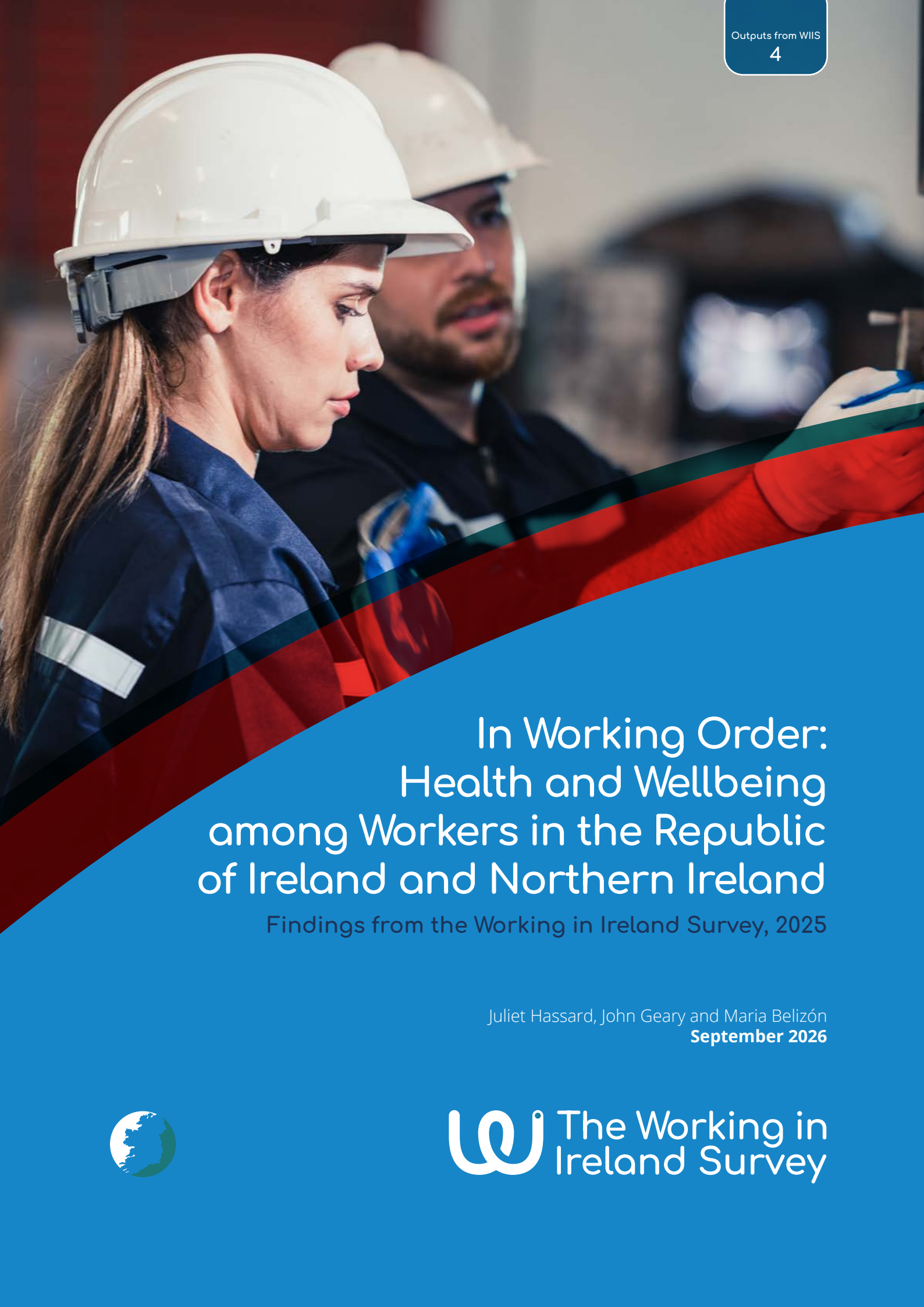




In Working Order: Health and Wellbeing among Workers in the Republic of Ireland and Northern Ireland

Findings from the Working in Ireland Survey, 2025

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September 2026



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Ireland Survey



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1. Executive Summary

This report presents findings from the 2025 Working in Ireland Survey (WIIS), providing one of the most comprehensive overviews to date of worker health, wellbeing, and psychosocial working conditions across the Republic of Ireland (RoI) and Northern Ireland (NI). It examines overall health outcomes, variation across worker groups, and the role of key workplace factors in shaping employee wellbeing.

1.1 Overall Health and Wellbeing Profile

The findings indicate a generally positive health profile among workers across both jurisdictions. Most report good general health and moderate levels of work-related stress. However, a consistent minority of workers experience poorer outcomes, including low psychological wellbeing, higher stress, and reduced general health. While patterns are broadly similar across NI and the RoI, there is some evidence of a higher concentration of adverse outcomes and strain-related symptoms among workers in NI. In particular, workers in NI report higher levels of fatigue, reduced energy, and emotional strain, suggesting a somewhat greater burden of work-related strain.

1.2. Early Indicators of Risk

A substantial proportion of workers report fatigue, reduced energy, and cognitive or emotional strain, highlighting early warning signs of potential health risks. These symptoms are more prevalent in NI and indicate the importance of early, preventative action before more serious health problems emerge.

1.3. Inequalities Across the Workforce

Health and wellbeing outcomes are not evenly distributed across the workforce:

- Sectoral differences are most pronounced, with elevated risks in sectors such as human health, transport and hospitality, and wholesale and retail, particularly in NI.
- Working time patterns matter, with part-time workers reporting poorer health and wellbeing, while full-time workers report higher stress.
- Demographic differences are evident, including higher stress and poorer wellbeing among women in the RoI and NI, and poorer health among older workers and those with lower educational attainment (used here as a proxy for socio-economic status) in NI.

These findings highlight the need for targeted and context-specific approaches, particularly in high-risk sectors and groups.

1.4. Psychosocial Work Factors and Wellbeing

The report demonstrates that how work is organised and experienced (including factors such as job demands, management practices, employee voice, and workplace relationships) plays a central role in shaping health and wellbeing. Key findings include:

- High job demands (e.g. work intensity and tight deadlines) show the strongest and most consistent associations with work-related stress.
- Supportive management practices (including respect, recognition, and support) are consistently associated with increased psychological wellbeing and lower work-related stress.
- Employee voice, trust, and fairness are associated with more positive health and wellbeing outcomes, highlighting their potential role as protective organisational factors.
- Difficulty disconnecting from work is common and moderately associated with higher work-related stress, reflecting potential risks associated with “always-on” work cultures.
- Exposure to bullying, harassment, and workplace violence, while not universal, affects a substantial minority, and is associated with poorer wellbeing and higher stress.
- Increased job autonomy is associated with more positive self-reported outcomes, particularly psychological wellbeing.

Overall, these findings reinforce that psychosocial working conditions (i.e., the social and organisational aspects of work) are key, modifiable determinants of worker health.

1.5. Implications for Policy and Practice

The evidence points clearly to the need for a preventative, systems-based approach to workplace health and wellbeing. This includes:

- Strengthening psychosocial risk management as a core component of organisational practices.
- Reducing excessive job demands and improving job design.
- Building line manager and leadership capability to support employee wellbeing and to improve working conditions and job quality.
- Enhancing employee voice, trust, and organisational fairness.
- Preventing workplace aggression, including bullying, harassment, and workplace violence, through early intervention, clear reporting routes, and organisational accountability.
- Supporting recovery and work-life boundaries, including the right to disconnect.

Importantly, the findings highlight that workplace mental health is shaped by organisational conditions rather than individual factors alone. Improving job quality, management practices, and wider working environments is, therefore, critical to supporting both employee wellbeing and organisational performance.

1.6. Conclusion

While most workers across the island of Ireland report positive health and wellbeing, a significant minority of workers experience poorer outcomes, with clear inequalities across sectors, groups, and working conditions. The stronger pattern of adverse outcomes observed in NI further underscores the need for targeted and systemic action. Taken together, the findings reinforce the importance of prevention-focused, organisation-level approaches that address the root causes of work-related stress and poor wellbeing. Strengthening psychosocial working conditions as a core component of job quality offers a clear opportunity to improve health, support workforce sustainability, and enhance productivity across both jurisdictions.

2. Introduction

This report examines the health and wellbeing of workers across the Republic of Ireland (RoI) and Northern Ireland (NI) using data from the 2025 Working in Ireland Survey. It provides an overview of the health profile of the working population and examines working conditions, with a particular focus on work-related psychosocial factors (such as management practices, employee voice, and exposure to bullying, harassment, and workplace violence) and their relationship with key health and wellbeing outcomes, including psychological wellbeing, self-reported health, and work-related stress.

Understanding the health and wellbeing of workers has become an increasingly important policy issue, reflected in growing concern with workplace mental health, psychosocial risks, and work-limiting ill health in Ireland, the United Kingdom (UK), and across the European Union (EU). Recent policy developments include the UK Government's Mayfield Review (*Keep Britain Working*; DWP, 2025) and the European Parliament's draft report on psychosocial risks and mental health at work, which calls for stronger EU-wide protections relating to work-related stress, burnout, harassment, and workplace mental health (European Parliament Committee on Employment and Social Affairs, 2026). This policy focus is further reinforced by international standards, such as ISO 45003 (ISO, 2021), which provide guidance for managing psychosocial risks and promoting psychological health and safety at work through a preventative, systems-based approach.

This growing policy focus is underpinned by a building economic case. A growing body of evidence demonstrates that poor mental health and work-related psychosocial risks generate significant costs for organisations and society (Green, 2025; Hassard et al., 2018a; 2018b; Hassard et al., 2019; EU-OSHA, 2019), with

indirect productivity losses, particularly presenteeism (reduced productivity due to ill health), accounting for the largest share (Deloitte, 2024). In the UK alone, poor mental health is estimated to cost employers approximately £51 billion annually (Deloitte, 2024), while work-related ill-health and injury across Europe account for an estimated 3–4% of Gross Domestic Product (EU-OSHA, 2019). Evidence suggests that well-designed, prevention-focused workplace health initiatives can be cost-effective (Deloitte, 2024; McDaid et al., 2022) and are associated with reduced absence and presenteeism, improved retention, and enhanced organisational performance (Thonon et al., 2023; Hassard et al., 2024; Dulal-Arthur et al., 2025).

Importantly, these estimates understate the full burden, as they do not capture the substantial human costs to workers, including psychological distress, fatigue, and reduced quality of life (Hassard et al., 2018a; EU-OSHA, 2019). These factors can contribute to reduced engagement and sustained performance, and in some cases may lead to increased absenteeism, labour market withdrawal, and broader economic inactivity (EU-OSHA, 2019; Hassard et al., 2023; Leka and Jain, 2024). Taken together, this evidence highlights that investing in mentally

healthy and supportive working conditions is both a public health priority and a strategic organisational investment.

2.1 The NI and RoI policy context: employee wellbeing and job quality

Building on this broader context, there has been growing policy recognition across both NI and the RoI of the importance of workplace health, employee wellbeing, and job quality. Recent policy and strategic developments reflect an increasing emphasis on preventative approaches to work-related stress, the management and prevention of psychosocial risks, and the promotion of supportive, healthy working environments.

In NI, this is reflected in recent policy developments (e.g., NI Department for the Economy Good Jobs Employment Rights Bill) and guidance and initiatives led by the Health and Safety Executive for Northern Ireland (HSENI), including workplace mental wellbeing guidance and wider efforts to support employers in managing work-related stress. Broader policy developments, such as the *Protect Life 2* suicide prevention strategy (NI DoH, 2019) and ongoing discussions linked to employment rights reform, also highlight the role of work and working conditions in shaping population mental health. Alongside this, initiatives promoting mentally healthy workplaces and supportive management practices point to an increasing focus on organisational culture, leadership, and prevention (e.g. HSENI's Mental Well-being at Work Advisory Service; HSENI, 2026a; and HSENI's Managing Work-Related Stress and Mental Wellbeing Resources; HSENI, 2026b).

In the RoI, workplace wellbeing is embedded within a broader public health and occupational health and safety framework. National strategies such as the *Healthy Ireland Framework* (RoI DoH, 2019a) and *Healthy Ireland at Work* (RoI DoH, 2019b) emphasise the role of workplaces as key settings for promoting health and wellbeing. Legislative and regulatory instruments, including the *Safety, Health and Welfare at Work Act 2005*, provide a framework for managing workplace risks, with growing recognition that this includes psychosocial risks such as work-related stress and workload pressures. This is supported by guidance and tools, such as Work PositiveCI (HSA, n.d.), which help employers assess and manage these risks in practice. Policy developments such as the Code of Practice on the Right to Disconnect (Workplace Relations Commission, 2021) further reflect growing attention to work-life balance and the impact of digital working practices.

At European level, policy frameworks (including the EU Strategic Framework on Health and Safety at Work, 2021–2027, EU, 2021; and the European Pillar of Social Rights, EU, 2017) have reinforced the importance of the active management of psychosocial risks, promoting mental health at work, and fair working conditions. These developments continue to shape policy direction in the RoI and, indirectly, in NI through wider UK and international policy alignment.

Taken together, these developments reflect a broader shift away from viewing workplace mental health solely as an individual issue, towards recognising the central role of job quality, work design, management practices, and workplace relationships in shaping employee wellbeing. While good work

can support health, engagement, and sustained labour market participation, poor working conditions (including excessive demands, low employee support, limited autonomy, and exposure to bullying or harassment) can contribute to poorer health outcomes, sickness absence, reduced productivity, and challenges in workforce retention (Leka and Jain, 2024; ERC, 2025).

