Interventions seeking to increase hope, self-efficacy, resilience, and optimism (HERO).
	OTHER	A variety of individual level interventions which fall into alternative therapies and approaches. Examples can include aromatherapy trainings, relaxation techniques, changing sensory input, affect school, gratitude journalling etc.
	Resilience	Aiming to increase worker ability to manage challenging situations and circumstances. Can sometimes include mindfulness and CBT elements.
Therapeutic Approaches	Therapeutic interventions	Approaches which involve psychological therapist support and facilitated sessions, often occurring on a one-to-one basis (e.g., psychotherapy).
	Counselling	Facilitated one-to-one sessions involving confidential talking therapy approaches with trained professional.
	Motivational Interviewing	Counselling based approach aiming to change behaviour through reducing ambivalence.

Category	Intervention Strategy	Intervention Description
	Emotional Freedom Technique (EFT)	Using tapping techniques on acupressure points to create desired signal input to brain.
Support pathways	Employee Assistance Programmes (EAP)	External support services to provide tertiary support and resources to workers experiencing mental health and other concerns.
	Screening	Screening assessments which can be used either during or pre-employment to gather information on worker mental health.
	Occupational health provision	Services provided by trained occupational health professionals to support and maintain worker health.
	Return to work/absence management	Including trainings, policies, and provisions which enable supported return to work for workers have been off work for a variety of reasons.
	Prevocational training	Training in skills required for typical employment, prior to employment commencing to facilitate a supported entrance to the workplace for those who have experienced poor mental health.
	Supported employment	Support provided for gaining and maintaining employment.
	Vocational Rehabilitation Interventions	Can consist of multiple types of support (e.g., supported employment and prevocational training) to enable those who have experienced severe cases of poor mental health to enter steady employment.
	Accelerated Recovery Programme (ARP)	Experiential interventions consisting of use of a variety of techniques such as neuro-linguistic programming, thought field therapy, imagery, self-care.
Sector specific	Post incident interventions/debriefing	Targeted interventions provided after exposure to critical incidents in the workplace (e.g., natural disaster, war). Particularly relevant for trauma exposed roles and first responders such as military, emergency services, and healthcare.

Category	Intervention Strategy	Intervention Description
	Clinical supervision	Professional support processes and training provided in role to increase knowledge and competence for practitioner-based roles, for examples, within healthcare.

To make best use of project timelines and resource, through conversations with the HSE, a shortlist of the above categories was selected to be focused on including work design, participatory interventions, leadership training and interpersonal interventions. This shortlist of interventions was chosen because the categories primarily target the prevention of stress at multiple levels (e.g., organisation, leader and team) rather than focusing solely on the individual and aiming to inform system-level risk control outlined earlier in the report. However, as noted above, interventions may target different levels of control depending on how they are implemented. Interventions have been categorised as primary, secondary or tertiary based on their primary aim in relation to psychosocial risk. The categorisation is indicative rather than fixed, operating at different levels depending on their design, intent and implementation. The output of this evidence mapping is presented in Table *2* below. For further information on the non-priority interventions, see Table 10.

M=	**Multiple reviews including intervention available**
S=	**Some reviews found, potentially outdated/ pre-covid**
N=	**No review found**

Table 2 Summary of evidence map

Intervention category	Intervention Strategy	Extent of evidence	Mentioned in NICE guidelines	Mentioned in WHO guidelines	Commonly targeted level of control[1]		
					Primary (Prevention)	Secondary (Development)	Tertiary (Support)
Work design	Changing break structure & form	M	x	x	P		
	Flexible, Remote & Home Working	M		x	P		
	Job design	M	x	x	P		
	Physical work environment	M		x	P		
Participatory interventions	Participatory interventions	M	x	x	P	S	
Leadership/ manager training	Leadership/manager training - To support others mental health	M	x	x	P	S	
	Leadership /manager training - To support own mental health	M	x	x	P	S	
Interpersonal interventions	Anti-bullying & incivility	S	x		P	S	
	Coaching	S	x		P	S	
	Mental health awareness training/literacy	M	x	x	P	S	

[1] **Note.** Some interventions can be assigned in multiple ways depending on the context and intention of their implementation. Interventions may also operate across multiple levels simultaneously. See section 4.5. for more detail.

Intervention category	Intervention Strategy	Extent of evidence	Mentioned in NICE guidelines	Mentioned in WHO guidelines	Commonly targeted level of control[1]		
					Primary (Prevention)	Secondary (Development)	Tertiary (Support)
	Mental health champions	S	x	x	P	S	
	Social/peer support	S	x		P	S	
	Teamwork (interprofessional)	M	x	x	P	S	
Skills Training	Skills training	S	x			S	
	Selection, Optimisation, and Compensation (SOC)	S	x			S	
Staying well	Health promotion	M	x	x		S	T
	Physical activity, lifestyle	M	x	x		S	T
	Volunteering/charity work	M				S	T
	Sleep interventions	S	x			S	T
Psychological Resources	Mindfulness & meditation	M	x	x		S	T
	Acceptance Commitment Therapy (ACT)	M	x	x		S	T
	Digital interventions	M	x			S	T
	Cognitive Behavioural Therapy (CBT)	M	x	x		S	T

Intervention category	Intervention Strategy	Extent of evidence	Mentioned in NICE guidelines	Mentioned in WHO guidelines	Commonly targeted level of control[1]		
					Primary (Prevention)	Secondary (Development)	Tertiary (Support)
	Positive psychology & Psychological Capital.	S	x			S	T
	OTHER - (Alternative relaxation, emotion focused WB promotion, Affect school, Imagery)	M	x	x		S	T
	Resilience	S	x			S	T
Therapeutic Approaches	Therapeutic interventions	S	x	x			T
	Counselling	S	x				T
	Motivational Interviewing	S	x				T
	Emotional Freedom Technique (EFT)	S	x				T
Support pathways	Employee Assistance Programme (EAP)	M					T
	Screening	M	x	x			T
	Occupational health provision	S	x				T
	Return to work/absence management	M		x			T
	Prevocational training	M		x			T
	Supported employment	M		x			T
	Vocational interventions	N		x			T

Intervention category	Intervention Strategy	Extent of evidence	Mentioned in NICE guidelines	Mentioned in WHO guidelines	Commonly targeted level of control[1]		
					Primary (Prevention)	Secondary (Development)	Tertiary (Support)
	Accelerated recovery programmes	S	x				T
Sector specific	Post incident interventions/debriefing	S					T
	Clinical supervision	M		x			T

3.2 Efficacy findings of selected primary interventions for WRS

The following section details the findings for efficacy of the shortlisted, broadly preventative interventions for WRS. This is a large and complex evidence base with little consistency across interventions and ways of reporting. Importantly, therefore, when reviewing the following findings, there are some wider observations which are helpful to keep in mind.

- Assessing change in organisational settings can be difficult. There are many factors which impact workplaces which cannot always be controlled for. Therefore, much of this research does not measure organisational level change or may not be able to specify the changes driven by the intervention as opposed to broader factors.
- The approach taken to determine if there was positive, mixed or no evidence for efficacy was to pragmatically take the majority outcome found across research (as detailed in Appendix 2 – Methodology – section 8.6.1, A note on efficacy). Therefore, if it is more likely to be effective for stress outcomes than not (over 50% chance) then we have suggested positive evidence.
- Often, the grey literature shows a more positive picture for efficacy than the academic literature. This is due to a tendency in the grey literature to describe interventions which were designed with a particular workforce or sector in mind (such as policing or transport). This bespoke approach arguably optimises the conditions for interventions to be effective. There is also a tendency for grey literature to emphasise "what works" rather than what is uncertain, because their intended audience/readership are other practitioners and employers looking for solutions. So, the presentation of findings is somewhat more curated compared to what would be expected in the academic literature.

3.2.1 Work design interventions

Work design interventions involve those which seek to alter or improve the design of how a workers' work is carried out, illustrated within Table 3.

Though varied in nature, this category consists of interventions which are often seen as key preventative approaches for WRS. In principle, these interventions are well aligned with a primary, hazard-led approach although the extent to which this is demonstrated explicitly varies considerably. The interventions were categorised into four groups based on common elements that were changed in the design of work.

Table 3 Work design intervention aggregate findings

Intervention Strategy	Sector Coverage	Geographical Coverage of Research	Aggregate Evidence of Efficacy	NESTA Range	Average Quality of Research	Study IDs
Changing break structure & form (Academic)	Various	Various (AMR, EUR, WPR)	No evidence	1 to 2	Low to High	12, 17
Flexible, Remote & Home Working (Academic)	Various	Various (EUR, AMR, WPR, SEAR)	Positive evidence	2 to 3	Moderate to High	1, 20
Job design (Academic)	Various	Various (EUR, AMR, WPR, SEAR, EMR)	Mixed	1 to 3	Moderate	1, 2, 5, 8, 11, 14, 22
Job design (grey)	Various	Various (AMR, EUR WPR)	Positive evidence	2	Moderate	2, 16, 21
Physical work/built environment (Academic)	Various	Various (AMR, EUR, WPR)	Mixed	1 to 2	Low	7, 18

Changing break structure & form

Research reviewed within the category of altering break structure included a variety of interventions offering different types of periods of recovery to workers (e.g., social breaks), as well as changes in structure of this (e.g., providing active walking micro breaks). It is recognised that breaks from work are necessary and are a legal requirement for worker health (UK Government, n.d.), the form and approach to these breaks is what is being assessed in the research. There is also a recognition of the difficulties in both implementing this approach and measuring their impact as seen through consultation, particularly in a more remote working environment.

Overall, there is limited evidence for such interventions, although findings do suggest that active microbreaks (where break time is spent engaged in physical movement) offer some benefits in reducing stress, particularly for desk and knowledge workers. However, these

studies rarely assess whether job demands or workload are reduced, meaning benefits may reflect short-term recovery rather than sustained hazard reduction. Papers included in this category do not always measure change in break duration and might focus more on different break types more conceptually (e.g., Lyubykh et al., 2022), but they provide some preliminary insight into the literature. It is worth noting that the measures of effectiveness of these have not been pooled to report overall effectiveness for this outcome. Considering the types of research in this area and the NESTA range being 1-2, this is a literature area which requires more maturity before clear conclusions can be made about its role in primary prevention of WRS.

Flexible, remote & home working

Flexible and home working are increasingly common practice in certain roles and sectors, although there is also a desire among organisations to encourage office attendance. A recent report published by the House of Lords (2025) details the Government's interest in flexible and home working. We note that flexible working is distinct from remote/home working, with remote working being considered an aspect of flexible working. They are sometimes considered and discussed together. The reviews included (Aust et al., 2023; Shaholli et al., 2024) discuss both but consider flexibility the main intervention. Within our consultation, stakeholders raised the important observation that flexible/home working can sometimes be used to avoid workplace stressors and therefore is not always a preventative approach in itself. Within the two recent academic reviews included in this research, generally a positive impact is seen for work life balance. This is as changes allow workers greater control to choose working times (Aust et al., 2023) with slightly less consistent, but generally positive findings, for health and wellbeing outcomes are observed.

There is a body of literature considering remote working more broadly, not as an intervention (often referred to as "teleworking"). This stream of research is more likely to highlight the negative impacts of this work approach due to the reduced potential for social support, such as increased isolation and presenteeism. However, when considering ways to prevent stress caused by these styles of working, flexibility in work location can help to manage these more negative effects (Shaholli et al., 2024).

Job design

Job design interventions can be targeted at all levels of an organisation and aim to change the way work is carried out to reduce or eliminate work demands. These differ from other interventions in the overarching "work design" category as their focus is specifically changing the way the tasks of the job are carried out. These interventions will look different depending on the sector and context they are applied to, but they are some of the most frequently recommended interventions in practice. Therefore, it is unsurprising that this was seen to be one of the more commonly researched intervention strategies in both the academic and grey literature. With this, it is also important to recognise that job design interventions are difficult to evaluate, especially at an organisational level due to the

difficulties with controlling for external variables (e.g., change in life circumstances). Moreover, they are complicated to implement in larger scales.

Research featured in the grey literature has considered job design interventions predominantly in a healthcare context, with evidence indicating beneficial impacts on stress-related outcomes (Bagnall et al., 2016). Improvements were found to be strongest when interventions tackle workload management, scheduling, and role clarity (Kinman & Teoh, 2018). It was typical for grey literature intended as guidance for a generic audience to cite job design among recommended interventions (e.g., Stevenson & Farmer, 2017; WHO 2022).

The academic literature showed a more mixed picture across studies. More consistently positive findings were seen for job design interventions which target the individual level where workers are supported to alter their own job design (Daniels et al., 2017) or are given more control over how their work is completed (Aust et al., 2023; Fox et al., 2022). As few studies measure psychosocial hazards, the effects may be driven by enhanced autonomy rather than systemic changes to job demands. This nuance was echoed in the consultation phase which revealed that a more informal and case by case approach to job design was seen as more effective than HR-led approaches.

In the review, WRS was often not the key outcome being measured and so was not consistently reported. Taken together, the combination of the findings suggest that job design interventions are likely to have some positive impacts on stress outcomes in some areas (such as changes at the worker level which allow for greater choice and control over how they do their work) but that the literature is largely still mixed in its finding due to the difficulty with measuring impacts of interventions of this sort. For organisations, considering the context of individual studies to find close comparisons is most likely to help the choice of relevant interventions. To further build knowledge in this area, the most valuable contribution could be made by robust evaluation designs, such as longitudinal studies or group comparisons, which could establish greater clarity on the impact of job design interventions.

Physical work/built environment

Alterations to the physical work environment are seen as helpful but potentially resource intensive to implement within organisations. Evidence of efficacy is mixed, largely due to limited stress-specific outcomes. Where hazard linkage is most explicit is in studies of biophilic and environmental design, which link changes in physical stressors (e.g., noise, privacy, exposure to nature) to improvements in stress-related outcomes (Fayyad et al., 2024; Ríos-Rodríguez et al., 2023).

Implications for research

- Further evaluation of job design interventions is required. Future research should more explicitly measure changes in psychosocial hazards alongside stress-related outcomes, including longitudinal or control group designs.
- Further process evaluation would help to improve the clarity of the evidence in this area by identifying contextual factors which may have an impact on efficacy.
- Further research on different job types is required, to ensure coverage beyond knowledge workers and including other work settings where the constraints on job design changes may be greater.
- Where work location is included as part of research, clarity is required on the level of control workers have over their work location to understand true flexibility.

Implications for practice

- Job design interventions should be chosen based on evidence or examples from relevant sectors, then their design, implementation and evaluation tailored to the specific organisational context to maximise their efficacy.
- Exploring the gaps between policies and practice may be helpful to increase the efficacy of current controls, e.g., investigating disparities in how flexible working policies are implemented in different areas of an organisation.
- Consider office environments particularly for knowledge/desk workers, seeking to incorporate nature where possible.

3.2.2 Leadership & manager interventions

Leader and manager trainings are one of the more frequently used and advocated for interventions by organisations and practitioners. The role of leaders and line managers in preventing and reducing WRS has long been recognised. In the UK, this is reflected in the HSE Management Competencies for Preventing and Reducing Stress, which set out the management behaviours that help to prevent psychosocial risks and support healthier working conditions. The Stevenson & Farmer review (2017) highlighted the central role leaders play in shaping workers' experiences of work and their mental health. Leadership and manager training has become one of the most adopted approaches used by organisations to address WRS. Employers often favour these interventions because they are seen as practical, acceptable and relatively easy to introduce. Relative to this wide scale adoption of leadership training interventions in practice, there is somewhat fewer explicit intervention studies.

In this review, leadership and manager interventions were grouped into two broad types: training aimed at improving workers' mental health**,** and training aimed at improving leaders' or managers' own mental health**.** Overall, the academic evidence shows mixed findings for both types of intervention when stress outcomes are considered. In contrast,

the grey literature generally reports more positive findings, as demonstrated in Table 4. This difference reflects both the types of outcomes measured and the way evidence is reported, rather than a direct contradiction between sources.

Table 4 Leadership & manager interventions aggregate findings

Intervention Strategy	Sector Coverage	Geographical Coverage of Research	Aggregate Evidence of Efficacy	NESTA Range	Average Quality of Research	Study IDs
Leader/manager training - targeting **worker mental health (academic)**	Various	Various (EUR, AMR, WPR, SEAR)	Mixed	2 to 3	Moderate	1, 9, 10, 21
Leader/manager training - targeting **worker mental health (grey)**	Policing, Water, Rail	UK	Positive evidence	2	Moderate	9, 20, 31
Leader/manager training - targeting leader/manager **own mental health (academic)**	Various	Various (EUR, AMR, WPR, SEAR, AFR)	Mixed	2 to 3	Low to Moderate	1, 3, 4, 21
Leader/manager training - targeting leader/manager **own mental health (grey)**	Various	UK	Positive evidence	3	Moderate	1

Leader/manager training - targeting worker mental health

While at first glance it may appear that the findings of this review stand in contrast with prior large-scale reviews which recommend these interventions (e.g., the WHO guidelines on mental health at work (2022) recommending leadership training as an approach), the differing results come from focusing on different outcomes. The current study included the same two reviews, as well as the WHO's update on this to synthesise these findings (Gayed et al., 2018; Kuehnl et al., 2019). With the outcome of interest of this review being more specific to WRS, it is noted that some of the broader outcomes which were relevant to the WHO review are not in scope for this one.

For example, Gayed and colleagues (2018) saw that manager training was effective for manager attitudes towards mental health, but this was not seen for workers' own distress

(the recipients of manager's approach). Further, a review carried out by Kuehnl and colleagues (2019) specifically considered stress outcomes. Here, the six studies which measured change in worker stress in response to their supervisor undergoing training did not show find any difference. They noted that the papers had a low quality of evidence. It is worth noting that this was a high-quality review, using rigorous and gold standard quality assessment tools which might be seen in more clinical research. When reviewing research for quality through these tools, it is expected that studies from the organisational and applied psychology literature are deemed of lower quality. In the context of organisational research, where randomised control trials are not always feasible, realistic, or beneficial, statements of quality using tools appropriate for more clinical research should be interpreted with caution.

While the evidence reviewed suggests mixed findings for stress, it is not to say that these interventions are not effective for addressing precursors or the antecedent outcomes to stress. The grey literature demonstrates more positive evidence as it often measures interventions which have been adapted for a specific organisation's contexts. For example, in a controlled trial, Wilson and colleagues (2020) observed sustained positive changes in mental health knowledge and 'preparedness to act' among rail managers, following online and face-to-face mental health awareness training.

