Stress in the Workplace – an Action Research case study of Social Services

Margaret Coffey

A thesis submitted in fulfilment of the requirements of Liverpool John Moores University for the degree of Doctor of Philosophy

March 2004

Abstract

The public sector is facing an impending shortage of staff, because young people no longer want to work in it and nearly a third of its workforce is over 50 years of age. Moreover, staff working within the public sector report that stress is the biggest single factor affecting their decision to leave. This thesis presents the findings of a large inclusive study carried out in two social service departments in the North West of England, since the introduction of Best Value, which was set up to improve the quality of local government services. The primary aim of the research was to explore work related stress in social services, using a 'problem diagnosis tool', in order to understand the stressors experienced and to inform the development of interventions aimed at reducing, and or eliminating them. This study used in-depth interviewing to develop an original questionnaire incorporating a wide variety of measures to assess potential stressors and mental well-being. The questionnaire response rate was 33% (n=1,234) and the results demonstrated statistically significant differences between staffing grades ($p<0.05$), with salaried staff reporting higher levels of psychological job demands, control, support, organisational constraints and absenteeism, whilst also reporting the poorest levels of well-being. Job satisfaction throughout both departments was low compared with established norms for various occupational groups. Staff working in Children and Families Division were the worst affected by stress, reporting the highest levels of absenteeism (with 54% of staff reporting being off sick in the previous 6 months), the poorest well-being, and the highest level of organisational constraints. Participatory action research (PAR) using focus groups (n=4) was used within this division to develop a better understanding of the difficulties experienced and develop context-specific interventions aimed at reducing or eliminating these stressors. Findings indicated that the areas of most concern to staff were predominantly organisational, rather than intrinsic to social care work, mainly stemming from a lack of resources. Stressors included: a heavy workload; lack of staff; insufficient recognition/loyalty; poor communication; too much change; and poor sickness levels. Points for action were developed participatively which called for: a review of workloads, staffing levels, and the use of temporary/agency staff; recognition and appreciation; improved communication; improved support and consultation at times of change; and the development of separate policies to deal with persistent long-term sickness absence. Following the development of action plans by management outlining proposed interventions, an evaluation of the process was carried out to highlight what worked well, what did not and in what context. The process evaluation findings highlighted a number of conditions which restricted the development of stress management interventions, together with highlighting a number of conditions necessary for potentially successful interventions to be achieved. These include: commitment from top management; a culture of trust; an assurance that findings will inform actions; the existence of a steering group; sufficient resources (both time and money); a realistic expectation of the outcomes discussed at the outset; an assurance of feedback to staff; a supportive union; and a contract drawn up at the outset setting out timescales and intentions to act on the findings. The process evaluation also highlighted health promotion outcomes achieved throughout the programme, namely; improved health literacy; changes to organisational policies and practices; and staff empowerment and participation. It is recommended that the interventions proposed by the focus groups are thoroughly evaluated from the baseline established by this research, and that the conditions necessary for successful stress management are adopted in future programmes.

Acknowledgements

I would like to acknowledge with thanks the financial backing of Merseyside Health Action Zone and Liverpool John Moores University, whose support made this project possible. I would also like to thank the staff of both the social service departments who took part in this study, for giving me their valuable time, efforts and practical support in carrying out this work within their organisations.

I would like to extend my sincere thanks to my supervisors, Professor Andy Tattersall and especially to my Director of Studies, Dr. Lindsey Dugdill, for their confidence in me, their academic and social support and their continuous encouragement over the past three years.

A heart-felt thank-you goes to my family, especially my husband Phil, my Mum and my daughters Susie and Sarah and to all my friends, above all Sue and Bev, for helping me in so many ways throughout my university career – I hope it was worth it!

Dedicated to Dad, with love always

TABLE OF CONTENTS

Chapter Five – Phase Two – Focus Groups

Chapter Six – Phase Three – Process Evaluation

Chapter Seven – Results

Chapter Eight – Conclusion and future recommendations

Figures **Page**

Tables

CHAPTER ONE - INTRODUCTION

1.0 Introduction

In recent years, stress has become a major concern for employers and employees, not only because of the health effects on individual workers, but also because of the economic impact on business and the social costs to European business (European Agency for Safety & Health at Work, 2003). Whilst some academics have argued that stress is almost a meaningless term (discussed in more detail below, p.7), there is a convincing body of research which shows that, whatever you choose to call it, there is a clear link between poor work organisation and subsequent ill-health (HSE, 2004). The HSE (2004) have decided to continue to use the word 'stress' as the most commonly used term to describe this experience, which they define as *"the adverse reaction people have to excessive pressure or other types of demands places on them"*

There is reasonable consensus in the scientific literature on the psychosocial and organisational hazards of work, deriving from both the content and context of work (see for example, Cox et al., 2000a; Cox et al., 2000b; Levi & Levi, 2000). In this respect, findings from 20 years of occupational health research have shown that stressful working conditions are associated with poor mental and physical health (see for example Cox et al., 2000a; HSE, 2000; Levi & Levi, 2000; Jex & Elacqua, 1999). The Confederation of British Industry recently reported that stress-related absence accounts for the loss of 187m working days a year, costing the country an estimated £12 bn per year (cited in The Guardian, 17th March, 2001). Within those global data it is clear that there are variations in levels of absence and associated costs to organisations across different occupational groups. The Employers' Organisation (2000) annual workforce survey shows, for example, that staff in social services suffer higher levels of sickness than staff in the private sector and other branches of local government (Winchester & Norris, 2000). Social services staff absences averaged 15 days' sickness per employee in 1998/99, with manual social care workers reported to take nearly four weeks. By region, Northern UK Authorities tend to have the highest absence rates. The Health and Safety Commission has responded by calling for public sector bodies to reduce their average absence rates by 30% by 2003 (Industrial Society, 1999).

Jackson (1983) stated that:

> *"to the extent that the job environment negatively affects the health of the individuals, it also negatively affects the organizations in which those individuals are employed"* (p.3).

In this respect, findings from the Audit Commission's Report 'Recruitment and Retention – a public service workforce for the twenty-first century' (September, 2002) indicated that the public sector is facing an *"imminent staffing crisis"* (p.2). This is because young people no longer want to work in it and nearly a third of its' workforce are over 50 years of age. The Audit Commission described this as a potential *"demographic time bomb"* (p.2), stating that there are also concerns about

> *"skill shortages, both in terms of basic skill levels in the workforce, and in the key leadership, management and technical skills that are needed to deliver public service improvements" (p.2).*

The Social Services Workforce Study (Employers Organisation, 2002) mirrors these trends reporting that amongst a total of 283,500 social service staff, around half to two thirds of employees were aged over 40; 81% of employees were women, and almost 81% of employees were known to be white. This makes it difficult for Social Service Departments (SSDs) to reflect the needs of their service users in term of gender and ethnicity. Moreover, considering that 92 per cent of young people studying for vocational qualifications in health and social care are female (Community Care, 2001) these difficulties seem set to worsen.

Considering vacancies and turnover, the latest Department of Health figures show that in September 2001, 9.4% of posts within SSDs covered by the survey were vacant (Employers Organisation, 2002). Based on the total workforce figure of 283,500, 9.4% represents a shortfall of approximately 26,650 staff. Although the report indicates that between 2000 and 2001 the level of vacancies overall fell in most employee groups by between 0.5% and 5%, the vacancy rate increased by over 2% amongst children's residential manager and supervisor posts. Whereas the turnover rate for most occupation groups within social services lay between 8% and 13%, for

care employees working in children's residential establishments, the rate was 15.3%. At the same time, in terms of recruitment and retention:

> *"the worst affected group was the recruitment of field social workers to work with children and families, for whom half the authorities (48%) reported that they were experiencing difficulties in recruiting"* (Employers Organisation, 2002, p.8).

Therefore, in terms of recruitment and retention, people working with children and families appear to be of most concern within social services.

It is therefore not surprising that in the Audit Commission's (2002) survey *"[p]eople told us that stress was the biggest single factor in their decision to leave"* (p.21). This is worrying, not only in the light of the growing recruitment and retention problems, but also as:

> *"there is a mounting body of evidence suggesting that job stress and staff burnout in human service programs adversely affect the helping process and the welfare of clients"* (Cherniss, 1980, p.29).

The philosophy for stress prevention held by the European Commission's Framework Directive (1999) is for employers to try to "eliminate the stressor(s)" (p.74), i.e. primary prevention. Organisational change *plus* stress management is recommended as a comprehensive approach to a healthy workplace (National Institute of Occupational Safety and Health, 2000; Cox et al., 2000b; European Foundation, 1997). However, preventative activities are still comparatively rare, and "a review of the stress management literature reveals that most interventions are weak, targeting only the individual, and that very few are adequately designed or evaluated in scientific terms" (Cox et al., 2000b, p.120; Springett & Dugdill, 1995). At the same time there are few studies to date that have reported positive results, with frequent methodological limitations in the research that has previously been published (Nytro et al., 2000). This is leading to a growing feeling of discontent with the stress management industry which, sceptics claim, can offer solutions that can do more harm than good, e.g. relaxation therapies, when the problem is that they have been

forced to take on too much work (Briner & Reynolds, 1999). This is due to the tendency, highlighted by Cox et al (2000b), to apply stress management strategies without an initial 'problem diagnosis' stage and to focus on single, rather than multiple intervention strategies. This method is described as essentially one of damage limitation in that it generally addresses the consequences of stress rather than its sources (European Foundation for the Improvement of Living & Working Conditions, 1997). Additionally, under the Health and Safety at Work Act (1974) organisations have a statutory legal responsibility for the health (both physical and mental) and safety of their employees, and have a duty in law to assess *all* risks to employee safety.

This thesis presents the findings of a recent study carried out in two social service departments in the North West of England. These Departments are part of large Borough Councils, together serving the needs of over 600,000 people living within their boundaries, of which approximately 18% are over the age of 65.

1.1 Aims of the research

The overall aim of this research was to develop an understanding of *what* stressors impact on social service staff, in order to develop an effective intervention, or range of interventions from a grounded research baseline, which could then be followed up with an evaluation study to assess the effectiveness of the interventions applied. This 'systematic approach', as recommended by Cox et al (2000b), NIOSH (1999), and the European Foundation (1997), highlights the importance of going beyond a *"piecemeal response to health problems as they arise"* (European Foundation, 1997, p.26). This approach advocates active involvement of higher management; employee participation; personnel management; occupational health service; external guidance; works councils; health and safety committees and trades unions.

The reported research has been carried out in three phases. Firstly, a baseline survey was used to identify what stressors were impacting on social service staff and the potential impacts these were having in terms of mental well-being and job satisfaction. This phase also sought to identify which groups, if any, were worst affected by these stressors. The second phase used focus groups in the most severely

affected work area in order to develop effective interventions or a range of interventions in a participatory way from the grounded research baseline already established. The third phase of this research was an evaluation of the process, which was used to identify: what worked well, what did not and in what context; to inform the literature on change management (which tends to give the impression that change is relatively simple, as long as an organisation sticks to recommended recipes); to identify any successes that were not anticipated; and finally, to build evidence concerning the conditions which need to be created in order to achieve successful outcomes and improve intervention effectiveness. This systematic process follows recommendations which advocate approaches to stress management which seek to identify stress problems, look for evidence about cause and effect, make informed decisions about interventions, and evaluate the results (see for example, Briner 2000; International Labour Organization, 2000). Therefore the key research questions for the study are outlined below.

1.1.1 Research questions

- What stressors impact on social services staff?
- By what means can these stressors be reduced or eliminated?
- What services would staff like to be provided by their occupational health service?
- How successful will the future interventions (to be developed with the participants) be in reducing or eliminating stress?

1.2 Objectives

- To develop a research instrument to collect baseline data on those stressors impacting on social service staff.
- To gather and analyse baseline data from which change can be assessed.
- To develop interventions aimed at reducing or eliminating those stressors impacting on social service staff.
- To implement and evaluate the interventions, using a range of qualitative and quantitative tools.
- To inform service provision with social service occupational health units.

CHAPTER TWO – LITERATURE REVIEW

2.0 Introduction

The topic of the healthy work place is vast (Shannon et al., 2001), and as a result the volume of organisational stress research has grown markedly in recent years (Dewe et al., 2000). Therefore this section of the thesis is of necessity limited in its coverage. It's aim is to discuss the key themes that have arisen from the literature, pertinent to the aims of this study, which are to primarily investigate: what stressors impact on social services staff; by what means can these stressors be reduced or eliminated and how successful will future interventions (to be developed with the participants) be in reducing or eliminating occupational stress?

The first section is predominantly theoretical, focusing on: the theoretical models of stress; definitions, frameworks and theories of stress; and philosophies of stress prevention. Within this section individual differences in coping with stress are also briefly considered. The following section is more practical, aiming to put the previous theoretical section into context by focusing on: the scale, causes and consequences of stress; an overview of the public sector; factors contributing to stress in social services with a particular focus on the problems associated with absenteeism in the public sector. The review then goes on to consider what can be done to tackle the problems associated with stress by focusing on stress management, in terms of: interventions; the process of managing interventions within the workplace; and the costs and benefits of preventing stress in the workplace. Finally, participatory action research using focus groups is considered as an approach to creating changes in the workplace aimed at reducing/eliminating stress where possible.

2.1 Theoretical models of stress

Influential theoretical models of stress include Selye's General Adaptation Syndrome and Lazarus' transaction model of stress, with both models providing a different paradigm for conceptualising the problem of work-related stress (Ganster & Schaubroeck, 1991). Lazarus' model focuses on the individual's subjective appraisal of environmental demands, whereas Selye's model focuses more on the objective

features of the environment (Ganster & Schaubroeck, 1991). However, these models do not provide specific guidance as to the particular features of work that are most important, and with regard to work stress the theoretical approaches that have dominated the literature include the Person-Environment Fit model (French et al., 1982) and the Demand-Control model (Karasek, 1979) known as interactional theories of stress (Cox et al., 2000; Levi & Levi, 2000; Ganster & Schaubroeck, 1991), and the effort-reward model (Siegrist, 1996), known as a transactional theory of stress (Cox et al., 2000; Levi & Levi, 2000). Karasek's model is also known as an 'environmental theory' (see Theorell, 1999), which has greatly influenced work redesign, particularly in Sweden.