Despite this progress, important policy challenges remain. These include the need to strengthen the implementation of existing guidance, ensure consistent employer engagement with psychosocial risk management, and further embed preventative, organisation-level approaches to workplace wellbeing, including strengthening leadership development and line manager and leadership capability. There is also an increasing policy need to address emerging risks associated with digitalisation, work intensification, and blurred work–life boundaries, alongside ensuring that job quality and worker voice remain central to policy development.

In this context, the report presents descriptive findings from the 2025 Working in Ireland Survey, one of the first studies to examine worker health, wellbeing, and psychosocial working conditions across the island of Ireland, including both NI and RoI. It examines patterns in worker health, wellbeing, and key psychosocial working conditions across NI and the RoI. It first outlines the overall health profile of workers, before exploring variation across groups and sectors and examining key workplace factors associated with wellbeing.

3. The Working in Ireland Survey 2025

The Working in Ireland Survey 2025 (WIIS 2025) surveys people's work and employment on the island of Ireland. It is the most significant and comprehensive survey of its kind, covering a wide range of topics including skills and training, employee involvement and autonomy, the use of artificial intelligence, remote working, trade union allegiance, health and wellbeing, job churn and intention to quit, low pay, and job quality. The fieldwork for the survey was conducted between May 15th and August 28th, 2025. A total of 3,040 interviews were conducted in RoI and 1,260 in NI. The survey fieldwork was undertaken by Ipsos B&A in both jurisdictions.

To ensure a nationally representative sample of working people aged 16 years and over, the data were weighted for age, gender, region and economic sector to agree with the then most recent population estimates as derived from the RoI's Central Statistics Office's Labour Force Survey (LFS) Q1 2025, and in NI, the NI Statistics Research Agency's Labour Force Survey June-Aug 2025 and the Business Register and Employment Survey (BRES) NI, September 2022. All the analyses in this report use the weighted sample.

The Working in Ireland Survey 2025 is the second survey in the WIIS series. The first survey, conducted between May and August in 2021, was confined to the RoI. It had a sample size of 2,046. It also drew from a representative sample of people of working age in paid employment and was conducted by the same means as WIIS 2025.

A mobile telephone only sample approach was used. In the RoI, the approach used was Random Digit Dial (RDD) whereby a sample was randomly generated using known mobile stems as provided by the Commission for Communications Regulation. RDD is not an appropriate methodology for NI, as the use of mobile stems could result in calls being made to individuals across the United Kingdom. Instead, a sample comprising only NI mobile numbers was acquired for the research.

Respondents underwent a series of screening questions to confirm their eligibility for inclusion in the study, including inquiries about their age and employment status. The research was confined to working people, employed and self-employed, of over 16 years of age who were at work for at least one hour in producing goods and providing services for pay or for profit in the week prior to the survey.

All interviewers attended a training/briefing webinar convened by an Ipsos B&A project manager and which was attended by all call centre supervisors and the WIIS's principal investigator, John Geary. Interviewers had the opportunity to ask questions to all team members. Directly after the webinar, all interviewers logged on to the test script to familiarise themselves with the questionnaire and the routing of questions, and to address any queries they might have had before administering the survey in the field.

A pilot survey was also conducted to ensure that respondents understood the questions asked and were able to provide clear answers, as well as to ensure that the routing of questions was appropriate and that the questionnaire was not too long as to make unreasonable demands on respondents. New questions in the questionnaire were cognitively tested, first by members of the research team and second by the survey agency. Lessons were then shared and the questions adapted as required. The reformatted questions were then tested again during the pilot survey.

Several methods were employed to monitor the quality of interviewing, including a proportion of all interviews being monitored by supervisory staff from the start to the end of an interview. For the WIIS 2025, 13.4% of the RoI interviews and 15.9% of interviews in NI were fully monitored. Call centre managers were responsible for the scheduling of resources, monitoring of interviewers and sample management, and were in close contact with the project management team, including the PI, to ensure fieldwork was progressing well and to respond to queries from the interviewers. Interviewing was conducted between 2pm to 9pm Monday to Friday, 10am to 6pm on Saturday and 11am to 7pm on Sunday. Interviewees were dialled a minimum of three times, over various time periods such as afternoons, evenings and weekends.

4. The Health and Wellbeing Profile of RoI and NI Workers

4.1 Health and Wellbeing Outcomes

This section presents an overview of key health and wellbeing indicators among workers in the RoI and NI. It focuses on three core measures: self-reported general health, psychological wellbeing, and work-related stress. General health and psychological wellbeing capture overall physical and mental health status, while work-related stress provides an important indicator of work-related strain that is closely linked to health and wellbeing outcomes. Together, these measures provide a broad picture of the health and wellbeing of the working population. Examining these indicators helps to identify the extent to which workers are experiencing good health, as well as the proportion reporting poorer health and higher levels of stress. These findings are particularly important for understanding workforce sustainability, productivity, and the overall quality of working life across both jurisdictions.

The following section builds on this by examining strain-related symptoms, which provide more detailed insight into how work-related strain is experienced

in day-to-day working life and may act as early indicators of emerging health risks.

4.1.1 General Health

General health was assessed using a single item: *"In general, is your health...?"* Table 1 presents the distribution of responses across both jurisdictions. Overall, the findings indicate a positive health profile among workers in both NI and the RoI. In the RoI, most workers report good, very good, or excellent health (see Table 1), although a notable minority - around one in eight (12.5%) - report *fair* or *poor* health. A similar pattern was observed in NI, but with a higher proportion reporting poorer health, with almost one in five workers (18.4%) falling into this category.

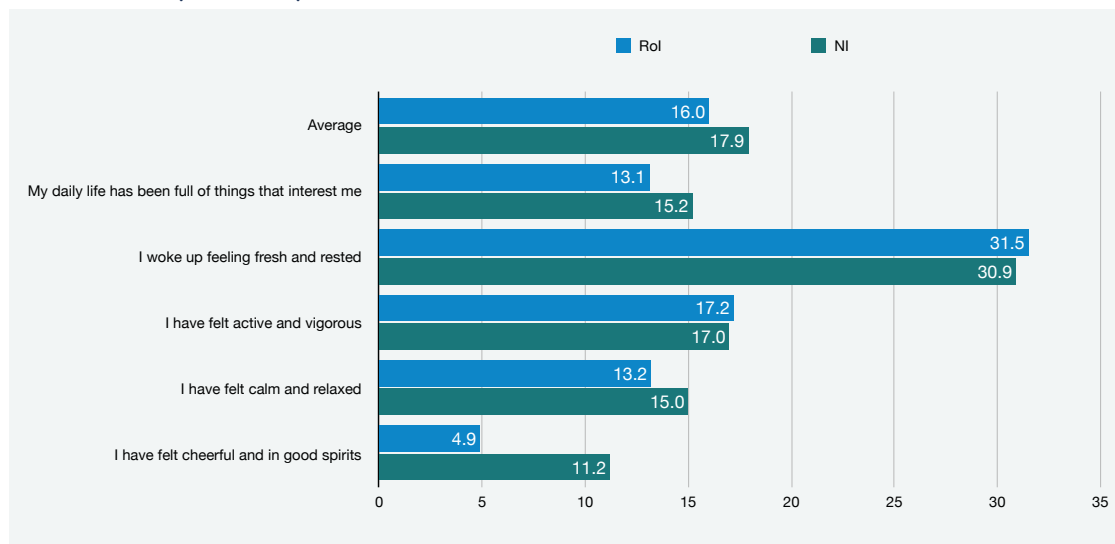
4.1.2 Psychological Wellbeing

Psychological wellbeing was measured using the WHO-5 Well-Being Index (World Health Organization, 2024). This five-item scale asks respondents to indicate how often they have experienced different facets of psychological wellbeing over the past two weeks. For the purposes of this survey, the response scale was adapted to

Table 1. Self-Reported General Health Profile of Workers in NI (n=1,256) and RoI (n=3,025)

Category	NI		RoI	
	% Reported	95% CI	% Reported	95% CI
Excellent	18.6	16.5 to 20.9	21.0	19.2 to 22.0
Very good	33.6	30.8 to 36.3	36.1	34.8 to 38.2
Good	29.4	26.9 to 32.0	30.4	28.7 to 32.1
Fair	14.5	12.5 to 16.3	11.0	10.0 to 12.1
Poor	3.9	2.9 to 5.0	1.5	1.1 to 1.9

Figure 1. Percentage of Workers Reporting Low Frequency of Positive Psychological Wellbeing States (“Never” or “A Little of the Time”) in NI (n = 1,245) and the RoI (n = 3,007)



a five-point format ranging from 1 (“never”) to 5 (“all of the time”), to ensure consistency with other survey items and reduce respondent burden. Responses were summed to produce a total score ranging from 5 to 25, with higher scores indicating better psychological wellbeing.

In the RoI, the mean wellbeing score was 17.5 (SD = 3.3; n = 3,007), compared to 17.3 in NI (SD = 3.9; n = 1,245), indicating broadly similar average levels across both jurisdictions. Figure 1 presents the proportion of participants, by jurisdiction, who reported experiencing each wellbeing item either “never” or “only a little of the time.” These responses provide an indication of the lower end of the wellbeing distribution, capturing those who report infrequent experiences of positive wellbeing states.

Overall, averaging across the five items suggests that approximately 17.9% of workers in NI report low frequency of positive psychological wellbeing states, compared to 16.0% in the RoI.

4.1.3 Work-related Stress

Work-related stress was assessed using a single item: “In general, do you find your job to be...?”, with response options of: not at all stressful, moderately stressful, very stressful, and extremely stressful. Smaller proportions report higher levels of stress. When responses are grouped, 17.7% of workers in NI (95% CI 15.6–19.8; n=223/1259) report their job as **being very** or **extremely stressful**, compared to 13.2% in the RoI (95% CI 12.0–14.4; n=402/3035).

Overall, while the distribution of work-related stress is broadly similar across jurisdictions, a higher proportion of workers in NI report high levels of work-related stress. This equates to approximately one in six workers in NI, compared to around one in eight in the RoI. As shown in Table 2, most workers in both NI and the RoI describe their jobs as moderately stressful, with similar proportions also reporting that their work is not at all stressful.

Table 2. Distribution of Self-Reported Work-Related Stress Among Workers in NI (n=1,259) and the Republic of Ireland (n=3,035)

	NI		RoI	
Category	%	95% CI	%	95% CI
Not at all stressful	18.1	15.9 to 20.2	17.9	16.6 to 19.3
Moderately stressful	64.2	61.4 to 66.8	68.8	67.2 to 70.4
Very stressful	12.2	10.4 to 14.1	10	9.1 to 11.1
Extremely stressful	5.6	4.4 to 6.8	3.2	to 3.9

4.2. Worker Health and Wellbeing: A Jurisdictional Comparison

Table 3 presents summary statistics for general health, work-related stress, and psychological wellbeing across the RoI and NI. Overall, workers in NI, on average, report poorer general health and higher levels of work-related stress compared to those in the RoI. These differences are statistically significant, although modest in magnitude. In contrast, psychological wellbeing is broadly similar across jurisdictions, with no statistically significant difference between NI and the RoI.

4.3 Strain-related Symptoms (Early Indicators of Risk)

In addition to overall health outcomes, this section examines a range of strain-related symptoms experienced

by workers, including fatigue, difficulties concentrating, and emotional strain. These symptoms are widely recognised as early warning indicators of work-related pressures and may signal emerging risks to health and wellbeing before more serious problems develop (Hassard & Cox, 2011).

Analysing these indicators provides an overview of workers' day-to-day experiences, highlighting patterns of fatigue, energy depletion, and cognitive and emotional strain within the workforce. Considering both overall health outcomes and these early indicators offers a more holistic picture of worker wellbeing and helps to identify areas where early, preventative action may be most needed. Strain-related symptoms were assessed using items with response options ranging from "all of the time" to "never."

Table 3. Summary of Health, Work-Related Stress, and Psychological Wellbeing by Jurisdiction

Outcome	RoI (Mean, SD)	NI (Mean, SD)	Mean Difference (RoI – NI)	p-value
General Health*	2.36 (1.0)	2.51 (1.1)	-0.15	< .001
Work-related Stress†	1.99 (0.6)	2.05 (0.7)	-0.07	.003
Psychological Wellbeing‡	17.56 (3.2)	17.38 (3.9)	0.18	.123

*Higher scores indicate poorer general health

†Higher scores indicate higher work-related stress

‡Higher scores indicate better psychological wellbeing

For analysis, responses were grouped into two categories: (1) high frequency (“all” or “most of the time”) and (2) low frequency (“some of the time”, “a little of the time”, or “never”). The item assessing feeling “full of energy while working” was reverse coded to ensure consistency and ease of interpretation, such that higher values reflect greater strain. **Figure 2** presents the percentage of workers reporting high levels of strain-related symptoms across NI and the RoI.

Across both jurisdictions, fatigue and energy-related symptoms were the **most reported** forms of strain. In the RoI, between 21.2% and 26.1% of workers reported high levels of fatigue-related symptoms, including difficulty recovering energy after work, physical exhaustion, and not feeling full of energy while working. Corresponding figures in NI were higher, ranging from 26.7% to 28.7%. Lower proportions of workers reported cognitive and emotional strain. In the RoI, 8.0% reported difficulty concentrating at work and 9.7% reported feeling irritable or tense. In NI, these figures were higher at 11.5% and 16.7%, respectively.