Within the grey literature several authoritative sources recommend this type of intervention including EU-OSHA (Virtanen et al., 2024), the Policy Institute (Hesketh et al., 2020) and Department for Work and Pensions/Department of Health and Social Care (DWP/DHSC) (2017). Because of the nature of this literature, this is recommended in the context of other potentially effective intervention options. For some organisations, through undertaking organisational stress risk assessment, it may become evidence that manager behaviour may be contributing to stress within the organisation and in which case, training for this would be important and recommended.

Leader/manager training - targeting leader/manager own mental health

When considering supporting leader/manager own mental health, a similar pattern was seen where evidence of efficacy for reducing stress outcomes may not be seen, but other wider outcomes (e.g., manager knowledge) demonstrate more promising findings. This pattern was also seen in the grey research.

Implications for research

- Future research should clearly separate outcomes relating to workers' stress from outcomes relating to leaders' or managers' own stress-related outcomes, so that organisations can make better-informed decisions.
- Further longitudinal research would be beneficial to demonstrate whether initial outcomes such as increased manager knowledge do lead to changes in manager behaviour and contribute to other outcomes in the longer term.

Implications for practice

- Leadership and manager training alone is not sufficient to prevent WRS.
- As explained in report 3 (Barriers and Enablers), ensure other organisational barriers preventing managers from effectively resolving root causes of negative outcomes are reduced (such as lack of role clarity) to allow further benefit from leader/manager trainings.

3.2.3 Interpersonal interventions

Interpersonal interventions encompass a wide range of intervention strategy types (see Table 5). The common theme to all these approaches is that they involve the processes of how people relate, support, and communicate with one another.

Table 5 Interpersonal interventions aggregate findings

Intervention Strategy	Sector Coverage	Geographical Coverage of Research	Aggregate Evidence of Efficacy	NESTA Range	Average Quality of Research	Study IDs
Anti-bullying and incivility (Academic)	Various	Various (EUR, AMR, WPR, SEAR	No evidence	2	Low to moderate	1, 16
Coaching (Academic)	Education	Various (AMR and WPR)	Mixed	1 to 3	Low	14, 15

Intervention Strategy	Sector Coverage	Geographical Coverage of Research	Aggregate Evidence of Efficacy	NESTA Range	Average Quality of Research	Study IDs
Mental health awareness training/literacy and MHFA (Academic)	Various	Various (WPR, AMR, EUR	Mixed	1 to 3	Low to High	13, 19, 25, 26
Mental health awareness training/literacy and MHFA (grey)	Various	UK	Positive evidence	3	Moderate	6
Mental health champions (Academic)	No Information	No Information	No Information	No Information	No Information	No Information
Social/peer support (Academic)	Various	Various (AMR and EUR)	Positive evidence	2 to 3	Moderate on average (low to high)	6
Social/peer support (grey)	Various	UK and USA	Positive evidence	2	Moderate	5, 14, 16, 21
Teamwork (interprofessional)	Various	Various (EUR, AMR, WPR, AFR)	No Evidence	1 to 3	Low to High	8, 23, 26

Anti-bullying and incivility

Interventions which seek to reduce workplace violence (e.g., training de-escalation techniques, changes to organisational policy, promoting civil behaviour) were seen to have

limited evidence of efficacy on WRS. Not only were there limited studies considering this area, but the outcomes used were often not specific to stress or wellbeing. Therefore, a clear judgement is difficult to make. Improvements were more likely to be seen for other outcomes such as confidence and knowledge.

Coaching

Workplace coaching is seen to have mixed findings for WRS with limited impact on work-related wellbeing outcomes in the education sector (Naghieh et al., 2015). There are more positive findings present for this approach for other outcomes such as positive impacts on behaviours, resilience and self-efficacy (Nicolau et al., 2023). Therefore, coaching may be considered more of a resource to boost other areas of wellbeing, rather than seen as a tool to prevent WRS. However, endorsement of coaching can be found in the grey literature including reviews of effective interventions published by EU-OSHA (Virtanen et al, 2024) and Public Health England (Bagnall et al., 2016).

Mental health awareness training/literacy & mental health first aid

Mental health awareness training, which is often discussed interchangeably with MHFA, was seen to be a contentious intervention category among people consulted. Widely adopted in practice, as reflected by positive findings in the grey research, it is often now considered a “tick box” attempt at preventing WRS. Stakeholders in the field believe it is better thought of as useful signposting/resource which should be embedded into wider workplace wellbeing strategies, instead of a preventative intervention on its own.

In fact, the grey research included here was a psychological skills training intervention across eight weeks. Results showed that compared to the control group, stress scores were seen to be lower in the intervention group post-intervention (Chandler et al, n.d.). When considering the larger reviews within the academic literature, the evidence of efficacy is more mixed. A meta-analysis of MHFA (although not explicitly just in work settings) saw a small positive change in workers’ own distress levels (Maslowski et al., 2019). More limited evidence is seen for the outcomes of the recipients of MHFA. Other reviews see positive findings for education interventions on stress and burnout outcomes (Waddell et al., 2023) though details for the length and form of these interventions were not specified. In the WHO supplementary files (2022), data were not pooled for effects of mental health literacy and training. Notably, stress specific outcomes were not captured in the studies; however, for broader mental health outcomes as well as other outcomes (knowledge, attitudes, helping behaviour), findings were generally mixed/inconsistent. These findings continue to echo those seen in the scoping review published by the HSE in 2018 where there was limited evidence for actual change in worker mental health or stress outcomes.

Taken together, the findings suggest that though mental health literacy and first aid programmes can be an easy to implement tool within organisations, they do not provide

the preventative buffer which is required to control WRS. Therefore, such an intervention, should only be part of a much larger organisational strategy and approach.

Mental health champions

This category was added to the evidence map through consultation as it was recognised as a commonly used intervention in practice. During the search we did not find any reviews for these interventions. There was also no endorsement or assessment of this approach within the grey literature or evidence demonstrating its efficacy.

Social/peer support

Across both grey and academic literature, there is more consistent support for the effectiveness of social and peer support interventions on mitigating WRS outcomes. However, the evidence for this does not come from large-scale reviews and the evidence basis is still developing. In the research found, these approaches are more often assessed within trauma exposed roles such as healthcare, emergency services, and education sectors. In these contexts, some evidence of reduced distress was seen (Fallon et al., 2023; Kinman et al., 2018).

Grey literature also suggests benefits with respect to outcomes such as retention, turnover, and reduced long-term sickness absence (Cambridgeshire Constabulary, 2024; Office of the Surgeon General, 2022). The Pause Point intervention for Police Officers (Cambridgeshire Constabulary, 2024) provided opportunities to check-in with workers and check that they were thriving. There was an emphasis on their welfare as opposed to their performance which meant staff could actively seek respite and recovery from sometimes traumatic role. Staff reported feeling refreshed and more able to recover from difficult work experiences. Further, there is also endorsement of this approach from the European Trade Union Institute (Leka & Jain 2024), DWP/DHSC (2017) and EU-OSHA (Virtanen et al., 2024).

Teamwork/team dynamic (interprofessional)

Interventions which tackle and seek to improve team dynamics and collaboration within groups were seen to have limited evidence for effectiveness at reducing WRS. Two reviews considered this in the healthcare sector, one of which saw that there was little change in wellbeing for healthcare workers (Turcotte et al., 2023), though there were positive impacts for safety and team climate. The other was the WHO supplementary files (2022) which saw that compared to control groups, there was reduction in burnout as well as broader positive impacts on job satisfaction and reduced absenteeism in the intervention group. However, these files did not pool the data: in broader/unspecified sectors and contexts, outcomes were not specific enough to WRS to allow further judgement to be made. Sources in the grey literature that recommend teamwork as a guiding principle include WHO (2022) and SOM (Teoh, 2023).

Implications for research

- Consider reviewing teamwork and peer support interventions in broader contexts to assess their efficacy in non-trauma exposed roles.
- Further research on the role and impact of mental health champions would be helpful to explore the efficacy of this commonly used intervention.

Implications for practice

- Ensure that Mental Health First Aid (MHFA) and awareness training is only a very small part of the wellbeing strategy/approach to managing stress at work, as it should be recognised that this intervention is helpful in raising awareness and signposting workers to support, but does not address the fundamental risks presented by WRS.
- Social and peer support interventions are particularly relevant in roles exposed to trauma.

3.2.4 Participatory interventions

In practice, participatory interventions are not a single 'intervention' but an approach to designing and implementing changes such as job redesign or workload changes with active worker involvement. Common to all participatory interventions is worker participation during the design, implementation and evaluation of the process (see Figure 5). Participatory interventions can therefore encompass any of the interventions presented in the catalogue, if the methodology of the implementation heavily involves worker participation (Nielsen et al., 2010). Though consultants can be used to support the participatory intervention approach, they can also be facilitated within the organisation and therefore a consultant is not essential. Participation within intervention decision making and design for managing WRS is considered essential to their success by the experts who were consulted. Organisations are often seen to consult workers when stress has already occurred, by which time, it is too late. As well as involving worker input into intervention design, participatory approaches also emphasise evaluation processes and continual learning loops, making these flexible and adaptable approaches to managing WRS. Due to this more involved approach, it is recognised that while these are seen to show positive evidence of efficacy, they may be logistically demanding for organisations which are not familiar in the approach.

Figure 5. Participatory intervention process



Authoritative sources of guidance in the grey literature highlight participatory approaches as a key enabler of effective organisational interventions, e.g., Stevenson and DWP/DHSC (2024) and WHO (2022). In an evidence review focussed on the healthcare sector worker participation is linked to environments that promote open dialogue, peer and manager support, and shared responsibility for wellbeing (Bagnall et al., 2016).

Table 6 Participatory interventions aggregate findings

Intervention/ Strategy	Sector Coverage	Geographical Coverage	Aggregate Efficacy	NESTA Range	Quality of Research on average	Study IDs
Participatory interventions	Various	Various (EUR, AMR, WPR, SEAR)	Positive evidence	2 to 3	Moderate	1, 2, 8, 24

Taken together the research included in this review shows positive evidence for these types of intervention (see Table 6 for study IDs). This is not to say that the findings are unanimous as there is still some variability within the research. Many participative interventions involved changes to job design and similar to findings for other intervention types, the increased control perceived by workers through involvement with the process is

important for their efficacy (Aust et al.,2023; Fox et al., 2022). Similarly to the concerns with measuring efficacy for job design interventions, participatory approaches can sometimes show mixed findings (Daniels et al., 2017) and therefore a contextual approach is needed.

Implications for research

- Evaluations of participatory approaches need to capture a broad range of hazards and outcomes to allow for an assessment of through which mechanisms the change is occurring at work (e.g., to assess whether WRS/identified risk has been reduced directly, or whether they have been reduced as a result of other processes such as worker participation in the approach leading to increased perceived control, tackling other risks, or increasing peer support for example).

Implications for practice

- Facilitators need to understand how to engage workers, and to assess when the organisation and stakeholders are ready to use a participatory approach.
- Organisations can incorporate participatory principles into the implementation of any of the interventions in the overall catalogue of approaches by working with workers to identify hazards and shape the implementation of solutions.

3.3 Link to psychosocial hazards

As shown in Table 7, few studies and interventions explicitly mention targeting/seeking to improve specific psychosocial hazards. There are certain interventions, which more explicitly target certain hazards, e.g., anti-bullying interventions targeting relationships at work. There are, however, many areas and papers which may have links to hazards which can be implicitly assumed (e.g., participatory interventions may be seeking to target demands in some cases) but that these are not always explicitly stated in the literature itself. Further, some research does not make any links to psychosocial hazards.

Table 7 Mapping of hazards mentioned in included academic studies

Intervention category	Intervention name	Psychosocial Hazard Mentioned	Management Standard Mapping	Study IDs
Work design	Changing break structure & form	Implicit, not specified		12, 17
	Flex working/home working	Working time arrangements	Demands/Control	1
		Implicit, not specified		20
	Job Design	Role overload, ambiguity, task-related	Demands/Role	14
		Control, demands	Demands/Control	1
		Implicit, not specified		2, 5, 8, 11
		No		22
	Physical work environment	Noise, privacy	Demands	7
		Sensory environment	Demands	18
Participatory interventions	Participatory interventions	Implicit, not specified		1, 2, 8, 24
Leadership training	Leadership training interventions - To support worker mental health	Implicit but not specified		1, 21
		No		9, 10
	Leadership training interventions - Manager training - Own mental health	Implicit, not specified		1, 21
		No		3, 4
Interpersonal interventions	Anti-bullying and incivility	Bullying, incivility	Relationships	16
		Exposure to violence	Relationships	1
	Coaching	Role clarity, supervisory support	Role/Support	14

Intervention category	Intervention name	Psychosocial Hazard Mentioned	Management Standard Mapping	Study IDs
		No		15
	Mental health awareness training/literacy and MHFA	Bullying, incivility	Relationships	25
		No		13, 25, 26
	Social/peer support	Implicit, not specified		6
	Teamwork (interprofessional)	Implicit, not specified		8, 23
		No		26

3.4 Overall findings

Looking at the findings of this review overall, through the consultation process, a range of observations were made about the nature of the current evidence base and their practical implications.

Taken together, these findings indicate that while the evidence base on interventions for WRS is extensive, it is not well aligned with a hazard-led approach to stress risk management. Unlike many previous reviews, which synthesise evidence primarily by intervention type or health outcome, this review examines whether the evidence supports the identification and management of psychosocial hazards in practice.

3.4.1 Diverse array of interventions being used

The evidence map and intervention catalogue show the large number and diverse selection of interventions which are currently being used by organisations and have been examined in research. This demonstrates the range of interventions available for implementation by organisations. However, research findings demonstrate the effectiveness of interventions is variable.

Overall, the interventions demonstrate relevance as management as part of a WRS risk assessment, albeit with varying levels of efficacy. For some interventions, they may be evaluated differently in the context of an organisation's wider 'wellbeing' strategy, which is particularly the case for MHFA or awareness programmes and leadership training. We have evaluated their efficacy for reducing WRS but acknowledge that these interventions may have broader benefits or targeted outcomes (e.g., burnout, depression, etc) which should be considered in decision making.

The majority of reviews included did not comment on whether the interventions being reviewed caused harm or unintended consequences and when comments were made, they were brief and did not reveal a specific pattern. This is likely due to the current study seeking to undertake a review of reviews. Within each interventions research area, there may be more detail on this. The general assumption of the intervention literature is that the interventions have a net positive impact.

Similarly, many of the reviews considered research carried out in various sectors and therefore most of these findings are applicable more generally. Where in some cases the research more specifically called out sectors such as healthcare or education, these have been shared, particularly regarding the grey literature.

While process evaluation studies (which examine the implementation of an intervention in detail throughout to understand the factors shaping its success) may be fewer in number, the apparent strength of the evidence for participatory approaches demonstrates that organisations can also use the evidence to inform how they implement interventions.

3.4.2 Questions over quality and confidence in findings

When considering the literature overall, the quality of the research and confidence in the findings can be considered questionable, as rated by existing frameworks. Through consultation, it was highlighted that this does not necessarily mean more research is needed, but rather we may need to adapt how we judge the quality of the research and how we use it.

One of the included reviews presents this challenge clearly. Though not linking back to a specific intervention, this review synthesised multiple organisational-level interventions and outcomes (Aust et al., 2023), collating a large amount of data. In their synthesis of organisational-level interventions which considered stress outcomes specifically, in six reviews (made up of 47 studies), they saw contradictory evidence for the efficacy of these interventions in reducing stress. These studies were deemed as moderate to high quality, three of which were meta-analyses (which examine the data from a larger number of participants statistically to provide more robust results). Interestingly, in the reviews which involved narrative reviews, more positive findings were seen. This highlights the fine line between scientific quality and contextual practice. While meta-analyses are often seen as the gold standard of reviews, they can often miss key nuances between studies as data is aggregated. On the other hand, narrative reviews may be considered to be limited as they do not allow for wider judgements of efficacy across an intervention type, but they do allow for the capturing of greater detail. Therefore, in considering the implications of this review for interventions, further investigation would be needed of the findings to consider their applicability in the context of an organisation.

Due to challenges like this, a key finding of this process is that the frameworks used to judge research quality in complex and applied settings do not always allow for clear conclusions to be reached which can inform practice. This suggests a need to consider evidence in relation to organisational context and decision-making, rather than relying solely on traditional hierarchies of evidence that do not account for this complexity as they seek to justify overall, generalisable conclusions.

3.4.3 Lack of links to psychosocial hazards

Looking across the intervention research, there is limited evidence aligning specific interventions with particular causes of WRS, psychosocial hazards, or with reference to factors underpinning HSE's Management Standards. This is partly due to the multi-disciplinary nature of WRS research, where much of it is not informed by a H&S perspective and therefore may not apply concepts such as the elimination of hazards to their research approach. Further, consideration of levels of control and the distinction between primary, secondary and tertiary interventions has not been considered across the evidence base, nor has a consistent model of understanding hazards been applied.

Given that the beginning of most intervention cycles is an assessment of particular psychosocial hazards, for example by using the HSE Management Standards approach, the current evidence base does not allow for the alignment of solutions to identified risks. As research is increasingly aligned to the outcomes or impacts of WRS (e.g., mental ill health and particularly burnout) a clear, logical approach from identified risk to suitable intervention and desired change in outcomes cannot be reliably generated from existing research. This points to another gap between academic research and practice where research prioritises investigating change in outcomes, but practice considers a wider range of factors, which includes the risk in the workplace, regulatory requirements or factors of local relevance or interest. The lack of mapping in this area is particularly surprising given the period of time that the Management Standards and other taxonomies of psychosocial hazards have been in place and suggests a lack of conceptual alignment between intervention research and established risk management frameworks. As highlighted in research report 1, this lack of conceptual clarity limits effective and coordinated action between stakeholders.

3.4.4 Lack of evaluation and understanding of contextual factors in existing research

In each intervention category, the research identified includes relatively few examples of process evaluation. For organisations looking to implement an intervention, this may provide a lack of clarity on the factors to consider, possible barriers and facilitators, and the interaction between interventions and contextual factors. Given the mixed findings for different interventions, this is a serious limitation of the evidence as it does not provide practitioners with an existing, contextual knowledge base when considering whether an intervention is likely to be successful in their own organisation or to identify factors that could help increase the likelihood of success of an intervention that has a mixed track record. Further clarity on what works, in what circumstances, and for whom would help to make greater progress in this complex area.