Interactional models focus on the structural features of the person's interaction with their work environment, while, transactional models are more concerned with the psychological mechanisms underpinning that interaction (Cox et al., 2000). Transactional theories appear to build on the conceptual structures of the interactional models, focusing on the possible imbalance between demands and ability or competence (Cox et al., 2000). According to transactional theories stress is a negative psychological state, involving characteristics of both emotion and cognition, therefore *"they treat the stress state as the internal representation of particular and problematic transactions between the person and their environment"* (Cox et al., 2000, p.41, see also Dewe et al., 2000).

2.2 Definition of stress

The word stress is derived from the Latin word stringere, which means to draw tight, and was used in the 17th century to describe hardships or affliction (Cooper, 1996). During the 18th century, stress was defined as force, pressure, strong effort or strain, preceding definitions of strain and load which were used in engineering terms, and came to influence how stress affects individuals, as an external pressure on the individual producing strain (Cooper, 1996). One of the first scientific attempts to explain the stress process was made by Hans Seyle in 1946, who described the three stages of; alarm reaction; resistance; and exhaustion that the individual encounters in stressful situations (Payne, 1999; Cooper, 1996). It is since then that research on occupational stress has begun.

"At the beginning of the third millennium, academics and practitioners are no more able to cite an uncontested definition of stress than those grappling with the subject in the 1960s" (Rees & Redfern, 2000, p.120). Cox et al (2000b) state that essentially there are three different, but overlapping approaches to its definition and study, namely: the engineering approach, physiological approach, and psychological approach. However, it has been suggested that the available evidence to date takes a multi-factorial and holistic view point, which supports the psychological approach. *"Within this framework, stress is defined as a psychological state which is both part of and reflects a wider process of interaction between the person and their (work) environment"* (Cox et al., 2000b, p.56). This definition highlights the importance of the person's role in appraising the situation, which ultimately determines whether the situation is actually a stressor, i.e. if a person perceives the demands as threatening and perceive that they lack the abilities to cope with them, then stress will result (Payne, 1999). Dewe et al (2000) assert that revisiting the troublesome concept of stress should not be the issue:

> *"but to agree that our energy should now be directed towards creating theoretical structures that recognize that stress is a continually changing relationship between the person and the environment and that no one part can be said to be stress because each is a component of a complex process and each is linked to the other by powerful cognitive processes"* (p.280).

This psychological approach to stress is in accord with transactional models of stress, which sees stress as a negative psychological state, being the internal representation of particular and problematic transactions between the person and their environment (Cox et al., 2000).

Rees and Redfern (2000) assert that the lack of clarity surrounding the definition of stress allows different groups (e.g. trades unions, employers or employers) to be guided by their own perceptions of stress when dealing with stress-related issues, resulting in proposed intervention strategies being based on the prevailing (sometimes contradictory) perceptions of the factors responsible for the problem. Moreover, these diverse perceptions, with differing emphasis on person-based or environment-based factors, can lead to the minimising of the potential effects of other causes. Rees and

Redfern (2000) highlight how the Confederation of British Industry (1999) for example see stress as potentially beneficial, asserting that much of the negative stress has little to do with factors internal to the organisation, whereas the TUC (1996) highlight the causal factors which are considered to be the direct responsibility of the employer. It is interesting to note that whilst this interaction between the person and his/her environment is acknowledged in union publications on stress *"trade union-led discussion of the specific causes of stress tends to be focused at the organisational and national level"* (Rees & Redfern, 2000, p.123).

2.3 Overview: Frameworks, Theories and Definitions

It is concluded (see for example Cox et al., 2000) that there is growing agreement around the adequacy and usefulness of the psychological approach to stress, which defines stress as a psychological state, which is both part of and reflects a wider process of interaction between the person and their work environment. In this respect, a number of overview models have been offered that summarise the stress process, the most notable being Cooper's model, (1976 cited in Cox et al., 2000) below:

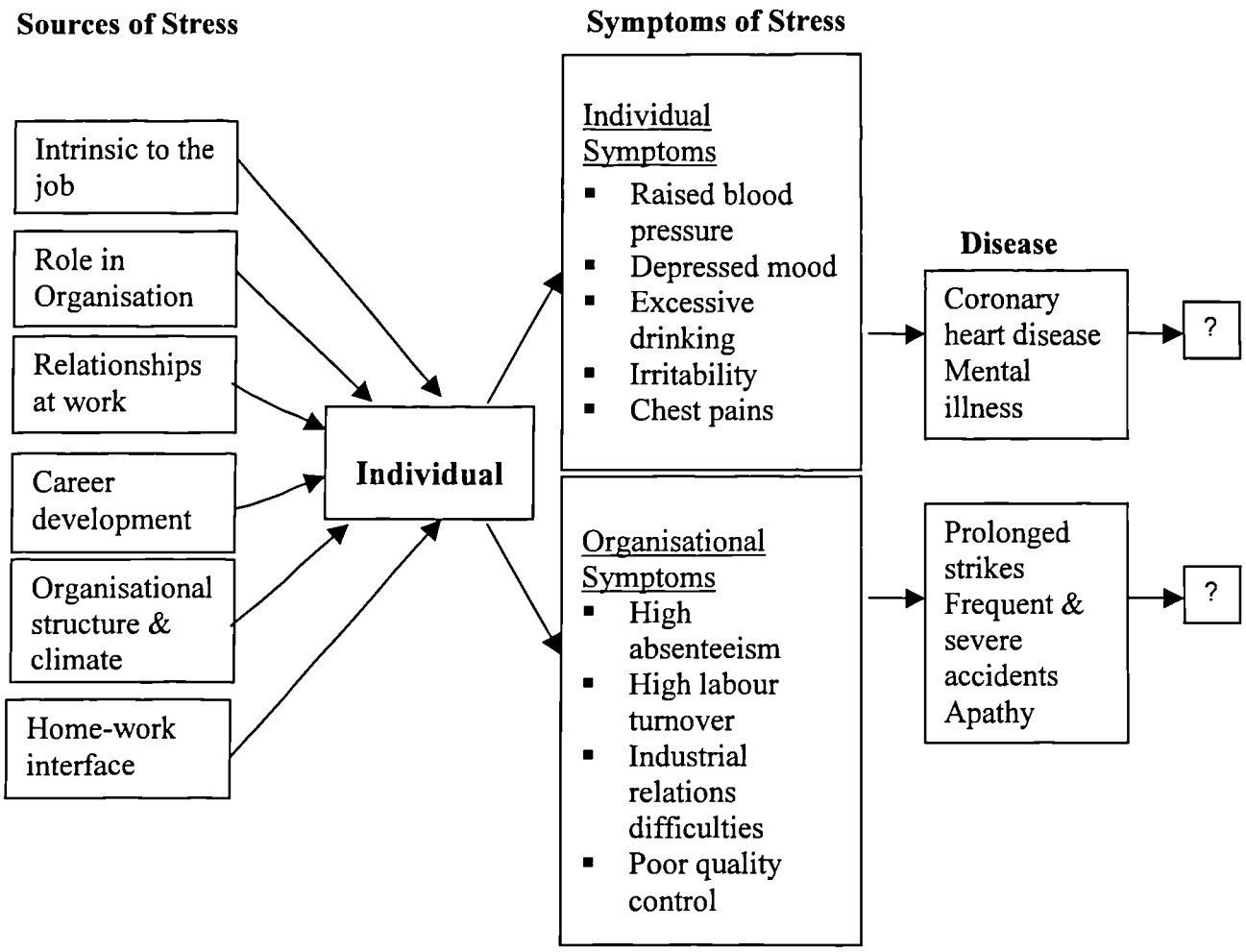


Figure 1: Adapted from Cooper and Marshall's (1976) model of the dynamics of work stress (cited in Cox et al., 2000).

2.4 Individual Differences

There is evidence that the work environment creates stressors, although the amount of stress is affected by the nature of the person who is exposed to it (see for example Cox et al., 2000; Payne, 1999). In this respect, individual differences can be as a result of: genetics in the form of gender and intellectual ability; ascriptions acquired as we develop, such as age, social class, and personality and dispositional factors developed under the influence of both genes and experience (Payne, 1999). Dewe et al (2000) maintain that future research should concentrate on the context of the transaction between the individual and their environment, i.e. those mechanisms through which the stress process develops. However, Clarke and Cooper (2000) highlight that even in seemingly stressful jobs, such as the police (Hart et al., 1995) or

teaching occupations (Hart, 1994) research indicates that organisational factors such as poor communication and bad administration, rather than factors intrinsic to the job, were the main predictors of psychological distress. In addition, the purpose of this research was to develop an understanding of *what* stressors impact on social service staff, in order to develop an effective intervention/range of interventions from a grounded research baseline, which can then be followed up with an evaluation study, rather than to explore the stress process. In this respect, Cox et al (2000) assert that *"a more radical approach is required, as the present research paradigm for individual differences may not be capable of providing the necessary progress"* (p.123). Similarly, the European Union Framework Directive's principles of prevention include combating the risks at source, and adapting the work to the individual, rather than the individual adapting to work (Levi & Levi, 2000). Smith (1998b) maintains however that organisational and individual approaches are to some extent comparable stating that *"the organizational approach is, after all, essentially a highly individual approach, just administered collectively"* (p.1).

Therefore, whilst recognising that individual differences will undoubtedly play a part in people's reactions to stressful environments, it is outside the scope of this thesis to explore the role of such differences. Additionally, the organisations concerned already have secondary forms of stress management interventions in place, i.e. stress management training courses and counselling services, which could potentially help individuals in terms of coping skills etc., however, the focus of this thesis is on *primary* prevention, which takes place at the organisational level, and is aimed at reducing or eliminating the sources of stress in the work environment (see for example Cox et al., 2000; Levi & Levi, 2000). To quote Dr Anton Obholzer, Chief Executive of the Tavistock and Portman NHS Trust speaking at The Cranfield conference *"any individual carrying stress at work does so on behalf of the group, and it's no use caringly frog-marching them off for counselling. You don't give the pit canary therapy, you get it out of the pit"* (cited in Smith, 1998b, p.2).

2.5 Philosophies of stress prevention

The philosophy of the European Commission's Framework Directive (1999) is for employers to try to *"eliminate the stressor(s)"* (p.74), i.e. primary prevention.

Similarly, the EU Framework Directive's principles of prevention include; avoiding risks; combating the risks at source; and adapting the work to the individual (Levi, 2002). This would involve a combination of job-redesign; improving social support; proving reasonable reward for the effort invested by workers; and adjusting occupational physical, chemical and psychosocial settings to the workers' abilities, needs and reasonable expectations (Levi, 2002). The National Institute for Occupational Safety and Health assert that organisational change *plus* stress management (secondary prevention) provides a comprehensive approach to preventing stress at work (NIOSH, 2000). Cox et al (2000b) and the European Foundation (1996) agree, however, their research shows that the majority of action taken by EU Member States is aimed at modifying the stress response or stress-related health outcome, with preventative activities still comparatively rare. Where health promotion activity in the workplace has taken place:

> *"a review of the stress management literature reveals that most interventions are weak, targeting only the individual, and that very few are adequately designed or evaluated in scientific terms"* (Cox et al., 2000b, p.120; see also Burke & Richardson, 2000; Springett & Dugdill, 1995).

Similarly, few studies of organisational stress indicate that a multi-level approach has been attempted (Ivancevich & Matteson, 1988).

Cox et al (2000b) also highlight the tendency to apply stress management strategies without an initial 'problem diagnosis' stage and state that stress management strategies often focus on single, rather than multiple intervention strategies. This method is described as essentially *"one of damage limitation"* in that it generally addresses the consequences of stress rather than its sources (European Foundation for the Improvement of Living & Working Conditions, 1996). Moreover, the traditional approach to stress has been that it is defined by the expert, rather than self-defined by the 'client' (Shipley & Orlans, 1988). *"In order to understand the nature of stress and to design an appropriate stress management programme, we suggest that it is necessary to conduct a stress audit or psychological risk assessment"* (Sutherland & Cooper, 2000, p.126). In this respect, the management of stress at work is based on risk assessment (see for example, Booton, 2002). The benefits of conducting a stress

audit include; using a diagnostic instrument as a proactive approach to stress management; identifying organisational and individual strengths and weaknesses, thereby helping the organisation to target scarce budgetary and time resources; it can help to identify both the target and approach to stress management (i.e. primary, secondary or tertiary); it can provide a baseline measure from which to evaluate any subsequent interventions; and it can help to raise the issue of stress in the workplace and de-stigmatise it (Sutherland & Cooper, 2000). Components of a stress audit (Sutherland & Cooper, 2000) should include identifying the sources of stress; stressor outcomes (including sickness absence levels; job satisfaction levels or levels of anxiety or depression); identify any individual differences which may be moderating or mediating the stress response (e.g. age; gender; occupation; education level or socio-economic status); identify predictors of stress, or those factors most strongly associated with stressor outcomes; and finally, ascertain and measure staff attitudes, i.e. what employees need and want in order to reduce stressors in their workplace. Additionally, Sutherland and Cooper (2000) recommend using qualitative data, such as interviews, to identify stressors specific to the company and assist in the interpretation of the larger-scale questionnaire survey, with the questionnaire design being based on the findings from the qualitative data.

This research aims to address the current gaps in the research, as outlined above, by attempting to firstly carry out a 'problem diagnosis' stage to identify the stressors, and then by using focus groups to generate qualitative data which can be used to participatively develop interventions aimed at eliminating them, i.e. primary prevention. Following NIOSH (2000) and Sutherland and Cooper (2000) it also seeks to inform a user-led occupational health service with the potential to manage stress, i.e. secondary prevention.