Overall, while the pattern of strain is broadly similar across jurisdictions, workers in NI consistently reported higher levels across all indicators, with the most notable differences observed in emotional and fatigue-related symptoms. This pattern is consistent with earlier findings, which show higher levels of poorer health and work-related stress among workers in NI.

Table 4 shows that workers in NI reported slightly higher average levels of strain than those in the RoI across most indicators. Significant differences were confined to emotional strain and fatigue-related symptoms, with workers in NI reporting more frequent feelings of being irritable or tense, greater difficulty recovering energy after work, and higher levels of physical exhaustion. Differences in trouble concentrating and feeling full of energy while working were small and not statistically significant.

Figure 2. Percentage of Workers Reporting High Levels of Strain-Related Symptoms by Jurisdiction: NI (n=1248 to 1252, dependent on item) and RoI (n=3011 to 3022)

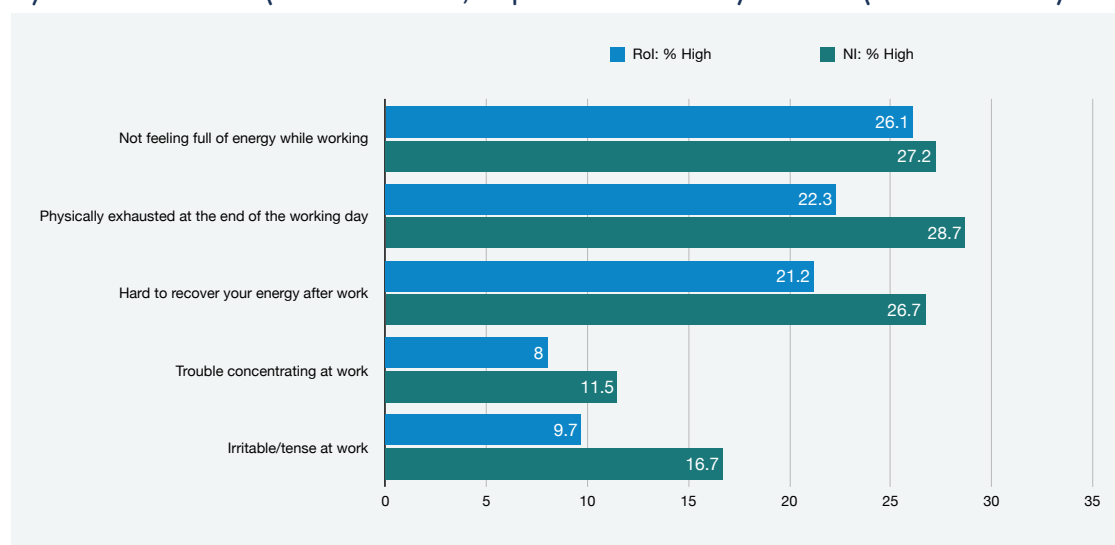


Table 4. Mean Levels of Strain-Related Symptoms by Jurisdiction

Symptom	Rol (Mean, SD)	NI (Mean, SD)	Mean Difference (Rol – NI)	p-value
Irritable or tense at work	2.25 (1.01)	2.50 (1.15)	-0.25	< .001
Trouble concentrating at work	2.06 (1.03)	2.11 (1.17)	-0.06	.130
Hard to recover energy after work	2.59 (1.16)	2.67 (1.28)	-0.09	.028
Physically exhausted at end of day	2.62 (1.18)	2.77 (1.32)	-0.15	< .001
Full of energy while working*	3.06 (1.02)	3.09 (1.10)	-0.03	.400

*Item reverse coded so that higher scores indicate greater strain. Note: Scale ranges from 1 = “never” to 5 = “all of the time”

4.3 Conclusion

Overall, the findings point to a generally positive health profile among workers in both NI and the Rol. However, a consistent minority experience poorer health, lower wellbeing, and higher levels of work-related stress. While outcomes are broadly similar across jurisdictions, there is some evidence that general health, work-related stress, and strain-related symptoms are more pronounced among workers in NI, particularly in relation to fatigue, reduced energy, and emotional strain. The presence of strain-related symptoms highlights early warning signs of potential health risks within the workforce. Taken together, the findings suggest that while many workers are doing well, there are clear and persistent differences between jurisdictions, alongside identifiable groups at greater risk. This reinforces the importance of considering both overall health outcomes and early indicators of strain when assessing workforce wellbeing and identifying areas for preventative action.

5. Who Is Most at Risk? Differences Across Worker Groups

This section examines how health and wellbeing outcomes vary across different groups of workers in NI and the RoI. Building on the overall profile presented in the previous section, the analysis explores differences in self-reported health, psychological wellbeing, and work-related stress by key characteristics: sector, occupation, employment type, and demographic factors such as age and gender. The aim is to identify whether certain groups of workers are more likely to report poorer health, lower psychological wellbeing, or higher levels of work-related stress. By examining these patterns, the analysis provides insight into where risks may be concentrated within the workforce and highlights groups who may benefit most from targeted support and intervention.

5.1 Health and Wellbeing by Industry Sector

Table 4 presents variation in poor health, work-related stress, and poor psychological wellbeing across industry sectors. Cells highlighted in red indicate sector values that exceed

the upper confidence interval of the estimated population prevalence for each outcome and are, therefore, identified as potential priority areas. For general health and work-related stress, these outcomes are based on single-item measures, with poorer outcomes defined using responses at

Table 4. Sectoral Variation in Poor Health, Work-Related Stress, and Psychological Wellbeing Among Workers in The Republic of Ireland and Northern Ireland (NACE10 Classification).

Industry Sector	Poor General Health		Work-related Stress		Low Psychological Wellbeing	
	NI ¹	RoI ²	NI ³	RoI ⁴	NI ⁵	RoI ⁶
Agriculture, Fishing & Mining*	0	7.2	0	7.2	0.0	9.6
Energy & Construction	15.5	13.3	16.5	13.3	11.9	18.2
Wholesale & Retail	23.3	13.1	16.8	13.1	17.3	20.8
Transport & Hospitality	21.7	13.2	20.3	13.2	17.7	19.6
ICT, professional & support	19.1	12.5	14.8	12.5	18.7	19.1
Financial services & defence	13.3	14.5	13.3	14.5	15.6	15.9
Public administration	16.3	10.6	9.9	10.6	11.1	16.6
Education	15.4	15.4	20.3	15.4	12.2	14.4
Human Health	21.4	19.9	25.5	19.9	17.1	19.9
Manufacturing	15.6	10.9	10.4	10.9	15.6	16.3
Mean values (and 95% confidence interval) for the respective jurisdiction	18.4 (16.4 to 20.6)	12.5 (11.4 to 13.8)	17.7 (15.6 to 19.8)	13.2 (12.0 to 14.4)	15.9 (13.3 to 17.3)	17.9 (15.9 to 18.5)

*low sample size (n=1, NI; n=125, RoI); ¹n=1232; ²n=2989; ³n=1233;

⁴n=3002; ⁵n=1219; ⁶n=2975.

the extreme ends of the scale (e.g. fair/poor health; very or extremely stressful work). In contrast, poor psychological wellbeing is derived from a composite measure (WHO-5) of five items, with low psychological wellbeing defined as scores at or below one standard deviation below the mean within each jurisdiction (NI≤13; RoI≤14).

This combined approach allows for consistent identification of workers experiencing poorer outcomes across different measures, while reflecting the distinct measurement properties of single-item and composite indicators. Together, this visual approach helps to highlight where poorer health and wellbeing outcomes may be more concentrated across sectors.

In NI, notable sectoral differences are evident across all outcomes. The highest levels of poor general health are observed in wholesale and retail (23.3%), transport and hospitality (21.7%), and human health (21.4%), all exceeding the NI working population estimate (18.4%). A similar pattern is observed for work-related stress, with particularly elevated levels in human health (25.5%), education (20.3%), and transport and hospitality (20.3%), compared to the NI population estimate (17.7%). For low psychological wellbeing, higher levels are observed in ICT, professional and support services (18.7%), transport and hospitality (17.7%), and wholesale and retail (17.3%), relative to the NI population estimate (15.9%).

In the RoI, sectoral variation is more compressed, with fewer sectors exceeding population benchmarks. Poor general health is highest in human health (19.9%) and financial services and defence (14.5%), compared to the population estimate

(12.5%). For work-related stress, elevated levels are observed in human health (19.9%) and education (15.4%), relative to the RoI estimate (13.2%). Low psychological wellbeing is highest in wholesale and retail (20.8%), transport and hospitality (19.6%), and ICT and professional services (19.1%), compared to the RoI population estimate (17.9%).

Across both jurisdictions, the human health sector consistently reports elevated levels of work-related stress and poorer health outcomes. In NI, this pattern extends to psychological wellbeing, with levels approaching the population estimate, indicating that this sector experiences a broader clustering of adverse outcomes. Transport and hospitality and wholesale and retail sectors also show comparatively poorer outcomes, particularly in NI. In contrast, sectors such as public administration and manufacturing tend to report more favourable outcomes relative to population averages.

5.2 Variation in Health and Wellbeing by Employment Contract and Working Time Status

Table 5 presents variation in low psychological wellbeing, work-related stress, and poor general health by employment contract in NI and the RoI. Overall, there is little evidence of substantial differences between workers in permanent and non-permanent employment across the three health outcomes.

In the RoI, levels of low psychological wellbeing, work-related stress, and poor general health were broadly similar regardless of employment contract. Similarly, in NI, levels of work-related stress and poor general

health varied little between workers in permanent and non-permanent employment. However, workers in non-permanent employment reported higher levels of low psychological wellbeing than those in permanent employment (20.1% vs. 14.8%), with this difference approaching statistical significance ($\chi^2(1) = 3.70, p = .06$).

More distinct patterns emerge when comparing full-time and part-time workers. In the RoI, levels of low psychological wellbeing were similar among full-time and part-time workers. However, full-time workers reported higher levels of work-related stress than part-time workers (14.2% vs. 10.8%; $\chi^2(1) = 4.31, p = .04$), while part-time workers were more likely to report poor general health (15.3% vs. 11.9%; $\chi^2(1) = 4.84, p = .03$).

In NI, levels of low psychological wellbeing were comparable among full-time and part-time workers. Full-time workers reported higher levels of work-related stress than part-time workers (19.1% vs. 12.9%; $\chi^2(1) = 5.79, p = .02$). Part-time workers also reported higher levels of poor general health than full-time workers (22.4% vs. 17.9%), with this difference approaching statistical significance ($\chi^2(1) = 2.89, p = .09$).

Overall, these findings indicate that while employment contract type is not strongly associated with health and wellbeing outcomes, working time status (particularly in NI) is more clearly linked to differences in self-reported psychological wellbeing and general health. In particular, part-time workers appear more likely to experience lower

Table 5. Health and Wellbeing Outcomes by Employment Contract (Permanent vs Non-Permanent Job) and Working Time (Full Time and Part Time) Status in NI and RoI

		Low Psychological Wellbeing (%)	Work-related Stress (%)	Poor General Health (%)
Employment Contract				
RoI	Permanent	18.1	13.3	12.4
	Non- Permanent	17.2	15.7	13.6
	χ^2 (df=1), p value	n.s.	n.s.	n.s.
NI	Permanent	14.8	17.9	18.9
	Non- Permanent	20.1	13.8	18.8
	χ^2 (df=1), p value	n.s.	n.s.	n.s.
		RoI, N=3007; NI, N=1245	RoI, N=3036; NI, N=1258	RoI, N=3022; NI, N=1257
Working Time Status				
RoI	Full-time	17.8	14.2	11.9
	Part-time	19	10.8	15.3
	χ^2 (df=1), p value	n.s.	4.31, p=.04	4.84, p=.03
NI	Full-time	15.6	19.1	17.9
	Part-time	21.1	12.9	22.4
	χ^2 (df=1), p value	n.s.	5.79, p=.02	2.89, p=.09
		RoI, N=3007, NI, N=1245	RoI, N=3036, NI, N=1260	RoI, N=3022, NI, N=1257

psychological wellbeing, while full-time workers report higher levels of work-related stress. This highlights the importance of considering different dimensions of job quality and working patterns when assessing worker health and wellbeing.

5.3 Demographics: Gender, Age, Ethnicity, & Education Level

This section examines variation in low psychological wellbeing, work-related stress, and poor general health across key demographic characteristics in NI and the RoI, including gender, socio-economic status, ethnicity, and age. These characteristics are important for understanding how health and wellbeing outcomes are distributed across the workforce and for identifying potential inequalities between different groups of workers.

Examining these patterns provides an initial indication of where differences in health and wellbeing may be concentrated. While the analysis does not establish underlying causes, it highlights areas where more in-depth exploration is needed to better under-

stand the drivers of these differences and to inform targeted supports and policy responses.

5.3.1 Gender

Analysis by gender was restricted to respondents identifying as men or women, as the number of participants identifying outside these categories was too small to permit reliable analysis. See Table 6 for an overview. In the RoI, women report higher levels of poor psychological wellbeing (20.1% vs 16.0%) and work-related stress (15.8% vs 11.6%) compared to men. These differences are statistically significant ($\chi^2 = 8.2$, $p = .004$; $\chi^2 = 11.3$, $p < .001$, respectively). Levels of poor general health are broadly similar across genders. However, in NI, women report higher levels of low psychological wellbeing compared to men (**18.5% vs. 13.8%**), and this difference is statistically significant ($\chi^2(1) = 5.1$, $p = .024$). In contrast, levels of work-related stress and poor general health are broadly comparable between men and women.

