In Good Shape

Psychosocial Risks and Mental Health in Social Services

Desk Research

August 2026

Co-funded by the European Union

Project: 101197579 – InGoodShape

SOCPL-2024-SOC-DIALOG

Contents

Introduction and scope

Psychosocial risks are risks arising from how work is designed, organised and managed, and from the social environment in which work is performed. Social services, together with healthcare, are among the most exposed sectors.

Psychosocial risks are not separate from service quality: they affect continuity of care, sickness absence, turnover, recruitment, retention, team functioning and the ability to provide safe and dignified support. [1]

The InGoodShape project addresses physical and mental health risks in social services as part of a wider effort to improve working conditions and strengthen social dialogue in the sector. This short report, based on desk research, summarizes existing publications on the mental-health and psychosocial-risk dimension, while keeping a practical link with musculoskeletal disorder prevention where the two risks interact. It is completed by prevention recommendations from the project consortium, drafted together with an expert.

This report draws mainly on recent EU-OSHA research on work-related psychosocial risks and mental health in health and social care, and is complemented, among others, by practice-oriented material from the InGoodShape project, the FORTE project and the IWorCon project[2]. The scope is deliberately narrower than the source report: social services outside healthcare, especially NACE 87 and NACE 88, including LTC, homecare, mobile support and other home-based care. It does not reproduce the general context or methodology of the source report; it extracts operational lessons for organisations, managers, OSH actors, worker representatives and field teams seeking concrete, proportionate and simple ways to reduce psychosocial risk.[3][4][5]

The text asks what can be built into day-to-day work organisation, management routines, social dialogue, team support, scheduling, incident handling and training so that risks are prevented at source wherever possible.

Individual support remains an important component of prevention and should be combined with organisational and collective measures addressing work-related risk factors. This means that psychosocial risks should be addressed both through collective and organisational prevention, rather than being treated only as individual difficulties.

1 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, risk categories and prevalence, p. 22.

2 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, p. 12.

3 InGoodShape project page, Federation of European Social Employers.

4 FORTE project (2024), Improving working conditions in social services: Good practices from across Europe, introduction, p. 3.

5 IWorCon project (2024), Improving working conditions in social services: 10 recommendations, introduction, p. 2.

1. Main Risk factors

Risk factors should be read as adverse conditions in the work system, not as weaknesses of individual workers. The most useful distinction is between risks linked to working conditions and work organisation (e.g., workload, scheduling, etc.) and risks linked to the social environment of work (e.g., harassment, violence, etc.). In practice, risk factors are usually a combination of elements: time pressure that can aggravate violence exposure; lone work that can diminish support; emotional strain that can increase physical risk-taking; and digital tools that can either reduce or intensify workload. [6]

Work organisation influences other psychosocial risk factors, including work content, such as the potential gap between worker skills and actual duties, working conditions, the working environment and interpersonal relations. It includes how tasks and responsibilities are distributed, how authority and decision-making are organised, how work is coordinated, and how workers are able to participate in decisions that affect their work. These organisational choices can therefore contribute to or reduce psychosocial risks.

1.1 Workload, time pressure and staffing gaps

The central issue is an imbalance between work demands, available time, staffing level and capacity of individuals and teams to recover. At sector level, severe time pressure and overload of work is one of the most reported psychosocial risks. [7]

In residential care and LTC, the pressure often manifests as repeated rushing to provide personal care, insufficient time and cover to cope with unexpected needs and to support people with dignity, and the requirement to complete documentation after shifts. In home-based care, pressure may also arise where travel times are not accurately taken into account, visit sequences do not adequately reflect changing care needs, or where staffing constraints make the attendance time of visits particularly demanding.

According to the European Trade Union Institute, psychosocial stress can also be intensified when performance is measured mainly through numerical targets (as result of funding requirements) rather than the safety, quality and complexity of support provided. This can create pressure to prioritise the number or speed of tasks completed over the time needed to respond appropriately to individual needs.[8]

1.2 Working time, rotas and recovery

Working time becomes a psychosocial risk when long hours, irregular hours, night or weekend work, short-notice rota changes, split shifts and insufficient rest reduce opportunities for recovery and make working time less predictable. In LTC, the organisation of working time can matter as much as total working hours. [9]

6 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, risk categories and prevalence, p. 22.