2.6 Stress – scale, causes and consequences

Throughout the past few years, levels of concern have been expressed by such organisations as the Department of Health, the Health and Safety Executive, the CBI and a number of Trades Unions, in addition to a number of employers regarding the high cost of stress in financial and human terms, as well as to the national economy (Raymond, 2000). Furthermore there have been a growing number of cases of legal

compensation for stress, the most famous being Walker v. Northumberland County Council (1995), which resulted in costs of approximately £500,000, Mr. Walker being awarded £175,000 (Raymond, 2000). As a result there have been a number of surveys undertaken to investigate occupational stress, its scale, sources and consequences.

2.6.1 Scale and costs of occupational stress

To assess the scale of occupational stress in the UK, the Health and Safety Executive have carried out a number of surveys, including Surveys of Work-Related Illness (SWI), which have been conducted in 1990, 1995, 1998/99, and 2001/02 (HSE, 2002c). Other surveys include the Bristol Health at Work Survey (HSE, 2000a), and research carried out by Smith et al (2000a) looking at impact of demographic factors and type of job on occupational stress. Data from these surveys indicate that in 2001/02 approximately 563,000 individuals were suffering from work-related stress, depression or anxiety in Britain (HSE, 2002c). Furthermore, 80,000 were estimated to be reporting work-related heart disease (HSE, 2002c).

The Bristol Stress and Health at Work Study (SHAW) (Smith, 2001; HSE, 2000a) which is based on the responses of approximately 8,000 people in the Bristol area, found that about one in five workers reported feeling either very, or extremely stressed by their work, equating to about 5 million workers in the UK. Being very stressed was associated with a range of job design factors, including having too much work to do, or not being supported by management and was associated with a range of outcomes, including poor mental health and back pain, and health-related behaviours such as drinking alcohol and smoking (HSE, 2000a). The difference in the figures from the SHAW study and the SWI studies is almost ten-fold, because:

> *"SWI estimates represent more serious cases where individuals reported unprompted that work stress was making them ill, i.e. had some significant physical of psychological impact on their health, whereas SHAW survey estimates represent individuals' assessments of the stress levels in this job"* (HSE, 2002c, p.2).

Therefore, SHAW can be considered as an estimate of those people who feel they are exposed to significant amounts of work stress, whereas SWI data is an estimate of the number of people who believe that they have suffered significant effects as a result of such exposure (HSE, 2002c).

The different measures used, together with variations in the way illnesses are described and classified makes it difficult to assess trends in work-related stress (HSE, 2002c), however:

> *"limiting analyses to England and Wales and attempting to align stress figures to a similar basis suggests an approximate doubling of the prevalence rate of self-reported stress from 1990 to 1999 and no significant change between 1999 and 2001"* (p.3).

Furthermore, the stigma attached to stress, or the awareness and knowledge of stress can change considerably over time and influence the reporting of work-related stress (HSE, 2002c). Kevin Barraclough (2000) a GP warns that the recent medicalisation of stress, highlighted by Dr. Furedi, can actually increase the sense of injury, and invite people to perceive themselves as ill. Barraclough (2000) points out that *"there are many therapists, lawyers, and others who have a vested interest in creating a climate in which people are encouraged to interpret their daily problems through the metaphor of psychological illness"* (p.519). In terms of work-related stress 20% (500,000) of reported cases of ill health (about 92,000 new cases occurring each year) were stress related, which is estimated to be resulting in 6.5 million working days lost annually, at a cost (based on 1995/96 prices) of approximately £3.7 to £3.8 billion (HSE, 1999). More recently, working days lost due to stress, depression or anxiety in 2001/02 were estimated at 13.4 million days, with the average number of days lost per case being 29.2 (HSC, 2002).

The Confederation of British Industry (CBI) has similarly being conducting annual absence and labour turnover surveys since 1987. The latest survey, January/February 2002 reviewed 746 organisations, representing approximately 9% of the UK workforce, or approximately 2.3 million employees (CBI, 2002). Findings indicated that workplace absence has fallen to its lowest level for at least 14 years, although the

cost to employers has risen by more than a billion pounds, with projected costs across the whole workforce of £11.8 bn in 2001 (CBI, 2002). This increase in costs is due to the need to cover absenteeism by spending on overtime or temps, due to lack of operational slack and greater competitive pressures (CBI, 2002). The average number of days lost in the public sector was 10.1, compared to 6.7 on average in the private sector, with the gap between the two sectors reported to be widening. *"The public sector employs 27 per cent of the workforce but, at £3.6 billion, accounts for 32 per cent of the total cost"* (CBI, 2002, p.2). The CBI estimate that of these figures, stress-related absence accounts for the loss of 187m working days per year, costing the UK approximately £12 bn (The Guardian, 17th March, 2001). Further research commissioned by the International Stress Management Association (ISMA) and Royal and SunAlliance (R&SA) indicated that 70% of UK adults have experienced stress in the workplace, with nearly half (49%) of those who experienced stress at work, indicating that it had increased over the past 12 months (ISMA, 2000).

28% of European workers, approximately 41 million people, were reported to be affected by stress at work in 2000 (European Agency for Safety & Health at Work, 2003). Cox et al (2000) suggest that between 50% and 60% of all working days lost are due to stress. Based on 1999 figures, in Europe it is estimated that work-related stress is costing member states at least 20 billion euro annually (European Agency for Safety & Health at Work, 2003).

In June 2000 (HSE, 2001) in Britain the Revitalising Health and Safety (RHS) strategy was launched which set three national targets for improving health and safety performance by 2010. These targets included: a reduction in the number of working days lost per 100,000 workers from work-related injury and ill-health (including stress) by 30%; a reduction in the incidence of work-related ill health by 20%; and a reduction in the incidence rate of fatalities and major injuries by 10%. By 2004, government aims to have achieved half of the improvements under each target (HSE, 2001).

In Europe, the European Commissioner for Employment and Social Affairs, Anna Diamantopoulou, highlighted how work-related stress is being continually identified by both the European Parliament and the European Economic and Social Committee

as one of the key themes for attention (Diamantopoulou, 2002). In response, in December 2000 the European Social Agenda committed the European Commission to developing a Community strategy on health and safety at work, which aims to promote well-being at work in addition to preventing accidents at work and occupational diseases (Diamantopoulou, 2002). This strategy is based on the Guidance on Work-Related Stress (Levi & Levi, 2000) and the European Agency's report on the State of Occupational Safety and Health in the European Union (2000).

2.6.2 Source of workplace stress

The workplace, where many of us spend much of our lives, is a potential source of stress however it is also a potential source of good health promotion (Shipley & Orlans, 1988). Cox et al (2000) having extensively reviewed the literature on the nature of those psychosocial hazards of work which are experienced as stressful and/or carry the potential for harm, found that there is reasonable consensus in the literature, with ten different categories of job characteristics, work environment and organisations identified which may be hazardous (see table 1) (See for example Levi & Levi, 2000; Raymond, 2000; Rees & Redfern, 2000; Smith et al., 1998; Cox & Griffiths, 1996; Jones & Fletcher, 1996; Cooper, 1996; Spurgeon & Barwell, 1995; Cox & Cox, 1993, Warr, 1987a).

Table 1: Stressful Characteristics of Work (Cox et al., 2000, p.68)

Category	Conditions defining hazard
Context to work	
Organisational culture and function	Poor communication, low levels of support for problem-solving and personal development, lack of definition of organisational objectives.
Role in organisation	Role ambiguity and role conflict, responsibility for people.
Career development	Career stagnation and uncertainty, underpromotion or overpromotion, poor pay, job insecurity, low social value to work.
Decision latitude/control	Low participation in decision making, lack of control over work (control, particularly in the form of participation, is also a context and wider organisational issue).
Interpersonal relationships at work	Social or physical isolation, poor relationships with superiors, interpersonal conflict, lack of social support.
Home-work interface	Conflicting demands of work and home, low support at home, dual career problems.
Content of work	
Work environment and work equipment	Problems regarding the reliability, availability, suitability and maintenance or repair of both equipment and facilities.
Task design	Lack of variety or short work cycles, fragmented or meaningless work, underuse of skills, high uncertainty.
Workload/workpace	Work overload or underload, lack of control over pacing, high levels of time pressure
Work schedule	Shift working, inflexible work schedules, unpredictable hours, long or unsocial hours.

The literature is extensive on the sources of workplace stress accordingly it is only possible to briefly discuss each factor below.

2.6.3 Organisational Culture and Function

Organisational culture and management style are frequent sources of stress, including factors such as lack of participation and effective consultation, lack of consistency, office politics, poor communication, and restrictions on behaviour (Smith, 2000b; Cartwright et al., 2000; Levi & Levi, 2000; Cooper, 1996). Stevenson (2000) adds that authoritarian management holding staff in low esteem, seem likely to be among the causes of occupational stress, leading to low job satisfaction and poor communication. In this respect, Professor Sir Michael Marmot, Director of the Whitehall II study (cited in HSE 2000) claims that:

> *"[p]oor work design is a major preventable cause of mental and physical illness. There is likely to be a virtuous circle: management practices that are good for the health of employees are likely to be good for their productivity. Good management is therefore in the interest both of the organization and its workers"* (p.2).

Bacharach and Bamberger (1992) advise that the structuring and design of work in the public sector is critical in achieving the goal of retaining a health and effective professional workforce, given the minimal flexibility that public sector administrators have with regard to monetary compensation. In this respect, a central factor is the level of participation and involvement offered to employees (Spurgeon & Barwell, 1995).

Organisational change can also have negative effects on employees, including: job loss; reduced status; interpersonal conflict at work and home; loss of identity; and threats to individual self-esteem and well-being (Terry & Callan, 2000). In this respect, the experience of change has been isolated as a central defining feature of stress (Terry & Callan, 2000; Cooper, 1996).

2.6.4 Role in organisation

Three critical factors identified as being major sources of potential stress include; role ambiguity; role conflict; and the degree of responsibility one has for others (Cooper,

1996, Spurgeon & Barwell, 1995), especially in public sector organizations (Bacharach & Bamberger, 1992). Furthermore, Smith (2000b) found *"a consistent pattern of results indicating that adequate prestige, status, respect, support and work prospects are all significantly associated with lower levels of work stress"* (p.116). Gardner and Oswald (2002) claim that high levels of education seems to contribute to lower levels of mental stress in later life. Conversely, Smith (2001; see also Bourbonnais et al., 1996) found in the Bristol Stress and Health at Work study that *"educational attainment was found to be an important factor, with those educated to degree level or equivalent having a higher proportion of the high-reported stress category"* (p.78). In this respect, those earning £20,000+ p.a. reported significantly more high stress than those earning below this level (Smith, 2001). Additionally, Bourbonnais et al (1996) found that more women than men were likely to report higher levels of symptoms or distress.

2.6.5 Career development

Job insecurity has been found to be significantly associated with higher reports of occupational stress (Smith, 2000b; Cooper, 1996; Spurgeon & Barwell, 1995). Additionally, issues of promotion, both in terms of being under-promoted and over-promoted have been found to be a potential source of stress (Cooper, 1996; Spurgeon & Barwell, 1995). Recently, Li and Wearing (2002) in a study of the top 350 UK quoted companies found that female non-executive directors, who accounted for just of 6% of the non-executive directors in the sample, are at a disadvantage in gaining promotions such as chair of important sub-committees, or chairs of the board itself.

2.6.6 Interpersonal relationships at work

Relationships with supervisors, colleagues, subordinates and customers are potential sources of stress (Payne, 1999; Cooper, 1996; Jones & Fletcher, 1996). In this respect research has shown that support from colleagues and immediate superiors has been found to be associated with significantly lower levels of perceived work stress (Levi & Levi, 2000; Smith, 2000b; Cooper, 1996; Spurgeon & Barwell, 1995), and increased levels or organisational citizenship (Daniels & Harris, 2000). *"Poor relationships at work can be characterized as having low trust, low levels of*

supportiveness and low interest in problem-solving within the organization" (Spurgeon & Barwell, 1995, p.118).

Low social support at work, after controlling for psychological distress, age, sex, smoking and physical activity, has been found to be associated with elevated heart rates during the daytime, with the effect persisting throughout the evening after work (Evans & Steptoe, 2001).

2.6.7 Home-work interface

Family responsibilities are an important factor in raising the stress level, particularly in families in which both parents' work and single-parent families (International Labour Organization, 2001; Smith 2000b; Cooper, 1996). Smith (2000b) found that:

> *"job stress is more strongly associated with the impact of the job upon one's family life and is more important in determining job stress over time than the way in which one's family life interferes with the time one can devote to work"* (p.118).

The provision of family care appears to magnify the impact of stress on women as research has shown that the total workload of women working full-time is higher than their male counterparts (International Labour Organisation, 2001; Ganster & Schaubroeck, 1991). Even though marital status was found to be influential in the reporting of high stress (Smith, 2001), it was in fact widowed, separated or divorced employees reporting a greater proportion in the high-reported stress category. However, no association between domestic load and psychological distress at work using the Psychiatric Symptom Index (PSI) was found by Bourbonnais et al (1996).

2.6.8 Work environment, work equipment and task design

Poor mental well-being has been found to be directly related to unpleasant work conditions, especially with regards to noise; vibration; lighting and extremes of temperature (Fay & Sonnentag, 2002; Cooper, 1996; Spurgeon & Barwell, 1995). The concept of 'sick building syndrome' refers to *"a building in which the occupants*

experience a range of symptoms causing discomfort and a sense of being unwell, rather than specific illnesses" (Health & Safety Executive/Local Authorities Enforcement Liaison Committee (HELA), 2000, p.1; see also U.S. Environmental Protection Agency, 1991). Additionally stressors, such as inadequate or broken tools or equipment, lead direct impairment of job performance and execution (Fay & Sonnentag, 2002). Monotonous work has also been found to be a major contributor to stress related illness (European Agency for Safety & Health at Work, 2000). Furthermore having a variety of interesting things to do was associated with relatively low levels of work stress Smith (2000b).