Table 6. Health and Wellbeing Outcomes by Gender in NI and RoI

		Low Psychological Wellbeing (%)	Work-related Stress (%)	Poor General Health (%)
RoI	Man	16.0	11.6	12.7
	Woman	20.1	15.8	12.4
	χ^2 (df=1)	8.2	11.3	n.s.
	p-value	.004	<.001	
	Valid N	2988	3018	3005
NI	Man	13.8	18.3	19.9
	Woman	18.5	17.3	17.6
	χ^2 (df=2)	5.1	n.s.	n.s.
	p-value	.02		
	Valid N	1238	1252	1252

n.s.= not statistically significant

5.3.2. Health and Wellbeing by Socio-Economic Status (Educational Attainment)

Educational attainment is used as a proxy indicator of socio-economic status. While education does not capture all dimensions of socio-economic position (such as income or wealth) it provides a practical indicator for examining socio-economic inequalities in workforce health and wellbeing within survey data. Using this approach, education attainment shows differing patterns of association with health and wellbeing outcomes across NI and the RoI, as shown in Table 7.

Across both jurisdictions, there is no evidence of an association between education level and low psychological wellbeing, with similar proportions observed across education groups. In contrast, education level is significantly associated with poor general health in both NI and the RoI (NI: $\chi^2(2) = 9.2$, $p = .010$; RoI: $\chi^2(2) = 12.1$, $p = .002$). In both contexts, workers with lower levels of educational attainment report higher levels of poor health, suggesting

a socio-economic gradient in general health outcomes.

For work-related stress, patterns differ between jurisdictions. In NI, differences across education levels are not statistically significant. However, in the RoI, education level is significantly associated with work-related stress ($\chi^2(2) = 14.0$, $p < .001$), with higher levels observed among those with college education compared to those with lower levels of attainment.

Overall, these findings suggest that while educational attainment is not associated with differences in psychological wellbeing in either jurisdiction, it is linked to general health, with poorer outcomes concentrated among those with lower levels of education. In contrast, associations with work-related stress appear more context-specific, emerging in the RoI but not in NI, and may reflect differences in the distribution and exposure to work demands across education groups, as well as broader socio-economic inequalities in work conditions.

Table 7. Health and Wellbeing Outcomes by Educational Attainment in NI and RoI

		Low Psychological Wellbeing(%)	Work-related Stress (%)	Poor Health (%)
RoI	Up to upper secondary	18.1	12.1	14.4
	Non-tertiary & short cycle tertiary	17.4	9.9	15.2
	College education	18.1	15.5	10.6
	χ^2 (df=2)	n.s	14.0	12.1
	p-value		<.001	.002
	Valid N	2795	3002	2989
NI	Up to upper secondary	19.2	14	14.4
	Non-tertiary & short cycle tertiary	15.0	9.9	20.4
	College education	15.1	9.2	18.4
	χ^2 (df=2)	n.s	n.s.	9.2
	p-value		n.s.	.01
	Valid N	1195	1208	1207

n.s.= not statistically significant

Table 8. Health and Wellbeing Outcomes by Ethnicity in the Republic of Ireland and Northern Ireland

		Low Psychological Wellbeing (%)	Work-related Stress (%)	Poor Health (%)
RoI	White	17.7	13.7	15.8
	Ethnicity Minority Groups	19.2	13.6	13.6
	χ^2 (df=1)	n.s.	n.s.	n.s.
	p-value			
	Valid N	2975	3001	3001
NI	White	15.9	17.7	18.9
	Ethnicity Minority Groups	17.6	16.7	5.6
	χ^2 (df=1)	n.s.	n.s.	n.s.
	p-value			
	Valid N	1242	1255	1253

n.s.= not statistically significant

5.3.3 Ethnicity

As shown in Table 8, across both jurisdictions, there is little evidence of statistically significant differences in health and wellbeing outcomes by ethnicity. *However*, findings for ethnic minority groups in NI should be interpreted with considerable caution due to the relatively small number of participants from these groups within the sample. While some differences are observed, for example, higher levels of poor psychological wellbeing among workers from ethnic minority backgrounds in NI alongside lower reported levels of poor health, these estimates are based on small subgroup sizes and are, therefore, subject to greater uncertainty and are best treated with caution.

5.3.4 Age

In the RoI, differences in health and wellbeing outcomes across age groups are relatively modest and do not reach statistical significance. By contrast in NI, levels of poor health increase with age, rising from 11.7% among workers aged 15–34 to 21.7% among those aged 45 years and older. This difference is statistically significant ($\chi^2 = 15.1$, $p < .001$). However, differences in poor psychological wellbeing and work-related stress across age groups are comparatively small. See Table 9.

Table 9. Health and Wellbeing Outcomes by Age in the Republic of Ireland and Northern Ireland

		Low Psychological Wellbeing (%)	Work-related Stress (%)	Poor Health (%)
RoI	15-34	17.0	12.1	11.8
	35-45	19.1	13.4	10.7
	45+	17.8	13.8	13.1
	χ^2 (df=2)	n.s.	n.s.	n.s.
	p-value			
	Valid N	2989	3015	3003
NI	15-34	15.0	13.8	11.7
	35-45	18.2	17.4	13.1
	45+	15.0	18.6	21.7
	χ^2 (df=2)	n.s.	n.s.	15.1
	p-value			<.001
	Valid N	1239	1254	1251

n.s.= not statistically significant

5.4 Conclusion

Overall, the findings highlight important differences in health and wellbeing outcomes across worker groups in both NI and RoI, with patterns varying by sector, working arrangements, and demographic characteristics. While many workers report relatively positive outcomes, poorer health and wellbeing are more concentrated within specific groups. The clearest and most consistent differences emerge at the sectoral level. In particular, workers in human health, transport and hospitality, and wholesale and retail report elevated levels of poor health, work-related stress, and poor psychological wellbeing, especially in NI.

In the RoI, elevated outcomes appear more concentrated within a smaller number of sectors, most notably human health. This suggests that sector-specific working conditions, job demands, and workforce pressures play an important role in shaping

employee health and wellbeing and highlights the need for more detailed examination of psychosocial risk profiles within these sectors to inform targeted interventions, with a particular focus on prevention.

Differences by employment arrangement are comparatively modest, particularly in relation to permanent versus non-permanent employment. However, working time status appears more strongly associated with wellbeing outcomes. Across both jurisdictions, part-time workers tend to report poorer health and psychological wellbeing, while full-time workers report higher levels of work-related stress. This pattern may reflect differences in workload intensity, financial security, work-life balance, or caring responsibilities.

The findings also point to important demographic differences. In the RoI, women report higher levels of poor psychological wellbeing and work-re-

lated stress compared to men, while in NI women report significantly higher levels of low psychological wellbeing. In addition, lower educational attainment (used here as a proxy for socio-economic status) is associated with poorer general health in both jurisdictions, indicating a clear socio-economic gradient in health outcomes. Age-related differences are also evident in NI, where poorer health is more concentrated among older workers. Although no statistically significant differences were observed by ethnicity, findings for ethnic minority groups in NI should be interpreted with caution due to small sample sizes.

Taken together, these findings indicate that poorer health and wellbeing outcomes are not evenly distributed across the workforce, but instead cluster within particular sectors, and specific groups of workers. Overall, the findings reinforce the importance of targeted, preventative approaches that address psychosocial working conditions, sector-specific demands, and inequalities in work and employment experiences across both jurisdictions.

6. The presence of unions and workers' health and wellbeing

A central task of trade unions is to improve workers' conditions of employment and their health and safety. We turn now to examine whether the presence of unions in a workplace is associated with better health and wellbeing outcomes for workers.

6.1. Trade Union Membership

Table 10 presents variation in poor psychological wellbeing, work-related stress, and poor health by trade union membership status in NI and the RoI. Trade union membership status (current union members, former union members, and never been a member) shows differing patterns of association with health and wellbeing outcomes across the RoI and NI.

In the RoI, there is no evidence of an association with psychological wellbeing, with similar levels of low

wellbeing observed across groups (current members: 17.4%; past members: 17.8%; never members: 17.8%). There is also no significant association with general health, with comparable levels of poor health across membership groups (11.3%, 13.4%, and 12.1%, respectively). However, a significant association is observed for work-related stress ($X^2=8.11$ (2), $p=.02$). Current union members are more likely to report high stress (16.8%) compared to those who have never been members (12.1%), while those with past membership report similar levels (13.1%).

Table 10. Health and Wellbeing Outcomes by Trade Union Membership Status in NI and RoI: Percentages and Chi-square Tests

		Poor Psychological Wellbeing (%)	Work-related Stress (%)	Poor General Health (%)
NI	Current union member	17.8	23.4	22.7
	Former union member No, but I have been in the past	10.3	13.3	20.5
	Never been a member of a trade union	15.0	14.0	14.7
	χ^2 (df=2)	5.02	15.73	10.03
	p-value	.08	<.001	.007
	Valid N	1062	1072	1070
RoI	Current union member	19.3	16.8	11.3
	Former union member No, but I have been in the past	17.4	13.1	13.4
	Never been a member of a trade union	17.8	12.1	12.1
	χ^2 (df=2)	n.s.	8.11	n.s.
	p-value		.02	
	Valid N	2680	2707	2696

n.s.= not statistically significant

In NI, a more consistent pattern is observed across all outcomes. There is a significant association between union membership and work-related stress ($p < .001$), where current members report higher levels of work-related stress (23.4%) compared to never members (14.0%), with past members again reporting lower levels (13.3%). For general health, there is also a significant association ($p = .007$), with current members reporting higher levels of poor general health (22.7%) compared to those who have never been members (14.7%), and past members reporting intermediate levels (20.5%). The relationship for psychological wellbeing was approaching statistical significance ($\chi^2(2) = 5.02, p = .08$).

Overall, these findings suggest that trade union membership is more strongly associated with health and wellbeing outcomes in NI than in the RoI. In both contexts, current union members tend to report higher levels of work-related stress, while in NI this pattern extends to poorer psychological wellbeing and general health. These findings likely reflect differences in sectoral distribution, job demands, and organisational context, rather than a direct effect of union membership itself.

6.2. Trade Union Recognition

Table 11 presents variation in low psychological wellbeing, work-related stress, and poor general health by whether the respondent's employer recognises a trade union for the purposes of collective bargaining in NI and RoI.

In NI, levels of low psychological wellbeing and poor general health are broadly similar between workers in organisations with and without recognised trade unions. However, workers in union-recognised organisations report higher levels of work-related stress (19.3% vs 14.5%), and this difference is statistically significant ($OR = 1.40, 95\% CI 1.02-1.94$). This suggests that workers in unionised settings are more likely to report higher levels of stress, although this association is likely to reflect differences in organisational context, sector, or job demands rather than a direct effect of union recognition.

In the RoI, no significant differences are observed in work-related stress by trade union recognition. However, statistically significant associations are observed for both self-reported general health and low psychological wellbeing. Workers in organisations with recognised trade unions report lower levels of poor health (9.7%) compared to those without union recognition (13.7%). The odds of reporting poor health are approximately 32% lower among workers in union-recognised workplaces ($OR = 0.68, 95\% CI 0.53-0.87$). A similar pattern is observed for psychological wellbeing. Workers in organisations without union recognition are more likely to report low psychological wellbeing (19.6% vs 15.8%), with approximately 30% higher odds of low wellbeing compared to those in union-recognised workplaces ($OR = 1.30, 95\% CI 1.10-1.60$).

Table 11. Health and Wellbeing Outcomes by Trade Union Recognition in NI and the Rol: Percentages and Crude Odds Ratios (ORS)

Union recognition for pay and conditions by management:		Low Psychological Wellbeing (%)	Work-related Stress (%)	Poor General Health (%)
NI	Yes	15.0	19.3	18.1
	No	15.4	14.5	18.4
	Valid N	1061	1071	
	ORs	n.s.	1.4 (1.0 to 1.9)	n.s.
Rol	Yes	15.8	13.4	9.7
	No	19.6	13.8	13.7
	Valid N	2681	2707	2695
	ORs	1.3 (1.1 to 1.6)	n.s.	.681 (.53 to .87)

n.s.= not statistically significant

Overall, these findings suggest that trade union recognition is not consistently associated with psychological wellbeing but shows differing relationships with stress and general health across jurisdictions. In NI, union recognition is associated with higher reported stress, while in the Rol it is associated with more favourable general health outcomes. These contrasting patterns highlight the importance of considering organisational context and sectoral differences when interpreting the role of trade unions in shaping worker health and wellbeing.

6.3 Perceived Trade Union Influence Working Conditions and Work Organisation: Implications for Health and Wellbeing

Perceived trade union influence over working conditions and organisation shows differing patterns of association with health and wellbeing outcomes across NI and Rol, with stronger and more consistent relationships observed in NI, as shown in Table 12.

6.3.1 Influence over employment terms and conditions

Perceived trade union influence over employment terms and conditions were associated with health and wellbeing outcomes in both NI and the Rol, with stronger and more consistent patterns observed in NI. In NI, workers reporting low levels of trade union influence on employment terms and conditions were more likely to experience low psychological wellbeing (22.2% vs 11.7%; OR = 1.9, 95% CI 1.3 - 2.8) and work-related stress (25.0% vs 16.9%; OR = 1.6, 95% CI 1.1–2.6) compared to those reporting high influence. Differences in poor general health followed a similar pattern (22.4% vs 15.8%), although these were not statistically significant. In the Rol, differences in work-related stress, general health and low psychological wellbeing were not observed.