In reference to evaluation in practice, the consultation further highlighted that duty holders similarly lack evaluation data on their chosen interventions. Given the complexity of measuring the impact of a single intervention in an organisational context this is unsurprising but taken in the context of the wider evidence base creates an ongoing lack of clarity around efficacy. To support risk management, both within individual organisations and in general, further and more robust evaluations in practice would also provide useful data.

3.4.5 The value of risk assessments

As outlined above, choosing an intervention based on mixed evidence requires a robust understanding of organisational context and both the problem that needs to be solved and the best way to solve it. Throughout the consultation for this research, on top of the awareness of the legal obligation to carry out organisational risk assessment, participants

stressed the importance of these in informing the intervention selection process as well as being a key part of the HSE Management Standards approach and the wider approach to occupational health & safety. The understanding this creates of the particular risks in an organisation offers a firm foundation for intervention. This not only informs the choice of appropriate evaluation, but also the measurement of their effectiveness as it allows for assessment of not just broader outcomes but perceptions and impact of the identified risks. Further, risk assessments allow for diagnosis of hazards more proactively, allowing organisations to prevent and manage psychosocial hazards before they result in WRS and other negative health and performance outcomes. In this context, risk assessment is not simply one input into decision-making but an essential mechanism for selecting and tailoring interventions where the evidence base cannot provide definitive answers.

3.4.6 Developing an integrated approach

As highlighted previously, interventions cannot be considered in isolation, as they are most effective when deployed as part of an integrated system, comprising primary, secondary and tertiary systems occurring at the same time (Lecours et al., 2023; Nielsen et al., 2023). In this respect, in choosing interventions, organisations should consider how an intervention will add to their current approach to preventing and managing WRS and how coherent it will be with the other interventions or risk controls currently in place.

Many organisations already have primary prevention measures in place, such as workload management, clear role expectations and supportive management practices, but may not recognise these as controls for WRS. Making these existing controls visible and explicit would provide a foundation on to which additional interventions can be layered. Ensuring that a range of types of interventions are in place to tackle WRS in a number of ways, allowing for co-ordinated action from different groups (e.g., individuals, line-managers, HR and health professionals), and ensuring these are complimentary, will amplify the benefits of the chosen approach. Within such an integrated system, interventions that show mixed evidence when evaluated in isolation, may still contribute meaningfully when combined effectively with other measures.

4 Conclusion

Preventing and managing WRS remains a complex area for consideration for organisations. While the importance of tackling stress has never been clearer, many of the challenges that have characterised this area over several decades of research continue to affect the clarity and usefulness of the evidence base. This review highlights both the wide range of interventions currently available to organisations and the lack of consensus within the evidence base to offer definitive, universal solutions. Taken together, the findings point to the need to move away from a continued search for answers about 'what works', towards a more considered use of evidence that reflects the realities of organisational practice.

4.1 Recognising strengths and limitations

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 the methods used to gather, scrutinise and synthesise data in this research are discussed fully in Appendix 7 - Strengths and limitations.

This mixed method approach has several notable strengths:

- Attempting a hazard-led synthesis of a broad and diverse evidence base.
- Bringing together peer-reviewed research and grey evidence provides a realistic picture of interventions used in practice, including those under-represented in the academic literature.
- Iteratively refining and validating findings through expert consultation, strengthening confidence in interpretation and conclusions.

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

- Limited ability to link interventions explicitly to specific psychosocial hazards, reflecting how evidence is currently reported.
- Focusing specifically on WRS rather than broader mental health or organisational outcomes means that some relevant interventions and their effectiveness may not be captured and findings may differ from reviews with a wider or more specific scope.
- Variable quality and reporting across the evidence base, particularly in relation to intervention content, implementation and evaluation.

4.2 Understanding the context

For organisations, managing stress requires an understanding of organisational context and a clear definition of the problem to be solved. Through the use of effective stress risk assessment, organisations can establish their particular risk profile and use this as a foundation for selecting and implementing an integrated system of interventions that address WRS in complementary ways. In choosing the interventions, rather than seeking strong evidence across diverse contexts, organisations should prioritise evidence from similar organisational settings or from organisations facing comparable psychosocial risks. They should also **demonstrate how interventions have been selected to address the psychosocial hazards identified**. Where available, organisations should look to learn from the experiences of others and consider the factors that influence successful implementation as highlighted in research report 3.

4.3 Combining interventions

The findings reinforce that no single intervention is sufficient to address WRS and psychosocial hazards. Interventions are most effective when considered as part of an integrated system of controls, where different approaches at both the level of control (primary, secondary and tertiary) and across the IGLOO levels (individual, group, leader, organisation and outside) work together to prevent and manage risks in complementary ways. The catalogue of interventions demonstrates that many approaches exist, which can be tried, carefully measured, evaluated and adapted to meet an organisation's particular requirements. As part of this, the strongest suggestion from the evidence base is that this process should be **targeted** at identified hazards, **participative**, giving workers the opportunity to both identify problems and collaborate in solutions, and **evaluative**, ensuring that organisations measure impact and pivot if required. In changing environments, challenging economies and with the complexity of workplace contexts, this adaptable approach becomes even more important to success.

4.4 Evaluating interventions and their impact

For researchers, organisational action could be supported through developing further clarity of the links between psychosocial hazards, interventions and outcomes. As the research base on WRS approaches the issue from a variety of theoretical standpoints and diverse professional perspectives, not all studies consider the role of interventions in terms of eliminating specific hazards or managing their impact. By measuring interventions in a more targeted way, the practical implications for intervention choice will be easier to identify. In addition, capturing process evaluation information throughout intervention processes will also allow for more robust action on WRS across interventions, as well as highlighting the influence of specific contextual factors.

Overall, it is important to recognise that WRS is a complex concept that summarises the relationship between a range of factors in how work is organised and delivered, and a plethora of personal and professional outcomes which are important both to individuals and organisations. In preventing and managing WRS, it is therefore important for all stakeholders to establish a more fine-grained view of the problem at hand. **Considering specific psychosocial hazards and particular outcomes which are of concern will allow for more effective interventions.** While WRS provides a shorthand for describing this complex process, addressing it effectively requires a more nuanced and contextual understanding of the underlying risks.

Importantly, the limited evidence explicitly linking psychosocial hazards to interventions should not be interpreted as evidence that primary interventions are ineffective. Rather, it highlights a misalignment between the way interventions are commonly evaluated in research and the requirements of stress risk management in practice. The current evidence base is therefore not well aligned with the needs of hazard-led prevention, reinforcing the central role of risk assessment, context and integrated systems of control.

5 Considerations

5.1 For research

The findings of this review highlight several priorities for future research to better support hazard-led stress risk management and the development of effective primary control measures for WRS.

- **Link psychosocial hazards, interventions and outcomes explicitly.** Future research should move beyond assessing stress, burnout or mental health outcomes alone, and explicitly examine whether interventions lead to measurable changes in underlying psychosocial hazards. This would better support hazard-led stress risk assessment and intervention selection in practice.
- **Understand how interventions are implemented in practice.** Alongside outcome monitoring, greater attention should be given to how interventions are implemented in real organisational settings, including barriers, facilitators and contextual influences. Process evaluation approaches are useful here. This is particularly important given the mixed findings observed across intervention types in this review and will help inform decisions about adaptations, scaling and sustainability.
- **Specify organisational and sectoral context.** Research should more clearly describe organisational context, including sector, job roles and workforce characteristics. The review found that evidence is often synthesised across diverse contexts, limiting its usefulness for organisations seeking guidance relevant to their own settings.
- **Evaluate integrated systems of intervention.** Future studies should capture what policies, practices and controls are already in place before new interventions are introduced and examine how combinations of interventions interact over time. The findings suggest that interventions rarely operate in isolation yet are commonly evaluated as standalone initiatives.
- **Adopt a systems-based analytical lens.** Research would benefit from exploring the coherence and alignment of interventions within organisational systems, including leadership practices, job design, policies and support mechanisms. There may be value in drawing on human resource management research on *bundles of practices* to inform this approach.
- **Address gaps in sector and role coverage.** The review suggests that some sectors and job roles remain under-represented in the evidence base. Broadening the scope of future research would improve understanding of how psychosocial risks and effective controls vary across different working environments.

5.2 For organisations

- **Start with a work-related stress risk assessment and keep it under review.** Organisations should use WRS risk assessments to identify the key hazards that may contribute to WRS within their specific context. Risk assessment should be used proactively to inform action at an organisation level (selection of interventions) and reviewed periodically, rather than treated as a one-off or reactive exercise at an individual level.
- **Take a systems-based approach to intervention.** Interventions are most effective when considered as part of a wider, integrated system of controls rather than as isolated actions. A combination of measures may be required to address interacting risks, with primary, secondary and tertiary interventions working together in a coherent way.
- **Be clear about the intended purpose and outcomes of intervention.** Organisations should define what they are aiming to change and how success will be assessed. This includes consideration of changes in psychosocial hazards as well as relevant outcomes such as stress, wellbeing, absence or performance. Clear outcome definition supports meaningful evaluation and ongoing review.
- **Select interventions that are appropriate to identified risks and organisational context.** Intervention choice should be informed by the specific psychosocial risks identified and the organisational setting, rather than reliance on generic recommendations alone. Evidence drawn from organisations operating in similar contexts, or facing comparable challenges, may be particularly informative for decision-making.
- **Involve workers and other stakeholders throughout the process.** Worker involvement plays an important role in identifying risks, shaping interventions and reviewing their impact. Participatory approaches can improve relevance, acceptability and implementation, and may increase worker influence and control, which the evidence suggests is an important mechanism for effectiveness.
- **Monitor, evaluate and adapt interventions over time.** Managing WRS is an ongoing process. Organisations should expect interventions to take time to embed and may need to be adapted in response to feedback, changing circumstances or evaluation findings. Monitoring both the process of implementation and the impact supports learning and continuous improvement.
- **Contribute to shared learning where possible.** Where resources allow, organisations are encouraged to evaluate their interventions and share learning on what was implemented, in what context, and with what impact. This can help address gaps in the evidence base. Everyone has a role to play by promoting good practice in risk assessment, evaluation and the reporting of contextual factors.

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Waddell, A., Kunstler, B., Lennox, A., Pattuwage, L., Grundy, E.A., Tsering, D., Olivier, P. and Bragge, P., 2023. How effective are interventions in optimizing workplace mental health and well-being? A scoping review of reviews and evidence map. *Scandinavian journal of work, environment & health*, *49*(4), p.235.	25
World Health Organization (WHO) (2022) *WHO guidelines on mental health at work: Web annex: Evidence profiles and supporting evidence*.	26

6.2 Grey literature review:

Papers marked with an Asterix appear in the aggregate findings as this focused only on sources from which it was possible to extract substantive, evidence-based information.

Several of the sources listed below set out a large number of recommended interventions, which limited their suitability for structured extraction. These were typically guidance documents presenting extensive lists of recommendations without linking each item to supporting evidence. To ensure a consistent and systematic approach, we applied a threshold of five or more recommendations as an exclusion criterion for detailed extraction.

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ILO (2016) *Workplace stress: A Collective Challenge, World Day for Safety and Health at Work, 28 April 2016*.	13
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Leka, S. and Jain, A. (2024) *Conceptualising work-related psychosocial risks*. Brussels: European Trade Union Institute.	18
Midlands Engine, Coventry University, University of Warwick, West Midlands Combined Authority and Mind (2024, March 28) *Mental Health and Productivity Pilot (MHPP): Final report—Executive summary*. Midlands Engine.	19
*Northumbrian Water Limited 'Wellbeing Programme'. United Kingdom: European Agency for Safety and Health at Work.	20
*Office of the Surgeon General (2022) *Framework for workplace mental health and well-being*. U.S. Department of Health and Human Services.	21
Pandey, A., Sanganeria, A., Singh, H. and Agarwalla, N. Kumar Reddy, P. (2022) *Mental health and well-being in the workplace*. Deloitte.	22
SafeWork SA (2024) *Psychosocial risk assessment*. Government of South Australia.	23
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Teoh, K., Dhensa-Kahlon, R., Christensen, M., Frost, F., Hatton, E. and Nielsen, K. (2023) *Organisational interventions to support staff wellbeing: Case studies and learnings from the NHS*. Birkbeck, University of London. March 2023.	26
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7 Appendix 1 – Background to WRS

7.1 History of research into work-related stress

Understanding of WRS 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 & Folkman, 1984).

Theories further developed by considering how the resources available to an individual affected perception 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 & 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.

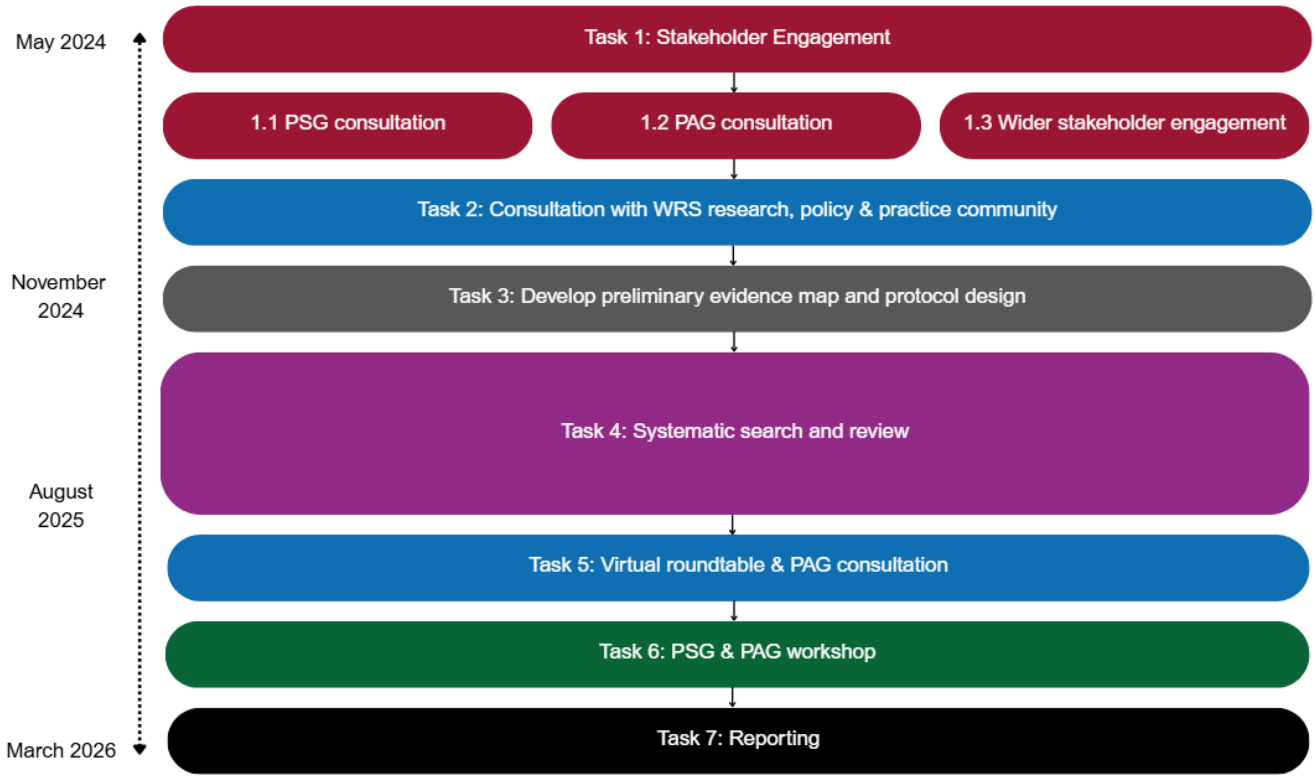
8 Appendix 2 – Methodology

8.1 Approach

The HSE required an up-to-date review of the evidence in relation to practical control measures/interventions at various levels (primary, secondary, tertiary) to inform future guidance and judgements on risk assessment suitability.

A multi-phase, mixed methods approach combined findings from: stakeholder engagement, a systematic search and review, roundtable discussions and consultation with Project Advisory and Steering Groups (illustrated within Figure 6). Throughout, the project was overseen by several groups to ensure project governance and integrate a wide range of expertise. Given the complexity and size of the evidence base surrounding WRS interventions, a stepped approach was taken to iterate and make best use of the evidence.

Figure 6 Flow chart of research approach



8.2 Project governance

8.2.1 Project Steering Group

The 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 three months throughout the project to review deliverables and obtain early insights.

8.2.2 Project Advisory Group

The 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 WRS to promote a coordinated approach.
- Gain a critical eye and sense-check approach to ensure the most robust and appropriate approaches available were used, optimising 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 one 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 IOM, the IES, with input provided by the 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 Stakeholder Engagement and Call for Evidence

8.3.1 Consultation

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 WRS research, policy and practice 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.
- **Knowledge exchange workshop**.

8.3.2 The call for evidence

In recognition of the recent evidence review activities to develop new legislative and guidance frameworks, a call for evidence approach was chosen to leverage existing knowledge residing within the WRS research, policy and practice community to help ‘make the most of what we have got’.

The approach aimed to:

- Gather evidence from researchers, policy makers, and professionals to help answer all three research questions.
- Identify sources that may not have been captured through traditional targeted searches.
- Identify any new and ongoing research/practice.
- Engage the work and health community in the research.

Experts in the field and wider community who published or commissioned reviews and intervention studies in this area were engaged to identify both published and unpublished papers and reviews. This was to help identify where more reviews were needed, where

there may have been opportunity for further research or to update a review and where the current research team efforts should be directed.

A dedicated webpage was created to host the call for evidence through an embedded form to allow multiple submission types (file uploads, links, free text) on Affinity Health at Work's website. A project mailbox was also set up to allow email submissions. This was launched in August and remained open until the end of September and was shared to the work and health community via:

- Email to stakeholders identified by research team and HSE
- PAG and PSG members who were sent an email template to share with colleagues
- Affinity Health at Work, IES, IOM, SOM and HSE social networks
- Banners on the SOM website and in Occupational Medicine
- HSE Bulletin

An evidence map template was created based on known requirements, which was updated to log evidence as it came in. To begin with, all submitted evidence was logged. Then extraction of the information began, starting with and focusing on the submitted academic research, specifically reviewing interventions for wellbeing in the workplace.