2.6.9 Workload, workpace and work schedule

Looking at the literature, research has identified heavy workloads or work overload as being one of the main causes of stress throughout a wide range of occupations (Burbeck et al., 2002; Tudor, 2002; Spurgeon & Cooper, 2001; Gillespie et al., 2001; Cox et al., 2000; Smith et al., 2000b; Cooper, 1996; Spurgeon & Barwell, 1995). These pressures can include constant time pressures, a lot of responsibility, constant interruptions, or unfair treatment at work (Smith, 2000b; Spurgeon & Barwell, 1995). However, the evidence is equivocal, with some studies of workload and role overload finding positive relationships with performance (Jex, 1998). Daniels and Harris (2000) conclude therefore that for work load and job control, the evidence indicates that *"job conditions influence performance asymmetrically and only in certain conditions. That is, extreme forms of job control may enhance performance, and extreme working hours may reduce performance"* (p.305).

In terms of working hours, UK employees tend to work longer than their European counterparts (generally for significantly lower financial reward), with a substantial number exceeding the statutory 48-hour weekly maximum (Stevenson, 2000). In this respect, extended working hours sustained over long periods have been associated with an increase risk of cardiovascular disease (CVD) (Spurgeon & Cooper, 2001). It is not surprising therefore, to find that (Smith, 2001) working full-time was found to be more stressful than working part-time in the Bristol Stress and Health at Work Study.

Shift working has also been linked to a range of physical health problem, together with increased risks of both anxiety and depression (Spurgeon & Cooper, 2001; Smith et al., 2000b; Spurgeon & Barwell, 1995).

> *"Current evidence suggests, as a significant source of occupational stress, shift-working is likely to increase the risk of mental health problems in all workers, and that this risk may be magnified in certain vulnerable groups"* (Spurgeon & Cooper, 2001, p.95/96).

Cardiovascular disorders have been found to be associated with various types of shift work, particularly night work, with Spurgeon and Cooper (2001) stating that these work patterns can be seen as a source of occupational strain, which may act to increase physiological risk factors for CVD, and may also encourage behaviour patterns such as poor diet, smoking, or limited physical activity which are associated with increased risk. Problems associated with shift work have been found to increase with age and are more pronounced in female shift workers (Spurgeon & Cooper, 2001).

2.6.10 Job control, satisfaction and stress

Spector (2002) asserts that *[o]ne of the most important elements in the occupational-stress process is the perception of control"* (p. 134). Perceived control is an important element in all stages of the job stress process, i.e. the work environment; perceived stressor; negative emotion and strain (Spector, 2002). Low levels of perceived control have been found to be associated with a number of strains, including: anxiety, frustration, physical symptoms and doctor visits in the previous twelve months (Spector et al., 1988). Unsurprisingly therefore, low job control has been found to be associated with an increased number of absence spells (Arola et al., 2003). As a result it is increasingly common to see job control, autonomy and decision latitude being increased in order to improve job performance (Jones & Fletcher, 1996). In this respect, the job demands control model (discussed in more detail in the methodology section) (Karasek, 1979) has provided the underlying theoretical basis for the majority of studies on the effects of work control (Terry & Jimmieson, 2001; Jones & Fletcher, 1996).

Having control over work, or sufficient decision latitude, is important because it enables staff to deal with demands by taking personal action (Karasek, 1979), consequently control can moderate the effects of job demands on the cardiovascular system and health status in general (Jones & Fletcher, 1996). Karasek showed that satisfaction at work, mental health, and satisfaction with life in general are best predicted by an optimum combination of job demands and levels of decision latitude or discretion (Payne, 1999). Active jobs are those which people perceived as high on demands and high on decision latitude, which produced elevated levels of satisfaction and positive mental health (Payne, 1999). Distress however is caused in Karasek's model by the combination of low decision latitude and high demands (High Strain Jobs). Low demands and high discretion combined produce relatively stress-free environments where people have higher satisfaction and low stress (Low Strain Jobs) (Payne, 1999). Similarly in Warr's vitamin model of stress (Warr, 1987) control assumes a central role considered important for well-being, as it can potentially allow the individual to adjust the levels of other stressors. However, Jones and Fletcher (1996) point out that *"[d]iscussions of control at work frequently assume that the concept is clear and unambiguous, but even the major theories of job control contain elements within their definitions that may be controversial"* (p.36). Jones and Fletcher (1996) use Karasek's model as an example, pointing out that including measures of skill discretion and decision authority is broader than the popular meaning of control.

The International Labour Organization (2001) asserts that women still tend to occupy less senior jobs then men, resulting in lower levels of control in their jobs. This finding is supported by a recent study of the top 350 UK quoted companies, which found that female non-executive directors accounted for just over 6% of the non-executive directors, with their numbers declining as the company size decreases (Li & Wearing, 2002). Burbeck et al (2002) along with a number of other authors (see for example Bishop et al., 2003; McLean, 1999) assert that having control appears to be important in stress, as well as in new episodes of coronary heart disease. Additionally, McLean (1999) asserts that lack of control and role conflict are associated with job dissatisfaction.

Looking at job satisfaction, Spurgeon and Barwell (1995) assert that the concept of job satisfaction is only poorly understood. However, put simply, job satisfaction and dissatisfaction are dependent on factors to do with the workplace, in addition to factors to do with the individual (Spurgeon & Barwell, 1995). Challenging, rather than overwhelming, working conditions, a comfortable working environment, and reward systems that are perceived of as fair and also under employee control tend to result in high job satisfaction (Spurgeon & Barwell, 1995). However:

> *"job satisfaction is a powerful predictive concept that is also practically very important since a large body of evidence suggests that those who have a positive set of attitudes to their work behave differently from those who see work from a negative viewpoint"* (Spurgeon & Barwell, 1995, p.110).

Job satisfaction with pay, prospects, colleagues, physical working conditions, the running of the section, and the way one's abilities are used have all been found to be significantly associated with low levels of work stress (Smith, 2000b). Length of service has also been found to be associated with job satisfaction, with those who dislike their jobs tending to change them, although only fairly small relationships are generally found between job satisfaction and such factors as absenteeism and turnover (Spurgeon & Barwell, 1995). A study by Parlmore (1969, cited in Spurgeon & Barwell, 1995) reported that job satisfaction was *"a better predictor of the age at which people would die than a range of more obvious predictors including measures of physical health, smoking habits and economic position and security"* (p.110).

2.6.11 Consequences

"There is now considerable evidence that perceived stress at work is widespread and is associated with ill health at work" (Smith, 2001, p.74; International Labour Organisation, 2001; Smith, 2000b; National Institute for Safety & Health, 1999; Cahill et al., 1995; Cox & Cox, 1993). Pathogenic mechanisms include emotional reactions (e.g. anxiety and depression); cognitive reactions (e.g. inability to concentrate or make decisions); behavioural reactions (e.g. alcohol or drug abuse); and physiological reactions (e.g. neuroendocrine and immunological dysfunction) (Levi, 2002). Shipley and Orlans, (1988) assert that the accumulation of stressful

experiences, accompanied by unhealthy coping behaviour, may lay early foundations for subsequent disease, which may be irreversible. Additionally, stress at work is associated with more frequent minor physical problems, such as digestive problems, headaches, upper respiratory tract illness, and backache, and with mental health problems, such as anxiety, depression, and sleeping problems (Spurgeon & Cooper, 2001; Smith, 2001; Smith, 2000; Smith, 2000b; Payne, 1999). Payne (1999, see also Cox et al., 2000), highlight stress as a *process* involving the person interacting with their environment, making appraisals of the interaction, trying to cope, whilst sometimes failing to deal with the problem that arise. This process is outlined by Payne (1999) below:

Table 2: Psychological outcomes of different stress situations (Payne, 1999)

Strength of Stressors	**Duration of Stressors**		
	Short term	**Medium term**	**Long term**
Weak Low demands	Bored Restless Lethargic	Torpidity Loss of direction Helplessness	Dismay Disillusionment Depression Sense of failure Alienation
Moderate Challenging demands	Aroused Liveliness Fun	Challenge Enjoyment Satisfaction Self-efficacy	Achievement Feelings of adequacy or competency and high self-esteem
Strong Excessive Demands	High arousal Tension Excitement	Anger Fear Worry for future Tiredness Accomplishment (if coping)	Anxiety Depression Exhaustion Loss of self-confidence

Additionally, stress has been shown to suppress the immune system, for example Ronald Glaser of the Ohio State University Medical Centre and colleagues, showed that the *"immune response induced by vaccination against pneumococcal pneumonia was lower in people who were chronically stressed"* (Senior, 2001, p.1). Significant associations have also been found between work stress and major depression (Wang & Patten, 2001). Depression, which is the extreme end of stress, has been implicated

as: a primary risk factor for cardiovascular disease; as a cofactor in ulcer formation; and a delaying factor in wound healing (Senior, 2001). Links have also been demonstrated between work-related stress, violence, drug and alcohol abuse and tobacco consumption (International Labour Organization, 2000). For a comprehensive review of this topic in the form of a bibliography, see Ugon (2000).

2.6.12 Legal aspects of stress

The legal aspects of stress are extremely complex and new legislation appears regularly (Raymond, 2000). Consequently, any more than a brief discussion of the key legal aspects of stress is considered outside the scope of this thesis. There is no exact law pertaining to stress, although significant Acts include Health and Safety Act 1974, The Management of Health and Safety at Work Regulations 1992, and The Working Time Regulations 1998 (Raymond, 2000). Under the Management of Health and Safety at Work Regulations 1992 and the Health and Safety at Work Act 1974 there is a statutory duty relating to workers' health, safety and welfare, to carry out risk assessments regarding both physical and psychosocial hazards, and manage the risks as far as is reasonably practicable (Smith, 1998a). The possibility of an employee succeeding in a civil suit for damages following the employer's negligent breach of his common law duty of care (to provide a safe system and conditions at work) has been firmly established since the Walker v. Northumberland County Council case in 1995 (Smith, 1998a). Additionally an employee could claim constructive dismissal after leaving by claiming that their employer did not provide them with a safe place to work (Smith, 1998a).

The Trades Union Council (TUC) conducts surveys, which have been run every two years, and have shown that since 1996 stress has topped the list of participants concerns of the main hazards in their workplace (Tudor, 2002). The most recent research from the TUC (Bryson, 2003) shows that stress claims continue to be a major issue, with 2,503 claims being started in the calendar year 2001, although the overall numbers were less than the previous year, probably due to the change in legislation. Previous surveys by the TUC (Tudor, 2002) showed that the number of stress cases had risen from 459 in 1997 to 6.428 in 2000.

Recently, however, following Terence Sutherland v. Penelope Hatton (2002), the Court of Appeal has redefined the guidelines under which employees can claim damages for psychological illness through stress at work (Harper, 2002). This judgment has led to two teachers and a factory worker, losing awards totalling nearly £200,000, despite being unable to return to their jobs because of stress-related illness (The Guardian, 6th February, 2002). The appeal court ruling makes it clear that if employees feel under stress at work they should inform their employers and give them a chance to do something about it, and that if they fail to do this, a compensation claim is less likely to succeed (The Guardian, 6th February, 2002; Harper, 2002). The court found that; no occupations should be regarded as intrinsically dangerous to mental health; employers generally should assume that the employee can cope with the normal pressures of the job, unless they know of some particular problems with vulnerability; if an employer offers a confidential counselling service, with access to treatment, then they are unlikely to be found in breach of duty; and if the employers only alternative was to either sack or demote the employee, then they would not be found in breach of duty in allowing a willing worker to continue in the job (Harper, 2002). Harper (2002) claims that:

> *"in many respects the decision represents a victory for common sense as it places equal responsibility on employees to bring their condition to the attention of the employer and/or make a decision not to carry on in the same employment if they find that employment stressful"* (p. 48).

Less obvious consequences of stress include bruxism, or worn teeth, with the British Dental Foundation reporting that more young people are presenting with bruxism due to teeth grinding whilst asleep (The Guardian, 27th January, 2000). Bruxism amongst young professionals has been attributed to rising stress at work, with symptoms including: headaches; painful teeth; broken fillings; an aching jaw or neck; and ringing ears (The Guardian, 27th January, 2000). Furthermore, earlier this year, a survey was conducted by NOP on behalf of the Prudential (2003), which *"has shown that after a stressful day at work, 18 million of us hit the shops for a dose of retail therapy"* (p. 1), resulting in spending estimated at approximately £5.4 billion.

Stress does not only affect the individual, examples of how stress can affect an organisation include: increased complaints from clients; less committed staff; an increase in accidents; increase in staff turnover; increased absenteeism; reduction in performance by the workforce; and compensation claims for stress-related illness (Raymond, 2000; Cartwright et al., 1995; Spurgeon & Barwell, 1995; Cox & Cox, 1993). Indices that are indicative of organisational ill health, other than the obvious ones of sickness absenteeism, high turnover and low productivity, include high insurance and health care costs, low levels of commitment and job satisfaction, poor accident and safety records, and generally worsening industrial relations. However 'job performance' is regarded by Jex (1998) as a *"deceptively simple term"* (p.25), considering it is in fact a complex multidimensional concept (Fay & Sonnentag, 2002). Job performance can relate to behaviours engaged at whilst at work, both in terms of behaviours which are not specific to tasks at work, or those which solely contribute to job performance, such as task performance (Daniels & Harris, 2000; for a comprehensive review of definitions of job performance, see Jex, 1998), or more simply, the difference between in-role and extra-role performance, which is essentially voluntary (e.g. personal initiative (PI)) (Fay & Sonnentag, 2002). Jex (1998) proposes that stressors can impact on job performance both, directly and indirectly, most often *negatively* impacting on job performance by first negatively impacting on important antecedents e.g. level of effort, or motivation (see also Fay & Sonnentag, 2002). Fay and Sonnentag (2002) *"argue that the role of stressors for challenging and proactive types of extra-role behaviors is different than for in-role behaviors"* (p.223). Results of their study indicated that working under time pressure and enduring situational constraints were positively related to changes in the extra-role behaviour of PI (Fay & Sonnentag, 2002). Similarly, Daniels and Harris (2002) having reviewed the literature, conclude that *"[s]tudies that have examined average job satisfaction within organizations have produced the strongest evidence of a link between well-being and performance"* (p.307). Daniels and Harris (2002) point out however, that the number of studies are limited, and recommend better designed studies which attempt to investigate the extent to which job satisfaction mediates the relationship between job and organisational characteristics and performance.