6.3.2 Influence over work organisation

Perceived trade union influence over the way work is organised showed a clear association with health and wellbeing outcomes in NI, but not in the Rol. In NI, workers reporting low trade union influence were substan-

tially more likely to report low psychological wellbeing (18.5% vs 12.1%; OR = 1.5, 95% CI 1.0–2.3) and work-related stress (25.0% vs 16.9%; OR = 1.60, 95% CI 1.10–2.60) compared to those reporting high influence. Differences in poor general health again followed a similar direction but were not statistically significant. In contrast, in the RoI, there was little evidence of meaningful differences in psychological wellbeing, work-related stress, or general health by perceived trade union influence over work organisation.

6.3.3 Influence over flexible working arrangements

Perceived trade union influence over flexible working arrangements showed

more modest and mixed associations with health and wellbeing outcomes across jurisdictions. In NI, there was no evidence of an association with all three outcomes. In the RoI, there was no evidence of an association with psychological wellbeing or general health. However, workers reporting low influence were more likely to report higher levels of work-related stress (16.1% vs 11.7%; OR = 1.50, 95% CI 1.00–2.10), although this association is marginal.

6.4 Conclusion

Overall, the findings indicate that the relationship between trade unions and worker health and wellbeing is *complex and context-dependent*, varying across

Table 12. Health and Wellbeing Outcomes by Perceived Trade Union (TU) Influence Across Domains in NI and the RoI: Percentages and Crude Odds Ratios (OR)

TU influence over...	Level of TU influence	Low Psychological Wellbeing	Work-related Stress	Poor General Health	Low Psychological Wellbeing	Work-related Stress	Poor General Health
		NI			RoI		
Employment terms & conditions	High	11.7	16.9	15.8	15.6	13.5	9.9
	Low	22.2	25.0	22.4	18.8	14.7	10.7
	Valid n	520	522	518	1006	1015	1015
	Crude ORs	1.9 (1.3 to 2.8)	1.6 (1.1 to 2.6)	n.s.	n.s.	n.s.	n.s.
Work organisation	High	12.1	16.9	15.8	15.7	13.2	10.3
	Low	18.5	25.0	22.4	16.5	14.4	9.8
	Valid n	527	522	518	1009	1016	1016
	Crude ORs	1.5 (1.0 to 2.3)	1.6 (1.1 to 2.6)	n.s.	n.s.	n.s.	n.s.
Flexible working	High	15.4	16.9	16.9	16.0	11.7	9.7
	Low	12.8	21.9	20.2	16.6	16.1	10.4
	Valid n	520	520	518	987	995	996
	Crude ORs	n.s.	n.s.	n.s.	n.s.	1.5 (1.0 to 2.1)	n.s.

n.s.= not statistically significant

membership, recognition, and (most notably) perceived influence. While trade union membership and recognition show mixed and sometimes inconsistent associations with health outcomes, a clearer and more consistent pattern emerges when considering *perceived influence over working conditions*.

Across both jurisdictions, but particularly in NI, workers who report *greater trade union influence over core aspects of work (such as pay, working conditions, and work organisation)* tend to, on average, report better psychological wellbeing and lower levels of work-related stress. In contrast, simply being a union member or working in a union-recognised organisation does not consistently correspond to better outcomes and, in some cases, is associated with higher reported stress, likely reflecting underlying differences in sector, job demands, and organisational context.

Taken together, these findings suggest that it is not the presence of trade unions alone that matters for health and wellbeing, but the extent to which workers perceive they have *meaningful voice and influence over their working conditions*. This highlights the importance of moving beyond structural indicators of representation to consider how effectively worker voice is translated into influence in practice, and how this may contribute to healthier and more supportive work environments.

7. Psychosocial Work Factors & Wellbeing

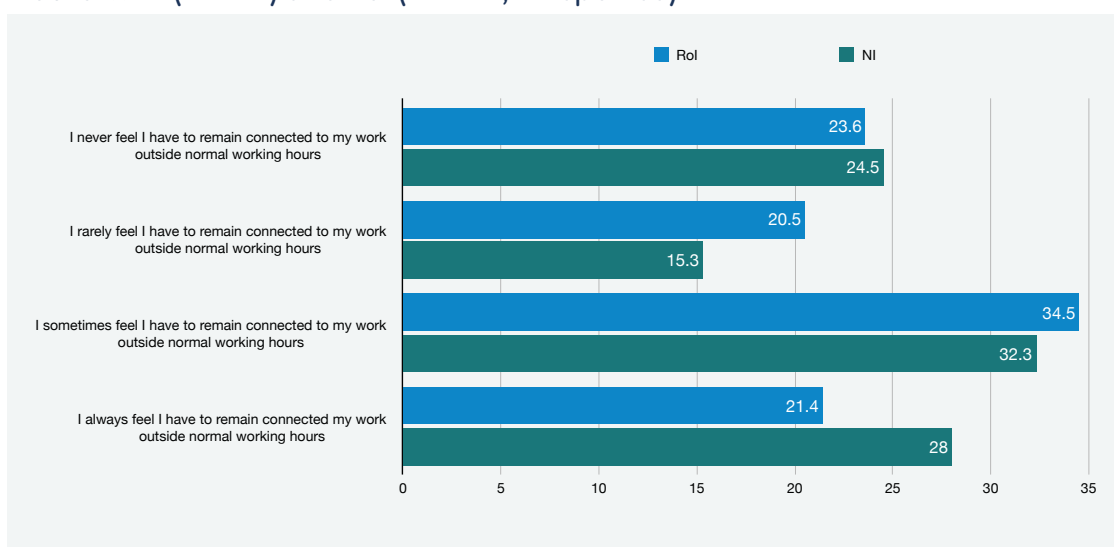
This section examines how key psychosocial aspects of the work environment are associated with workers' health and wellbeing in NI and the RoI. These factors reflect the conditions under which work is organised and experienced, including job demands, working time arrangements, management practices, workplace relationships, and exposure to negative behaviours. Specifically, the analysis considers factors such as time pressure, job autonomy, the ability to disconnect from work, supportive management practices, employee voice and participation, workplace relationships, and experiences of bullying, harassment, and violence.

Understanding these factors is important as they represent modifiable aspects of work that can either support or undermine employee health and wellbeing. Examining their associations with health outcomes provides insight into potential areas for intervention, with a particular emphasis on preventative approaches that address working conditions before more serious problems emerge. This is closely aligned with a psychosocial risk management approach, which focuses on identifying, assessing, and addressing workplace factors that may impact employee health and wellbeing.

7.1 Right to Disconnect from Work

The ability to disconnect from work outside normal working hours is increasingly recognised as an important psychosocial work factor, supporting recovery, rest, and psychological detachment from work. Opportunities to mentally disengage from work are central to employee recovery processes and are associated with better health, reduced fatigue, and improved psychological wellbeing. In contrast, ongoing expectations of availability and constant connectivity may contribute to increased job demands, blurred work-life boundaries, and reduced opportunities for recovery.

Figure 3. Perceived Need to Remain Connected to Work Outside Normal Working Hours in NI (n=1260) and RoI (n=3040; % reported)



In NI, over one quarter of workers (28.0%) report that they *always* feel they have to remain connected to work outside normal working hours, compared to 21.4% in the RoI. A further 32.2% of workers in NI and 34.5% in the RoI report that they *sometimes* experience this expectation. By comparison, only around one quarter of workers in each jurisdiction report that they *never* feel required to remain connected outside working hours (NI: 24.5%; RoI: 23.6%). See Figure 3 for overview.

These findings suggest that expectations of ongoing work connectivity are relatively common across both jurisdictions, particularly in NI where workers are more likely to report always feeling connected to work outside normal working hours. This pattern may indicate reduced opportunities for recovery and psychological detachment from work among a substantial proportion of workers.

Further analysis examined the associations between workers' reported need to remain connected to work outside normal working hours and health and wellbeing outcomes.

In the RoI, a weak positive association was observed with poor psychological wellbeing ($r = .09$, $p < .001$), indicating that greater difficulty disconnecting from work is associated with poorer wellbeing. A moderate negative association was observed with work-related stress ($r = -.26$, $p < .001$), suggesting that workers who report a greater need to remain connected are more likely to experience higher levels of work-related stress. A weak negative association was also observed with self-reported health ($r = -.04$, $p = .027$), although the magnitude of this relationship is small.

A similar pattern is observed in NI. A weak association is evident between difficulty disconnecting from work and poor psychological wellbeing ($r = .10$, $p < .001$), alongside a moderate association with work-related stress ($r = -.26$, $p < .001$). No statistically significant association was observed between the right to disconnect and general health in NI.

Overall, these findings highlight the importance of supporting opportunities for recovery and disconnection from work. Difficulty disconnecting is most strongly associated with higher levels of work-related stress, with weaker links to other health outcomes, underscoring the risks associated with constant connectivity and "always-on" work cultures.

7.2. Supportive Management Practices

Overall, employees in both NI and the RoI report largely positive perceptions of their managers across all measures. See Table 13. The highest levels of agreement are observed for being treated with respect, with 86.8% of workers in NI and 90.2% in the RoI reporting that their manager respects them as a person.

Slightly lower levels of agreement are reported in relation to praise and recognition (78.0% in NI; 80.0% in the RoI) and support for development (78.6% in NI; 79.7% in the RoI). Higher levels of agreement are observed for support during health-related issues, particularly in the RoI (87.5% compared to 83.1% in NI).

A small proportion of workers report neutral views across these items (ranging from 5.2% to 10.1%), while between 4.5% and 13.0% indicate that

Table 13. Perceptions of Supportive Management Practices in NI (n=1,070; %) and the RoI (n=2,710; %)

Your supervisor or manager....	Respects you as a person		Gives you praise and recognition when you do a good job		Encourages and supports your development		Supports you when you are dealing with health-related issues	
	NI	RoI	NI	RoI	NI	RoI	NI	RoI
Strongly Agree /Agree	86.8	90.2	78.0	80.0	78.6	79.7	83.1	87.5
Neither	6.4	5.2	9.0	9.5	10.1	9.8	10.1	6.8
Strongly Disagree/ Disagree	6.8	4.5	13.0	10.6	11.3	10.5	8.2	5.7

they disagree or strongly disagree. Disagreement is most pronounced in relation to praise and recognition and developmental support, particularly in NI.

Overall, while perceptions of management practices are positive across both jurisdictions, slightly lower levels of agreement and higher levels of disagreement in NI, especially in relation to recognition and support, suggest potential areas for strengthening everyday management practices.

Table 14 presents correlations between supportive supervisor behaviours and health and wellbeing outcomes in NI and the RoI. Across both jurisdictions, all supportive management behaviours are significantly associated with better psychological wellbeing, lower work-related stress, and better general health (all $p < .001$).

The strongest and most consistent associations are observed for psychological wellbeing. Employees who report that their manager treats them with respect, provides praise and recognition, supports their development, and offers support during health-related difficulties are less likely to report poor psychological wellbeing (ranging from approximately $r = -.17$ to $-.23$ across both jurisdictions).

Moderate associations are also evident for work-related stress, with higher levels of perceived managerial support associated with lower reported stress (ranging from approximately $r = .14$ to $.23$). These relationships are consistent across both NI and the RoI, although slightly stronger associations are observed for support during health-related issues in NI. Associations with general health are weaker but remain statistically significant. Supportive management behaviours are linked to better self-reported health, although the magnitude of these relationships is generally small (ranging from approximately $r = .11$ to $.16$).

Overall, these findings suggest that supportive and relational management practices are consistently associated with more positive employee health and wellbeing outcomes, with the strongest relationships observed for psychological wellbeing and work-related stress.

Table 14. Correlations (all $p < .001$) Between Supportive Supervisor Behaviours and Health and Wellbeing Outcomes in Rol and NI

You Supervisor/ Manager....		Psychological Wellbeing	Work-related Stress	General Health
Respects you as a person	Rol	-.21	.17	.12
	NI	-.18	.17	.12
Gives you praise and recognition when you do a good job	Rol	-.22	.14	.16
	NI	-.23	.16	.14
Encourages and supports your development	Rol	-.23	.17	.15
	NI	-.202	.183	.133
Supports you when you are dealing with health-related issues	Rol	-.18	.15	.12
	NI	-.17	.23	.15
n	Rol	2,684	2,708	2,695;
	NI	1,061	1,071	1,069

7.3 Employee Voice, Fairness, Trust, and Workplace Relationships

Overall, employees in both NI and the Rol report generally positive perceptions of workplace relationships, fairness, and support, although some variation is evident across specific areas. See Table 15.

The highest levels of agreement are observed for support from colleagues and the ability to raise concerns.