Call for evidence findings

By the time the call for evidence closed on the 1st October 2024 it had received:

- 80 submissions to the form, many including multiple sources, resulting in 250 items of evidence being added to the map
- 400+ registrations of interest from the WRS community
- Over 20 submissions to the OSCAR mailbox
- Four meetings with individuals to gather evidence verbally

8.3.3 Knowledge exchange workshop

A Knowledge Exchange Workshop (KEW) was facilitated virtually to engage stakeholders. The 32 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 following method was used:

- Participants were divided into four breakout groups, mixed by discipline and role to encourage knowledge sharing and stimulate discussion.
- Each group was facilitated by an experienced member of the research team. Detailed notes were taken, and participants were invited to shared reflections in the chat function.

- Further documentation was shared with the study team during/following the KEW. This evidence was integrated into the log of evidence.
- Detailed notes were gathered, and themes were identified using thematic analysis. Initial themes were developed by two members of the research team and shared and discussed with all facilitators to check understanding and improve sense-making.

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.

8.4 Evidence Mapping

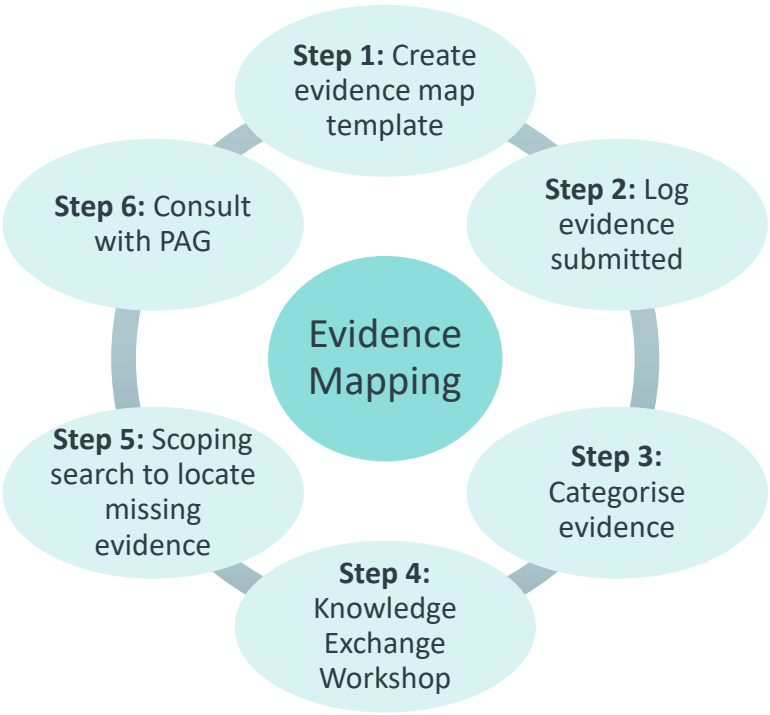
8.4.1 Evidence mapping approach

The findings from the consultation, call for evidence and knowledge exchange workshop were integrated to form an evidence map. To do this, the process illustrated in Figure 7 was followed:

Step 1: An initial evidence map template was designed with three members of team. This was then adapted throughout the mapping and extraction process to ensure it functioned in a helpful way to allow for the gaps in the literature to be seen.

Step 2: Throughout the mapping process, the team reviewed and logged the incoming evidence periodically to familiarise themselves with the sources. The team also reviewed best practice frameworks to apply to the categorisation of the evidence drawing on evidence reviews and the wider health and wellbeing literature.

Figure 7 Stages of evidence mapping



Step 3: Where possible, evidence was categorised against the below dimensions:

- Source of evidence – academic, practitioner, commentary
- Name of intervention
- Target level of Intervention (prevent/primary, develop/secondary, support/tertiary)
- Level of intervention implementation – individual, group, leader, organisation or overarching
- Quality of evidence
- Psychosocial factor targeted
- Outcomes targeted

As some interventions mentioned multiple strategies they were coded as such, therefore counts across categories include some duplicates.

Steps 1-3 were led by one member of the research team who regularly checked understanding and decisions with two other members of the research team and, where further consultation was required, during weekly team meetings with the wider team.

Step 4: The knowledge exchange workshop was carried to gain further perspectives and support filling gaps in the evidence map.

Step 5: A scoping search was conducted to identify review articles specifically reporting interventions targeting psychosocial risk/hazards, as this was identified as a gap through the consultation.

- Searches were conducted for systematic reviews on Google Scholar and Web of Science.
- 65 papers were found of potential interest.
- Papers which referred to psychosocial risk/hazard were given priority. This left six papers.
- Whilst one or more psychosocial risk/hazard were referred to in these six papers, none of the papers either mapped interventions to the psychosocial risk/hazard nor mapped outcome measures to them.
- One intervention in the review targeted psychosocial risk/hazard and this paper was then used to frame the other interventions relative to hazards – supporting leadership behaviour (Stuber et al., 2021).

Step 6: The PAG was consulted to support the identification of further evidence which may not have been captured so far. Some additional evidence was added at this stage.

By the end of the evidence mapping, the total number of items of evidence on the map was 401.

8.4.2 Evidence map considerations

When mapping the evidence, the following considerations were made:

- Where possible (e.g., in the case of evidence reviews) the evidence was deduplicated to avoid double counting/inflating the evidence base, however, as this was a mapping exercise within a set timeframe, some cases of duplication remained.
- Where different interventions were identified within the same paper (e.g., reviews), findings for each intervention type were recorded separately.
- Where papers discussed predictors or buffering factors (e.g., social support buffering the impact of psychosocial risk, not in relation to interventions), these were not recorded/deemed out of scope.
- Reflecting the wider psychosocial risk research, information relating to other mental health outcomes was captured.
- Evidence was categorised into primary, secondary, or tertiary level interventions using the definitions as described by HSE (2021).

8.4.3 Steps following the call for evidence, workshop and PAG discussions

Based on the consultation process to date and the finding from the call for evidence, the overall reflections were:

- Reporting on interventions tends to focus on outcomes rather than causes. Therefore, reviewing evidence of interventions targeting specific psychosocial hazards, such as the Management Standards, may not yield the efficacy information hoped for to inform decision making.

- While it was felt research would be likely to find that the overall quality of evidence for interventions is low, this does not preclude making recommendations based on the evidence available, as argued by the WHO and NICE. Literature searches should be inclusive in their approach and consider and synthesise a range of evidence.
- Even where reviews of interventions do exist, there may be benefit from a further examination of intervention design and implementation fidelity as existing systematic reviews have aimed to summarise the impact of interventions rather than looking at the specific mechanisms or the context applied. To provide the best possible advice to organisations, a more granular approach may be needed to understand which interventions work for whom in what circumstances.
- While there are some calls for a sector-specific approach to be taken, given the evidence available it was recommended that sector-relevance should considered and recorded where available, but that a sector-specific strategy would not be adopted at this stage.
- Based on discussions with the HSE the following protocol was created to guide the systematic search and review of the literature.

8.5 Systematic search and review

Based on the evidence mapping exercise and the list of priority interventions, the research team created the below protocol. Prior to sign off, the PAG and PSG were consulted on this approach.

8.5.1 Systematic search and review protocol

Primary Research Question:

“What control measures/interventions show efficacy for preventing and managing WRS?”

Secondary Research Questions:

- What is the strength of the evidence for these interventions?
- What sectors are these effective for?
- What psychosocial hazards are these effective in managing/mitigating?
- Are some interventions more “useful” than others (e.g., create positive changes to wellbeing at multiple levels, multiple hazards or for multiple outcomes)?
- Are there some frequently used interventions within organisations which do not have evidence for efficacy?

In developing this protocol, the research team:

- Considered the research questions outlined by HSE in the tender document.
- Considered interventions identified through the Call for Evidence conducted as part of this project, in which approximately 401 items of evidence were gathered.
- Considered interventions identified through the Knowledge Exchange Workshop conducted as part of this project, attended by 32 participants with expertise from policy, practice and research.
- Reviewed the search strategy and scope of reviews in work, stress and mental health including recent evidence reviews conducted as part of the development of the WHO guidance for mental health at work.
- Considered the time and resources available for the review.
- Consulted with the research team, HSE project team and PAG members.

Background

This protocol sets out a proposed approach for locating and organising evidence to aid future guidance and judgements on risk assessment suitability. Specifically, the approach has been informed by the need for an output that can readily be translated to inform policy decisions and support the development of practical, actionable guidance to:

- Share with duty holders and other practitioners from multiple disciplines (H&S, HR, OH, Leaders) who are seeking to make evidence-based decisions when choosing and implementing interventions and activities to prevent and manage WRS.
- Share with inspectors who are seeking to determine whether employers have taken reasonable action to prevent and manage WRS, and/or to guide recommendations made by inspectors as to the possible actions for employers to take to demonstrate their duty of care.

Drawing on the data gathering and consultation stages above the following observations were made:

- There is a large body of evidence, including multiple systematic reviews of the evidence, which examines the links between many different **interventions** with various **well-being outcomes** that are associated with WRS**.**
- Some interventions have been tested using robust designs, but **generally the quality of evidence on intervention efficacy is low to moderate** in this area (when considering typical standards of evidence and compared to other areas of health and work risk where multiple meta-analysis for specific interventions with intervention fidelity can be found).
- Studies lack clarity and consistency regarding **which interventions target which psychosocial hazards** in the workplace.
- Studies lack clarity and consistency regarding the **complex causal factors leading to WRS**, specifically regarding interplay between individual/non-work factors (e.g.,

individual difference, home/life demands) and work-related factors (e.g., psychosocial risks factors) and their impact on the experience of WRS/health and wellbeing outcomes.

These observations of the available data echo evidence identified by recent guideline development groups. For example:

- The **World Health Organisation's *Guidelines on mental health at work*** assembled several working groups, with oversight in the form of a Steering Group, composed of WHO departments relevant to guideline topic, a Guideline Development Group to provide technical expertise, and an Expert Review Group comprised of technical experts, employers and representatives. The guidelines draw on available evidence and were developed through comprehensive and iterative rounds of consultation. The systematic reviews conducted to inform the development of the guidelines consistently identified the quality of evidence on efficacy is low, largely due to a combination of sampling and methodological limitations and the volume of data available to make generalisable conclusions on efficacy. The web annex with full evidence tables is available at: https://iris.who.int/bitstream/handle/10665/363102/9789240053076-eng.pdf?sequence=1&isAllowed=y (accessed on 1st Dec 2024)
- **SafeWork Australia's *Managing Psychosocial hazards at Work: Code of Practice*** engaged experts from policy, practice and research to inform the development of the guidelines. While the Code of Practice provides an organised record of example control measures for psychosocial hazards to guide risk management, no reference to the efficacy of these interventions or how these interventions have been identified as suitable. The Appendix documents can be found at : https://www.safeworkaustralia.gov.au/sites/default/files/2022-08/model_code_of_practice_-_managing_psychosocial_hazards_at_work_25082022_0.pdf (accessed on 1st Dec 2024)

We currently **lack a systematically organised record of interventions and their efficacy** to guide decision making in relation to WRS.

Review aim:

To produce **a systematically organised record of workplace interventions and their efficacy** to support decision making.

Proposed methodology

We propose to conduct a series of **systematic searches and reviews** of the evidence available for a comprehensive set of commonly used interventions to prevent and manage WRS. This approach combines a thorough search process, quality assessment of the evidence and enables the flexibility of scrutinising a broad evidence base to identify what is known, and identify recommendations for practice (Grant, 2009). Due to the need to

ensure the outcome is appropriate to provide practical guidance, this review will combine both academic and grey literature. We will clearly document the scope of our searches for each intervention for transparency and note that further examination and research is required where appropriate. This approach aims to meet the need for creating an organised record of interventions and their efficacy using a rigorous approach that stands up to academic scrutiny.

Step 1: Identify a comprehensive set of commonly used interventions for inclusion in the review

The following steps will be taken to identify and agree the interventions for inclusion in the review:

- Interventions will be identified from the evidence map created from the call for evidence (consisting of 401 items of evidence); the Knowledge Exchange Workshop (32 professionals); discussions with the PAG; and a focused scoping review of the evidence pertaining to psychosocial hazards by the research team.
- Sharing the list of possible interventions with the PAG and PSG for comment to identify gaps and priority interventions for inclusion. Please see Table 8 for initial proposed list.

Table 8 Proposed list of interventions to include in the evidence review

Intervention Category	No. lines on Evidence Map	Sources
Action Planning	3	CfE
Alternative relaxation	3	CfE
Awards and accreditation	1	CfE
Awareness Campaigns	2	CfE
Coaching	2	CfE
Communication & Feedback	15	CfE
Education	1	CfE, SS
Guidance	15	CfE
Health promotion	3	CfE
ISO45003	1	CfE
Leadership style	12	CfE, SS
Line manager training	20	CfE
Mentoring	4	CfE

Intervention Category	No. lines on Evidence Map	Sources
Participatory Intervention	5	CfE
Policy	1	CfE
Post incident interventions	4	CfE
Preventative Workplace Guidelines	1	SS
Psychological	18	CfE, KEW
Return to work/ Absence management	1	CfE
Risk Assessment	16	CfE
Screening	5	PAG
Sleep interventions	4	CfE
Social Support	7	CfE
Stress Management & Educational Interventions	7	CfE
Support	1	CfE
Tech Interventions	1	CfE
Therapeutic interventions	2	CfE, SS
Toolkit/standards	5	CfE
Training	2	CfE, SS
Various	21	CfE, SS
Volunteering/charity work	1	CfE
Work Design	72	CfE, SS

KEW =Knowledge Exchange Workshop, EM = Evidence Map, CfE = call for evidence, PAG= Project Advisory Group, SS= scoping search
Please note – additional interventions may be identified following a final review of the interviews.

Step 2: Conducting targeted systematic searches to locate available evidence for each of the interventions included in the agreed list

Academic databases, Google Scholar, and grey literature sources will be used to locate evidence using the intervention term and health and wellbeing outcomes as per the WP2 systematic review. The research team will initially prioritise searches for systematic reviews of the intervention in question. Where these are not available the team will identify

the best available relevant evidence, inclusive of all forms of empirical evidence (quantitative and qualitative).

Sources to be searched:
VIA EBSCO host

- Academic Search Ultimate
- APA PsycArticles
- APA PsycBooks
- APA PsycExtra
- APA PsycInfo
- Business Source Ultimate
- CINAHL Ultimate
- Health Policy Reference Center
- MEDLINE Complete

In addition, we will search:

- Web of science
- Google Scholar

In addition, we are likely to search the following for grey literature:

- Chartered Institute of Ergonomics and Human Factors (CIEHF),
  - https://publications.ergonomics.org.uk/
- Chartered Institute of Personnel and Development (CIPD)
  - cipd.org.uk
- College of Policing
  - https://www.college.police.uk/research
- EU-OSHA
  - https://osha.europa.eu/en/publications/intro-text-featured-publications-carousel
- Health and Safety Executive (HSE)
  - https://www.hse.gov.uk/research/rrhtm/index.htm
- Mind
  - https://www.mind.org.uk/about-us/our-policy-work/reports-and-guides/
- National Institute for Health and Care Excellence (NICE)
  - https://cks.nice.org.uk/
  - https://www.nice.org.uk/guidance
- Society of Occupational Medicine (SOM).
  - https://www.som.org.uk/work-and-health/information-healthcare-professionals
- United Nations Global Compact
  - https://unglobalcompact.org/library

- What Works Centre for Wellbeing
    - https://whatworkswellbeing.org/resources/

We will also gather contributions from:

- PAG and PSG
- Open call for additional evidence during an expert consultation.

Searches will take place between January-April 2025.

Restrictions to searches:

- Published in English language
- Publication period from 2014-2025
- Published research and research under review.

Step 3: Examining the quality and quantity of evidence

- We recognise that the quality and quantity of evidence available for each of the interventions varies widely. As mentioned, where possible the research team will prioritise searching for systematic reviews of interventions efficacy on outcomes of interest. Should no systematic reviews exist, the team will identify the best available relevant evidence from both academic and grey literature, recognising that there may be some interventions used in practice with limited academic research. These searches will be inclusive of all forms of empirical evidence (quantitative and qualitative).
- This systematic search and review approach aims to identify the best available evidence rather than an exhaustive search of the evidence-base.
- The quality of data available will then be mapped for each intervention against the NESTA standards of evidence as a coherent framework appropriate for multi-disciplinary audiences.
- The process including terms used and data gathered will be systematically recorded for transparency.
- At regular intervals, the research team will come together to review the available evidence and strategy to ensure that terms used and approach to locating and selecting evidence is standardised, and well documented.

Step 4: Synthesis and reporting

Based on the interventions and evidence identified through the above activity, overarching findings will be synthesised using thematic analysis. Findings will be presented in quick view tables and an accompanying narrative.

To aid sense-making, the list of interventions will be organised thematically, giving due attention to secondary research questions e.g., the level of intervention (primary, secondary and tertiary), outcome of interest, and quality of evidence. A series of tables will

be created to support the organisation of the findings, mapping the interventions to the outcomes changed as well as quality of evidence.

Through discussion with the HSE, it was agreed that, where available, the review would examine: the efficacy of interventions and the strength and quality of the supporting evidence; contextual relevance including sector, workforce and organisational size; assignment by level of intervention (primary, secondary, tertiary); and the potential utility of interventions across the HSE Management Standards factors.

8.5.2 Systematic Search and review approach

The team **conducted a series of systematic searches and reviewed the evidence** of the prioritised set of commonly used interventions to prevent and manage WRS**.**

Why a systematic review was not appropriate
While a classic systematic review approach has its benefits, particularly when carried out in a focused literature area, during the evidence mapping and scoping process it became evident due to the wide coverage of intervention types and outcomes, a more flexible approach would be needed, which still maintained the rigor and systematic approach. Therefore, it was decided that in order to take a pragmatic view of the best available evidence, a series of **systematic searches and reviews** would allow the team to bring together research from various intervention areas. This approach combines a thorough search process, quality assessment of the evidence and enables the flexibility of scrutinising a broad evidence base to identify what is known, and identify recommendations for practice (Grant, 2009).