According to a recent survey, three-quarters of staff want to see legislation to tackle stress in the workplace (The Guardian, 17th March, 2003). In this respect, The

Guardian (17th March, 2003) reports that the Health and Safety Executive is aiming to introduce work-related stress audits, or risk assessments, as part of its routine health and safety inspections by the end of the year. Risk assessments are being proposed to identify hazards such as bullying at work, poor management and poor work practices, with a view to both developing and following through an action plan aimed at addressing them.

2.7 The Public Sector

"The biggest single reason that people identify for joining the public sector is the opportunity to 'make a difference' for service users and local communities" (Audit Commission, 2002, p.13). However, as Postle (2002) states, *"many care managers expressed feelings of 'divided loyalty', being no longer clear whether they served individuals' needs or those of a bureaucratic organisation..."* (p.345).

In 2001, there were 5.2 million jobs in the public sector, showing an increase of 91,000 (1.8 per cent) on the previous years (Hardwidge, 2002). The public sector is characterised as; having a broad range of stakeholders with sometimes conflicting interests; having complex objectives, i.e. not being driven by a single goal such as profit; being substantially influenced by politics; and having groups of professionals working with them who demand relatively autonomous working conditions, e.g. doctors and social workers (Lawler & Hearn, 1995). 63% of public sector workers are female; 30% work part time; 27% are aged 50 years or over; 44% have at least one degree or National Vocational Qualification; 10% are on either fixed-term or temporary contracts; 59% belong to trades unions and public sector workers report being more satisfied, but more stressed in their jobs, compared to workers in the private sector (Audit Commission, 2002). Women in the public sector are reported to work long hours, reporter greater stress than men and are reported to put off having children because of their careers (Davies & Thomas, 2002). Gardner and Oswald (2001) assert that overall working life in Great Britain grew worse in the 1990s, although the deterioration was particularly sharp in the public sector.

In the UK throughout the 1980s and 1990s there has been a considerable escalation in the rate and scale of change which has been affecting the public sector since the early

1970s (Bennett, 2002; Lawler & Hearn, 1995). Lawler and Hearn (1995) assert that this has resulted in *"public sector organizations either being privatised or being subject to pressures to increase the effectiveness of their management along with increasingly stringent financial review"* (p.7). Janice Robinson, senior adviser in social care for the King's Fund, feels that the government is trying to move too fast with its modernisation agenda (The Guardian, 20th March, 2003).

These changes are characterised by the introduction of the 'three Es' of efficiency, effectiveness and economy, together with a rise in concern for quality, a move to greater evaluation of performance and a change in service users from 'clients' to 'consumers' (Bennett, 2002; Lawler & Hearn, 1995). A further government initiative has been the introduction of Best Value (BV) (Bennett, 2002). BV was introduced by the Labour government to replace the 'competitive compulsory tendering' (CCT) regime (The Guardian, 12th March, 2001). At the heart of the BV's performance management framework is evaluation, learning and continuous improvement (DETR, 1999). The aim is to achieve continuous improvement in performance and improved accountability for performance (DETR, 1999). BV requires councils to apply the four C's to all of their services:

- challenge – challenging traditional approaches to their services;
- consult – local people and local key stakeholders and monitor customer satisfaction on services;
- compare – i.e. benchmark their services against other councils, private and non-profit service providers;
- and compete – look at the cost effectiveness of their spending to ensure that in-house services are the most cost effective, by subjecting them to external competition (The Guardian, 12th March, 2001).

However, despite the number of changes, over time, there has been a relative decline in public sector pay (Gardner & Oswald, 2001).

Looking at staffing in the public sector:

> *"there are concerns about shortfalls in the number of staff, with fewer younger people being attracted to work for the public sector in the first place and a potential 'demographic time bomb' with 27 per cent of the public sector workforce now aged 50 or over"* (Audit Commission, 2002, p.2).

Additionally, in terms of basic skill levels and the key leadership, management and technical skills needed to deliver public service improvements there are concerns (Audit Commission, 2002). As mentioned above, resources are limited in the public sector however the cost of recruiting a member of staff is reported to be £3,456 (Audit Commission, 2002). Moreover, it is reported that *"a new recruit performs at only 60 per cent of their productive potential when they are first appointed, reaching 100 per cent only after they have been in post for a year"* (p.3).

In the public sector, the six main factors identified by the Audit Commission (2002) that underpin people's decision to leave were:

> *"the sense of being overwhelmed by bureaucracy, paperwork and targets; insufficient resources, leading to unmanageable workloads; a lack of autonomy; feeling undervalued by Government, managers and the public; pay that is not 'felt fair'; and a change agenda that feels imposed and irrelevant"* (p.22).

More recently, findings from the Chartered Institute of Personnel and Development's survey on employee attitudes in the public sector indicate that workers are increasingly stressed and dissatisfied with their work, with 30% of local government workers reporting that they find their work stressful, the main causes being high workload and long hours (cited in Pay & Workforce Research, 2003).

2.7.1 Job satisfaction and well-being in the public sector

Gardner and Oswald (2001) used data from the British Household Panel Study to look at two aspects of well-being, job satisfaction and mental strain. Job satisfaction was measured using a scale where respondents were asked to rate their level of satisfaction

with respect to seven aspects of their employment and mental strain was measured using the GHQ-12.

Looking at job satisfaction, results from Gardner and Oswald's study (2001) indicate that public sector job satisfaction levels are lower than the private sector, exhibiting a sharp drop in mean job satisfaction levels in the early 1990s, which flattened out in 1994 and rose slowly thereafter. Similarly, mental strain among British workers rose over the decade with public sector workers reporting a pronounced increase in measured stress, relative to private sector employees, worsening by approximately 1 full point, from 10.36 to 11.32 between 1991 and 1999. Overall, 26.8% of health service workers (measured using the GHQ-12), compared to 17.8 of people in the general population reported significant levels of minor psychiatric disorder (Wall et al., 1997). More recently, amongst health care managers, stress (measured using the GHQ-12) was reported to be higher than private sector managers in the British Household Panel Survey, at 32.8 per cent, compared to 21.3 per cent (using 3/4 caseness cut-off) (Borrill & Haynes, 1999).

2.8 Factors contributing to Stress in Social Services

Looking more specifically at social services, this branch of local government was estimated to employ somewhere between 875,000 to 1.25 million staff, who were made up predominantly of part-time female staff (Eborall & Garmeson, 2001). Independent providers provided about two-thirds of the total staff, making them the major employers (Eborall & Garmeson, 2001). Factors identified in the literature as contributing to stress in this public sector department are considered below.

2.8.1 The nature of work in social services

As mentioned above, the public sector has been characterised by massive changes since the 1970's, with the result that *"[s]ocial work's modern history is one of accelerating change, challenge and insecurity"* (Beresford & Evans, 1999, p.671, see also Jones, 2001; Eborall & Garmeson, 2001; Penna et al., 1996). Eborall and Garmeson (2001) add that it is a highly fragmented industry, operating in different settings, for different providers, with users ranging from small children to the very

elderly. Social services have been placed on the divide between public and private sectors due to the separation of purchasing and providing, and the move to the mixed economy of welfare (Balloch, 1999a). Janice Robinson, senior advisor in social care for the King's Fund, provides us with one example of how these changes have impacted on social services, stating that:

> *"the government's proposed financial penalties for social services departments that fail to promptly arrange community-based care for medically fit hospital patients will only make a bad situation worse"* (The Guardian, 20th March, 2003b).

Organisational change can be a major source of stress and uncertainty for staff, and *"managed badly, change can cause irreparable damage to employee wellbeing and organisational culture"* (Donaldson, 2002, p.25), with one of the key determinants of stress being uncertainty. However, given the changing nature of work in social services, Balloch et al (1999a) assert that it is surprising how little research has been carried out looking at the impact these changes have had on social service staff.

Whilst working with social services users and their relatives has always been challenging (Balloch, 1996), there is evidence to suggest that this work is becoming even more demanding. Balloch (1996; see also Eborall & Garmeson, 2001; Jones, 2001) highlights four main reasons for this. First, the development of consumerism demands that practitioners become more sensitive to service users' needs and rights and has meant that staff have had to rethink their own value systems. In this respect, many staff perceive they are at *"a considerable risk of, at least, complaints and, at worst, litigation"* (Postle, 2002, p.344; see also Eborall & Garmeson, 2001). Second, the boundaries between health and social services have blurred as residential and domiciliary services try to meet the needs of the growing population of frail older people leading to increased demands on social services staff (Eborall & Garmeson, 2001; Balloch et al., 1999b). Third, violence and abuse towards staff appears to have increased. The TUC report 'Violent Times' (1999) reported that in November 1998 Jenny Morrison, a social worker, was stabbed to death by a patient, whilst one in five employees in care homes had been violently attacked or abused at work in the previous year. Fourth, because of stricter eligibility criteria service users are

presenting with more difficult and complex problems than was previously the case (Eborall & Garmeson, 2001; Jones, 2001; Balloch, 1996). This has happened because of the closure of institutions and long stay hospital wards, leading to people with high dependency and expensive care needs living in the community, with a subsequent shift of care costs from the NHS to social service departments (Postle, 2002; Eborall & Garmeson, 2001). Social services have been forced to respond by using 'eligibility criteria' to allocate resources to those in most need, with 'need' being defined as those most a risk (Postle, 2002). A further major change, reported by Eborall and Garmeson, (2001; see also Jones, 2001) is in Government policy, leading to the Children Act 1989 and the National Health Service and Community Care Act 1990, which were designed to improve delivery of care to individuals in need. *"Implementation of these* [acts] *in 1992 and 1993 respectively resulted in major changes to the entire role, structure and culture of local authority social service departments"* (Eborall & Garmeson, 2001, p.23). (See Eborall & Garmeson, 2001 for full details of the policy changes and their impacts).

There appears to be a lack of job descriptions which clearly define the different roles of staff working in social care in England (see Appendix 1). However, homecare workers are predominantly involved in working with the elderly in domiciliary care, whilst social work staff are most likely to be working with a range of clients, both in hospitals in the community (Bradley & Sutherland, 1995; Balloch et al., 1995).

A recent study by Pousette and Hanse (2002) looking at occupational differences as predictors of ill health, reported that although workers in human services (i.e. social services) reported high levels of discretion in their jobs, they also reported high levels of workload and stress symptoms. Pousette and Hanse (2002) suggest that this could be attributed to the chronic lack of resources (i.e. time) to help clients with essential needs, which places the worker in a moral dilemma and is highly frustrating (see also Eborall & Garmeson, 2001; Jones, 2001). This is supported by research on social workers and home help staff (Bradley & Sutherland, 1995), which used in-depth interviews of identify sources of stress for these two groups, as well as the Occupational Stress Indicator (OSI) to measure sources of job stress, self-assessments of physical and mental health and individual differences, including Locus of Control and Type A behaviour. Similarly, looking at the emotional demands amongst workers

interacting with patients, clients or children requiring emotional involvement and empathy, Zapf et al (2001) found emotion work (measured using the Frankfurt Emotion Work Scales) to be predictive of all burnout variables (emotional exhaustion, depersonalization and personal accomplishment).

Table 3: Comparison of ten most frequently cited sources of stress for home help and social work groups (Bradley & Sutherland, 1995)

Home help		Social work	
Source of stress	**%***	**Source of Stress**	**%***
Client depends a great deal on my service	50	Resources inadequate to meet client needs	48
Coping with death of client	45	Lack of alternative facilities if client not progressing	57
Physical demands of job	41	Time pressures	56
Dealing with clients who are ill	39	Paperwork	54
Work overload	39	Having to refuse services to clients	52
Emotional involvement with clients	37	Dealing with crises	51
Time pressures	37	Client vulnerability	48
Feel that I have to keep up a front to clients regardless of how I feel inside	35	Lack of participation in decisions which affect my job	46
Being responsible for client finances	33	Work overload	41
Clients whose behaviour is difficult to handle	33	Lack of influence over how resources used	41
N	**74**	***N***	**63**

* Percentage of sample reporting 'fairly high' or 'extreme' stress

The OSI results indicated that in terms of 'organisational structure and climate' home help workers experienced significantly lower levels of this source than social workers. Conversely, home help workers reported significantly more stress than social workers in respect of 'career achievement' (Bradley & Sutherland, 1995). Looking at health scores (using the OSI) no significant differences in health scores between the two groups were reported, although both home helps and social workers reported significantly poorer mental well-being, and poorer physical well-being than other occupational groups, when compared to a large sample (n=8088) (Bradley & Sutherland, 1995). Both groups identified physical and emotional exhaustion as

symptoms they experienced frequently. Nearly 70% of social workers reported that they had *'felt like'* or *'thought about'* quitting their jobs in the previous year compared to 36% of hope helps, not surprisingly therefore, home helps reported being more committed to their jobs than social workers. These results, combined with the results highlighted in Table 3 underline the importance of looking at the varied roles within the wider organisation, which will be considered further below.

