Letter to: Mishiba, T (2023): The Legal Regulation of Psychological Hazards at Work: The Hypothesis regarding the Benefits of the Mental Health Approach Compared to the Psychosocial Risk (PSR) Approach. *J Work Health Saf Regul 2023; 2: 97–109*. DOI: 10.57523/jaohlev.ed.23-002

Anthony D. LAMONTAGNE[1], Birgit GREINER[2], Norito KAWAKAMI[3], Reiner RUGULIES[4], Tessa KEEGEL[5], Angela MARTIN[6], Andrew NOBLET[7], Alicia PAPAS[8], Nicola REAVLEY[9], Peter SMITH[10], Katrina WITT[11], Kathryn PAGE[12], and Birgit AUST[13]

We appreciate Prof. Mishiba's detailed consideration of strategies to address psychosocial risk and mental health concerns in the workplace[1)] and share his interest in this important topic. Our articulation of an integrated approach to workplace mental health has been referred to in footnote 4 (Mishiba, p. 98)[2)] as representing Prof. Mishiba's "mental health approach," and some of our other research has been referred to and discussed elsewhere in the piece (p. 102)[3)]. While we agree with many of Prof. Mishiba's points, we disagree on some key points, as set out below.

The psychosocial risk (PSR) approach and the "mental health approach" are set up in opposition to each other in Prof. Mishiba's arguments. We, in contrast, see the two approaches as complementary. In our integrated approach

Received: December 21, 2024; Accepted: December 26, 2024; J-STAGE Advance Published Online: February 28, 2025
[1]Institute for Health Transformation, Deakin University, Geelong, Australia
[2]University College Cork, Cork, Ireland
[3]University of Tokyo, Tokyo, Japan
[4]National Research Centre for the Working Environment, Copenhagen, Denmark
[5]Monash University, Melbourne, Australia
[6]Menzies Institute, University of Tasmania, Hobart, Australia
[7]Deakin Business School, Deakin University, Geelong, Australia
[8]Flourish DX, Melbourne, Australia
[9]Melbourne School of Population & Global Health, University of Melbourne, Melbourne, Australia
[10]Institute for Work & Health, Toronto, Canada
[11]Orygen Centre for Youth Mental Health, Melbourne, Australia
[12]School of Business, Law and Entrepreneurship, Swinburne University of Science and Technology, Melbourne, Australia
[13]National Research Centre for the Working Environment, Copenhagen, Denmark
Corresponding Author: Anthony D. LaMontagne. Institute for Health Transformation, Deakin University, Geelong, Australia
Email: tony.lamontagne@deakin.edu.au

to workplace mental health—which Prof. Mishiba cites as representing the "mental health approach"—we articulate the need for three complementary areas of action: 1) protecting from harm at work, 2) promoting the positive aspects of work, and 3) responding to mental health problems as they manifest in the workplace context[2–5]. Further, the PSR approach only considers work-related adverse impacts on mental health, whereas the integrated approach addresses both work- and non-work-related mental health, both positive (positive mental health and well-being) and negative (mental health problems and disorders).

In our integrated approach[2–5], the prevention and control of PSR fall under "protecting from harm" (e.g., reducing job insecurity), whereas optimizing the health-enhancing aspects of work falls under "promoting the positive" (e.g., promoting workplace social support and connection). Protecting workers from work-related harm to their mental health is a legal/regulatory as well as an ethical mandate in most industrialized democracies, whereas promoting the positive is voluntary. We would acknowledge, however, that there is nuance both in the language and the concepts in the area of PSR and mental health. Some psychosocial working conditions are relevant to both positive and negative mental health outcomes. For example, low job control is a risk factor for depression, but high job control promotes well-being, and high social support at work mitigates the adverse impacts of low job control and high job strain (protecting from harm) while also promoting well-being (promoting the positive). This is part of the rationale for our integrated approach—that specific elements or activities in an integrated approach could provide multiple benefits for health at and away from work. For example, if well executed, a peer support program provides workplace social support that mitigates the impacts of adverse working conditions (protecting from harm) while also promoting social connection (promoting the positive) and providing peer-level access to timely, non-discriminatory help for distressed workers (responding to problems regardless of being work-related or from another cause).