In both jurisdictions, the majority of workers report being satisfied with support from colleagues (Rol: 89.6%; NI: 87.1%) and feeling able to approach management with a grievance or concern (Rol: 88.4%; NI: 84.8%). Perceptions of fairness are also relatively positive, with 82.3% of workers in the Rol and 75.3% in NI agreeing that their organisation treats employees fairly. However, slightly lower levels of agreement are observed in relation to trust in management (Rol: 66.0%; NI: 61.1%) and

Table 15. Employee Perceptions of Trust, Fairness, Support, and Voice in NI (n=1,072) and the Rol (n=2,710; %)

	In general, employees in your organisation trust management		For the most part, this organisation treats its employees fairly		I am satisfied with the help and support I get from my colleagues at work		I am able to express my views to management about my pay		I am able to approach management if I have a grievance or concern at work	
	Rol	NI	Rol	NI	Rol	NI	Rol	NI	Rol	NI
Strongly agree/ agree	66	61.1	82.3	75.3	89.6	87.1	65.1	68.8	88.4	84.8
Neither	14.9	17.7	8.4	11.9	6.1	6.9	15.5	13.8	5.3	7.2
Strongly disagree/ disagree	19.1	21.2	9.2	12.8	4.4	6.1	19.4	17.5	6.3	8.1

the ability to express views about pay (RoI: 65.1%; NI: 68.8%).

Levels of disagreement are highest for trust in management and voice around pay, with 19.4% and 17.5% of workers reporting that they disagree or strongly disagree with these statements in the RoI and NI respectively. In contrast, disagreement is relatively low in relation to colleague support and the ability to raise concerns. Overall, while workplace relationships and support appear strong across both NI and the RoI, lower levels of trust in management and perceived ability to express views on pay suggest areas where organisations may strengthen communication, transparency, and employee voice.

Table 16 presents associations between key psychosocial workplace factors (trust in management, fairness, colleague support, and employee voice) and worker health and wellbeing outcomes in NI and the RoI (all $p < .001$). Across both jurisdictions, more

positive perceptions of the workplace are consistently associated with better psychological wellbeing and lower work-related stress. The strongest and most consistent associations are observed for psychological wellbeing, with moderate negative correlations for trust in management, organisational fairness, and the ability to raise concerns (typically around $r = -.22$ to $-.27$). This indicates that workers who perceive higher levels of trust, fairness, support, and voice are less likely to experience poor psychological wellbeing.

Similar patterns are observed for work-related stress, with small-to-moderate positive associations (ranging from approximately $r = .13$ to $.22$). These findings suggest that more favourable workplace conditions are associated with lower levels of stress, with slightly stronger associations observed in NI for factors such as trust and fairness.

Associations with general health are weaker but remain statistically signifi-

Table 16. Associations (all $p < .001$) Between Psychosocial Workplace Factors and Employee Health and Wellbeing: NI (n=1245) / RoI (n=3007)

Workplace factor		Psychological Wellbeing	Work-related Stress	General Health
Employees trust management	RoI	-.26	.17	.10
	NI	-.26	.20	.14
The organisation treats employees fairly	RoI	-.26	.19	.13
	NI	-.27	.22	.17
Satisfaction with support from colleagues	RoI	-.23	.14	.13
	NI	-.22	.13	.16
Able to express views to management about pay	RoI	-.22	.15	.09
	NI	-.22	.15	.14
Able to approach management about grievances or concerns	RoI	-.26	.16	.15
	NI	-.26,	.15	.14
Valid n	RoI	2,281	2,708	2,695
	NI	1,061	1,071	1,069

cant. Positive perceptions of workplace factors are linked to better self-reported health, although the magnitude of these relationships is generally small (typically $r = .09$ to $.17$). Slightly stronger associations with general health are observed in NI compared to the RoI.

Overall, these findings indicate that workplace environments characterised by trust, fairness, supportive relationships, and opportunities for employee voice are consistently associated with more positive health and wellbeing outcomes. The strongest relationships are observed for psychological wellbeing and work-related stress, highlighting the importance of psychosocial working conditions as key areas for preventative action.

7.4 Bullying, Harassment and Violence

Exposure to bullying, harassment, and work-related violence is an important occupational health concern with implications for workers, organisations, and wider society. Research shows that these experiences are associated with poorer health and wellbeing, higher work-related stress, and adverse organisational outcomes such as sickness absence, turnover, and reduced productivity (Hassard et al., 2018b). There is also growing recognition of the wider economic and societal burden associated with these experiences, including costs related to healthcare use, productivity losses, and reduced quality of life. These impacts are likely to be underestimated, particularly where indirect and intangible costs are not fully captured (Hassard et al., 2019).

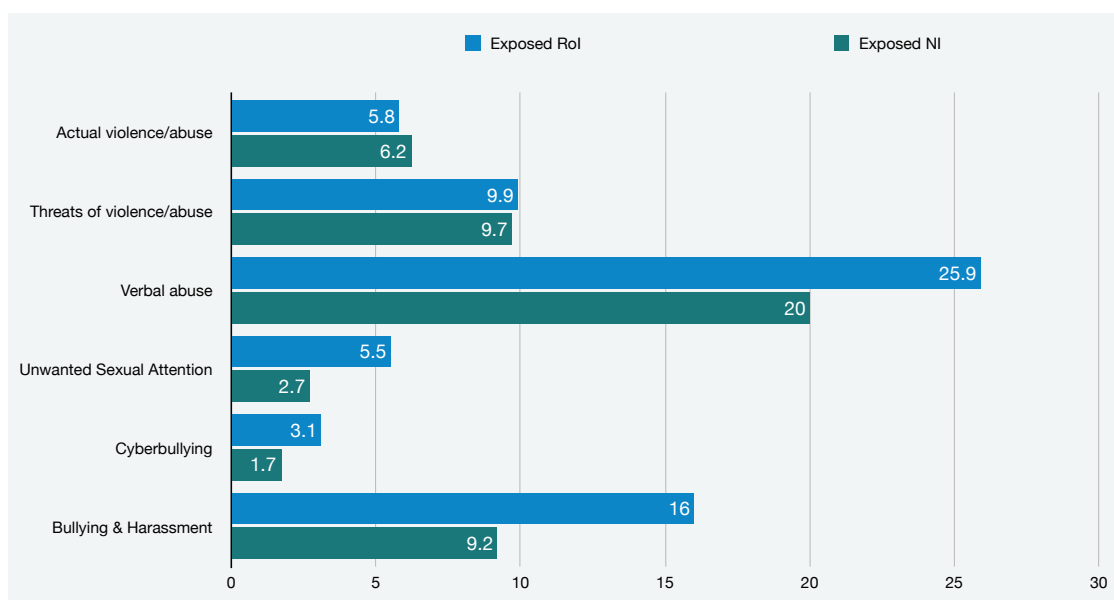
This section provides an overview of the prevalence of exposure to bullying, harassment, and work-related violence among workers in NI and the RoI, and examines associations with key health and wellbeing outcomes, including poor health, work-related stress, and poor psychological wellbeing. Crude odds ratios are presented to estimate the strength of these associations. Table 17 presents the prevalence of exposure to bullying and harassment, cyberbullying, unwanted sexual attention, verbal abuse, threats of violence or abuse, and actual violence or abuse among workers in NI and the RoI. Across both jurisdictions, most workers report never experiencing these behaviours. However, exposure to certain forms of workplace aggression remains relatively common, particularly verbal abuse and bullying-related behaviours.

In the RoI, verbal abuse is the most frequently reported form of exposure, with around one in four workers (25.9%; see Figure 3) reporting experiencing it at least a few times a year. This is followed by bullying and harassment (16.1%), threats of violence or abuse (9.9%), and actual violence or abuse (5.8%). Exposure to cyberbullying and unwanted sexual attention is less common, although a notable minority of workers report experiencing these behaviours.

Table 17. Frequency of Exposure to Bullying, Harassment, and Work-related Violence in NI (n=1065) and the RoI (n=2686; %)

	Bullying & Harassment		Cyberbullying		Unwanted Sexual Attention		Verbal abuse		Threats of violence or abuse		Actual Violence/abuse	
	RoI	NI	RoI	NI	RoI	NI	RoI	NI	RoI	NI	RoI	NI
Daily/ almost daily	1.4	1.1	0.1	0.3	0.3	0	2.5	2.9	1.1	1.4	0.6	0.5
Weekly	1.7	1.5	0.2	0.6	0.9	0.1	3.6	2.4	1.3	1.1	0.6	0.8
Monthly	2	1.6	0.5	0.5	0.7	1.2	3.2	5.1	1.3	2.5	0.7	1
A few times a year	11	5	2.3	0.3	3.6	1.4	16.7	9.6	6.2	4.6	3.9	3.9
Never	84	90.8	96.9	98.3	94.5	97.3	74.1	80	90.1	90.3	94.2	93.8

Figure 4. Percentage of Workers Reporting Exposure to Workplace Aggression and Violence at Least a Few Times a Year



A similar pattern is observed in NI, although prevalence rates are generally lower. Verbal abuse remains the most commonly reported form, with one in five workers (20.0%) reporting exposure at least a few times a year. Smaller proportions report experiences of bullying and harassment (9.2%), threats of violence or abuse (9.7%), and actual violence or abuse (9.7%). Exposure to cyberbullying and unwanted sexual attention is comparatively rare. Overall, these findings suggest that while frequent exposure is relatively uncommon, a

substantial minority of workers experience workplace aggression or violence on at least an occasional basis, particularly verbal abuse and bullying-related behaviours.

Table 18 presents crude odds ratios examining associations between exposure to workplace aggression and health and wellbeing outcomes in NI and the RoI.

Across both jurisdictions, exposure to bullying and harassment, cyberbullying, and verbal abuse is associated

with poorer psychological wellbeing and higher levels of work-related stress. In the RoI, workers exposed to all forms of unwanted workplace aggressions are approximately one and a half to two times more likely to report low psychological wellbeing. In NI, associations with low psychological wellbeing are more limited, with significant relationships observed for bullying and harassment and verbal abuse, while other forms of aggression are not statistically significant.

The strongest and most consistent associations are observed for work-related stress. In the RoI, exposure to all forms of workplace aggression is associated with substantially higher odds of reporting high work-related stress, with odds ratios typically ranging from approximately 3.0 (95% CI 2.2 to 4.0) to 3.6 (95% CI 2.5 to 5.2). A similar

pattern is observed in NI, with elevated odds of stress associated with bullying and harassment, verbal abuse, threats of violence, and actual violence. The largest association is observed for cyberbullying in NI (OR = 5.8, 95% CI 2.2–15.2), although this estimate should be interpreted with caution given the relatively low prevalence of exposure.

Associations with general health are generally smaller and less consistent. In the RoI, exposure to bullying and harassment and verbal abuse is associated with modestly higher odds of poor health, while other forms of exposure are not statistically significant. In NI, a broader pattern is observed, with exposure to bullying and harassment, cyberbullying, verbal abuse, threats of violence, and actual violence all associated with increased odds of poor health, although effect sizes remain modest.

Table 18. Crude Odds Ratios for Associations Between Workplace Aggression and Health and Wellbeing Outcomes in NI and the RoI

		Bullying & Harassment	Cyberbullying	Unwanted Sexual Attention	Verbal abuse	Threats of violence or abuse	Actual Violence/abuse
Low psychological wellbeing							
	RoI	2.1 (1.7 to 2.4), n=2674	1.8 (1.3 to 2.5), n=2670	1.8 (1.4 to 2.5), n=2688	1.6 (1.4 to 1.9), n=2673	1.4 (1.1 to 1.8), n=2674	1.4 (1.1 to 1.9), n=2671
	NI	1.5 (1.1 to 2.3), n=1051	n.s.	n.s.	1.5 (1.1 to 2.0), n=1059	n.s.	n.s.
Work-related Stress							
	RoI	3.3 (2.6 to 4.2), n=2644	3.3 (2.0 to 5.2), n=2645	1.9 (1.2 to 2.8), n=2645	3.5 (2.8 to 4.4), n=2644	3.0 (2.2 to 4.0), n=2644	3.6 ((n=2644
	NI	3.2 (2.0 to 4.9), n=1051	5.8 (2.2 to 15.2), n=1049	n.s.	3.0 (2.1 to 4.3), n=1050	3.6 (2.3 to 5.6), n=1050	2.8 (1.6 to 4.8), n=1051
Poor Health							
	RoI	1.8 (1.3 to 2.3), n=2645	n.s.	n.s.	1.5 (1.2 to 1.9), n=2644	n.s.	n.s.
	NI	1.9 (1.2 to 3.0), n=1051	3.8 (1.5 to 9.7), n=1051	n.s.	1.8 (1.2 to 2.6), n=1050	2.0 (1.2 to 3.1), n=1050	2.3 (1.3 to 3.9), n=1050

n.s.= not statistically significant

Overall, these findings indicate that exposure to workplace aggression is most strongly associated with work-related stress, with more moderate associations observed for psychological wellbeing and weaker or less consistent associations for general health. This pattern highlights the importance of addressing workplace aggression as part of preventative approaches to managing psychosocial risks and supporting employee wellbeing.