2.8.2 Social Workers

Social work is a potentially stressful occupation due to the nature and organisational structure of the work (Jones, 2001; Storey & Billingham, 2001; Cherniss, 1980). Social work deals with some of must disadvantaged and vulnerable groups in society (Jones, 2001) and is reported to be in a state of crisis, being both under funded and grossly understaffed (Davies, 1998). Postle (2002) claims that:

> *"[s]ocial work began, and has continued to exist, in a state of ambiguity and tension, experiencing the difficulties inherent in exercising both compassion and control, and mediating between the state and the individual"* (p.335).

Because of this Taylor (2000) claims that social workers may justifiably feel that the management perspective is at odds with their professional task, with managers failing to understand the nature of these tasks. Therefore, it is hardly surprising to find social work regularly among the top three most stressful jobs (Davies, 1998).

Bradley and Sutherland (1995), Postle (2002), Storey and Billingham (2001) and Jones (2001) found that problems relating to resources were the most frequently cited stressors amongst this group (see Table 3), followed by time pressures and carrying out administrative tasks, including financial assessments (Postle, 2002; see also Storey & Billingham, 2001). Social work by its very nature involves crisis situations demanding immediate attention, which seemed to result in over half the social workers in this study reporting that they spent time at home catching up on paperwork, which created additional pressures (Bradley & Sutherland, 1995). Similarly Jones (2001) found that bureaucracy and paperwork was accounting for a

considerably large percentage of social workers' time. Spending time on paperwork and IT also results in care managers having less time to work and develop relationships with their service users (Postle, 2002).

Child protection is one area of social work, which clearly places considerable emotional demands on health care professionals (Cresswell & Firth-Cozens, 1999; see also Bennett et al., 1993; Jones et al., 1991). Three main issues can impact on the professional: revulsion about what has happened to the children; issues relating to the professionals themselves in terms of their own past experience of childhood and family life; and issues of counter-transference, where the professional may develop feelings of guilt, sadness, violation and powerlessness (Cresswell & Firth-Cozens, 1999). Additionally, fear of things going wrong has been found to be a factor contributing to the difficulties in retaining social workers (Eborall & Garmeson, 2001). A small survey of child protection professionals (n=27) carried out in 1996, used the GHQ-12 to measure stress and found *"seven (26%) scoring at the conservative threshold of 4 or above and 12 (44%) scoring at 3 or above"* (Cresswell & Firth-Cozens, 1999, p.139). Using the Sources of Stress Questionnaire (SSQ), the highest levels of stress were reported as being caused by the fear of making mistakes, followed by overwork, organisational change, and effects of job on personal life (Cresswell & Firth-Cozens, 1999).

> *"Significant correlations were found between depression levels and levels of stress caused by overwork, effects of job on personal life, conflicts between career and personal life (both of which are likely to be a reflection of overwork, relationships with senior managers in Trusts and with adult mental health professionals, as well as the stress caused by dealings with children"* (Cresswell & Firth-Cozens, 1999, p.141).

However, given the small survey sample, caution is urged, as the differences in perceived stressfulness may be largely due to individual differences, rather than real differences between the effects of particular stressors.

Results from the OSI used in Bradford and Sutherland's (1995) study indicated that the main sources of dissatisfaction among the social work group related to

organisational factors and government policy, reflected in a measure of intention to quit. Similarly, Jones (2001) found that the most negative stress and frustration was coming from the organisation, rather than the clients. At the same time, pay levels are poor, in the residential sector particularly (Taylor, 2000) and frustration and disillusionment, together with the lack of marketability of social work skills, have been cited as a possible reason for 'the increasingly dispirited worker' to retreat into ill-health.

Bradley and Sutherland (1995) therefore recommend that stress management interventions should *"include organizational change which deals with the stress at source, in addition to considering ways of helping the individual to learn techniques to cope with those stressors which cannot be changed or diminished"* (p.328). Looking at the different roles within social work, Davies (1998) asserts that:

> *"[a] social work manager may describe it* [stress] *as being caught in the 'middle', unable to satisfy anybody and being unable to sleep at night. A social worker may describe it in terms of some entity that has its origins in managers or clients and, somehow passed on to them, makes it practically impossible to do their job"* (p.9).

The Workforce studies, carried out by the National Institute for Social Work conducted a longitudinal study of Social Service managers and Social Workers in the UK (see McLean, & Andrew, 2000; McLean, 1999). This study looked at commitment, satisfaction, stress, and control and will be discussed under those headings below.

2.8.3 Job satisfaction, stress and control in social services

Job satisfaction is reported (see above) to have fallen in the public sector over the past 10 years, at the same time as well-being has reportedly worsened (Gardner & Oswald, 2001). Eborall and Garmeson (2001) assert that this is a main contributing factor to difficulties in retaining social workers. Additionally, lack of job satisfaction and stress are reported to affect staff performance, morale and commitment, which in turn can affect the overall functioning and productivity of the organisation (McLean &

Andrew, 2000; McLean, 1999). In this respect, McLean (1999) asserts that *"[a] quality service requires committed staff who obtain satisfaction from their work"* (p.62). Additionally, social workers reported that they did not feel cared for, trusted or acknowledged for their abilities and skills (Jones, 2001). Bradley & Sutherland (1995) found (using the OSI) that social workers were less satisfied than other occupations with relationships in the workplace, and with organisational processes and structures, although their research indicated that home helps were more satisfied than both social workers and other occupational groups. Similarly, the Workforce studies (using Warr et al's., (1979) job satisfaction scale to measure extrinsic and intrinsic job satisfaction), found a decline in job satisfaction levels *"with mean scores lower for men, staff aged less than 40, staff in manager, field social work and residential jobs, and those working with children and families"* (p.66). Job satisfaction was higher among women, staff over 50 years, home care workers and those who worked with older people. However, overall most social service staff experienced high levels of job satisfaction from their work (McLean & Andrew, 2000; McLean, 1999; Jones et al., 1991). A study of local authority residential care workers in the North West of England (Penna et al., 1995) found that two factors connected to direct caring work brought about job satisfaction, these were working with people in a caring situation and the satisfaction staff feel on seeing improvements in their clients. Staff who reported having a lack of support reported the lowest scores for job satisfaction in the Workforce studies (McLean & Andrew, 2000; McLean, 1999).

Using the General Health Questionnaire (GHQ-12) to identify those who were experiencing stress, results indicated that levels of stress were increasing over time (McLean & Andrew, 2000; McLean, 1999) with managers and field social work staff having higher mean scores than other staff, followed by residential workers, whilst home care workers reported low levels of stress. McLean (1999) concludes that *"men, younger staff, managers, field social work staff and staff who worked with children and families had higher stress, and lower job satisfaction"* (p.72). GHQ-12 scores for staff who reported not having enough support in dealing with stress were found to be double the scores of those who reported having enough support (McLean & Andrew, 2000; McLean, 1999).

The Workforce studies found that *"control and role conflict were frequently associated with stress, for example, staff having responsibility without power, receiving contradictory instructions, being overwhelmed by users' problems and disagreement about good practice"* (McLean, 1999, p.75). Their results indicated that staff with low control and low job satisfaction levels had the highest stress levels, whilst staff with high control and high job satisfaction had the lowest stress (McLean, 1999). This association held for gender, age, ethnicity, worker group and job type (McLean, 1999, McLean & Andrew, 2000).

However, it is worth noting, that the above trends do not appear to be new. The above findings seem to mirror surveys on social workers carried out on the 1980's, which found high levels of strain amongst social workers, coupled with having too little time to complete work to their own satisfaction, having to ration scarce resources, client needs and working conditions (Jones et al., 1991). Findings from Bennet et al (1993) and Jones et al (1991) highlighted how for social workers, working with children and families, caused a considerable amount of pressure.

2.8.4 Homecare Workers

One particular group of employees reporting a number of difficulties are Homecare Workers. A large survey of homecare workers (n=3047) undertaken by Unison (2001) found that over half the homecare workers in the survey had worked in unsafe homes and there has been a significant shift in responsibilities and the content of work for many. This shift is from domestic care to personal care, with 67% of staff reporting that they predominantly deliver personal care, compared to 16% reporting that they did so five years ago (Unison, 2001, see also Community Care, 2003c; Bradley & Sutherland, 1995). At the same time, because more dependent people are staying at home longer, 89% of homecare workers reported that their needs have increased, with 75% of homecare workers reporting that they look after older people with dementia; 20% reporting that they look after younger people with learning disabilities; and 14% who report that they look after younger people with mental health problems. In addition to this, *"homecare workers are regularly helping with catheters, medication, and liasing with health practitioners and preparing people for health practitioners"* (p.4). Bradley and Sutherland (1995) state that this change in

role from domestic tasks towards the provision of personal care is reflected in their findings (Table 3). In addition, homecare workers generally work in isolation on a one-to-one basis with the client, often lacking support in the event of having to deal with a difficult client (Bradley & Sutherland,1995; see also Eborall & Garmeson, 2001), which is of concern, given that social support has been reported as a buffer in the development of work stress (Bradley & Sutherland 1995; Karasek, 1979). Bradley and Sutherland (1995) conclude that training programmes in the organisation could help home helps to deal with some of difficulties they faced because of their emotional involvement with highly dependent clients, in addition to looking at ways to reduce their potential isolation, perhaps through staff support groups. Within this group, difficulties in recruiting care workers is being exacerbated from competition from other service industry jobs offering more flexibility and better pay for less demanding work, and who are more tolerant of absence (Eborall & Garmeson, 2001).

2.8.5 Hours of work

Balloch and McLean (1999) report that, defining full-time work as 30 hours a week or more, nearly all men worked full-time, whereas approximately 50% of women worked part-time. However, looking at four different roles within social services; managers; field social work staff; home care workers and residential workers, it was found that almost all managers and field social work staff worked full-time, whereas 37% of residential workers in England worked part-time and full-time working was uncommon amongst home care staff (Balloch & McLean, 1999). Penna et al's., (1996) study of residential care staff found that *"[d]espite the pressure on staff...their commitment to their clients is impressive, and is manifest in the amount of unpaid overtime undertaken to get the job done property"* (p.2). The Workforce studies similarly found that amongst full-time staff, a substantial amount of overtime was worked which was unpaid (Balloch & McLean, 1999).

2.8.6 Violence

Four social workers have been killed in the line of duty in the 1980s, with a further three deaths in the 1990s (Community Care, 2003a). The TUC (1999) report that care working is one of the high risk jobs, with 21% of care workers reporting that they had

been attacked at work. Similarly, 58% of residential care workers recently survey (Penna et al., 1996) reported that they were often exposed to violence from clients, with those in smaller establishments (10 or less clients) being more likely to report exposure to violence than those working in large establishments. These trends appear to be reflected internationally, with Raymond-Pierre Bodin, Director of the European Foundation for the improvement of Living and Working Conditions reporting that *"both men and women experience violence at work, but women remain more vulnerable then men, with women often concentrated in "high-risk" jobs such as nursing, social work and teaching"* (European Foundation, 2003, p1). Eborall and Garmeson (2001) assert that as the workforce is stretched and levels of stress and emotional exhaustion increase, it is harder to take the increasing amounts of violence and abuse from service users.

In Britain the government reacted by launching the National Task Force on Violence against Social Care Staff in 1999, to produce strategies to reduce violence, together with a national plan with recommendations and timescales. The overall target is to reduce the figures on violent incidents by 25 per cent over three years, beginning with the establishment of baseline data by each organisation (Community Care, 2003a). As yet, it is not known how many baselines have been established, however, in July 2001 Unison asked local authority social workers if their employers had produced new guidelines on violence at work, and only forty per cent said yes (Community Care, 2003a). However, the Social Service Inspectorate, who is monitoring the situation, said that by October 2001, 79 per cent of councils had made a good start on new guidelines and policies (further information can be found on www.doh.gov.uk/violencetaskforce).

2.8.7 Perceptions of social work and social care

"Work that is seen to have value is likely to motivate people, especially people who want to 'make a difference'" (Audit Commission, 2002, p.18). In this respect findings from research commissioned by the Department of Health (Research Works Limited, 2001) found perceptions of social work were heavily influenced by the media, with respondents unanimously reporting that coverage was negative (see also Eborall & Garmeson, 2001). Storey and Billingham, (2001) reported that 58.8% of

social workers in their study (n=34) felt that the public image of social work increased their levels of stress. Social workers were viewed as people who 'checked up' on problem families, being mostly associated with child care and child abuse, and respondents reported that contact with social workers was not considered a reassuring or welcome experience (Research Works, 2001). Social work, whilst considered a worthwhile job, was also considered to be poorly paid, demanding, stressful potentially dangerous and of low status (Beresford & Evans, 1999). Social workers were stereotypically thought of as being young, female, hippyish, and idealistic. Social carers were viewed more positively, being seen as home helps who fulfilled vital roles in supporting people in need, although again social carers were viewed as being predominantly female and poorly paid. However, social carers were not viewed as negatively as social workers (Beresford & Evans, 1999).

However, research into Public Voices by The Guardian (2003) has found that in the past year the perception is that there have been signs of real progress in social care, with £2.4 bn extra investment in social services over 2003-06 being put forward in last years budget (The Guardian, 20th March, 2003). Although this extra investment is very positive, there are underlying problems that hinder significant improvements, particularly in expanding care capacity in elderly care services (The Guardian, 20th March, 2003). Further difficulties, highlighted by the tragic murder of Victoria Climbie, signified that there was not enough money to provide for sufficient staff and care services close to where children live (The Guardian, 20th March, 2003). Additionally, this lack of funds available for local authorities makes it difficult to attract and keep care staff and pay for care home placements (The Guardian, 20th March, 2003).

2.8.8 Recruitment and Retention

The latest Department of Health staffing return shows that at 30th September 2001 within Social Service Departments (SSDs) the average grossed vacancy rate for posts covered by the survey was 9.4%; proportionately there was a higher concentration of older employees, with around a half to two thirds of employees aged over 40 (Social Services Workforce Study, September 2002). At the same time, SSDs are facing growing difficulties in reflecting the needs of their communities, as 92 per cent of

young people studying for vocational qualifications in health and social care are girls (Community Care, 2001).