Prof. Mishiba argues that the regulation of PSR is not an appropriate way to intervene and protect employees from harm at work. We disagree, but we also did not find a clear articulation of what Prof. Mishiba understood as the "PSR approach" in his paper. In our view, one important aspect of taking a regulatory approach to PSR is that it formally establishes that working conditions can cause mental health problems and disorders. This has long been contested, but we would argue that the evidence is now very strong[3,6,7]. Thus, PSR should be regulated as a modifiable risk factor for work-related mental illness, just as any other recognized work-related cause of injury or illness should be. While some employers might act to minimize PSR out of moral or ethical obligations, productivity concerns, or for other reasons, other employers tend to operate according to their legal or legislated requirements. While an employer's general "duty of care" includes the psychosocial work environment by default, some employers might only be motivated to act by regulatory requirements to assess and control PSR.

Thus we only partially agree with Prof. Mishiba, who states: "While improvements in work organisation and other work environments are important, they should be carried out for the sake of better human resource management (HRM) rather than enforcement by law" (p. 104). We agree that "better HRM" would be

desirable and that legal enforcement and punishment should be the last resort to apply when other measures fail, but we also believe that regulatory intervention will be required to shift prevalent practice towards best practice[3].

We support the general regulatory approach that has been taken in a number of countries as well as in the ISO 45003:2021[8] and some other voluntary standards, which we would summarize as mandating risk assessment and mitigation of the identified risks to the "extent feasible" or "extent practicable[3,9–11] The qualification on mitigation recognizes that not all risks can be eliminated fully—such as police officer exposure to violence or the high emotional demands experienced by mental health professionals. For PSR that is challenging to eliminate, other means to mitigate those risks can be brought to bear, such as preventing or limiting exposure to violent or emotionally demanding situations through job and work design or re-design, promoting and supporting the positive aspects of such work, and providing for timely and non-discriminatory supports to those showing signs of distress (for example, see Arnetz[12] and Andersen[13]).

A recent review of EU member states' approaches to the regulation of PSR acknowledged a range of approaches, from having specific legislation on PSR (e.g., Belgium, Sweden, and Finland) to those having some reference to PSR in their legislation (e.g., Spain, Greece, and Poland), to those adopting a "soft law" approach without specific mention of PSR (e.g., Ireland)[11]. What each of these has in common is the provision of requirements or advices on how to conduct risk assessments, accompanied by guidance on risk management (strategies to mitigate identified PSR). Some jurisdictions go further with inspection/enforcement regimes, requirements for in-house expert advice or counseling, population or sector-based thematic information campaigns, and collaboration between regulators and workplace stakeholders. Jurisdictions vary in their specific approaches for a wide range of reasons that are beyond the scope of this discussion—it is the core work health & safety approach of "Identify-Assess-Control (IAC)" that we see as essential to any regulatory approach to PSR.

Perhaps it is a specific form of PSR regulatory intervention that Prof. Mishiba opposes. For example, some might propose an exposure limit approach based on normative working population data using established multi-item survey measures (e.g., effort-reward imbalance, "high" job insecurity, "low" job control). This might be implied by the statement that PSR factors "can also be sources of strength…" (p. 103) and that exposure to psychosocial factors "…can be either good or harmful, depending on the quality and quantity of stress, the recipient's values and perspectives, and other circumstances" (p. 103). We agree, for example, that what might be an excessive demand for one person could be a welcome challenge for another, depending on personal or organizational resources, circumstances, or perceptions. We also concur that it would be difficult to specify such thresholds for assessing compliance in a regulatory context, but this challenge is not new. Occupational exposure limits have always been based on population average responses, be they to physical, chemical, psychosocial, or other exposures. Perhaps it would be the case that variability of exposure-response would be greater for psychosocial—mental health relationships than for toxic chemical—cancer relationships, for example. And perhaps such thresholds should vary by worker demographics, skill levels, or industrial sectors.

However, this is not where PSR regulatory interventions have gone to date. The fundamental occupational health & safety IAC approach that has been adapted leaves room to account for context, and—where risk assessment is routinely conducted (e.g., Denmark) or encouraged (e.g., Ireland), normative benchmarks are used in a guidance capacity rather than as absolute limits. In countries or contexts where psychosocial risk assessment is not widely or routinely practiced (e.g., Australia), we believe that regulation is a reasonable means to compel the IAC approach, accompanied by awareness campaigns, resources for skill building in psychosocial risk assessment and management, and other workplace stakeholder supports.