7 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, high workload and time pressure, pp. 23-24.

[8] ETUI, Psychosocial risks in the healthcare and long-term care sectors: Evidence review and trade union views, Report 2022.04, 2022, p. 47.

9 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, working time, shift work and work-life balance, pp. 24-26.

Compliance with working-time requirements (Directive 2003/88/EC, commonly known as the Working Time Directive) provides an essential baseline. Psychosocial risk assessment should consider the distribution of demanding shifts, the predictability of schedules, opportunities for recovery and the scope for employee input into working-time arrangements.

Short-notice changes can also create additional pressure when workers have limited ability to plan their personal lives or arrange care responsibilities around their schedules. Predictability and consideration of employee preferences in working time arrangements can therefore be important protective factors.

1.3 Lone work and home-based care

Home-based care creates specific challenges because the workplace is a private home.

Workers have limited control over the physical working environment and may face situations involving family presence, pets, smoking, hygiene, privacy, aggression or other conditions that are difficult to anticipate or manage. The worker may also be alone, travelling between workplaces, without immediate peer support. [10]

This does not make prevention impossible. It means that a pre-care assessment, clear and agreed tasks and boundaries, escalation routes and support arrangements have to be built around the reality of mobile and home-based work, rather than copied from residential settings.

Lone work can also increase psychosocial risk when workers have limited access to immediate managerial or peer support, particularly when they encounter difficult interactions or unexpected situations. Clear arrangements for contacting colleagues or managers and for escalating concerns are important protective measures, and regular team meetings and opportunities for informal peer to peer interactions can provide essential benefits.

1.4 Violence, harassment and adverse social behaviour

Violence, threats, verbal abuse, harassment, bullying, discrimination and unwanted sexual attention are among the most damaging risks because they can be difficult to report and they affect personal safety, dignity, trust and sector retention. Identified and safe channels should be available to facilitate reporting. Available EU-level evidence shows much higher exposure to third-party violence or verbal abuse in health and social care than across all sectors. [11]

In social services, adverse behaviour can be linked to care recipient distress, cognitive impairment, unmet needs, waiting times, and family tensions or poor communication. Understanding these circumstances can help services adapt prevention and support measures.

Violence or abuse is never acceptable and must not become accepted as a normal part of the job.

1.5 Emotional and ethical demands

Social services are relational services. Workers manage dependency, loneliness, trauma, safeguarding issues, family conflict, physical and/or mental deterioration, loss of autonomy and end-of-life situations.

10 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, home-based care and live-in care context, pp. 12 and 20.

11 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, adverse social behaviour and third-party violence, pp. 33-34.

Emotional and ethical demands become harmful when exposure is intense, repeated, unrelenting and unsupported. [12]

Workers may experience moral strain, such as ethical stress, where they perceive a gap between the care and support, they would ideally provide and what can be delivered within available time, staffing, resources and operational constraints.

Repeated exposure to these situations can contribute to frustration, exhaustion, depression and disengagement from the work.

Emotional and ethical stress can also be increased by unclear responsibilities, conflicting expectations or situations in which workers feel that the actions required from them are inconsistent with their professional values.

1.6 Autonomy, participation and support

Low autonomy reduces the ability to adapt pace, method, sequence and communication to real situations. Low social support reduces the ability to recover, ask for help, learn from incidents and prevent isolation. Both are relevant in residential teams and in fragmented homecare routes. [13]

Autonomy does not mean the absence of rules. It means individuals working with sufficient personal discretion within safe boundaries.

Participation does not mean endless consultation. It means involving those with practical knowledge of the work at an early stage, so that their experience can inform operational decisions.

1.7 Recognition, pay, precariousness and groups in vulnerable situation

Psychosocial risk may arise where workers perceive an imbalance between the demands of the role and the rewards associated with it, including pay, recognition, career prospects, job security and respect. This issue may be particularly relevant in some lower-paid care and support roles.