Example search terms:

Key: “Intervention name and likely synonyms” & Review & Intervention

Possibly supplementary terms:

Outcomes	Context
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 OR well-being OR wellbeing	work OR Occup* OR organiz* OR organis* OR work-related OR Job-related

The team took the following approach after the evidence map:

- **Conducting further necessary top-up searches** (e.g., where few review studies have been found or where evidence identified is less recent.
- **Extracting data from review studies** relevant to the **priority intervention categories** according to the agreed protocol.
- **Reading review studies that were not intervention specific** and extracting intervention specific findings within them and integrating with the above findings.
- **Assessing the standard of evidence per intervention** using the principles of the Nesta Standards of Evidence model as a broad framework to accommodate the diverse nature of the literature.
- **Synthesising evidence** and evidence-based judgement on efficacy per intervention.
- For **nonpriority interventions**, a definition will be provided with reference to other sources for further information.

Quality assessment:
Due to the complexity and variety of papers and outcomes considered, no single quality assessment tool was deemed as reflective of the evidence for this systematic search. As part of the consultation with the PSG and PAG, the complexities of this were discussed. In order to provide some consistency in rating across the reviews, while remaining mindful of the concerns regarding the quality of evidence in this field and the limitations of applying traditional approaches to quality assessment as mentioned in Section 1.2, the below process was followed by the research team:

- Where available, statements made by the review authors on the quality of evidence of the specific finding for the paper were extracted in the first instance. Where this level of granularity was not available, the statement of quality of evidence across the papers in the review was extracted. Therefore, within the extract sheet this was clearly labelled as either intervention specific or general.
- If no author statement was present, the research team used their expert opinion to determine a judgement on quality of evidence with and provided a narrative summary. This approach is consistent with established methods used in overviews of reviews where author-reported judgements of evidence quality are extracted where available and supplemented with reviewer judgement only where assessments are absent or insufficiently detailed (Mackenbach et al, 2025; Medley et al., 2018).
- Based on either of the above, a final overall quality statement was made (low, moderate, high). Factors which contributed to these labels were:
  - **Low:** Mainly cross-sectional research, lack of quality assessment details provided, limited detail on interventions/studies, quality assessment tools used by reviews yielded majority low-quality studies.
  - **Moderate:** Study designs contain multiple Randomised Controlled Trials (RCT) or controlled studies, details on quality assessment processes provided, quality assessment tools used by reviews yielded majority moderate quality studies.

- **High:** Multiple systematic reviews of high-quality studies, quality assessment tools used and explained, quality assessment tools used by reviews concluded study quality was high.

Standards of evidence: The Nesta Standards of Evidence (Nesta, 2013) provide a structure to determine whether a set of activities make a difference. They set out five levels of evidence, where lower levels show that there is only limited evidence; higher levels show that more evidence is available. As such, they help us understand how well an intervention has been tested, and how far it has progressed along the evaluation journey (see Table 9: Nesta categorisation approach).

Table 9: Nesta categorisation approach

Nesta Standard of Evidence	Nesta Expectation	What this means in relation to interventions for WRS
Level 1	The research describes what was done and why it matters, logically, coherently and convincingly	Descriptions of the intervention exist, and reported benefits of why and how it will make a difference e.g., qualitative data or cross-sectional survey
Level 2	The research can capture data that shows a positive change, but cannot confirm the study caused this	The presence of the intervention is associated with work and health outcomes e.g., over-time survey data
Level 3	The research can demonstrate causality using a control or comparison group	Specific interventions offer benefits over those afforded to a control group e.g., Controlled trial, over time, using quantitative measures
Level 4	The research has one + independent replication evaluation/s that confirms these conclusions	Replication of controlled trial, preferably a randomly controlled trial comparing specific and similarly delivered interventions
Level 5	The research has manuals, systems and procedures to ensure consistent replication and positive impact	Specified pathways to access specific interventions, delivered in a systematic and replicable way across different locations or contexts

Linking interventions to psychosocial hazards:
Included reviews were systematically assessed for the extent to which they explicitly identified psychosocial hazards as targets or outcomes of intervention, rather than inferring hazard change from improvements in mental health or wellbeing. To support transparent synthesis, each extraction point (either at review level or at intervention-level within the review) was coded using the following classification:

- No linkage. Reviews reporting impact on individual or organizational outcomes, with no reference to psychosocial hazards.
- Implicit but not specified. Reviews that discussed job characteristics or working conditions conceptually but did not explicitly extract or synthesize intervention effects in relation to specific psychosocial hazards.
- Explicit. Reviews that clearly identified the psychosocial hazards targeted and explicitly linked specific interventions to changes in these hazards.

Coding focused on how evidence was synthesised and reported within the review rather than scrutinising whether the primary studies influenced the hazards, or whether the hazard itself was systematically measured pre and post intervention. Coding decisions were applied conservatively to avoid over-interpretation.

Moderation
To ensure a rigorous and accurate extraction and quality assessment process, frequent moderation checks were undertaken within the extracting team, and a formal moderation was carried out for 10% of the papers by someone outside the immediate research team. Any discrepancies were discussed and resolved as a wider research team.

8.6 Approach to synthesis of findings

The full extract was synthesised to determine overall efficacy of interventions in the priority intervention list.

8.6.1 A note on efficacy

The challenges of determining quality of evidence in this field was noted during discussions with the PSG, PAG and within our research team. A pragmatic, systematic approach was therefore taken. As a summary:

Efficacy was determined by extracting the detail on the findings of the reviews and where the specific intervention of interest was seen to create positive change on notable outcomes of interest (e.g., stress, distress). A portion of these ratings were moderated.

These scores were aggregated in the following ways:

- Positive evidence: where the majority of studies in the intervention category found evidence of efficacy.
- No evidence: where the majority of studies in the intervention category did not find evidence of efficacy.
- Mixed: where there was lack of consensus among reviews.

8.6.2 A note on study quality for academic papers

Aggregated quality was determined by the majority of ratings (e.g., where two reviews were rated as moderate quality, one as low, this was rated as moderate). Where these were an even split between two ratings, the rating is combined (e.g., low to moderate). Occasionally, where there was a wide range of study quality across low to high, an average was determined a best fit (e.g., moderate on average).

8.7 Roundtable consultation methodology

The draft findings from the evidence review were shared at an online roundtable event and separately with the PAG. Participants were identified through an existing spreadsheet of the project team's professional contacts, they were a mix of in-house roles such as Human Resources, H&S and leadership, health professionals such as occupational health and advisory bodies and academic contacts. A selection of contacts were selected by the project team and invited to take part via email. Those who expressed interest received a formal invitation from the project's email account. The consultation took place on Microsoft Teams on 23 October 2025 and lasted approximately 90 minutes.

The findings from the evidence review were presented and questions posed for discussion in small breakout groups of four to six people, facilitated by a member of the research team. The discussion was structured around the following questions:

- Which of these interventions do you use/advocate to manage WRS?
- How are these findings useful and relevant for your context?
- Which interventions seem most practical or impactful?
- What gaps or challenges do you see?
- Would you use the findings to help choose interventions, what is missing? What outputs would be most valuable for your role/organisation?

The consultation focused on the key outputs from the research and the discussions are summarised below.

Twenty-seven participants took part in the roundtable event including 13 professionals working in-house within Human Resources or Health and Safety, four health professionals, and eight representing advisory bodies. Four members of our PAG provided feedback on the questions asked.

9 Appendix 3 - Evidence map findings

9.1.1 Evidence map findings

As described, the information presented in the evidence map combined evidence submitted as well as a rapid scoping search of available evidence – it was not an exhaustive systematic review of the evidence and their quality.

There were around 100 intervention strategies considered within the research submitted, which were grouped into 30 categories. It is noteworthy that some documents (e.g., systematic reviews) mentioned more than one intervention type.

This formed an output which was a catalogue of all the interventions and control measures known for WRS (see Table 1).

Through this mapping process, the research team noted the following:

- Current evidence is limited and unclear regarding the efficacy of interventions.
- This is due to insufficient quantity of evidence for each intervention, and limited quality of study designs.
- The lack of evidence of intervention efficacy in this space has also been identified by others (e.g., NICE (2022) and WHO (2022)) in recent reviews conducted to inform guidelines on mental health at work.
- The lack of strong evidence should not be conflated with a lack of efficacy for these interventions; rather, more time is needed to gather comprehensive evidence using robust designs.

This output was shared with the HSE and it was decided that the interventions listed in Table 8 would be prioritised for a systematic search and review of the evidence. This was due to these being more focused on preventative/primary interventions for WRS. Reflections on the Status of Evidence Following the Call, Workshop and PAG Discussions. Wider interventions identified within the evidence map though not prioritised for systematic search are presented for information within Table 10.

Drawing on the findings to date, the following observations of the evidence base for interventions to prevent WRS were made:

- There is a large body of evidence which examines the links between many different interventions with various wellbeing outcomes that are associated with WRS.
- Some interventions have been tested using robust designs, but generally the quality of evidence on efficacy is low in this area (when considering typical standards of

evidence and compared to other areas of health and work risk where multiple meta-analyses for specific interventions with intervention fidelity can be found).

- Studies lack clarity and consistency regarding which interventions target which psychosocial hazards in the workplace; and which outcomes are measured.
- Studies lack clarity and consistency regarding the complex causal factors leading to WRS, specifically regarding interplay between individual/non-work factors (e.g., individual difference, home/life demands) and work-related factors (e.g., psychosocial risks factors) and their impact on the experience of WRS/health and wellbeing outcomes.
- We are currently lacking a systematically organised record of interventions and their efficacy to guide decision making.

Table 10 Non-priority interventions and relevant reviews found through evidence map

Intervention category	Intervention name	Key papers found
Skills Training	Skills training	NICE universal individual level (pp. 195, 199) NICE organisational universal level (p. 71)
	Selection, optimisation, and compensation (SOC)	NICE universal individual level (p. 201)

Intervention category	Intervention name	Key papers found
Staying Well	Health promotion	Mygind, L., Kjeldsted, E., Hartmeyer, R.D., Mygind, E., Bølling, M. and Bentsen, P. (2019) 'Immersive nature-experiences as health promotion interventions for healthy, vulnerable, and sick populations? A systematic review and appraisal of controlled studies', Frontiers in Psychology, 10, p. 943. Otto, A.K., Gutsch, C., Bischoff, L.L. and Wollesen, B. (2021) 'Interventions to promote physical and mental health of nurses in elderly care: A systematic review', Preventive Medicine, 148, p. 106591. MacMillan, F., Karamacoska, D., El Masri, A., McBride, K.A., Steiner, G.Z., Cook, A. and George, E.S. (2017) 'A systematic review of health promotion intervention studies in the police force: Study characteristics, intervention design and impacts on health', Occupational and Environmental Medicine, 74(12), pp. 913–923. MacMillan, F., Kolt, G.S., Le, A. and George, E.S. (2021) 'Systematic review of randomised control trial health promotion intervention studies in the fire services: Study characteristics, intervention design and impacts on health', Occupational and Environmental Medicine, 78(6), pp. 454–463. Stanulewicz, N., Knox, E., Narayanasamy, M., Shivji, N., Khunti, K. and Blake, H. (2019) 'Effectiveness of lifestyle health promotion interventions for nurses: A systematic review', International Journal of Environmental Research and Public Health, 17(1), p. 17. Chan, C.W. and Perry, L. (2012) 'Lifestyle health promotion interventions for the nursing workforce: A systematic review', Journal of Clinical Nursing, 21(15–16), pp. 2247–2261. Hazavehei, S.M.M., Moghadam, S.M.K., Kholenjani, F.B. and Ebrahimi, H. (2018) 'The influence of educational interventions to reduce occupational stress:

Intervention category	Intervention name	Key papers found
		A systematic review', Journal of Health & Safety at Work, 7(4). Jiménez-Mérida, M.R., Romero-Saldaña, M., Molina-Luque, R., Molina-Recio, G., Meneses-Monroy, A., De Diego-Cordero, R. and Vaquero-Abellán, M. (2021) 'Women-centred workplace health promotion interventions: A systematic review', International Nursing Review, 68(1), pp. 90–98. Sharifnia, A.M., Fernandez, R., Green, H. and Alananzeh, I. (2022) 'The effectiveness of spiritual intelligence educational interventions for nurses and nursing students: A systematic review and meta-analysis', Nurse Education in Practice, 63, p. 103380. NICE organisational universal-level (p. 68)

Intervention category	Intervention name	Key papers found
	Physical activity, lifestyle	Bischoff, L.L., Otto, A.K., Hold, C. and Wollesen, B. (2019) 'The effect of physical activity interventions on occupational stress for health personnel: A systematic review', International Journal of Nursing Studies, 97, pp. 94–104. Shrestha, N., Kukkonen-Harjula, K.T., Verbeek, J.H., Ijaz, S., Hermans, V. and Pedisic, Z. (2018) 'Workplace interventions for reducing sitting at work', Cochrane Database of Systematic Reviews, (6), CD010912. Zhang, M., Murphy, B., Cabanilla, A. and Yidi, C. (2021) 'Physical relaxation for occupational stress in healthcare workers: A systematic review and network meta-analysis of randomized controlled trials', Journal of Occupational Health, 63(1), e12243. Zhang, Y., Sun, J., Wu, C., Fei, Y., Hu, W. and Lang, H. (2024) 'Comparing the effectiveness of mind–body practices (MBPs) and various psychological methods on occupational stress among healthcare workers: A network meta-analysis of randomized controlled trials', BMC Health Services Research, 24(1), p. 962. Della Valle, E., Palermi, S., Aloe, I., Marcantonio, R., Spera, R., Montagnani, S. and Sirico, F. (2020) 'Effectiveness of workplace yoga interventions to reduce perceived stress in employees: A systematic review and meta-analysis', Journal of Functional Morphology and Kinesiology, 5(2), p. 33. NICE findings universal individual level (p. 203) NICE targeted individual-level (p. 60) NICE universal individual level, psychotherapy and yoga (pp. 179, 199)

Intervention category	Intervention name	Key papers found
	Volunteering/charity work	Fleming, W.J. (2024) 'Employee well-being outcomes from individual-level mental health interventions: Cross-sectional evidence from the United Kingdom', Industrial Relations Journal, 55(2), pp. 162–182. Nichol, B., Wilson, R., Rodrigues, A. and Haighton, C. (2024) 'Exploring the effects of volunteering on the social, mental, and physical health and well-being of volunteers: An umbrella review', Voluntas.
	Sleep interventions	Takano, Y., Iwano, S., Aoki, S., Nakano, N. and Sakano, Y. (2021) 'A systematic review of the effect of sleep interventions on presenteeism', BioPsychoSocial Medicine, 15, pp. 1–10. Tout, A.F., Tang, N.K., Sletten, T.L., Toro, C.T., Kershaw, C., Meyer, C. et al. (2024) 'Current sleep interventions for shift workers: A mini review to shape a new preventative, multicomponent sleep management programme', Frontiers in Sleep, 3, p. 1343393. NICE findings universal individual level (p. 205) NICE targeted individual-level internet sleep recovery (p. 51)

Intervention category	Intervention name	Key papers found
Psychological Resources	Mindfulness & meditation	Fendel, J.C., Bürkle, J.J. and Göritz, A.S. (2020) 'Mindfulness-based interventions to reduce burnout and stress in physicians: a systematic review and meta-analysis', Academic Medicine, 96(5), pp. 751–764. Guillaumie, L., Boiral, O. and Champagne, J. (2017) 'A mixed-methods systematic review of the effects of mindfulness on nurses', Journal of Advanced Nursing, 73(5), pp. 1017–1034. Bartlett, L., Martin, A., Neil, A.L., Memish, K., Otahal, P., Kilpatrick, M. and Sanderson, K. (2019) 'A systematic review and meta-analysis of workplace mindfulness training randomized controlled trials', Journal of Occupational Health Psychology, 24(1), p. 108. Heckenberg, R.A., Eddy, P., Kent, S. and Wright, B.J. (2018) 'Do workplace-based mindfulness meditation programs improve physiological indices of stress? A systematic review and meta-analysis', Journal of Psychosomatic Research, 114, pp. 62–71. Lomas, T., Medina, J.C., Ivtzan, I., Rupprecht, S. and Eiroa-Orosa, F.J. (2019) 'Mindfulness-based interventions in the workplace: An inclusive systematic review and meta-analysis of their impact upon wellbeing', The Journal of Positive Psychology, 14(5), pp. 625–640. Michaelsen, M.M., Graser, J., Onescheit, M., Tuma, M.P., Werdecker, L., Pieper, D. and Esch, T. (2023) 'Mindfulness-based and mindfulness-informed interventions at the workplace: A systematic review and meta-regression analysis of RCTs', Mindfulness, 14(6), pp. 1271–1304. Micklitz, K., Wong, G. and Howick, J. (2021) 'Mindfulness-based programmes to reduce stress and enhance well-being at work: A realist review', BMJ Open, 11(3), e043525.