Prof. Mishiba also questions the applicability of the hierarchy of controls (p. 103). We agree that the use of the hierarchy does require nuance in the context of PSR; for example, it is not possible to completely eliminate exposure to trauma paramedics. We would, however, strongly argue that the general hierarchy of preferencing primary over secondary over tertiary prevention still stands. This is also referred to as the "hierarchy of controls"[14] or the "principles of prevention"[15] in the work and health context, and it applies equally to PSR and other occupational risks. A decade ago, the EU explicitly expressed this in a legislative context[15]. In relation to mental health and psychosocial risks, it was affirmed in the general EU Framework Directive that "health" includes mental health, and the duty of the employer to control for known risks following the "principles of prevention" should preference primary prevention of PSR at the source of the hazard, which is synonymous with the hierarchy of controls described above (the "principles of prevention" are detailed on p. 5 of the EU Commission document[15]).

Further, we disagree that the "weakness of the PSR approach lies in its tendency to perceive psychosocial factors solely as risks that need elimination" (p. 103). For one, as expressed above, psychosocial working conditions can be health- and well-being-promoting or harmful, and not solely risks that need elimination. To illustrate, we agree that one cannot *eliminate* job demands, but *excessive* demands can be eliminated, and their impacts can be moderated by increasing job control and social support or both of these strategies in combination. Indeed, the most widely studied and validated theoretical models of demand-control[16], effort-reward imbalance[17], and job-demand-resources[18] express that it is the balance of health-averse and -favorable exposures (i.e., job demands and control, job-related efforts and rewards, and job demands and resources) that predict adverse—or favorable—impacts on health & well-being. A further nuance here is that health-favorable psychosocial working conditions can and should be considered in risk assessments for psychosocial hazards because they, too, may contribute to work-related mental health.

The concept of the balance of health-averse and health-favorable psychosocial and other working conditions is also logically necessary for work to be *good* for health and well-being. For example, it has been shown in within-person longitudinal analyses that young workers transitioning into high psychosocial quality jobs (*not* exposed to any of four adverse psychosocial working conditions) are associated with an improvement in mental health. In contrast, there is a dose-related decline in mental health for those workers transitioning into jobs with increasing numbers of adverse psychosocial working conditions[19].

With regard to Prof. Mishiba's characterization of the evidence in support of a PSR

approach, we agree on some points but disagree on others. The 2022 WHO Guidelines on Mental Health at Work[20] are criticized as "lacking convincing evidence of their effectiveness" (p. 102). The WHO Guidelines are based on a series of rigorously conducted systematic reviews combined with human rights and ethical considerations. We acknowledge that for most of the recommendations, the evidence was characterized as "very low," "low," or "moderate" certainty of the evidence, resulting in mostly "conditional" recommendations (for full disclosure, LaMontagne sat on the WHO Guideline Development Group). We agree that the evidence is not strong, as evaluated in systematic review terms preferencing trial-based experimental evidence[21], particularly about organizational interventions (referring to interventions aiming to improve working conditions or the organization of work as a means of improving mental health). We would argue, however, that the evidence is adequate to support these recommendations when combined with the hierarchy of controls prevention principles, as expressed above and in the accompanying ILO Policy Brief[22].

Further, we would argue that the evidence base to date is biased towards individual- and illness-directed interventions, in large part due to the tendency of individual participant randomized controlled trials (RCT) to target proximal, shorter-term outcomes and that individual RCTs require less time and resources to conduct[9]. This privileges individual- and illness-directed interventions over organizational interventions, which conflicts with prevention principles[9]. In contrast, organizational-level interventions are more complex and require multiple steps to achieve improvement in mental health; they target more distal, longer-term outcomes, and they require longer timelines and greater resources. Thus, organizational interventions are more subject to disruption and implementation failure[9,23,24]. The limitations of experimental designs for complex (e.g., organizational) interventions are becoming increasingly recognized, with calls for a more pluralistic approach to the level of evidence required to justify action[21,25]. To further strengthen the evidence base for the WHO guidelines and other recommendations in this area, we would prioritize further research on interventions directed at improving working conditions and the organization of work[9,23,24,26–28] as a means to improving mental and other health outcomes.

On a more positive note, there is growing evidence of improvements in psychosocial working conditions leading to improvements in mental health. Recent systematic reviews[29–31] show that certain types of organizational-level interventions can lead to improvements in employees' health. These are, in particular, interventions that enhance job control and participation, working time-related changes (e.g., influence on work schedules), and better organization of core tasks (e.g., better use of resources, enhanced work processes).