Women, older workers, younger workers, migrant workers, live-in carers, workers with insecure hours and/or multiple jobs and workers with disabilities or health limitations are particularly at risk. Risk assessment should consider how exposure differs across these groups, without stigmatising them or transferring responsibility to individuals.

1.8 Digitalisation and administrative burden

Digital tools can help to reduce psychosocial risks only when they simplify documentation, give faster access to information, support safer scheduling, reduce route pressure or connect isolated workers to help.

They can also increase the risk of negative psychosocial outcomes when they are introduced and implemented without worker input or consultation, add to reporting burden, give the worker the impression of intensifying surveillance, accelerating pace, and reducing discretion. [14]

12 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, emotional and ethical demands, pp. 34-35.

13 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, autonomy and social support, pp. 30 and 37.

14 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, digital technologies and workload, pp. 31-32.

Advanced technologies can also create additional concerns, including misplaced trust in automated systems, low acceptance of new technologies, automation bias and feeling of job insecurity linked to perceived difficulties in adapting to change.

The practical question is therefore not whether a digital tool is used, but how it changes the work. A tool can be preventive only when it removes administrative burden, supports safer and more flexible scheduling or helps workers access information and support.

In any case digitalisation should be introduced with ongoing consultation from the beginning and with adequate training and ongoing support.

1.9 Interactions with musculoskeletal disorders

Psychosocial risks and musculoskeletal disorders should not be managed in separate silos. Time pressure, fatigue, stress, violence, low support and lack of control can contribute to unsafe movements and reduced recovery; pain and physical fatigue can also worsen stress and mental overload. [15]

For example, a high-risk homecare situation may therefore be physical and psychosocial at the same time: moving a distressed person in a cramped bathroom, under time pressure, without suitable equipment, while working alone.

Prevention is stronger when both dimensions are assessed together.

The following field signs can help managers, workers and worker representatives recognise when psychosocial risks may be present in day-to-day work. They are not diagnostic indicators, but practical signals that may justify closer assessment.

15 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, interlinkages with MSDs, pp. 38-39.

Psychosocial Risk Situations

Field signs that deserve attention

The following field signs may indicate emerging psychosocial risks.
Consider the frequency, persistence and impact on workers.

01 Workload and time pressure

KEY INDICATORS

- Skipped breaks
- Unfinished records
- Frequent overtime
- Rushed visits
- Repeated handovers saying “no time”

02 Home-based lone work

KEY INDICATORS

- Unsafe home environment
- Family conflict
- Unclear boundaries
- No call-back procedure
- Worker anxiety before visits

03 Violence and adverse behaviour

KEY INDICATORS

- Repeated verbal abuse
- Threats
- Sexual comments
- Discriminatory behaviour
- Incidents described as “normal”

04 Emotional and ethical demands

KEY INDICATORS

- Frequent distress after shifts
- Guilt about poor-quality support
- Conflict between instructions and care values

05 Low support or participation

KEY INDICATORS

- Problems raised repeatedly without feedback
- Weak team meetings
- New workers left to cope alone

Early recognition and open communication are essential to prevent harm and support a safe and sustainable working environment.

2. Preventive actions

Prevention is most effective when it follows the standard occupational safety and health logic: avoid risks where possible, assess risks that cannot be avoided, combat risks at source, adapt work to the individual and prioritise collective measures before individual coping measures. [16][17]

Psychosocial risk prevention should combine organisational measures addressing work-related factors with appropriate individual support, while giving due priority to prevention at source in line with OSH principles.

2.1 Risk assessment as a management routine

Risk assessment should operate as a living management routine rather than as an annual document, and as an ongoing cycle : identify the situations that create risk, prioritise a small number of issues, decide actions, assign responsibility, check implementation / impact and revise. Repeat.

Digital tools can help with this cycle and generate usable action plans. [18]

For social services, the assessment should explicitly cover workload, working time, violence, emotional demands, autonomy, support, digital tools, home-visit conditions and links with musculoskeletal risks.