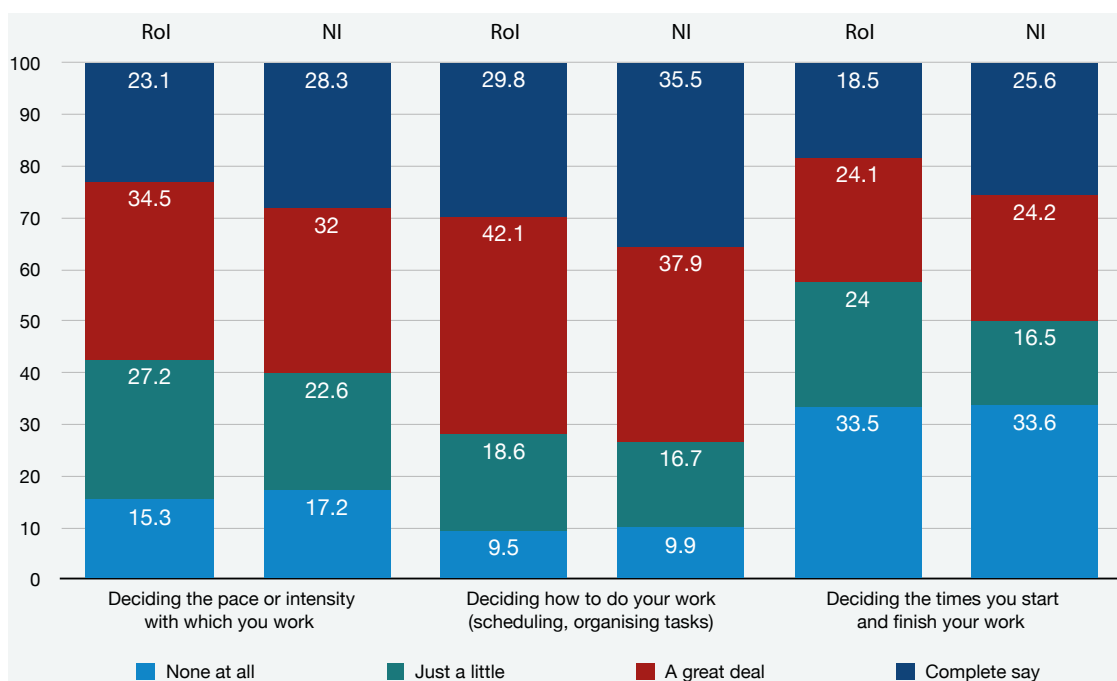
7.5 Work Autonomy

Figure 5 presents levels of employee autonomy across three aspects of work: control over work pace or intensity, how work is carried out (e.g. scheduling and organising tasks), and working time (start and finish times) in NI and the RoI. Overall, a majority of workers in both jurisdictions report having at least some level of control across all three areas. However, the degree of autonomy varies across the three items.

The highest levels of autonomy are observed in relation to how work is carried out. In both the RoI and NI, the largest proportion of workers report having “a great deal” or “complete say” in deciding how to organise and schedule their work tasks. By contrast, lower levels of autonomy are reported for control over work pace or intensity, where a greater proportion of workers indicate having only limited or no control.

The lowest levels of autonomy are observed in relation to working time. In both jurisdictions, a substantial proportion of workers report having little or no control over the times they start and finish work, although around half report having a great deal or complete say. Differences between NI and the RoI are relatively modest. Workers in NI report slightly higher levels of complete autonomy in some areas, particularly in how work is organised, while patterns are otherwise broadly similar across jurisdictions.

Figure 5. Employee Control Over Work Pace, Tasks, and Working Hours in NI (n=1,260) and the RoI (n=3,031; %)



Overall, the findings suggest that while many workers have some control over how they carry out their work, autonomy is more constrained in relation to work pace and especially working time. This highlights potential areas for organisations to strengthen job design and flexibility as part of approaches to supporting employee wellbeing.

Table 19 presents associations between different aspects of job autonomy and employee health and wellbeing outcomes in NI and the RoI. Across both jurisdictions, greater autonomy is consistently associated with better psychological wellbeing, although the strength of these relationships is small. In the RoI, all three forms of autonomy (control over work pace, how work is carried out, and working time) are positively associated with psychological wellbeing (ranging from $r = .09$ to $.18$). A similar pattern is observed in NI for control over work pace and how work is organised, although no significant association is found for control over working time.

Associations with work-related stress are weaker and less consistent. In the

RoI, higher levels of autonomy are associated with lower work-related stress across all three measures, although effect sizes are small (ranging from $r = -.04$ to $-.16$). In NI, only autonomy over work pace shows a small but significant association with lower stress, while other relationships are not statistically significant.

Associations with general health are minimal. In the RoI, small negative associations are observed for autonomy over work pace and how work is organised, indicating a weak relationship with better self-reported health. In NI, no significant associations are observed between autonomy and general health.

Overall, these findings suggest that job autonomy is most consistently associated with psychological wellbeing, with weaker and less consistent relationships observed for work-related stress and general health. This indicates that while autonomy may play a role in supporting wellbeing, its influence on broader health outcomes appears more limited.

Table 19. Associations Between Job Autonomy and Health and Wellbeing Outcomes in NI and the RoI

Autonomy at Work		Psychological Wellbeing	Work-related Stress	General Health
Deciding the pace or intensity with which you work	RoI	.18**	-.16**	-.04*
	NI	.13**	-.06*	n.s.
Deciding how to do your work (scheduling, organising tasks)	RoI	.13**	-.08**	-.05*
	NI	.14**	n.s.	n.s.
Deciding the times you start and finish work	RoI	.09**	-.04*	n.s.
	NI	n.s.	n.s.	n.s.
Valid N	RoI	2,985	3010	2,998
	NI	1,241	1,252	1,252

** $p < .001$; * $p < .05$; n.s. = non-significant.

7.6 Work Intensity and Job Security

Figure 5 presents workers' experiences of key job demands, including working at high speed, working to tight deadlines, and perceptions of being easily replaceable, in NI and the RoI.

Across both jurisdictions, a substantial proportion of workers report being exposed to these demands at least some of the time. In relation to working at high speed, around one third of workers report experiencing this some of the time (RoI: 36.6%; NI: 32.8%), with a notable proportion reporting more frequent exposure. In NI, workers are more likely to report working at high speed all of the time (18.3%) compared to the RoI (13.0%).

A similar pattern is observed for working to tight deadlines. In the RoI, over 40% of workers report working to tight deadlines all or most of the time (41.8%), with a comparable but slightly higher proportion in NI (44.8%). Again, workers in NI are more likely to report experiencing this demand all of the time.

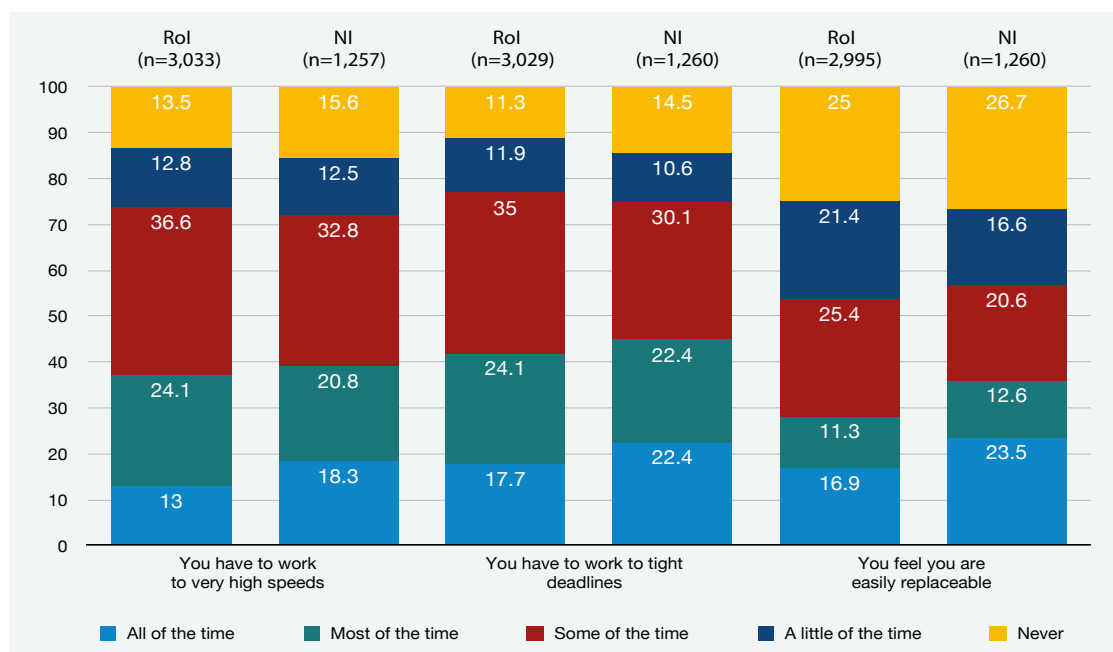
Perceptions of being easily replaceable show a more mixed distribution. While a proportion of workers report experiencing this *"all or most of the time"* (RoI: 28.2%; NI: 36.1%), a larger share report that they rarely or never feel this way, particularly in the RoI.

Overall, these findings suggest that job demands related to work intensity and time pressure are relatively common across both jurisdictions, with somewhat higher levels reported in NI. Perceptions of job insecurity are more varied but remain notable for a substantial minority of workers, particularly in NI.

Table 20 presents associations between key job demands (working at high speed, working to tight deadlines, and perceptions of being easily replaceable) and health and wellbeing outcomes in NI and the RoI. Across both jurisdictions, higher job demands are consistently associated with poorer psychological wellbeing, although the magnitude of these relationships is small. Workers who report greater exposure to high work speed, tight deadlines, and feelings of replaceability are more likely to report poorer psychological wellbeing (ranging from approximately $r = .10$ to $.16$).

The strongest and most consistent associations are observed for work-related stress. In both NI and the RoI, working at high speed and working to tight deadlines are moderately associated with higher levels of stress (ranging from approximately $r = -.30$ to $-.36$). These findings indicate that work intensity and time pressure are key factors linked to elevated stress. Perceptions of being easily replaceable are also associated with higher stress, although the magnitude of this relationship is smaller.

Figure 6. Frequency of Exposure to High Work Intensity, Tight Deadlines, and Job Insecurity in NI and the RoI (%)



Associations with general health are weaker and less consistent. No significant relationships are observed between work intensity and general health in either jurisdiction. Small associations are observed for working to tight deadlines in the RoI and for perceptions of being easily replaceable in both jurisdictions, indicating a limited relationship with self-reported health.

Overall, these findings suggest that job demands, particularly those related to work intensity and time pressure, are most strongly associated with work-related stress, with smaller and less consistent relationships observed for psychological wellbeing and general health. This highlights the importance of managing workload and time pressure as part of preventative approaches to supporting employee wellbeing.

Table 20. Associations Between High Work Intensity, Tight Deadlines, and Job Insecurity and Health and Wellbeing Outcomes in NI and the RoI

Work Intensity and Employment Security		Psychological Wellbeing	Work-related Stress	General Health
You have to work at very high speeds.	RoI	.16**	-.36**	n.s.
	NI	.11**	-.34**	n.s.
You have to work to tight deadlines.	RoI	.12**	-.34**	-.05**
	NI	.10**	-.30**	n.s.
You feel you are easily replaceable.	RoI	.11**	-.09**	-.08**
	NI	.13**	-.10**	-.12**
Valid N	RoI	2,964	2,964	2,978
	NI	1,245	1,246	1,243

** p<.001; *p<.05; n.s. = non-significant.

7.7 Conclusion

Overall, the findings highlight the importance of psychosocial working conditions as key determinants of employee health and wellbeing across both NI and the RoI. Factors related to how work is organised and experienced, including work intensity, time pressure, management practices, workplace relationships, and exposure to negative behaviours, show consistent associations with wellbeing outcomes.

Across the section, the strongest and most consistent relationships are observed for work-related stress and psychological wellbeing. Higher job demands, particularly work intensity and tight deadlines, are associated with elevated stress, while supportive management practices, positive workplace relationships, and opportunities for employee voice are associated with more favourable outcomes. Exposure to bullying, harassment, and violence is also strongly linked to poorer wellbeing, particularly in relation to work-related stress. Other factors, such as the ability to disconnect from work and job autonomy, show more modest but still meaningful associations, particularly for psychological wellbeing. Across several indicators, workers in NI tend to report less favourable conditions and stronger associations with adverse outcomes.

Taken together, these findings reinforce the importance of a preventative approach to workplace health that focuses on managing psychosocial risks. This includes reducing excessive job demands, strengthening management and leadership capability, supporting employee voice and trust, and addressing workplace aggression. Improving these modifiable aspects of work has the potential to support better health and wellbeing outcomes across the workforce.

8. Employee Performance, Engagement, and Retention

This section examines the associations between health and wellbeing outcomes and employees' perspectives on performance, organisational engagement, and intentions to remain with their organisation.

Employees' willingness to go beyond their formal role, (captured by agreement with the statement *"I am willing to work harder than I have to in order to help the organisation"*) is significantly associated with health and wellbeing outcomes in both jurisdictions. Better psychological wellbeing is associated with greater willingness to exert additional effort (NI: $r = -.168$, $p < .001$; RoI: $r = -.214$, $p < .001$). Small but significant positive associations are also observed with general health (NI: $r = .127$, $p < .001$; RoI: $r = .105$, $p < .001$).

A similar pattern is observed for perceptions that *"this organisation really inspires the very best in me in the way of job performance."* Moderate associations are evident with psychological wellbeing (RoI: $r = -.304$, $p < .001$; NI: $r = -.262$, $p < .001$), indicating that better wellbeing is linked to more positive perceptions of performance and engagement. Smaller associations are observed with work-related stress (RoI: $r = .163$, $p < .001$; NI: $r = .137$), and general health (RoI: $r = .131$, $p < .001$; NI: $r = .143$, $p = .001$).

In contrast, poorer health and wellbeing are associated with intentions to leave the organisation. Employees who report poorer psychological wellbeing are more likely to indicate that they are *"likely to look for a new job in the next year"* (RoI: $r = .205$, $p < .001$; NI: $r = .194$, $p < .001$). Higher work-related stress is also associated with increased turnover intentions in the RoI ($r = .169$, $p < .001$), while poorer general health shows a small but significant association with intentions to leave (RoI: $r = -.069$, $p < .001$).