With regard to the characterization of our recent overview of work and mental health (p. 102)[3], we would reiterate that occupational health policy and practice should be based on a combination of principles and evidence and would point out that our integrated approach to workplace mental health, which Prof. Mishiba cites as his preferred strategy, is, in fact based on a synthesis of evidence and principles[2,4,5]. With regard to the shortcomings in demonstrating the impacts of policy interventions (p. 102), we acknowledge that there has been relatively little evaluation of the implementation or effectiveness of specific policy interventions

on psychosocial working conditions; and that this is an evidence gap that urgently needs to be addressed. We further acknowledge that the available evidence on policy interventions is mixed, only in some cases showing better psychosocial working conditions and lower levels of work-related stress in countries with specific regulatory policies on PSR or work-related stress[9,10]. Further research is urgently needed on monitoring and surveillance[32], innovative strategies to support best practices in the workplace, as well as policy implementation and effectiveness evaluation[3,9,10].

In conclusion, we would suggest that the growing emphasis over recent years on "mental health" in the workplace seems to have eclipsed the need for addressing PSR and ignores the impacts of psychosocial working conditions on other health outcomes, including cardiovascular disease, musculoskeletal disorders, and premature mortality[9,33]. Further, too much of a mental health focus tends to individualize responsibility, whereas the prevention of harm is both an organizational and worker responsibility. In our view, a rebalancing to focus more strongly on the improvement of psychosocial working conditions is needed. This is, in fact, being sought through regulation in a growing number of jurisdictions (e.g., recently in Australia and Malaysia[10]), as well as through voluntary policy interventions such as the ISO standard[9]. Finally, we would assert that rather than a "PSR" or a "mental health" approach, our integrated approach encompassing both and more is what is needed to protect and promote health and well-being in the workplace.

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Reply to Professor LaMontagne's Response to My Editorial

Takenori MISHIBA

Corresponding author: Takenori Mishiba. Department of Law, Kindai University, 228-3 Shin-kamikosaka, Higashi-Osaka, Osaka 577-0813, Japan
Email: t-mishiba@jus.kindai.ac.jp

First of all, I would like to express my deep gratitude for the sincere reply to my editorial.

I will provide a concise re-reply rather than a structurally detailed one as below.

1 The reason I cited your literature was to demonstrate that a category called the "mental health approach" can also be valid. It was not to substantiate the absolute superiority of the mental health approach. I fundamentally agree with the integrated approach you advocate. I am merely concerned that, in certain academic circles, the psychosocial risks approach (PSR approach) is being overly emphasized. Additionally, I highlighted the difficulty in differentiating between harmful and non-harmful psychosocial factors.

2 As I stated in my editorial, I too believe that the mental health approach and the PSR approach are not in a mutually exclusive relationship but rather in a complemental one. However, many proponents of the PSR approach

seem to argue as if this is a given assumption, often without even acknowledging the existence of other approaches. It appears as though the deep exploration of a particular stance is presented as an academic paper, which I find unfair. Furthermore, there are often descriptions that expand the scope of the approach, seemingly encompassing everything from workers' management to organizational management. Given the nature of the matter, I believe that in the integrated approach you adopt, it might be difficult to clearly distinguish between positive and negative approaches.

Of course, hazards that cause severe health problems must be eliminated. However, such management is fundamentally a legal right of the employer, not a legal obligation. There may be differences in law and business ethics between Japan and Western countries, but no employer benefits from health problems, and even if legally mandated, I doubt the practical feasibility. In Japan, job security is well-established both legally and ethically which makes this point even more relevant. I cannot agree with arguments that seem to constrain the background (business circumstances), management policies, and individuality of each company. Even if some negative health impacts are anticipated, if the individual consents, the freedom and right to choose how to live and work should also be protected.

Both employers and employees should engage in trial and error to find counterparts that align with their capabilities and values, and self-help efforts to become suitable partners are necessary. There are limits to any welfare state's support mechanisms.

3 The PSR approach, as I understand it, refers to an approach that, when both psychosocial factors in the workplace and other factors are potentially related to health issues, attempts to address them by treating them as issues of psychosocial risks and primarily placing the legal responsibility for management on the employer, similar to hazardous chemicals. By adopting the PSR approach, the law mandates the employer to manage these risks. Proponents of the PSR approach argue that the reason it has not been effective thus far is that employers have not yet fully implemented the management of PSR. However, from my own experience observing numerous cases in Japan, even companies that voluntarily strive to manage PSR do not necessarily succeed, unlike with the management of other risks.