Risk assessment should focus on work as it is actually carried out, not only on formal procedures or job descriptions. Participatory methods such as group discussions, interviews and workplace observation can help identify how risks arise in practice and allow workers to contribute to prioritising solutions.

16 IWorCon project (2024), Improving working conditions in social services: 10 recommendations, Recommendation 1 on OSH risk assessment, pp. 3-5.

17 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, prevention measures, pp. 47-48.

18 FORTE project (2024), Improving working conditions in social services: Good practices from across Europe, G2P digital risk assessment practice, pp. 5-7.

Worker representatives should always be involved in risk analysis, prevention measures and follow-up.

Proactive prevention should include ongoing monitoring and reporting, together with the improvement of policies and procedures as risks evolve. This requires organisational leadership and sustained commitment so that psychosocial risk management remains an ongoing part of the organisation's agenda.[19]

Prevention should be followed by checking whether working conditions have actually changed. This means looking not only at whether an action was completed, but also at whether the underlying risk has been reduced. Worker feedback can help determine whether measures are working in practice and whether further adjustment is needed.

2.2 Workload, scheduling and recovery design

Staffing levels and workload allocation are important elements of psychosocial risk prevention.

Adequate and safe staffing is a primary preventive measure. Where immediate staffing increases are not possible, workload risk can still be reduced by redesigning task distribution (in line with worker skills and grade levels), protecting recovery time, removing low-value duplication, classifying demanding visits or shifts, and avoiding sequences that combine high physical and emotional load. [20]

Participatory scheduling can help identify risks that are not visible from the rota alone, such as repeated late-to-early turns, routes that leave little opportunity for breaks, or demanding visits repeatedly assigned to workers with limited support or experience.

2.3 Violence and adverse behaviour prevention

A preventive approach combines clear definitions, simple reporting, rapid support and changes to the service plan. The aim is not to blame service users or colleagues, but to ensure that potentially predictable aggression, harassment or intimidation leads to practical changes: altered timing, environmental adaptation, family meetings, communication changes or specialist support. [21]

Reporting should lead to feedback and preventive action. Workers should be able to see what has changed after they have reported incidents.

2.4 Social support, debriefing and anti-stigma

Social support needs a structure: scheduled team time, peer discussion, skilled and professional supervision and mentoring, manager call-back after difficult visits and confidential access to support. Informal goodwill is useful but insufficient when exposure is high. [22]

[19] EU-OSHA (2025), *How do psychosocial risks impact health and social care sector workers? Key lessons learnt and policy pointers*, p. 4.
20 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, staffing, rest, work-life balance and participatory scheduling, pp. 55-58.

21 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, addressing violence and adverse social behaviour, pp. 70-72.

22 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, supportive work environment and mental health support, pp. 66-70.

The FORTE project wellbeing-talks practice illustrates a simple way to create a protected moment for employees to express concerns, reflect on work-life balance and identify psychosocial risks early. [23]

Creating and maintaining support networks can help mitigate the potentially damaging effects of the emotional demands of care work. Providing workers with a safe space to debrief and express their views, including through peer support groups and access to psychological support, can help reduce psychosocial risks.

All management levels should contribute to the development of practices that support employees.[24]

Anti-stigma and anonymity messages should be explicit: asking for support after violence, distress, burnout symptoms or ethical strain is a normal preventive act, not a sign of weakness or poor performance.

2.5 Autonomy and participation

Participation can support prevention by ensuring that practical knowledge of the work informs operational decision-making. Short, regular forums can be used to ask: what is making safe work difficult, what can be changed locally, what needs escalation, and what evidence shows whether the change worked? A simple approach is a regular team review of the top three stressors, with one action chosen for implementation.

Local managers need enough autonomy and authority to adjust routines, not only to record problems. There should be a genuine desire to prevent psychosocial risks. Workers should be involved because they have direct knowledge of how work is actually carried out. Their participation contributes to identifying real problems and developing genuine, practical and relevant solutions.

Effective dialogue between management, workers and worker representatives is an essential condition for prevention.