Intervention category	Intervention name	Key papers found
		Janssen, M., Heerkens, Y., Kuijer, W., Van Der Heijden, B. and Engels, J. (2018) 'Effects of Mindfulness-Based Stress Reduction on employees' mental health: A systematic review', PLOS ONE, 13(1), e0191332. https://doi.org/10.1371/journal.pone.0191332 NICE universal individual level (pp. 176–197, 180) NICE targeted individual-level (p. 46)

Intervention category	Intervention name	Key papers found
	Acceptance and Commitment Training (ACT)	Prudenzi, A., Graham, C.D., Clancy, F., Hill, D., O'Driscoll, R., Day, F. and O'Connor, D.B. (2021) 'Group-based acceptance and commitment therapy interventions for improving general distress and work-related distress in healthcare professionals: A systematic review and meta-analysis', Journal of Affective Disorders, 295, pp. 192–202. Rad, Y., Prudenzi, A., Zernerova, L., Gerson, J. and Flaxman, P.E., 2025. Effects of workplace acceptance and commitment therapy (ACT) programs on psychological flexibility's subprocesses: A systematic review. *Journal of Contextual Behavioral Science*, *37*, p.100915. Reeve, A., Tickle, A. and Moghaddam, N. (2018) 'Are acceptance and commitment therapy-based interventions effective for reducing burnout in direct-care staff? A systematic review and meta-analysis', Mental Health Review Journal, 23(3), pp. 131–155. Rudaz, M., Twohig, M.P., Ong, C.W. and Levin, M.E. (2017) 'Mindfulness and acceptance-based trainings for fostering self-care and reducing stress in mental health professionals: A systematic review', Journal of Contextual Behavioral Science, 6(4), pp. 380–390. https://doi.org/10.1016/j.jcbs.2017.10.001 Öst, L.G. (2008) 'Efficacy of the third wave of behavioral therapies: A systematic review and meta-analysis', Behaviour Research and Therapy, 46(3), pp. 296–321. https://doi.org/10.1016/j.brat.2007.12.005 NICE universal individual-level (p. 186) NICE targeted individual-level (p. 49)

Intervention category	Intervention name	Key papers found
	Digital interventions	Cameron, G., Mulvenna, M., Ennis, E., O'Neill, S., Bond, R., Cameron, D. and Bunting, A. (2025) 'Effectiveness of Digital Mental Health Interventions in the Workplace: Umbrella Review of Systematic Reviews', JMIR Mental Health, 12(1), e67785. NICE targeted individual-level web guided self help (p. 51) NICE organisational universal-level digital stress prevention (p. 67)
	Cognitive Behavioural Therapy (CBT)	Kuribayashi, K., Takano, A., Inagaki, A., Imamura, K. and Kawakami, N. (2022) 'Effect of stress management based on cognitive–behavioural therapy on nurses as a universal prevention in the workplace: a systematic review and meta-analysis protocol', BMJ Open, 12(9), e062516. Joyce, S., Modini, M., Christensen, H., Mykletun, A., Bryant, R., Mitchell, P.B. and Harvey, S.B. (2016) 'Workplace interventions for common mental disorders: a systematic meta-review', Psychological Medicine, 46(4), pp. 683–697. Barrett, K. and Stewart, I. (2021) 'A preliminary comparison of the efficacy of online Acceptance and Commitment Therapy (ACT) and Cognitive Behavioural Therapy (CBT) stress management interventions for social and healthcare workers', Health & Social Care in the Community, 29(1), pp. 113–126. NICE universal individual-level (p. 181) NICE targeted individual-level CBT and problem solving (p. 44, p. 54–56)
	Positive psychology & Psychological Capital.	NICE universal individual-level (p. 190) NICE organisational universal-level (p. 69)

Intervention category	Intervention name	Key papers found
	OTHER	Zhang, M., Murphy, B., Cabanilla, A. and Yidi, C. (2021) 'Physical relaxation for occupational stress in healthcare workers: A systematic review and network meta-analysis of randomized controlled trials', Journal of Occupational Health, 63(1), e12243. Zhang, Y., Sun, J., Wu, C., Fei, Y., Hu, W. and Lang, H. (2024) 'Comparing the effectiveness of mind–body practices (MBPs) and various psychological methods on occupational stress among healthcare workers: a network meta-analysis of randomized controlled trials', BMC Health Services Research, 24(1), 962. Li, H., Zhao, M., Shi, Y., Xing, Z., Li, Y., Wang, S. et al. (2019) 'The effectiveness of aromatherapy and massage on stress management in nurses: A systematic review', Journal of Clinical Nursing, 28(3-4), pp. 372–385. NICE universal individual-level (p. 188) NICE targeted individual-level (p. 58, p. 62) NICE findings universal individual-level approaches (p. 189, 203–204) NICE targeted individual-level massage (p. 59)
	Resilience	NICE universal individual-level (p. 191)

Intervention category	Intervention name	Key papers found
Therapeutic Approaches	Therapeutic interventions	Huet, V. (2015) 'Literature review of art therapy-based interventions for work-related stress', International Journal of Art Therapy, 20(2), pp. 66–76. De Witte, M., Pinho, A.D.S., Stams, G.J., Moonen, X., Bos, A.E. and Van Hooren, S. (2022) 'Music therapy for stress reduction: a systematic review and meta-analysis', Health Psychology Review, 16(1), pp. 134–159. NICE targeted individual-level expressive writing (p. 54) NICE targeted individual-level auriculotherapy (p. 50) NICE universal individual-level music therapy (p. 206) NICE universal individual-level problem solving (p. 183) NICE targeted individual-level problem solving (p. 48) NICE universal individual-level psychotherapy & yoga (p. 199) NICE targeted individual-level positive psychotherapy (p. 57) NICE universal individual-level journalling (p. 199)
	Counselling	NICE targeted individual-level medical counselling (p. 61)
	Motivational Interviewing	NICE universal individual-level (p. 197)
	Emotional freedom Technique	NICE universal individual-level (p. 207)
Support pathways	Employee Assistance Programmes (EAP)	Joseph, B., Walker, A. and Fuller-Tyszkiewicz, M. (2018) 'Evaluating the effectiveness of employee assistance programmes: A systematic review', European Journal of Work and Organizational Psychology, 27(1), pp. 1–15. Long, T. and Cooke, F.L. (2023) 'Advancing the field of employee assistance programs research and practice: A systematic review of quantitative studies and future research agenda', Human Resource Management Review, 33(2), 100941. NICE organisational universal-level (p. 74)

Intervention category	Intervention name	Key papers found
	Screening	Opie, E., Brooks, S., Greenberg, N. and Rubin, G.J. (2020) 'The usefulness of pre-employment and pre-deployment psychological screening for disaster relief workers: A systematic review', BMC Psychiatry, 20, 211. https://doi.org/10.1186/s12888-020-02593-1 Marshall, R.E., Milligan-Saville, J., Petrie, K., Bryant, R.A., Mitchell, P.B. and Harvey, S.B. (2021) 'Mental health screening amongst police officers: factors associated with under-reporting of symptoms', BMC Psychiatry, 21, 135. https://doi.org/10.1186/s12888-021-03125-1 Greenberg, N. and Forbes, D. (2023) 'Workplace mental health screening for trauma-exposed workforces', Occupational Medicine, 75(6), pp. 266–267. https://doi.org/10.1093/occmed/kqad098
	Occupational health provision	NICE targeted individual-level (p. 59)
	Return to work/ Absence management	Nowrouzi-Kia, B. et al. (2023) 'Evaluating the effectiveness of return-to-work interventions for individuals with work-related mental health conditions: A systematic review and meta-analysis', Healthcare, 11(10), 1403. https://doi.org/10.3390/healthcare11101403 Nieuwenhuijsen, K. et al. (2020) 'Interventions to improve return to work in depressed people', Cochrane Database of Systematic Reviews, (10), CD006237. Brämberg, E. et al. (2024) 'Effects of work-directed interventions on return-to-work in people on sick-leave for common mental disorders—a systematic review', International Archives of Occupational and Environmental Health, pp. 1–23. Dewa, C.S., Loong, D., Bonato, S. and Joosen, M.C. (2015) 'The effectiveness

Intervention category	Intervention name	Key papers found
		of return-to-work interventions that incorporate work-focused problem-solving skills for workers with sickness absences related to mental disorders: a systematic literature review', BMJ Open, 5(6), e007122.
	Prevocational training	Suijkerbuijk, Y.B., Schaafsma, F.G., van Mechelen, J.C., Ojajärvi, A., Corbiere, M. and Anema, J.R. (2017) 'Interventions for obtaining and maintaining employment in adults with severe mental illness: a network meta-analysis', Cochrane Database of Systematic Reviews, (9), CD011867. World Health Organization (WHO) (2022) WHO guidelines on mental health at work. Geneva: WHO. ISBN 978-9240053052.
	Supported employment	Suijkerbuijk, Y.B., Schaafsma, F.G., van Mechelen, J.C., Ojajärvi, A., Corbiere, M. and Anema, J.R. (2017) 'Interventions for obtaining and maintaining employment in adults with severe mental illness: a network meta-analysis', Cochrane Database of Systematic Reviews, (9), CD011867. Fadyl, J.K., Anstiss, D., Reed, K., Khoronzhevych, M. and Levack, W.M. (2020) 'Effectiveness of vocational interventions for gaining paid work for people living with mild to moderate mental health conditions: systematic review and meta-analysis', BMJ Open, 10(10), e039699. Drake, R.E. and Bond, G.R. (2023) 'Individual placement and support: History, current status, and future directions', Psychiatry and Clinical Neurosciences Reports, 2(3), e122. World Health Organization (WHO) (2022) WHO guidelines on mental health at work. Geneva: WHO. ISBN 978-9240053052.
	Vocational Rehabilitation Interventions	Fadyl, J.K., Anstiss, D., Reed, K., Khoronzhevych, M. and Levack, W.M. (2020) 'Effectiveness of vocational interventions for gaining paid work for people living with mild to moderate mental health conditions: systematic review and meta-analysis', BMJ Open, 10(10), e039699.

Intervention category	Intervention name	Key papers found
	Accelerated Recovery Programme (ARP)	NICE targeted individual-level (p. 61)
Sector specific	Post incident interventions/debriefing	Tan, L., Petrie, K., Deady, M., Bryant, R.A. and Harvey, S.B. (2022) 'Systematic review of first responder post-deployment or post-incident psychosocial interventions', Occupational Medicine, 72(3), pp. 160–169.
	Clinical supervision	Martin, P., Lizarondo, L., Kumar, S. and Snowdon, D. (2021) 'Impact of clinical supervision on healthcare organisational outcomes: A mixed methods systematic review', PLOS ONE, 16(11), e0260156. Sewell, K.M., McMenemy, C., van Rensburg, M.J. and MacDonald, H. (2024) 'Organizational outcomes of supervision within human services: A scoping review', Human Service Organizations: Management, Leadership & Governance, 48(1), pp. 19–42. Dawson, M., Phillips, B. and Leggat, S.G. (2013) 'Clinical supervision for allied health professionals: A systematic review', Journal of Allied Health, 42(2), pp. 65–73.

10 Appendix 4 - Findings – systematic search and review

The search retrieved 26 academic and 33 grey literature papers to answer the question: What control measures/interventions show efficacy for preventing and mitigating WRS?

Eight papers included studies that examined one or more interventions, and we have therefore provided information on both the included papers, and by intervention.

Table 11 provides a summary of review paper characteristics for both the academic and grey literature.

Table 12 provides a per paper summary of the academic literature.

Table 13 provides a summary of intervention strategies, targets and strength of evidence from the academic review.

Table 14 provides a summary of intervention strategies, targets and strength of evidence from the grey review.

10.1 Summary review paper characteristics

Table 11 Summary review paper characteristics

Area	Academic	Grey
General Information	• 26 review papers included	• 33 papers reviewed (although many include more than one intervention)
Countries covered	• EUR (14 papers) • AMR (15 papers) • WPR (14 papers) • SEAR (4 papers) • AFR (2 paper) • EMR (1 paper) • Not reported (7 papers) • Various but not reported (2 papers)	• United Kingdom (21 papers) • Europe (4 papers) • International (4 papers) • USA (3 papers) • Australia (1 paper)
Sector	• Various but didn't report the sectors (10 papers)	• 22 generic • 5 healthcare

Area	Academic	Grey
	• 5 didn't report at all • 6 various and reported sectors (e.g., physicians, public safety workers, emergency services, manufacturing companies, office settings, health services, tertiary institution, construction, manufacturing, mining, utilities, transport, agriculture, and information technology and formal and informal sectors) • 4 healthcare only • 1 education only	• 2 policing • 1 nursing • 1 rail Industry • 1 education • 1 water Industry
Study design	• 14 systematic reviews • 5 systematic reviews and meta-analysis • 2 scoping reviews • 1 meta-analysis • 1 review of reviews • 1 review of reviews and evidence mapping • 1 integrative review • 1 evidence review	• 11 evaluations/case studies/RCTs • 10 non-systematic reviews • 6 systematic reviews • 6 guidance/policy
Number of participants	• 12 papers did not report • 132,423 total of reported	• 28 papers did not report • 3882 across papers where reported
Main targeted level of control (Nb)	• 15 primary • 3 secondary • 5 primary and secondary • 3 not reported	• Not applicable due to mixed nature of literature

Area	Academic	Grey
Intervention level	• 4 individual only • 6 group only • 6 leader only • 4 organisational only • 3 individual and organisational • 1 individual, leader and organisational • 1 individual and group • 1 multiple	• Not applicable due to mixed nature of literature
Stress related outcome	• 1 not reported • 10 wellbeing • 13 stress • 3 exhaustion • 7 burnout • 3 anxiety • 3 distress • 4 fatigue • 4 mental health • 2 help-seeking behaviour • 3 depression • 1 mental illness • 1 mood • 1 emotional health • 1 mental health literacy • 1 cognitive • 1 emotional health • 1 mindfulness • 1 family-work conflict • 1 work-life balance • 1 psychological strain • 1 recovery • 1 suicidal behaviours • 1 mental health knowledge • 1 mental health knowledge, attitudes, skills	*for papers where depth extraction was feasible due to addressing less than 5 interventions • 7 wellbeing • 5 stress • 2 burnout • 1 exhaustion • 1 fatigue • 7 mental health • 1 anxiety • 1 depression • 1 work-life balance • 1 psychological strain • 1 non-stigmatizing attitudes • 1 mental health knowledge, attitudes, skills • 1 mental health symptoms (general)

Area	Academic	Grey
Intervention risk or unintended consequences	• 23 reviews did not report risk of intervention • 3 reviews identified negative impacts of the intervention	• No unintended risks or unintended consequences reported
Quality of evidence approach	• 11 intervention specific • 8 general • 7 did not report on quality • Low: 16 (10 AJ, 6RJ) • Moderate: 5 (5AJ) • High: 2 (1AJ, 1RJ) • Low to moderate: 2 (2AJ) • Moderate to high: 1 (1AJ)	• No explicit quality criteria

10.2 Summary of review paper characteristics - academic review

The search retrieved 26 papers to answer the question: What control measures/interventions show efficacy for preventing and managing WRS? Thirteen interventions were categorised under work design: five looked at job design, two studies changing break structure & form, two flexible, remote and home working, two looked at physical work/built environment and two explored workload. Fourteen interventions were categorised under interpersonal interventions, this included: four exploring the effects of mental health awareness training/literacy and MHFS, four looking at teamwork, two anti-bullying, two explored coaching and two looked at social/peer support. Eight studies were categorised under leadership training, four were leader/manager training targeting worker mental health and four were leader/manager training targeting leader/manager own mental health. Four studies were participatory interventions.

10.2.1 Country

Studies were categorised by the researchers according to the WHO regional classifications (AFR: African Region; AMR: Region of the Americas; EMR: Eastern Mediterranean Region; EUR: European Region; SEAR: South-East Asia Region; and WPR: Western Pacific Region). Some studies spanned multiple countries.

Fifteen papers reported studies conducted in the AMR, 14 in the EUR, 14 in the WPR, four in the SEAR, one in the EMR, and two in the AFR. Seven papers did not specify the countries in which the studies were conducted and two stated various countries but did not specify which ones.

10.2.2 Sectors

Ten studies reported that the studies were conducted with various sectors, but they didn't report the specific sectors. Five papers didn't report the sectors at all. Six papers specified that the paper included various sectors and reported these sectors, these were physicians, public safety workers, emergency services, manufacturing companies, office settings, health services, tertiary institution, construction, manufacturing, mining, utilities, transport, agriculture, and information technology and formal and informal sectors. Four studies looked at healthcare only and one looked at the education sector only.

10.2.3 Study design

The review drew on 26 studies, including 14 systematic reviews, five systematic reviews and meta-analysis, two scoping reviews, one meta-analysis, one review of reviews, one review of reviews and evidence mapping, one integrative review, and one evidence review.

10.2.4 Level of control

In terms of level of control, 15 studies were assigned as primary, three were secondary, five were both primary and secondary and three did not report the level of control.

10.2.5 Level of intervention

The interventions operated at multiple levels. Four focused solely on individuals, six on groups, six on leaders, and four on organisations. Three interventions targeted both individual and organisational levels, one addressed individual, leader, and organisational levels, and one was assigned as 'multiple'.

10.2.6 Quality of evidence

Study quality was assessed either by the original authors or, where this was not reported, by the current reviewers using the available evidence. Sixteen studies were rated as low quality; of these, six ratings were based on reviewer judgement and ten on author judgement. Five studies were rated as moderate quality, all by the original authors. Two studies were rated as high quality, with one of these ratings made by authors and one by the reviewers. In addition, one study was classified by authors as moderate to high quality, and a further two as low to moderate quality.

10.3 Summary of review paper characteristics – grey literature

The search retrieved 33 papers to answer the question: “What control measures/interventions show efficacy for preventing and managing WRS? “, however, only 10 are reported in Table 14 and pulled into the overall findings in section 3. This is because the feasibility of extraction and tabulation of findings differed on the extent to which the literature provided in-depth description of the intervention(s) discussed (usually in papers describing fewer than five interventions). However, the majority of papers provided only a light-touch coverage of a wide range of interventions, typically reviews of guidance aimed at looking at illustrating the breadth of interventions available to address WRS often with limited supporting evidence.

Consequently, in the 10 papers that have been included in this appendix (some of which provided an in-depth experience in on more than one type of intervention), four papers included interventions that related to leadership/line management training. Within this, three papers focussed on line manager training interventions which aimed to improve how line managers identify, understand and support the wellbeing of those they manage and how to adjust work to reduce risks related to work stress. One paper included a focus on an intervention to train managers to support their own mental health and wellbeing at work (e.g., leader stress management). Five papers included studies that discussed interpersonal interventions. Four of the interventions included focussed on the role of social or peer support, where employees support each other with their mental health concerns, and one focussed on mental health awareness training to reduce the stigma associated with disclosing mental health and increase confidence in supporting others with identifying poor mental health. Finally, three papers included interventions that focussed on work design. These included four interventions with a specific focus on job design, looking at how to manage job demands and resources, and the how design of work tasks can have an impact on employee wellbeing and stress.

10.3.1 Country

Of the 10 papers included in the appendix, eight are highlighting interventions from the United Kingdom, one paper originates from the USA and another from Australia.

10.3.2 Sectors

Of the 13 interventions discussed in the papers, three were based in healthcare more generally, and one was specifically based in nursing. Two interventions were implemented in policing, two in the education sector, and one was focussed on the rail industry. Two interventions were implemented ‘cross-sector’ (with no further detail), with two further interventions implemented in ‘various’ unspecified sectors.

10.3.3 Study design

A number of study designs were used in the interventions extracted from the grey literature. Three interventions were evaluated using a case study design, three were based on evidence reviews, and one involved a document review (including the analysis of programme data, including Management Information and pre and post surveys). Two interventions included an RCT (one included a longitudinal survey design, and one which was a cluster design). One further intervention included a cultural audit (which included desk-based research, interviews, focus groups and qualitative analysis).