In terms of vacancies and turnover, the overall the level of vacancies has fallen between 2000-2001 in most employee groups by between 0.5% and 5%. However, the exception to this was children's residential manager and supervisor posts, where the vacancy rate increased by over 2% (Social Services Workforce Study, 2002). Similarly, although the turnover rate for most occupation groups lay between 8% and 13%, for care employees working in children's residential establishments it was 15.3% (ibid). At the same time, in terms of recruitment and retention *"the worst affected group was the recruitment of field social workers to work with children and families, for whom half the authorities (48%) reported that they were experiencing difficulties in recruiting"* (pg.8). It would seem therefore, that people working with children and families appear to be of most concern within social services.

Two factors reported to influence the recruitment and retention of social workers are salary levels and the status afforded to social work by society (Gibelman, 2003; Eborall & Gormeson, 2001). This is borne out by findings from Research Works (2001), which concluded that the lack of basic knowledge about social care and social work; the generally poor impressions both the nature of work and conditions; and the low profile, status and lack of positive endorsement by society would need to be considered when developing recruitment strategies.

In 2001 the Government began a three year initiative to encourage more people to enter social work and social care work, comprising a £1.5m national newspaper and radio advertising drive (Department of Health, 2001). The following year, James (2002) reported that ministers were claiming that the campaign had been an overwhelming success. However, despite this reported success, a more recent strategy to address the shortage of social workers has been to recruit from abroad, with the result that *"[a]lmost half of Zimbabwe's social workers now work in the UK following a dramatic rise in overseas recruitment over the past decade, which threatens to cripple the African country's welfare system*" (The Guardian, 19th February, 2003). At the same time, Jenny Goodall, director of social services at Brent Council, has urged local authorities to adopt a more co-ordinated approach to tackling

the skills crisis (Community Care, 2003b). This could include a national or regional approach to collecting workforce information, assessing future staffing needs, recruitment campaigns, addressing social service's image problem, and organising resources for student and staff training (Community Care, 2003b).

2.8.9 Pay, working conditions and procedural Justice

A recent study (NASW, 2003) found evidence that the more a profession is dominated by women, the lower the worker's average salary, for example, Gibelman (2003) looked at eight service industry's (including social services) that had 75% or more female employees and found an average weekly wage of £346.44. In contrast, looking at service industries which have less than 50% female employees, the average wage was almost *double*, at £653.66 (Gibelman, 2003). Balloch and McLean's (1999) research in social services supports this finding, reporting that women's hourly pay was on average nearly £2 less than men's. Looking at homecare workers Unison (2001) reported that in their survey of homecare workers (n=3,047), 97% were female and 99% were white, working for an average hourly rate of £5.25, now £5.68 (Community Care, 2003c). Gibelman (2003) asserts that these pay differences are due to continued patterns of discrimination, despite a number of policy initiatives dating back to the 1960s to address gender discrimination in the workplace. Therefore it is not surprising that, wages in the public sector are reported to have fallen behind those in the private sector, as years of pay restraint under the Conservative government has been followed by two years in which wages have been held back under Labour (Schifferes, 2002). Schifferes (2002) reported that *"the record-low unemployment makes it tempting for better paid public sector workers to move to more lucrative jobs in the private sector"*.

Dissatisfaction with wages led more than 1.2 million council workers in England, Wales and Northern Ireland to walk out in July in protest at a 3% pay offer (BBC News, 2002), with public sector workers comparing their levels of pay unfavourably with that of other groups. Some of the workers involved in this action stated that whilst their responsibilities have risen, their pay had effectively stood still, with some workers in full time posts earning less than £10,000 per year (BBC News, 2002). Poorer paid workers include care assistants, and nursery workers. In respect of social

workers, Gilbeman (2003) states *"clearly, there is a gap between what social workers seek for themselves and believe they deserve and what they actually earn"* (p. 22). Similarly, 85% of homecare workers surveyed (Unison, 2001) raised concerns about pay, conditions responsibilities or working practices.

The classic organisational theory of bureaucracy is aptly characterised by the *exchange model*, which is characterised by workers exchanging time and energy for incentives offered by the organisation, i.e. pay and benefits (Murphy & Cooper, 2000). This social exchange is a two-way transaction in which each side provides something to the other and also receives something in return (Adams, 1965). For example, employees agree to make specific contributions to an organisation in terms of their talents, experience time and effort, for which they expects the benefits, proportional to their contribution, in return (e.g. payment, fringe benefits and promotion prospect) (Guerts et al., 1999). Inequity in this relationship is associated with absenteeism (see for example De Boer et al., 2002), turnover intention (Guerts et al., 1999), and unpleasant emotional states, for example anger or guilt (Adams, 1965). This may lead a person to vary their inputs or productivity, either by increasing or decreasing them (Adams, 1965). Additionally a study of ancillary health care workers (n=167) found that employees reporting both high efforts and low rewards had higher risks of psychosomatic health complaints, job dissatisfaction and physical health symptoms (Van Vegchel et al., 2001; see also Hendrix et al., 1999; Adams, 1965). In this respect, in the Netherlands, in the health care sector, research has shown that one of the main reasons for work disablement are, among other things, high job demands and poor occupational rewards (Van Vegchel et al., 2001).

2.9 Absenteeism – scale, consequences and causes

Absenteeism is defined as, *"unauthorised employee absence from work at a time when they are due to work"* (The Industrial Society, 1999, p.1). In local authorities sickness absence level is a Best Value Performance Indicator (BVPI) (Employers Organisation, 2003). The most recent report (Employers Organisation, 2003) on Local Government indicates that the average sickness absence amongst the respondents to the survey was 4.5%, which has risen by around 0.3% from 2000/01. In respect of manual and non-manual jobs, where this information was provided, the

median rates for these employee groups were 5.8% (13.2 days) for manual occupations, compared to 4.3% (9.8 days) for non-manual occupations, whilst on the whole, absence rates for part-timers were slightly lower than full timers.

Looking at regional variations, in the North West these figures were 6.3% and 4.5% respectively (Employers Organisation, 2003). Overall, the figures revealed a north/south gradient in sickness absence rates, which has been a feature of whole economy studies of sickness absence (Employers Organisation, 2003). Looking at the nature of absenteeism in local authorities, previous surveys undertaken by the Employers Organisation between 2000 and 2002 and others (see for example Mullarkey et al., 1999; McLean, 1999; North et al., 1993) have found that sickness absence varies according to the nature of the work done in respect of non-manual and manual jobs. The Employers Organisation (2003) maintains that it is the *"nature of the work done, and not the terms and conditions of employees, which explains the difference in the incidence of sickness absence between manual and non-manual employees"* (p.4).

The measurement of the number of days absence attributable to stress is particularly difficult, due to the fact that the cause of absence is likely to be influenced by the extent to which the organisation recognises stress as a legitimate reason for absence and that the role of stress as a factor in physical illness is a matter of debate within the medical profession (Employers Organisation, 2003). Not withstanding this, in 2001/02, apart from the 'other illness' category (19.7%), stress-related absence accounted for the highest (19.3%) number of absence days ascribed to specified causes in English Local Authorities, followed by 'infections' (15.1%) 'other musculo-skeletal problems' (12.5%) and 'back problems' (9.2%) (Employers Organisation, 2003). Absenteeism in the public sector was estimated to be costing £6 billion per year in 1998 (OHR, 1999). As a result Chancellor Gordon Brown stated that *"specific targets are being set for each department to reduce absence rates by 20% in 2001 and 30% in 2003"* (OHR, 1999, p.1). The above figures represent local authorities in the public sector, however, looking more specifically at social service departments within local authorities, the Employers Organisation (2002) absence management survey within social services revealed that *"the mean number of day's*

absence per full time equivalent employee for 2000/2001 was 15.8 and the median figures was 16" (p.2).

The literature on absenteeism recognises sickness absence as a multifactorial aetiology (see for example, James et al., 2002; Neidhammer et al., 1998; Brooke & Price, 1989; Steers & Rhodes, 1978; Chadwick-Jones et al., 1982). However, theories on absence are conflicting. On the one hand organisational psychology identifies a number of psychosocial aspects of work, for example low levels of work demands, control (decision latitude), support, job satisfaction and various internal and external pressures to attend, which are associated with higher rates of sickness absence, and turnover intention, i.e. withdrawal behaviours (Bellman et al., 2003; DeBoer et al., 2001; Geurts et al., 1999; Neidhammer et al., 1998; Sagie, 1998; North et al., 1996; Hanisch & Hulin, 1991; Brooke & Price, 1989; Steers & Rhodes, 1978). Whereas, social psychology asserts that that absence behaviour is a *"social phenomenon that expresses rules or norms to which individuals collectively refer"* (Chadwick-Jones et al., 1982, p. 6), thus indicating that absences are taken only according to what is allowed by the occupational 'culture', or 'norm'. Recent research on perceived absence norms and their role in predicting absence behaviour (see for example Xie & Johns, 2000; Gellatly & Lauchak, 1998; Johns & Xie, 1998; Sanders & Hoekstra, 1998; Brooke & Price, 1989) supports this theory. In this respect, Chadwick-Jones et al (1982) critique organisational psychology for tending to isolate the individual, which they describe as being behaviourist in the worst sense, by attempting to reduce social phenomena to measurable stimulus-response units.

It is outside the scope of this thesis to enter into this debate, however, whilst recognising the social aspect of absenteeism, measurement of the social norms of absence is usually carried out by interview (see for example Chadwick-Jones et al., 1982) and due to the population size (n=3,771) and time constraints involved in this study, investigation of the social norms of absence was limited to the social patterning of absence by division and grade. However, the measurement of some of the psychological factors which may influence absence behaviour was within the scope of this research and the literature on these factors will be briefly considered below.

Looking firstly at social support, there appears to be reasonable consensus in the literature that low social support at work is a predictor of subsequent sickness absence (see for example, Bellman et al., 2003; Neidhammer et al., 1998; Standfeld et al., 1997; North et al., 1996), in some cases predicting both frequency and duration of sickness absence (Neidhammer et al., 1998). Moreover, Stansfeld et al (1997) found that *"social support at work appears to protect against short spells of psychiatric sickness absence"* (p.35). Findings from this study indicated that medium or high levels of social support at work reduced absence for more than 25% for men and more than 35% for women (Stansfeld et al., 1998). A recent study by Bellman et al (2003), supported these findings, whilst highlighting gender differences in social support as a moderator of occupational stress. Bellman et al (2003) found that social support had a significant interaction effect on organisational commitment for males only, and for females only, a significant interaction effect on state of mind, suggesting that social support interventions will produce different results for males and females.

Further gender differences were reported by Bridges and Mumford (2001), examining absenteeism in the UK, which found substantial differences in the probability of absence across various gender and family situations. *"For women, family income, education and preschool aged children all affect absenteeism; however, it is the presence of children aged less than 2 that has the major impact"* (Bridges & Mumford, 2001, p.282). For men in general, marital status, children aged 2-5 and age were the primary determinants of absenteeism (Bridges & Mumford, 2001). Similarly, employees with 'kinship responsibility' tended to be absent more frequently (Brooke & Price, 1989). In addition to gender differences, Pousette and Hanse (2002) found that certain psychosocial job factors had different impacts on strains in different occupations and Johns and Xie (1998) reported absence norms to be different between a Western and an Eastern Society, highlighting a diverse patterning of absence behaviour in a range of contexts.

Considering 'control', an inverse association between control at work and sickness absence has been widely reported (see for example, Smulders & Nijhuis, 1999; Neidhammer et al., 1998; North et al., 1996). Similarly, in a study of male employees in the public sector (n=1,755), a high level of control was found to be associated with

low levels of simultaneous and later days absent, whereas a lack of job control contributed significantly to the numbers of days absent (Smulders & Nijhuis, 1999).

A link between low job satisfaction and rates of sickness absence has been reported (see for example, Gardner & Oswald, 2001; Hanisch & Hulin, 1991; Brooke & Price, 1989; North et al., 1983). Similarly, Sagie (1998) reported that job satisfaction and organisational commitment were found to be strongly related to the aggregated duration of voluntary absence, defined as absences that are under the direct control of the employee (e.g. uncertified absence), which can be used for personal aims, such as testing the market for alternative employment prospects. Sagie (1998) concluded that *"unless the situation makes it impossible (e.g., in the case of involuntary absence), workers who are strongly committed to the organization or highly satisfied with their jobs show up at work more often than those with weak commitment and low satisfaction"* (p.167). However, Goldberg and Waldman (2000) found that job satisfaction was un-related to absenteeism, and along with Chadwick-Jones et al (1982) urge caution when considering statistical association between job satisfactions and absences. Chadwick Jones et al's (1982) examination of 29 studies, found inconsistencies in methods and measures used, populations sampled and the results reported. They conclude that although job dissatisfactions contribute to absence levels, the contribution is relatively small, and that social norms may in fact be much stronger influences (Chadwick-Jones et al., 1982).

Psychological job demands were not found to be a significant predictor of sickness absence in a study of 12,555 men and women (Neidhammer et al., 1998). However, in line with Parkes (1992) and North et al., (1993), Smulders and Nijhuis (1999) found that a *high* level of job demands was related to a low level of simultaneous and later days absent, holding for age, health, education, prior absence. Smulders and Nijhuis (1999) even suggested that in their study *"job demands seem to be preventative for absenteeism"* (p.127), possible acting as a pressure to attend.

Reviews on the literature on work stress (Kahn & Byosiere, 1992; Ganster & Schaubroeck, 1991), show that absenteeism is not a frequently researched effect of work stress. However, in a recent study, 'stress level' was reported to be positively correlated to absence behaviour:

> *"those individuals reporting to experience high levels of some stress in their current position are 10% more likely to have taken periods of absence from work than those without, the probability increasing with successively higher job stress"* (Leontaridi & Ward, 2002).