2.6 Training that changes work

Training is most effective when it is aligned with organisational prevention and improvement measures. Management training can support managers in areas such as communication, workload allocation, scheduling, reporting culture, team support and incident response, while worker training can complement these measures by supporting safe practices and appropriate responses to difficult situations.

2.7 Data and follow-up without bureaucracy

A small number of indicators can make risk visible without creating a paperwork burden. Useful indicators include absence, turnover, overtime, missed breaks, incidents of aggression, repeated complaints, use of support pathways, training completion and short staff survey results. [25]

Monitoring is only useful if the information is used to identify trends, discuss problems with teams and worker representatives, and adjust practices and strengthen prevention measures. Data should support prevention decisions rather than becoming a reporting exercise.

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23 FORTE project (2024), Improving working conditions in social services: Good practices from across Europe, wellbeing talks practice, pp. 23-26.

[24] EU-OSHA (2025), *How do psychosocial risks impact health and social care sector workers? Key lessons learnt and policy pointers*, p. 4.

25 FORTE project (2024), Improving working conditions in social services: Good practices from across Europe, AZW data and Czech satisfaction survey practices, pp. 7-11.

The following simple checks can help organisations assess whether prevention measures are visible in day-to-day work. They are intended as practical prompts rather than as a comprehensive monitoring framework.

Topic	Check list
Risk assessment	Can each team name its top three current psychosocial risks and the action agreed for each?
Scheduling	Does the rota show recovery time after high-intensity shifts or visits?
Violence prevention	After an incident, is there feedback on what changed before the next contact?
Support	Is there a routine for peer or manager support after difficult events?
Digital tools	Has the new tool removed a task, or has it added another task?

3. Some recommendations for field action

The following recommendations are based on desk research and are complemented by recommendations from the project consortium supported by an expert.

The recommendations are intended to be proportionate and can be introduced progressively.

Integrating them into routine work organisation can help embed prevention into day-to-day practice.

The goal is to make prevention visible and active in ordinary work organisation rather than create a separate project with little impact on daily practice. [26]

Prevention should prioritise action on the organisation of work and the conditions that create psychosocial risks. Individual support measures remain important, particularly when workers have already been affected, but they should complement rather than replace measures that address risks at source.

3.1 Start with a small, visible action cycle

Start with one service, team or defined situation rather than trying to address every psychosocial risk at once. For example, a service could focus on evening homecare visits, a residential unit with high absence, repeated verbal abuse in a particular setting, or a group of workers returning after sickness absence. Run cycle: identify the top three stress situations, choose one, implement one or two changes, then check whether the situation has improved.

3.2 Use a home-based care risk checklist

Before the first visit and whenever the situation changes, use a short, score rated checklist covering access, pets, family members, communication risks, equipment, moving and handling, hygiene, smoking, hoarding, medication issues, travel time, lone-working risk and emergency contact.

The checklist should trigger practical decisions for improvements rather than simply be stored as documentation.

Depending on the situation, this may include changing visit arrangements such as visit timing, dual worker visits, supervisor call-back, equipment request, family meeting or refusal of unsafe work.

3.3 Make violence and harassment reportable and actionable

Issue a clear unequivocal local rule for everyone (care recipients, managers and workers): any form of violence, bullying, threats, verbal and sexual harassment, discrimination are unacceptable reportable risks and will not be accepted as features of care work. Use a simple but comprehensive incident form, provide for a full and private debrief after serious incidents, ensuring that workers can remain anonymous where requested/required, without the worrying of reprisals and regular review of patterns and the workers wellbeing.

Reporting should lead to a visible follow-up: After an incident, workers should be informed about what was reviewed and what, if anything, will change in the way work is organised. Without feedback, workers may stop reporting incidents, and behaviours that create risk could become normalised.

26 EU-OSHA (2025), Work-related psychosocial risks and mental health in the EU health and social care sector, policy pointers, pp. 73-76.