10.3.4 Level of control

This was not reported in the grey literature.

10.3.5 Level of intervention

Where this was mentioned, interventions were aimed at leaders or line managers (four interventions), initially with leaders and then widened to all staff (one intervention) or addressed staff at all levels (four interventions).

10.3.6 Quality of evidence

Assessing the quality of grey literature can be complex, given the often-light touch approach of reviews and guidance documents, However, of the papers and interventions included in the appendix these were assessed by the project team to be of moderate quality.

Table 12 Summary of academic review paper characteristics

Citation	Country	Study Design	Number and type of studies
Aust et al, (2023)	Various (EUR, AMR, WPR, SEAR)	Review of reviews	52 R
Daniels et al, (2017)	Various (including EUR, AMR, WPR, SEAR)	Systematic review	33 S
Dannheim et al, (2021	Various (EUR, WPR, AMR)	Systematic review	10 S
Dannheim et al, (2025)	Various (EUR, AMR, WPR, AFR)	Systematic review and meta-analysis	25 S
De Simone et al, (2021)	Not reported	Systematic review and meta-analysis	20 RCTs
Fallon et al, (2023)	Various	Systematic review and meta-analysis	51 S
Fayyad et al, (2024)	Not reported	Systematic review	55 S
Fox et al, (2022)	Various (EUR, AMR, WPR)	Systematic review	83 S
Gayed et al, (2018)	Various (WPR, AMR and EUR)	Systematic review and meta-analysis	10 controlled trials
Kuehnl et al, (2019)	Various (AMR, EUR, WPR)	Systematic review	21 S
Lovern et al, (2024)	AMR	Integrative review	32 S
Lyubykh et al, (2022)	Various (including AMR, EUR, WPR)	Systematic review	83 S
Maslowski et al, (2019)	AMR	Review of randomised control trials	2 RCTs
Naghieh et al, (2015)	Various (WPR, AMR, EUR, SEAR)	Systematic review and meta-analysis	16 S
Nicolau et al, (2023)	Mostly WPR	Systematic review	12 S

Peng et al, (2023)	Not reported	Review of reviews and evidence mapping	80 R
Radwan et al, (2022)	Not reported	Systematic review	6 S
Ríos-Rodríguez et al, (2023)	Various (AMR, EUR, WPR)	Systematic review	12 S
Roche et al, (2024)	Various (AMR, EUR)	Scoping review	13 S
Shaholli et al, (2024)	Various	Systematic review	40 S
Stuber et al, (2021)	Various (AMR, WPR, EUR)	Systematic review	7 S
Tamminga et al, (2023)	Various (AMR, EUR, SEAR, WPR, EMR)	Systematic review	117 S
Turcotte et al, (2023)	Not reported	Review of reviews and evidence mapping	80 R
Verbeek et al, (2019)	Not reported	Scoping review	28 S
Waddell et al, (2023)	Various (EUR, AMR, WPR)	Systematic review	83 S
World Health Organization, (2022)	Not reported	Systematic review	29 S

10.4 Summary of intervention characteristics

From the 26 identified review papers in the academic review, 46 interventions were looked at. Thirteen interventions were categorised under work design, 14 interventions were categorised under interpersonal interventions, eight studies were categorised under leadership training, and one study was categorised under combined interventions. Four studies were categorised under participatory interventions

In addition to summarising intervention characteristics, studies were mapped against psychosocial hazards, intervention targets, levels of control, and strength of evidence to assess the robustness of evidence and inform the use of evidence in practice.

10.4.1 Linking interventions to psychosocial hazards

Most reviews treated psychosocial hazards implicitly rather than explicitly. Job demands, working conditions, leadership behaviours and social relationships were frequently

discussed as contextual factors or assumed mechanisms of change, but were not extracted, measured or synthesised as outcomes. It is often unclear whether reported improvements in health or wellbeing reflect meaningful reductions in psychosocial risk, or whether hazards within the work environment remain unchanged.

Only a small subset of reviews explicitly identified psychosocial hazards and linked specific interventions to measurable changes in those hazards. Of the 31 reviews included, 12 showed no linkage to psychosocial hazards, 14 treated hazards implicitly but did not specify or measure them, and five reviews explicitly linked interventions to named psychosocial hazards. This pattern highlights that explicit hazard-focused synthesis remains the exception rather than the norm within the intervention literature.

Where explicit linkage was present, reviews focused primarily on organisational, job design, environmental or interpersonal interventions**,** and examined hazards such as workload and role overload, role ambiguity, bullying and incivility, exposure to violence, and physical or environmental stressors (e.g., noise, privacy, workspace design). These reviews typically reported changes in hazards using validated measures and provide the most direct evidence relevant to primary, preventative control of psychosocial risks**.** However, the limited number of such reviews reinforces a key limitation of the current evidence base when informing hazard-led approaches to managing WRS.

Table 13 Summary of intervention strategies, targets and strength of evidence – Academic review

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Changing break structure & form	Lyubykh et al, (2022)	Implicit, not specified		Individual and Organisational	Primary	Stress Burnout Emotional exhaustion Psychological wellbeing Emotional health	Physical wellbeing Subjective tiredness Psychological and physiological arousal Improved concentration Increased motivation Job/task performance Productivity Psychological detachment Work engagement	Unclear	Low	1

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Changing break structure & form	Radwan et al, (2022)	Implicit, not specified		Individual and Group	Primary and Secondary	Mental fatigue Stress Cognitive	Not reported	No evidence	Moderate to high	2
Flexible working/home working	Aust et al, (2023)	Explicit	Working time arrangements	Organisation	Primary	Not reported	Job satisfaction Turnover Worklife balance Various health outcomes	Positive evidence (for work life balance)	High	3
Flexible working/home working	Shaholli et al, (2024)	Implicit, not specified		Individual	Primary	Stress Anxiety Depression Isolation Mental wellbeing Family-work conflict Fatigue Work-life balance	Not reported	Positive evidence	Moderate	2

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Job design	Lovern et al, (2024)	Implicit, not specified		Individual, Leader and Organisational	Primary and Secondary	Burnout Stress	Engagement Leadership	No evidence	Low to moderate	1
Job Design	Naghieh et al, (2015)	Explicit	Role overload, ambiguity, task-related	Individual and Organisational	Primary	Work stress levels	Work ability	No evidence	Low	2
Job design	Aust et al, (2023)	Explicit	Control, demands	Organisation	Primary	Psychosocial work environment aspects	Sleep quality Various health effects Physical work environment Job satisfaction Sickness absence	Positive evidence (Not stress specific)	Moderate	3
Job design	Daniels et al, (2017)	Implicit, not specified		Multiple	Primary (inferred)	Wellbeing	Improvements in job design	Positive evidence	Moderate	2

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Job design	De Simone et al, (2021)	Implicit, not specified		Individual and Organisational	Primary and Secondary	Burnout	Organisational changes Patient outcomes	Positive evidence (for burnout)	High	4
Job design	Fox et al, (2022)	Implicit, not specified		Organisational and Group	Primary	Wellbeing Burnout	Job satisfaction Job engagement Turnover	Positive evidence	Moderate	2
Job design	Naghieh et al, (2015)	Explicit	Role overload, ambiguity, task-related	Organisational	Primary	Anxiety Depression	Not reported	No evidence	Low	1
Job design	Tamminga et al, (2023)	No		Individual	Primary	Work-related stress Burnout Depression Anxiety		No evidence	Low	3

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Physical work environment	Fayyad et al, (2024)	Explicit	Noise, privacy	Individual and Organisational	Primary	Stress Wellbeing Mood Psychological stress	Sick leave Cognitive performance Employee productivity	No evidence	Low	1
Physical work environment	Ríos-Rodríguez et al, (2023)	Explicit	Sensory environment	Organisational	Primary	"Stress (physiological indicators and perceived)	Health complaints Creativity Job stress Job satisfaction Perceived organisational support Sick leave Belonging	Positive evidence	Low	2

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Leadership training interventions - To support worker mental health	Aust et al, (2023)	Implicit but not specified		Organisation	Primary	Stress Wellbeing Psychological symptoms	Absenteeism Work engagement Subordinates satisfaction, Psychological strain Turnover intentions	Unclear	Moderate to high	2
Leadership training interventions - To support worker mental health	Gayed et al, (2018)	No		Leader	Primary	Mental health Psychological distress	Not reported	No evidence	Moderate	2

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Leadership training interventions - To support worker mental health	Kuehnl et al, (2019)	No		Leader	Primary	Psychomental stress Wellbeing	Absenteeism	No evidence	Low	2
Leadership training interventions - To support worker mental health	Stuber et al, (2021)	Implicit, not specified		Leader	Primary	Mental health Insomnia Wellbeing Psychological distress Psychological strain Burnout Stress	Sickness absence	Positive evidence	Low to moderate	3

Leadership training interventions - Manager training - Own mental health	Aust et al, (2023)	Implicit, not specified		Organisation	Primary	Affective, behavioural, and cognitive outcomes in leaders Managers' mental health knowledge Non-stigmatising attitudes towards mental health Behaviour supporting employees experiencing mental health problems Mental health and wellbeing	Self-efficacy Satisfaction and performance Transformational leadership	Positive evidence (Not stress specific)	Moderate to high	3

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Leadership training interventions - Manager training - Own mental health	Dannheim et al, (2025)	No		Leader	Primary and Secondary	Psychological stress Mindfulness Mental health	Career satisfaction General work performance, Global job satisfaction Job satisfaction Job performance Non-specific sickness absence days Lost productive time Sickness absence	No evidence for stress. Positive evidence for mental health	Low	3

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Leadership training interventions - Manager training - Own mental health	Dannheim et al, (2021)	No		Leader	Secondary	Stress Wellbeing Exhaustion tendency	Absenteeism	No evidence (for stress) Positive evidence (for exhaustion tendency)	Low	2
Leadership training interventions - Manager training - Own mental health	Stuber et al, (2021)	Implicit, not specified		Leader	Primary	Mental health Insomnia Wellbeing Psychological distress Psychological strain Burnout Stress	Sickness absence	No evidence	Low to moderate	2

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Anti-bullying and incivility	Aust et al, (2023)	Explicit	Exposure to violence	Organisation	Primary	Cognitive outcomes	Affective, skills-based, clinical, and organizational outcomes Feeling safe, physical safety equipment, reporting, competencies, violence from patients Violence incidents, staff confidence, staff attitudes, and knowledge	No evidence	Low	2
Anti-bullying and incivility	Peng (2023)	Explicit	Bullying, incivility	Group	Not reported	Not reported	Civility	NA	Moderate	2
Coaching	Naghieh et al, (2015)	Explicit	Role clarity, supervisory support	Organisational	Primary	Anxiety Depression	Not reported	No evidence	Low	1

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Coaching	Nicolau et al, (2023)	No		Individual	Primary	Stress Wellbeing	Resources Self-efficacy	Positive evidence	Low	3
Mental health awareness training/literacy and MHFA	Maslowski et al, (2019)	No		Group	Primary and Secondary	Psychological distress	Stigmatising attitudes Helping behaviour	Positive evidence (for trainee distress)	Low	3
Mental health awareness training/literacy and MHFA	Roche et al, (2024)	No		Group	Not reported	Mental health literacy Mental health stigma and/or help-seeking or help-offering	Not reported	NA	Low	2

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Mental health awareness training/literacy and MHFA	Waddell et al, (2023)	No	Bullying, incivility	Group	Primary	Burnout Stress Fatigue Mental illness Mental wellbeing	Employee satisfaction	Positive evidence	High	3
Mental health awareness training/literacy and MHFA	World Health Organisation, (2022)	No		Leader	Not reported	Help-seeking behaviour (colleagues) Mental health knowledge, attitudes, skills (training recipients) Mental health symptoms & disorders (colleagues)	Not reported	No evidence	Low	1

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
						Positive mental health (colleagues) Suicidal behaviours (colleagues)				
Social/ peer support	Fallon et al, (2023)	Implicit, not specified		Group	Secondary	Distress	Not reported	Positive evidence	Low	2
Teamwork (interprofessional)	Fox et al, (2022)	Implicit, not specified		Organisational	Primary	Not reported	Not reported	No evidence	Moderate	1

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Teamwork (interprofessional)	Turcotte et al, (2023)	Implicit, not specified		Group	Secondary	Stress levels	Job stress Job satisfaction Teamwork climate Safety climate Perceptions of management Stress recognition Work environment Patient safety Working conditions	No evidence	Low	1

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Teamwork (interprofessional)	World Health Organisation, (2022)	No		Organisation	Not reported	Mental health symptoms & disorders Burnout Positive mental health – subjective well being	Job satisfaction Job performance Absenteeism	No evidence (not tested for stress). Positive evidence (for burnout based on one study)	Low	2
Participatory interventions	Aust et al, (2023)	Implicit, not specified		Organisation	Primary	Psychosocial work environment aspects Workers wellbeing	Changes in workers health Job retention	Positive evidence (Not stress specific)	Moderate	3
Participatory interventions	Daniels et al, (2017)	Implicit, not specified		Multiple	Primary	Wellbeing	Improvements in job design	No evidence	Moderate	2

Intervention strategy	Citation	Reporting of psychosocial hazards	Psychosocial hazard specified	Target audience of intervention	Main targeted level of control	Stress related outcomes	Other outcomes of interest	Efficacy of evidence	Quality of evidence	Standard of evidence
Participatory interventions	Fox et al, (2022)	Implicit, not specified		Organisational	Primary	Psychological distress Resilience Wellbeing Burnout	Job satisfaction Employee engagement Productivity Turnover rates Organisational climate assessments	Positive evidence	Moderate	2
Participatory interventions	Verbeek et al, (2019)	Implicit, not specified		Individual	Primary	Recovery Fatigue	Civility	Positive evidence	Low	2

Table 14 Summary of intervention strategies, targets and strength of evidence – grey review

Intervention strategy	Citation	Sector	Country	Study design	No references	Number of participants	Outcome measure	Outcome measure (Job related outcomes)	Efficacy of evidence	Quality of Evidence	Standard of Evidence
Job design	Bagnall et al. (2016)	Nursing	Australia	Evidence review, Case study 2 including longitudinal survey	49	350+	Psychological health e.g., psychological distress and emotional exhaustion.	Individual job satisfaction improved Job demands reduction	Positive evidence	Moderate	2
Job design	Kinman & Teoh (2018)	Healthcare	UK	Evidence review	158	N/A	Emotional exhaustion	Engagement, performance	Positive evidence	Moderate	2
Job design	Office of the Surgeon General (2022)	Various	USA	Case study	219	28 Gap stores, c1,500 workers	Sleep	Productivity, sales, revenue	Positive evidence	Moderate	2
Line manager training - Employee mental health	Wilson et al. (2020)	Rail Industry	UK	Longitudinal survey RCT	7	N/A	Psychosocial risk		Positive evidence	Moderate	3

Intervention strategy	Citation	Sector	Country	Study design	No references	Number of participants	Outcome measure	Outcome measure (Job related outcomes)	Efficacy of evidence	Quality of Evidence	Standard of Evidence
Line manager training - Worker mental health	Northumbrian Water Limited (n.d.)	Water	UK	Case study	5	N/A			Positive evidence	Moderate	2
Line manager training - Worker mental health	Devon and Cornwall Police (2023)	Policing	UK	Cultural audit' - including desk-based research, interviews and focus groups, and analysis.	N/A	N/A	Psychological safety, job satisfaction, wellbeing, self-reflection	Improved role satisfaction	Positive evidence	Moderate	2
Leadership training interventions - Manager training - Own mental health	Acas (2024)	Cross sector	UK	Cluster RCT and a 'before and after' evaluation	26	1,341 managers, 6,946 employees	Work-related stress, performance		Positive evidence	Moderate	3

Intervention strategy	Citation	Sector	Country	Study design	No references	Number of participants	Outcome measure	Outcome measure (Job related outcomes)	Efficacy of evidence	Quality of Evidence	Standard of Evidence
Mental health awareness training/literacy and MHFA	Chandler et al. (n.d.)	Cross sector	UK	RCT	53	398 (192 at time 2, 36 at time 3)	Self-efficacy Emotion regulation Quality of life	Work performance General job satisfaction Turnover intention	Positive evidence	Moderate	3
Social/ peer support	Cambridgeshire Constabulary (2024)	Policing	UK	Longitudinal evaluation	N/A	N/A	Work trauma	An increase in retention of staff in high-harm roles. Compared to other investigative teams within the organisation, retention of staff is high	Positive evidence	Moderate	2

Intervention strategy	Citation	Sector	Country	Study design	No references	Number of participants	Outcome measure	Outcome measure (Job related outcomes)	Efficacy of evidence	Quality of Evidence	Standard of Evidence
Social/peer support	Julings and Cowen (2023)	Education	UK	Document review Analysis of programme data - including Management Information, Pre and post surveys. Qualitative fieldwork with Delivery staff, Sector stakeholders, Participants.	18	N/A	Wellbeing	Peer support, idea generation	Positive evidence	Moderate	2

Intervention strategy	Citation	Sector	Country	Study design	No references	Number of participants	Outcome measure	Outcome measure (Job related outcomes)	Efficacy of evidence	Quality of Evidence	Standard of Evidence
Social/peer support	Kinman and Teoh (2018)	Healthcare	UK	Evidence review	158	N/A	Psychological distress	Work engagement	Positive evidence	Moderate	2
Social/peer support	Office of the Surgeon General (2022)	Various	USA	Case study	219	500	Burnout		Positive evidence	Moderate	2

11 Appendix 5 - Findings – Consultation

The draft findings from the evidence review were shared at an online roundtable event and separately with our PAG. Feedback from both activities will be 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.

Twenty-seven participants took part in the roundtable event including 13 professionals working in-house within Human Resources or Health and Safety, four health professionals, and eight representing advisory bodies. Four members of our PAG provided feedback on the questions asked.

The findings from the evidence review were presented and questions posed for discussion in small breakout groups of four to six people, facilitated by a member of the research team. The discussion was structured around the following questions:

- Which of these interventions do you use/advocate to manage WRS?
- How are these findings useful and relevant for your context?
- Which interventions seem most practical or impactful?
- What gaps or challenges do you see?
- Would you use the findings to help choose interventions, what's missing? What outputs would be most valuable for your role/organisation?