Certainly, even being exposed to the same risk, the outcome differs depending on the recipient's characteristics or conditions, which is also the case with hazardous chemicals. However, there is a fundamental difference between PSR on the one hand and physical and bodily risks on the other. This is likely because humans and organizations are qualitative entities that are difficult to measure with data. Each worker has different abilities and values. Organizational management policies and cultures also differ. Worker-to-worker relationships and worker-organization relationships vary as well. For example, even the same words or working conditions may cause excessive stress for some workers but not for others. As you also point out, the identification of psychosocial hazards is influenced by culture and era. Compared to other countries, Japan has legally recognized psychosocial hazards more broadly and meticulously. In other words, they have been grounds for public workers' compensation or for attributing fault to employers (for public workers' compensation certification, see https://t-mishiba.heteml.net/mentalhealth_law/certification.pdf [accessed: December 24, 2024] and

Abe 2024, and for employer fault, see Mishiba (2020), pp. 145–165).

Recently, in Japan, aggressive customer behavior and verbal abuse from customers (referred to as "customer harassment" in Japan) have been legally recognized as significant stress factors, but this was not the case previously. The same applies to Workplace Ostracism and Underutilization of Capacity. Many judicial precedents have previously justified supervisors' harsh reprimands when workers did not follow their instructions. Even if the psychological impact on workers is the same, society and culture significantly influence whether employers are legally required to respond. It is well known that incidents perceived as excessive stress factors or illegal harassment differ by country. The psychological impact of the same words also varies by country. Therefore, even if "Identify-Assess-Control (IAC)" is legally enforced, while it may raise awareness among stakeholders, determining violations is difficult, and it is prone to becoming a formality.

This principle likely underlies the EU-OSHA (2022) recommendation that AI-based worker management should remain human-centered—in other words, workers should not be treated merely as digital data. As you mentioned, even when analyzing quantitatively, the numerous variables make it extremely difficult. I respect past and emerging stress research, but the psychology of people and organizations inevitably involves complexity, layers, contradictions, and uniqueness.

Japan was the first country in the world to mandate stress checks legally, but this has not necessarily led to a reduction in workers with mental health problems (Mishiba 2020, p. 134; Mishiba 2022, p. 192).

4 I agree with the principle of prioritizing primary prevention over secondary and tertiary prevention in mental health. Taking preventive measures as much as possible is, of course, essential. However, as I understand it, National Institute of Occupational Safety and Health (NIOSH) 's hierarchy of controls mainly illustrates the three-step method, which prioritizes intrinsic measures at the design level. This does not necessarily align with the stages of prevention (primary to tertiary). I do not deny the application of the three-step method to mental health. I merely suggest that due to the nature of psychosocial matters, effective first-step measures inevitably include personal responses. Additionally, EU policy also involves trial and error and cultural influences, and they are not universally effective.

5 I am unaware of any national-level examples where stress management policies based on major stress measurement models, including the NIOSH model, have yielded clear results. Although varying in enforcement strength, many countries, including Denmark, Netherlands, and UK, have implemented PSR Management policies, but no apparent national-level effects have been confirmed. The same applies to Japan, which has introduced a legal stress check system, as mentioned above. Isn't it the case that, even with repeated efforts by researchers utilizing statistics, it remains difficult to achieve more than conditional and partial results? Certainly, measuring the long-term, multifaceted effects of preventive interventions is challenging for both individuals and organizations. However, how does this compare to other hazards? At least in Japan, when Chemical Management and Safety Management are mandated by law, certain effects are observed (Mishiba 2025, pp. 25–29). I believe the reason

for the difference in mental health measures lies in the qualitative nature of psychosocial matters mentioned above.

6 It might be easier to create fields for statistical research by having legal scholars adopt the PSR approach. However, from a broader perspective, at this stage, all approaches remain hypothetical, and even for negative issues, other approaches besides the PSR approach should be treated equally, and effective methods should be explored with an open mind.

While OHS has traditionally been effective in mandating obligations on employers, different measures are required for issues with different characteristics. I believe that even for negative issues, fostering awareness and respect for individuality among employers and employees, and promoting dialogue between the two, is more important than managing through thresholds. Except in cases involving malicious harassment, significant overwork, or sudden changes in working conditions, the PSR Approach differs from my mental health approach. If the integrated approach supports the PSR approach for negative issues, this would differ from the approach only in those cases. The key differences lie in whether legal enforcement is involved, who takes the initiative, and whether the compatibility of values, motivation, and abilities between employers and employees is emphasized.

However, my views strongly consider Japanese companies, where mutual consideration between labor and management is assumed. While there may be commonalities with Western Countries, I understand that the background dependence of mental health measures must be taken into account.

Finally, I believe that the accumulation of insights and research will provide solutions to this issue. I express my respect for Professor LaMontagne's efforts. I hope this discussion will lead to the integration of qualitative and quantitative arguments.

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