3.4 Treat rotas as a health and retention tool

Working-time arrangements are part of psychosocial risk prevention, not just an administrative scheduling issue. Services can review whether rotas provide sufficient work-life balance, recovery time, whether demanding shifts or visits are repeatedly concentrated among the same workers, and whether short-notice changes create avoidable pressure.

To achieve this, services can, for example, classify shifts or visits as green, amber or red according to workload, emotional strain, aggression risk, night work, travel and physical demand.

Services may consider using a simple workload classification for shifts or visits to support balanced allocation. Where operationally feasible, earlier publication of rosters, fewer short-notice changes, transparent allocation principles and review of repeated late-to-early sequences may support recovery and predictability

Digital / AI supported scheduling can help if it includes health and safety parameters and human oversight.

3.5 Build support into the working week

Support works best when it has a time, a person and a routine which is actively followed. Options can include team discussion such as a weekly 20-minute team review, a monthly peer group, a named buddy for new workers, a manager call-back after high-risk visits, and structured debriefing after violence, death of a service user, safeguarding incidents or serious complaints.

Protected time for discussion and debriefing can give workers an opportunity to raise emotional and ethical difficulties and identify emerging psychosocial risks. Team meetings and debriefings must be a genuinely safe space for workers.

3.6 Clarify roles, boundaries and escalation routes

Role ambiguity creates avoidable stress. Clear role descriptions such as short role-boundary sheets can be useful especially for homecare, residential care, night work and outreach.

To resolve role ambiguity, clear guidance must define what falls within the scope of the role and what exceeds worker competence or job description. It should also outline specific protocols for handling extra tasks which are outside of the job description or competence if requested by management or families, refusing work when safety is compromised (worker and care recipient), and escalating ethical concerns whenever safe or dignified support cannot be guaranteed.

3.7 Strengthen management and worker training

Managers have an important role in the working atmosphere and psychosocial risk prevention through their attitude and direction, team routines, work allocation, incident response, participation and feedback. Manager training should cover psychosocial risk identification, difficult conversations, debriefing, rota risks, conflict management, inclusive management, legal basics and practical use of risk assessment.

Worker training should complement these organisational measures and can cover areas such as conflict de-escalation, role boundaries, ethical escalation, support after incidents, inclusive communication and safe use of digital tools.

Worker training should be regularly updated based on emerging risks and workers' feedback.

Management and worker training should therefore be complementary.

3.8 Use data that teams understand

A useful dashboard can be very small: absence, turnover, overtime, missed breaks, incident reports, complaints, staff survey results, support use and unresolved actions. Trends and underlying reasons should be discussed with teams and worker representatives.

The key question is always what information shows about working conditions and what can be changed.

3.9 Integrate psychosocial and MSD prevention

High-risk situations in social services often combine emotional pressure and physical strain. A prevention review should therefore ask both questions at the same time: what makes the situation psychologically unsafe, and what makes it physically unsafe? Equipment, staffing, timing, training and service-user autonomy should be considered together.

3.10 Points to consider when designing prevention measures

- Treat abuse, exhaustion and pain as risks that require appropriate prevention measures rather than as inherent features of care work.
- Combine individual resilience, mindfulness or stress-management measures with organisational prevention where work-related risk factors are identified.
- Complement reporting arrangements with appropriate feedback and follow-up.
- Assess digital tools for their potential effects on workload, autonomy and perceived monitoring as part of their implementation.
- Use proportionate data and review actions progressively; useful improvements do not necessarily require a complex assessment framework.

The aim is not to implement every recommendation at once. A service can begin with one clearly defined risk, take one practical action, involve the workers concerned and review the result. If the measure reduces the risk, it can be maintained or extended; if it does not, the organisation can adjust the approach. This creates a practical link between risk assessment, prevention and continuous improvement.

Transparency note on AI assistance

Generative artificial intelligence was used as a drafting and synthesis support tool under human direction. The text was reviewed, adapted and was supplemented by human authors. The human authors remain responsible for the final content, source selection, factual accuracy, legal suitability and any dissemination. No automated decision-making concerning individuals is involved.

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Contributed to this report:

Co-funded by the European Union