11.1 Interventions currently used/advocated

Participants were asked to select a priority intervention that they used/advocated for their members from a list of interventions developed during the research. Twenty-five participants provided responses. Participants noted that line manager training (eight people), job design changes (five people) and home working (five people) were most frequently recommended. Due to a technical issue with the Mentimeter tool, participants could only select one intervention; nevertheless, the responses give a useful indication of the most frequently recommended approaches.

11.2 Perceived usefulness and relevance of findings

Several themes were identified through consultation:

Understanding that research remains inconsistent and fragmented: Participants acknowledged that while evidence on WRS is growing, it remains inconsistent and often

fragmented. Practitioner-led research was noted to vary in quality, and academic findings were often not easily transferable to workplace contexts. Grey literature was valued for offering practical insights, though the overall lack of robust and consistent evidence was seen as a barrier to organisational investment and action. Participants agreed that strengthening the evidence base and demonstrating impact in real-world settings should be a priority.

PAG members commented that the current research findings were helpful in that they focus on important areas which are known for the impact on WRS but have not previously been studied or synthesised in this way. They commented that several areas show clear impact which can potentially be expanded by incorporating some practical next steps. They further welcomed the transparent presentation of caveats about the interpretation of evidence and emphasised the **importance of reinforcing that an absence of evidence does not mean an intervention is ineffective.**

Organisational context: Applying research findings was said to depend heavily on organisational culture, maturity, and structure. The complexity of workplaces means interventions must be tailored to context, with smaller organisations facing distinct challenges, such as limited capacity to absorb absences. Participants highlighted that the tone and delivery of interventions influence engagement, and that approaches often fail to reflect modern working realities. There was a clear call for more innovative, technology-enabled solutions that move beyond reactive responses to stress.

Selection of interventions: Participants discussed the importance of selecting and positioning interventions appropriately. Many organisations were seen as relying too heavily on training, despite mixed evidence of its effectiveness in practice. While coaching was viewed positively, its success was said to depend on timing, context, and worker engagement. H&S professionals emphasised addressing root causes rather than symptoms, advocating for action higher in the hierarchy of control – aiming to eliminate hazards or reducing risks rather than just dealing with their impact. Participants also cautioned that linking wellbeing activities too closely with performance management can increase stress rather than alleviate it.

Participatory approaches essential: Participatory approaches and effective communication were identified as essential for intervention success. Many organisations were said to consult staff too late, reducing ownership and effectiveness. Line managers were seen as central to risk assessment and stress management but often lack skills and confidence to hold sensitive conversations. Participants stressed the need for follow-up evaluation to ensure interventions deliver meaningful outcomes and that psychosocial hazards should be assessed systematically, much like physical risks.

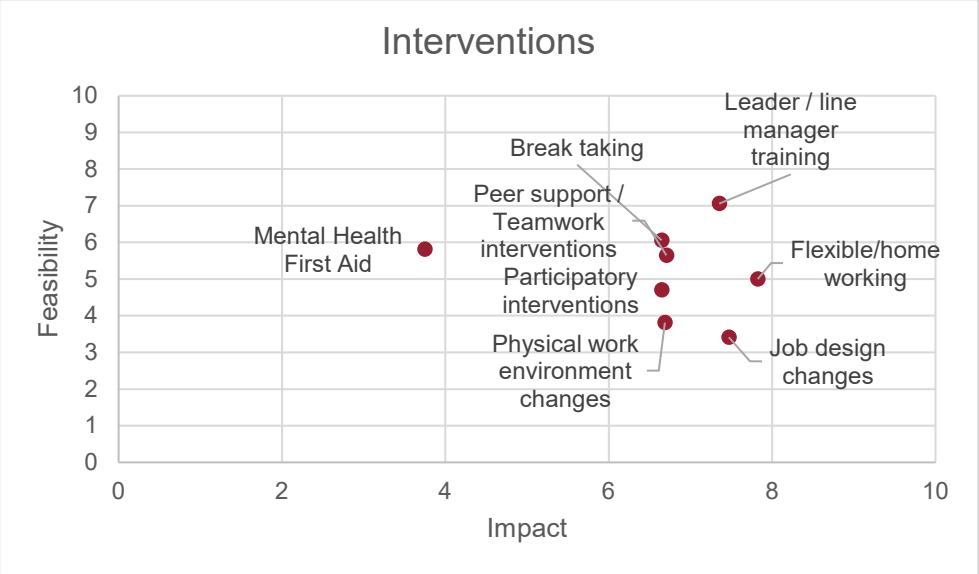
Sector-specific experiences: In education, limited funding and rigid structures constrained flexibility and adaptation, while wellbeing champions often faced workload

pressures and stress was seen as normalised and an accepted part of the job. In construction, the inability of operatives to work remotely created perceived inequities, compounded by stigma around mental health in a male-dominated environment. In social care, regular breaks were identified as particularly valuable in maintaining wellbeing during long shifts.

11.3 Perceived practicality and impact of interventions

Participants were asked to use a Mentimeter link to vote on the feasibility and impact of the specified interventions. Seventeen participants responded. Findings are displayed in Figure 8.

Figure 8 Intervention rating by impact and feasibility



A summary of the consultation regarding the practicality and impact of interventions revealed:

- **Flexible and home working** is seen a useful intervention for many. However, with some organisations are encouraging office attendance again, this is an area to monitor. Participants noted that workers may work from home to avoid workplace stressors, suggesting that flexibility alone does not guarantee wellbeing or address the source of these avoided stressors. This theme was also highlighted by the PAG.
- **Breaks** were valued but difficult to implement effectively, especially in flexible or home-working settings where there is no site or place for people to come together for social connection. Leadership behaviours were linked to whether staff felt able to take breaks, and measuring their impact in practice was considered challenging.
- **Job design interventions** were seen as constrained by sector realities but potentially powerful where individuals have control and leadership support.

Demonstrating their impact was seen as difficult, yet participants noted a shift toward more preventative approaches. PAG members similarly identified this as a particularly practical area for development.

- Adjustments to the **physical work environment** such as reducing noise or altering workspace layout, were considered beneficial but resource-intensive, requiring cultural buy-in.
- **Leadership and line management training** was consistently highlighted as high impact but limited without authority or structural support to tackle root causes. Participants emphasised that leadership capability should extend beyond technical competence to include people management and communication skills. The PAG also highlighted training such as resilience training for managers as a relevant example.
- **Participatory interventions** were recognised as effective but logistically demanding.
- **Mental Health First Aid (MHFA)** was widely implemented but often perceived as a "tick-box" measure. Participants felt MHFA was most useful for signposting rather than providing solutions, and that first aiders themselves require more support. The mixed findings on this intervention were also raised by the PAG, indicating that this may be an area which will need expansion in the report.
- **Individual Wellbeing Action Plans** (IWAPs) were praised for being bespoke and inclusive, helping to normalise wellbeing conversations across the workforce. Similarly, Reasonable Adjustment Passports (RAPs) were valued for ensuring agreed adaptations are documented, though inconsistent application was said to undermine trust.
- **PAG reflections:** PAG members also highlighted the importance of considering whether and how an intervention's impact can be measured, noting that ease of evaluation contributes significantly to perceptions of its practicality (and the amount of research evidence available).

11.4 Reflections and implementation challenges

Discussions highlighted several reflections on the findings and implementation challenges:

- **Organisational-level interventions** - those embedded in culture, leadership, and structure - are more effective than individual initiatives.
- **Use of technology:** While technology offers new possibilities, it can also add stress if poorly implemented.
- **Gaps in evidence:** There was surprise that the evidence base contained little on job control and career progression, both seen as central to "good work." Supporting workers to understand their roles and development opportunities was viewed as key to preventing stress.

- **MHFA:** Discussion around MHFA continued, with participants noting unclear boundaries, low utilisation, and potential conflicts when line managers act as first aiders. They emphasised the importance of confidentiality, feedback mechanisms, and integrating MHFA into broader wellbeing strategies rather than treating it as a standalone fix.
- **Work design considerations:** Discussions also highlighted that work design should consider relationships, workload intensity, and predictability, not just tasks. Local, informal discussions between staff and line managers were viewed as more effective than formal HR-led approaches to “job crafting.”
- **Barriers to implementation** such as limited time, money, and training capacity were seen as ongoing challenges. Leadership buy-in was regarded as the most crucial factor for credible and lasting change. Participants noted that many managers lack both the skills and capacity to lead wellbeing work effectively. Where leadership commitment is visible, however, teams were described as happier, more engaged, and more productive.
- **Contextual variation**: Variability in physical working environments, such as construction sites, can significantly affect what is feasible and highlights the need for tailored, context-specific approaches.

11.5 Preferred outputs and resources for implementation

- Participants called for **practical, accessible, and evidence-informed resources** to help translate findings into action across different organisational levels. For practitioners, **case studies, "how-to" guides, and tools to measure impact** were considered particularly valuable.
    - Senior leaders were said to benefit from outputs demonstrating the return on investment and focusing on organisational causes of stress rather than individual resilience.
    - Managers were described as needing clear, actionable guidance to help them navigate WRS confidently.
    - Use of prompts within stress risk assessments to consider physical environments and living conditions, noting that small changes, such as a fan on a desk or opening a window can make meaningful differences.
    - PAG members also suggested clarity is needed on what is meant by the term **"practitioner"** and the range of roles it may include, when considering the communication of who can support and deliver interventions**.**
- Participants emphasised the need for **better communication and collaboration between staff and management**, ensuring **shared responsibility** for wellbeing.
- **Generational differences** were discussed as an emerging consideration, with younger workers more likely to seek work-life balance and speak up about stress, while older colleagues may normalise it. Participants warned that failing to address these differing expectations could affect retention and morale.

In plenary discussions, participants affirmed that they **would use the findings to inform intervention choices but requested clearer guidance and contextual caveats**. Specifically, they highlighted the importance of:

- Providing information on the **nuance of the evidence presented** in the report. For example, distinguishing between types of "breaks" and incorporating more nuanced definitions of interventions in future outputs.
- including **data-informed, iterative approaches tools such as decision trees or flow diagrams to support organisations in selecting, testing, and refining interventions, backed by transparent communication and ongoing evaluation**.

PAG reflections: The PAG also raised considerations around presentation of the findings, particularly the need for clear communication where evidence is limited or mixed. They suggested ensuring that outputs are relevant to different audiences, such as occupational health professionals, academics and practitioners, and recommended a combined approach that blends narrative storytelling with academic rigour to convey findings effectively.

11.6 Application of findings and implications for practice

When asked if they would use the findings to help choose interventions and what is missing, participants generally felt the findings were valuable. Key themes included:

- **Clarity and interpretation:**
  - valued the inclusion of **study caveats upfront,** as this helped frame and contextualise the findings appropriately.
  - emphasised the **need for greater nuance and contextual interpretation**. They highlighted that some results, such as those relating to breaks, may appear overly simplistic or counterintuitive. Participants wanted more clarity on what constitutes a “break”, whether proactive pauses, reactive rest, or formal entitlements like lunch or annual leave, and noted that understanding these distinctions is essential to designing effective interventions.
- **Integration with organisational strategy:** Beyond interpretation, participants stressed the importance of situating interventions within broader organisational strategy rather than relying solely on tactical responses. They called for continuous measurement, monitoring, and the courage to discontinue what does not work, recognising that no single approach will suit all organisations.
- **Data use and confidentiality:** Challenges around confidentiality and data availability were also raised, especially regarding consent and access to employee assistance programme (EAP) data. Participants underscored the need for data-informed interventions and transparent communication with workers.
- **Practical tools and decision support:** Participants suggested a decision tree or flow diagram would be useful, to help organisations translate evidence into action, decide when to seek external expertise, and ensure feedback loops support ongoing learning and improvement.

12 Appendix 6 – Evidence Map

The conclusions above are drawn from the variety of evidence gathered by this project. The main sources of evidence are mapped against topic areas and conclusions within Table 15, with a Y (yes) or N (not found) to allow readers to explore the relevant appendices more efficiently.

Table 15 Mapping of sources of evidence contributing to findings

Topic	Conclusion	Evidence Map	Academic literature	Grey literature	Consultation
Catalogue of Interventions		Y	Y	N	N
Intervention Level Findings	Changing break structure & form	N	Y	N	N
	Flex working/home working	N	Y	N	N
	Job design	N	Y	Y	N
	Physical work/built environment	N	Y	N	N
	Leader/manager training - targeting worker mental health	N	Y	Y	N
	Leader/manager training - targeting leader/manager own mental health	N	Y	Y	N
	Anti-bullying and incivility	N	Y	N	N
	Coaching	N	Y	N	N
	Mental health awareness training/literacy and MHFA	N	Y	Y	N

	Mental Health Champions	N	Y	N	N
	Social/peer support	N	Y	Y	N
	Teamwork (interprofessional)	N	Y	N	N
	Participatory interventions	N	Y	N	Y
Overall Findings	Diverse array of interventions available with a range of evidence	Y	Y	Y	N
	Questions over quality and confidence in findings	N	Y	Y	N
	Lack of links to psychosocial hazards	Y	Y	Y	N
	Lack of process evaluation and understanding of contextual factors	N	Y	Y	N
	The value of the risk assessments	N	N	N	Y
	Developing an integrated approach	N	N	N	Y

13 Appendix 7 - Strengths and limitations

The report openly recognises that literature in this field is often low-to-moderate quality, fragmented, and inconsistent. To optimise the utility of the research, we have adopted a robust and transparent approach to support appropriate use/make the best use of available evidence to inform action and prevent over-claiming about effectiveness.

13.1 Strengths

A comprehensive, multi-phase mixed-methods design: The research draws on several complementary phases including evidence mapping, systematic searches, stakeholder consultation, a Call for Evidence, and a roundtable event to build a coherent understanding from diverse sources. This approach was taken to allow for strong triangulation and to ensure findings reflect both scientific evidence and real-world organisational experience. This is particularly relevant given the diversity of professional roles, practices and research perspectives across those working in the field (Collins et al., 2015).

Strong governance and expert oversight: The work was guided by a dedicated PSG, a multi-disciplinary PAG, and senior experts from the Affinity, IOM, IES and SOM consortium. These groups provided rigorous methodological scrutiny, ensured adherence to best practice, and helped maintain alignment with HSE's regulatory and policy needs. Regular iterative review strengthened the overall quality and defensibility of the research.

Integration of academic and grey evidence: The report brings together peer-reviewed literature (including systematic reviews, meta-analyses and high-quality narrative syntheses) with grey literature and practitioner insights, capturing evidence on interventions widely used in practice but underrepresented in academic research. This hybrid approach provides a realistic and sector-relevant picture of what organisations actually implement.

Transparent and reproducible methods: The methodology clearly documents search terms, inclusion/exclusion criteria, screening processes, quality appraisal decisions, and evidence extraction procedures. This transparency enhances reproducibility, credibility, and user confidence, and reflects good scientific practice.

Use of established appraisal frameworks: The project draws on the NESTA Standards of Evidence to describe the maturity and quality of the available evidence, helping users interpret findings proportionately and understand where confidence in effectiveness can or cannot be assumed.

Development of a structured intervention catalogue: The creation of a consolidated, organised intervention typology, distilling more than 400 evidence items into a structured map of intervention types, levels, and implementation characteristics is important.

Attention to intervention components and mechanisms: Where possible, evidence was mapped to specific intervention components, delivery mechanisms, and contextual factors, supporting improved understanding of what works, for whom, and under what conditions.

Meaningful stakeholder engagement: Extensive engagement, through the call for evidence, consultation events, and PAG input, ensured the findings are relevant, acceptable, and practically useful for organisations, practitioners, and policy makers. Stakeholders also helped contextualise ambiguous or conflicting evidence.

National policy relevance: The study is grounded in the UK regulatory context and aligns with HSE's prevention-led approach, offering outputs that can inform inspector guidance, organisational decision-making, and future development of national recommendations.

13.2 Limitations

Potential bias introduced through the Call for Evidence: The Call for Evidence generated 401 submissions, but this approach may introduce self-selection bias: overrepresentation of interventions that individuals or organisations were motivated to share, underrepresentation of less visible, emerging, or unpublished papers which are likely to be failed intervention types. The evidence map therefore reflects the current landscape of accessible materials rather than an exhaustive catalogue of all possible interventions.

Scope and definition of work-related stress: The project's focus on WRS reflects HSE's regulatory remit, but there is conceptual variability in how WRS is defined across the literature. Outcomes reported in included reviews were often broader than stress alone (e.g., burnout, psychological distress, wellbeing), and few studies explicitly connected interventions to psychosocial hazards. This may limit precision when mapping findings back to the HSE Management Standards.

Variable quality and granularity of available evidence: Across most intervention categories, studies were characterised by:

- small sample sizes
- non-experimental designs
- insufficient reporting on intervention content or implementation fidelity
- high heterogeneity in measures, settings, and populations

These limitations restrict the strength of conclusions and constrain generalisability. Some studies described interventions in very broad terms, while others lacked detail about context or mechanisms of action. In addition, many studies assessed outcomes over relatively short timeframes, with limited follow-up to examine whether changes in psychosocial hazards or stress-related outcomes were sustained. This limits conclusions about the longer-term preventative impact of interventions.

Diversity and breadth of intervention categories: Intervention categories such as breaks, job design, workplace flexibility, participatory interventions, or teamwork include multiple distinct approaches within each heading. This breadth makes it challenging to isolate specific components responsible for outcomes and limits the specificity with which conclusions can be drawn.

Limited reporting on implementation quality: Many included studies provided insufficient information about how interventions were implemented or the extent to which they were delivered as intended. This makes it difficult to distinguish between an intervention that is ineffective and one that was poorly executed or weakly supported by organisational infrastructure. Further evidence on implementation factors influencing the effective management of WRS is presented in the companion Project OSCAR report on barriers and enablers.

Limited equity, diversity, and inclusion reporting: Few studies reported how interventions work across different demographic groups (e.g., gender, ethnicity, age, disability) or role types. This constrains understanding of differential impacts and potentially masks inequities in intervention effectiveness.

Heterogeneity of organisational context: The evidence base includes studies from varied sectors and countries, but many sectors (e.g., micro-businesses, gig economy, high-risk industries) remain underrepresented. Contextual differences make direct comparison difficult and highlight the need for careful adaptation rather than direct transfer of findings.

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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