8.1. Conclusion

Overall, these findings suggest that better health and wellbeing are associated with higher levels of employee engagement and performance, while poorer outcomes are linked to greater intentions to leave. The strongest relationships are observed for psychological wellbeing, highlighting its importance for both organisational performance and retention.

9. Policy Recommendations

1. **Strengthen psychosocial risk management as a core workplace health priority.**

Employers should be supported to systematically identify, assess, and address psychosocial risks, including work intensity, time pressure, bullying, harassment, workplace violence, poor management practices, and limited employee voice. This aligns with international and European frameworks that recognise psychosocial risks as central occupational health challenges (e.g. EU-OSHA, 2026).

2. **Prioritise prevention, not only support after harm occurs.**

Workplace wellbeing strategies should focus on improving job quality, reducing excessive demands, strengthening supportive management practices, and preventing workplace aggression at source. This is consistent with international standards on psychological health and safety at work (e.g. ISO 45003).

3. **Develop line manager and leaders' capability as a central mechanism for prevention.**

Policy and organisational practice should prioritise training and support for line managers in areas such as supportive communication, recognising early signs of strain, workload management, responding to health-related issues, and fostering psychologically safe teams (ERC, 2025; Blake et al., 2023). Strengthening line manager capability is a key lever for improving wellbeing, engagement, and organisational outcomes (Hassard et al., 2024; Dulal-Arthur et al., 2025).

4. **Promote recovery and support the right to disconnect.**

Given the consistent association between difficulty disconnecting and work-related stress, organisations should establish clear expectations around out-of-hours communication and digital availability, alongside promoting healthy boundary-setting and recovery practices (Agolli et al., 2023). Existing policy frameworks (e.g. in the RoI) should be supported through active implementation and monitoring.

5. **Address job demands and work intensity as core psychosocial risks.**

High work intensity, tight deadlines, and workload pressures are among the strongest correlates of work-related stress. As part of psychosocial risk management, these demands should be systematically assessed and mitigated through job design, workload management, and appropriate resourcing to support sustainable work.

6. **Target sectors where poorer outcomes are concentrated.**

Particular attention should be given to sectors such as human health, transport and hospitality, wholesale and retail, and education, where adverse outcomes cluster. This should include sector-specific psychosocial risk profiling and tailored, preventative intervention strategies.

7. **Strengthen employee voice, trust, and organisational fairness.**

Organisations should improve consultation mechanisms, transparency, and opportunities for workers to raise concerns about

pay, workload, and working conditions. Enhancing employee voice and trust represents a key protective factor and supports early identification of workplace risks.

8. Treat bullying, harassment, and workplace violence as prevention priorities.

Policies should focus on early intervention, safe and accessible reporting routes, clear organisational accountability, and sector-specific prevention approaches. This includes embedding these risks within broader psychosocial risk management systems.

9. Address inequalities in work and health outcomes.

Targeted policy attention is needed for groups where poorer outcomes are more evident, including older workers, workers with lower educational attainment, and, in some contexts, women. This should focus on improving job quality, reducing exposure to adverse working conditions, enhancing access to training and progression, and supporting flexible and sustainable work across the life course.

10. Support early identification and response to fatigue and strain.

Given the prevalence of fatigue, cognitive strain, and emotional strain, particularly in NI, organisations should adopt preventative approaches that enable early identification and intervention. This includes strengthening line manager capability and ensuring effective use of occupational health services to assess risk, support employees, and inform organisational-level action on workload, job design, and working conditions (Blake et al., 2023; Hassard, Jain & Leka, 2021; Jain et al., 2021).

11. Embed health and wellbeing within broader job quality and employment policy.

Policy initiatives relating to job quality (e.g. flexible working, work-life balance, and fair work agendas) should explicitly integrate health and wellbeing considerations. This includes ensuring that measures such as flexible working and right-to-disconnect provisions are implemented in ways that address underlying psychosocial risks through job design, work organisation, and leadership practices (e.g. DfE, 2025).

12. Support implementation through practical tools and employer guidance.

Policymakers should ensure that organisations are not only encouraged but supported to act, through accessible tools, guidance, and frameworks (e.g. psychosocial risk assessment tools, management standards and leadership training, and implementation resources). The focus should be on embedding these approaches within routine organisational practice rather than one-off initiatives.

References

- Agolli, A., & Holtz, B. C. (2023). Facilitating detachment from work: A systematic review, evidence-based recommendations, and guide for future research. *Journal of Occupational Health Psychology*, 28(3), 129–159. <https://doi.org/10.1037/ocp0000353>
- Blake, H., Hassard, J., Bartle, C., & Thomson, L. (2023). Training for line managers should focus on primary prevention of mental ill-health at work. *Perspectives in Public Health*, 143(3), 124–125.
- Department for the Economy (DfE). (2025). *Good Jobs Employment Rights Bill Public Consultation Response*. Belfast: Department for the Economy, Northern Ireland Executive. Available at: Department for the Economy – Good Jobs Employment Rights Bill Public Consultation Response
- Department for Work and Pensions & Department for Business and Trade. (2025). *Keep Britain working: Final report*. UK Government. <https://www.gov.uk/government/publications/keep-britain-working-review-final-report>
- Deloitte (2024). *Mental health and employers: The case for employers to invest in supporting working parents and a mentally healthy workplace* (4th ed.). Deloitte.
- Dulal-Arthur, T., Hassard, J., Bourke, J., Wishart, M., Bartle, C., Roper, S., Belt, V., Leka, S., Pahl, N., Thomson, L., & Blake, H. (2025). Organizations offering line manager training in mental health and presenteeism: A secondary data analysis of organizational-level data. *Journal of Occupational and Organizational Psychology*, 98(1), e12552. <https://doi.org/10.1111/joop.12552>
- ERC – Enterprise Research Centre. (2025). *Mental health and wellbeing practices, outcomes and productivity*. Enterprise Research Centre. Available at: [Mental health and wellbeing practices, outcomes and productivity: Final project report - Enterprise Research Centre](https://www.erc.ie/publications/mental-health-and-wellbeing-practices-outcomes-and-productivity-final-project-report-enterprise-research-centre)
- EU-OSHA – European Agency for Safety and Health at Work. (2019). *The value of occupational safety and health and the societal costs of work-related injuries and diseases*. Publications Office of the European Union.
- EU-OSHA – European Agency for Safety and Health at Work. (2026). *Healthy Workplaces Campaign 2026–2028: Together for Mental Health at Work*. Luxembourg: Publications Office of the European Union. Available at: [Healthy Workplaces Campaign Guide – Together for Mental Health at Work | Safety and health at work EU-OSHA](https://www.osha.europa.eu/en/safety-and-health-legislation/eu-strategic-framework-health-and-safety-work-2021-2027)
- European Commission. (2021). *EU strategic framework on health and safety at work 2021–2027: Occupational safety and health in a changing world of work*. European Commission. <https://osha.europa.eu/en/safety-and-health-legislation/eu-strategic-framework-health-and-safety-work-2021-2027>

- European Commission, European Parliament, & Council of the European Union. (2017). *European pillar of social rights*. European Union. https://commission.europa.eu/system/files/2017-11/social-summit-european-pillar-social-rights-booklet_en.pdf
- European Parliament Committee on Employment and Social Affairs. (2026). *Draft report with recommendations to the Commission on psychosocial risks, stress and mental health at work (PE784.330)*. European Parliament. [EUR-Lex - 52021DC0323 - EN - EUR-Lex](https://eur-lex.europa.eu/lexuris/52021DC0323-EN-2026-05-22)
- Green, F. (2025). *Hard at Work: Job Quality, Wellbeing and the Global Economy*. Oxford University Press.
- HAS – Health and Safety Authority (HSA). (n.d.). *What is WorkPositiveCI?* Dublin: Health and Safety Authority. Available at: Health and Safety Authority – WorkPositiveCI (Accessed: 22 May 2026)
- Hassard, J., & Cox, T. (2011). *Work-related stress: Nature and management*. OSHwiki, European Agency for Safety and Health at Work (EU-OSHA). <https://oshwiki.osha.europa.eu/en/themes/work-related-stress-nature-and-management>
- Hassard, J., Dulal-Arthur, T., Bourke, J., Wishart, M., Roper, S., Belt, V., Leka, S., Pahl, N., Bartle, C., Thomson, L., & Blake, H. (2024). The relationship between line manager training in mental health and organisational outcomes. *PLOS ONE*, 19(7), e0306065. <https://doi.org/10.1371/journal.pone.0306065>
- Hassard, J., Jain, A., & Leka, S. (2021). *International comparison of occupational health systems and provisions*. Department for Work and Pensions, The Stationery Office. <https://www.gov.uk/government/publications/international-comparison-of-occupational-health-systems-and-provisions>
- Hassard, J., Teoh, K. R. H., Visockaite, G., Dewe, P., & Cox, T. (2018a). The cost of work-related stress to society: A systematic review. *Journal of Occupational Health Psychology*, 23(1), 1–17. <https://doi.org/10.1037/ocp0000069>
- Hassard, J., Teoh, K. R., Visockaite, G., Dewe, P., & Cox, T. (2018b). The financial burden of psychosocial workplace aggression: A systematic review of cost-of-illness studies. *Work & Stress*, 32(1), 6–32. <https://doi.org/10.1080/02678373.2017.1380726>
- Hassard, J., Teoh, K. R. H., Cox, T. (2019). Estimating the economic burden posed by work-related violence to society: A systematic review of cost-of-illness studies. *Safety Science*, 116, 208–221. <https://doi.org/10.1016/j.ssci.2019.03.013>
- Hassard, J., Thomson, L., & Blake, H. (2023). Understanding and exploring the cost of poor mental health at work for organizations and society. In *The Routledge companion to mental health at work* (pp. 77-96). Routledge.
- Health and Safety Authority. (2023). *Managing psychosocial hazards in the workplace*. https://www.hsa.ie/eng/publications_and_forms/publications/occupational_health/managing_psychosocial_hazards_in_the_workplace_2023/

- Health and Safety Executive for Northern Ireland. (2021). *Mental well-being guide for employers*. <https://www.hseni.gov.uk/publications/mental-well-being-guide-employers>
- HSENI - Health and Safety Executive for Northern Ireland (2026a). *Managing work-related stress and mental well-being resources*. Belfast: HSENI. Available at: HSENI Stress Management Resources (Accessed: 22 May 2026)
- HSENI - Health and Safety Executive for Northern Ireland (2026b). *HSENI's Mental Well-being at Work Advisory Service*. Belfast: HSENI. Available at: HSENI Advisory Service (Accessed: 22 May 2026)
- ISO - International Organization for Standardization (2021). *ISO 45003:2021 Occupational health and safety management—Psychological health and safety at work—Guidelines for managing psychosocial risks*. <https://www.iso.org/standard/64283.htm>
- Jain, A., Hassard, J., Leka, S., Di Tecco, C., & Iavicoli, S. (2021). The role of occupational health services in psychosocial risk management and the promotion of mental health and well-being at work. *International Journal of Environmental Research and Public Health*, 18(7), 3632. <https://doi.org/10.3390/ijerph18073632>
- Leka, S., & Jain, A. (2024). *Conceptualising work-related psychosocial risks: Current state of the art and implications for research, policy and practice (ETUI Research Paper—Report No. 2024.09)*. European Trade Union Institute. <https://doi.org/10.2139/ssrn.5114626>
- McDaid, D., Park, A.-L., Davidson, G., John, A., Knifton, L., McDaid, S., Morton, A., Thorpe, L., & Wilson, N. (2022). *The economic case for investing in the prevention of mental health conditions in the UK*. Mental Health Foundation.
- NI DoH – Department of Health. (2019). *Protect Life 2: A strategy for preventing suicide and self-harm in Northern Ireland 2019–2024*. Belfast: Department of Health Northern Ireland. Available at: Protect Life 2 Strategy (Accessed: 22 May 2026)
- RoI Department of Health. (2021). *Healthy Ireland at work: A national framework for healthy workplaces in Ireland 2021–2025*. Government of Ireland. <https://www.gov.ie/en/healthy-ireland/publications/healthy-workplace-framework/>
- RoI DoH – Department of Health. (2019a). *Healthy Ireland Framework 2013–2025*. Dublin: Government of Ireland. Available at: Healthy Ireland Framework 2013–2025 (Accessed: 22 May 2026)
- RoI DoH – Department of Health. (2019b). *Healthy Workplace Framework*. Dublin: Government of Ireland. Available at: Healthy Workplace Framework (Accessed: 22 May 2026)
- Thonon, F., Godon-Rensonnet, A.-S., Perozziello, A., Garsi, J.-P., Dab, W., & Emsalem, P. (2023). Return on investment of workplace-based prevention interventions: A systematic review. *European Journal of Public Health*, 33(4), 612–618. <https://doi.org/10.1093/eurpub/ckad092>

WHO – World Health Organization.
(2024). *The World Health Organization-Five Well-Being Index (WHO-5)*.
Geneva: World Health Organization. License: CC-BY-NC-SA 3.0 IGO

Workplace Relations Commission.
(2021). *Code of Practice on the Right to Disconnect*. Dublin: Workplace Relations Commission. Available at: Workplace Relations Commission – Code of Practice on the Right to Disconnect (Accessed: 22 May 2026)



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