Additionally, their study revealed that the workers most at risk from absenteeism were female, lower skilled, lower educated and trade union members (Leontardi & Ward, 2002). A study looking at stress amongst staff in NHS Trusts, using the GHQ-12 to measure stress reported similar findings. When comparing numbers of days absent for staff defined as cases by the GHQ-12 with non-cases this study found that overall staff defined as 'cases' reported double the number of days absent (5.2 compared with 2.6) than staff who were non-cases (Borrill et al., 1998).

Perceived unfairness, or inequity, at work is additional factor which has been found to be associated with higher absence levels at work (DeBoer et al., 2002; Guerts et al., 1999), turnover intention (Guerts et al., 1999), and intrinsic job satisfaction (e,g, the job as a whole, challenge from their work, and amount of interest in the job), which in turn was found to have direct effects on attendance motivation and turnover intention (Hendrix et al., 1999). DeBoer et al (2002) found that perceived unfairness contributed to the explanation of more absence than the traditional work-related stressors (i.e., work load and low job control). Additionally, a negative path between wages and absenteeism has been reported (see for example Goldberg & Waldman, 2000; Brooke & Price, 1989). Eisenberger et al (1990) found that in two studies covering employees from a range of occupations:

> *"employees' general perception of being valued and cared about by the organization is positively related to (a) conscientiousness in carrying out conventional job responsibilities, (b) expressed affective and calculative involvements in the organization, and (c) innovation on behalf of the organization in the absence of anticipated direct reward or personal recognition"* (p.57).

The Employers Organisation (2003) asserts that within local government *"a significant reduction in stress-related absence would clearly benefit both the authority as service provider and its employees"* (p.20). In this respect, strategies aimed at reducing absenteeism and facilitating the return to work of sick and injured workers is currently the subject of growing attention (James et al., 2002). However, James et al (2002) state that to date the nature and effectiveness of actions that can be taken to facilitate the return to work and continued employment of ill and injured workers has received little attention in the academic literature. In the UK the Disability Discrimination Act 1995 places employers under a duty to provide reasonable adjustments to support the continued employment of disabled workers, which includes those suffering from long-term ill health (HMSO, 1995). James et al (2002) assert that there has been a lack of attention to possible strategies to facilitate the return to work of ill workers and that limited knowledge exists regarding how British employers handle the management of longer term illness among workers. Moreover, the multiple causes of absence, with no strong cause-effect linkages, make it difficult to develop a 'cure' (Chadwick-Jones et al., 1982). 'Cures' tend to range between systems of reward, e.g. bonuses for absence-free employees, and punishments, e.g. warnings, followed by suspensions (Chadwick-Jones et al., 1982).

The European Foundation (1997) produced guidelines for preventing absenteeism in the workplace advocating four types of interventions. Firstly, procedural measures for the monitoring and control of absenteeism. Secondly, preventive work-oriented measures aimed at reducing the discrepancy between workload and capacity by reducing workload. Thirdly, preventive person-oriented measures to improve the balance between workload and capacity by increasing the capacity of individuals; and finally, reducing return-to-work, or 'reintegration', barriers. However, although in almost all countries great emphasis is placed on procedural measures to reduce absenteeism, prevention activities and reintegration activities are still comparatively rare and where preventive activities are applied, they are generally limited to person-oriented measures (European Foundation, 1997).

Looking at the current situation, in 2002, The Employers Organisation undertook the first ever survey of the management of sickness absence within social services. The survey reported on the methods employed to deal with sickness absence, which

included: back to work interviews after every occasion of sickness absence; trigger points (e.g. regular one-day absences) from which action was developed; regular calls and visits from management in respect of long-term sick leave; recruitment and induction processes to limit the chances of employees having poor attendance; focused action on specific parts of the department where short-term absence was high; occupational health or additional medical support to encourage the long-term sick back to work as quickly as possible; reliable internal sickness absence data; and health promotion, including stress management training. However, the main focus of these methods is on 'procedural measures', with the exception of one person-oriented measure to deal with long-term sickness absence and back to work interviews that could potentially be used to help reintegration into work. The only preventive measure is stress management training, which is person-oriented, with no evidence of *any* preventative work-oriented measures.

Therefore looking at the key issues, we can conclude that in social service departments, absence rates were reported to be 15.8 days per full time equivalent employee 2000/01. Levels of sickness absence reportedly differ according to: regions; the nature of work done; gender; nationality; grade; or marital status, to name but a few. There is a debate about the degree to which psychological factors (e.g. job satisfaction, control etc.) and social factors (e.g. occupational culture, absence norms etc.) influence absenteeism. Intervention strategies put forward by the European Foundation recommend a combination of: procedural measures; preventive work-oriented measures; preventive person-oriented measures and the reduction of re-integration barriers. However, in social services, the focus is very much on procedural measures, with the exception of one person-oriented measure (i.e. occupational health support) and back to work interviews, which could potentially be used to help reintegration into work. Moreover, the only person-oriented preventive measure undertaken is stress management training, and there is no evidence of ***any*** preventive work-orientated measures.

2.10 Stress Management Interventions

As a broad definition of interventions, Cox et al (2002) assert that *"[i]nterventions can be anything that has the potential to impact upon the work and well-being of*

employees" (p.56). Work related stress can be tackled on four levels, which include the individual worker, the work organisation, the nation and the European Union (Levi, 2002), although more commonly stress management interventions are discussed in terms of primary, secondary and tertiary interventions (see for example, Clarke & Cooper, 2000; Cox et al., 2000; International Labour Organization, 2000; Kristensen 2000; Sutherland & Cooper, 2000; European Commission, 1999; Cooper & Cartwright, 1997; Hurrell & Murphy, 1996; Kompier, 1996). Kristensen (2000) states that these differing views on the importance of worker characteristics versus working conditions as primary causes of stress suggest different ways to prevent stress at work. Dugdill (2001) asserts that the type of workplace health programme implemented is dependent on the political context, with U.S. programmes tending to be individualistic, focussing on behavioural change and lifestyles. Whereas Northern European programmes are more likely to be democratic processes, with unions taking a proactive role, and focus on organisational structures and job designs. In the UK approaches have been individualistic up until the 1990s however since then, movements such as Healthy Cities, have encouraged a change towards more structural models of health and health promotion (Dugdill, 2001). Interventions therefore can fall into two main methods, organisation-oriented and individual-oriented approaches (see for example Kompier et al., 2000; Kristensen, 2000; Schreurs, Winnubst & Cooper, 1996).

The philosophy of the European Commission's Framework Directive, and others (see for example, International Labour Organization, 2000; Cox et al., 2000), is for every employer to try to eliminate the root causes of work-related stress reactions, i.e. the stressors (European Commission, 1999), with individual changes seen as augmenting, rather than replacing organisational change (Cahill et al., 1995). However, despite this, individual level interventions, for example, the promotion of healthy lifestyles, or education to develop more effective stress management skills are the most common (Clarke & Cooper, 2000; Cox et al., 2000; Kompier et al., 2000; Kristensen, 2000; European Commission, 1999; Kompier, 1996).

Key factors identified for success in stress prevention, (see for example Kompier et al., 1998) include; a stepwise and systematic approach to the problem; adequate diagnosis or risk analysis; a combination of work-directed and worker-directed

measures; a participative approach, involving employees and middle management; and sustained commitment of top management (Shannon et al., 2001). Levi (2002) asserts that at all levels (individual, organisational, national and international) there is a need to identify work-related stressors, stress reactions, and stress-related ill health. However, as the focus of this thesis is on reducing or eliminating stressors principally at the organisational level, these types of interventions will be the main focus of section, following a brief review of the main shortcomings of individual-oriented approaches.

2.10.1 Individual-oriented approaches

As previously quoted, *"you don't give the pit canary therapy, you get it out of the pit"* (Obholzer, cited in Smith, 1998, p.2). This eloquently sums up the main criticism levelled at individual interventions, that whilst they maybe useful, they are probably insufficient, because they focus on the symptoms, or outcomes, of stress, rather than on the main causes of the stress reactions (European Commission, 1999). This approach is considered reactive rather than proactive, with Professor Lennart Levi stating that *"an ounce of prevention is worth a pound of cure"* (International Labour Organisation, 2000, p.1). Platt et al (1999) carried out a systematic review of the literature on changing labour market conditions and health, and reported that no individual level interventions were consistently found to be effective in producing effects on job or organisation-relevant outcomes, such as job satisfaction or absenteeism, although they could be effective in reducing physical and psychological symptoms. Additionally, Briner's (2000, see also Burke, 1993) review of the effectiveness of: stress management training; employee assistance programmes (EAPs); and health/fitness interventions, concluded that stress management in training is probably not worth using in its current form, as the available evidence suggests that they have little long-term benefit on employee well-being or performance; that there is very little systematic evidence from UK organisations that EAPs have any impact on stress levels; and that whilst health and fitness interventions may benefit the employees, these should not be confused with stress interventions. Furthermore, participation rates, even where such programmes are available, can vary, with authors (see for example, Grosch et al., 1998; Sloan & Gruman, 1988) questioning these programs ability to attract participants and seeking to establish how participation rates

can be increased, together with the fact that initial behaviour changes have been found to diminish over time (Shannon et al., 2001). Moreover, *"[a] focus on the individual is also inherently limited because it intervenes in a complex system at only one level"* (Shannon et al., 2001, p.320).

However, where employers cannot in the short-term adjust working conditions, the European Commission (1999) recommends offering relaxation techniques and/or physical exercise, medication, counselling or stress management, whilst recognising that individual level interventions are short-term approaches, which will not suffice in the longer term. Rees and Redfern (2000) suggest that training programmes should encourage the consideration of both the person and environment-based factors that are linked to stress, and in this respect that training and developments specialists adopt a holistic approach. The adoption of an environment based perspective would lead to questions being raised for example about the design of the job or working conditions (Rees & Redfern, 2000), asserting that *"intervention strategies should reflect the complexity of the area and recognise that potential causes of stress exist at both the individual and organisational level"* (p.126).

2.10.2 Organisational-oriented approaches

"Organisational stress interventions are defined as actions to eliminate or reduce stressful job characteristics and working conditions to improve worker well-being" (Murphy, 1999, p.150). In this regard, the European Commission (1999) recommend, after monitoring workplaces at national and regional levels, that:

> *"work-related stress should be prevented or counteracted by job redesign (e.g. by empowering the employees, and avoiding both over- and underload), by improving social support, and by providing reasonable reward for the effort invested by workers, as integral parts of the overall management system"* (p. iii).

Additionally, physical work settings should be adjusted to the workers' needs; abilities; and expectations (European Commission, 1999). Within the category of 'organisational interventions', Parkes and Sparkes (1998) make a further distinction

between socio-technical interventions; which are primarily concerned with changes to objective/structural aspects of the work situation (e.g. staffing levels or work schedules); and psychosocial interventions, which refer to strategies such as increasing participation or communication in order to change employees' perceptions of the work environment.

Looking at job redesign, Ganster (1995) asserts that most of the attention it has received has been informed by Karasek's (1979) model of job decision latitude (or control). This type of intervention has been most influential in Sweden, where management have been greatly influenced by work-organisation laws and research (Theorell, 1999; see also Terra, 1995). Looking at the relationship between Karasek's demand-control-support model and illness risks, empirical findings indicate that *"there is a health promotion potential in job redesign aiming at improved decision latitude and social support in workplaces"* (Theorell, 1999, p.618). Similarly, using the effort-reward model more adverse health effects are observed with high effort and low reward (Theorell, 1999), again indicating that job redesign could be effective in reducing stress. Yet, even in Sweden Theorell (1999) reports that there are very few studies that have actually documented the health consequences of improved work organisation, although case studies *"illustrate that it is possible to improve the work organization of public services and that such changes may benefit employee health"* (p.623). Terra (1995) found in a longitudinal study in the metal can industry that redesigning jobs and implementing self-regulating teams had positive and long-lasting effects on both workers' health and motivation and organisational output. However, despite this, and similar studies, in reviewing the literature on redesigning jobs as a way of intervening in the stress process, Briner (2000) concludes that notwithstanding the logic of changing those job conditions which may be causing harm, *"[t]he results of these studies demonstrate a remarkably consistent pattern. A few things get better, a few get worse, and most things stay the same"* (p.14). However, Briner (2000) maintains that this does not mean that in principle job redesign cannot work, but for it to do so a number of factors must be in place, above all, an initial assessment of the problem which pays particular attention to aspects of the job which can be changed without detrimentally affecting other aspects of the job. Kompier (1996) adds that successful job redesign should be participatory and stepwise, including: preparation; problem analysis; choice of measures; implementation and evaluation.

The social support buffering hypothesis has been widespread in the literature on work stress almost since its beginning (Ganster, 1995). In this regard, Theorell (1999) reports that improved feedback and the formation of more cohesive work groups have been found to be successful in increasing social support. However, on reviewing the literature, Ganster (1995) concludes that the *"evidence of a social support buffering effect with regard to work stressors is decidedly mixed"* (p.330; see also Lepore, 1998). An example of this can be illustrated using two recent studies, firstly, Baruch-Feldman et al (2002) found that in traffic enforcement agents' support was identified as an important correlate in a variety of work outcomes, i.e. support was found to be positively associated with satisfaction and productivity, and negatively associated with burnout, with variations in the strength of the relationship depending on whether the support was from families, co-workers or supervisors. On the other hand, Elfering et al (2002) reported that whilst support from supervisors had positive effects, support from close confidants had detrimental effects. Elfering et al (2002) assert that negative effects of social support by close confidants have frequently been found, which they suggest could be due to friends tending to be more empathetic, which may inadvertently reinforce compliant behaviour. In this respect, Ganster (1995) highlights that supervisors' excessive demands and personal insensitivity are considered to be critical daily hassles that can create strain and interfere with workers' performance, although there is very little research into individual differences among supervisors and their association with work outcomes.

In a study of U.S. Army personnel Bliese and Britt (2001) established that positive social environments (measured by calculating the variability of soldiers' perceptions of the leadership within their unit) were found to help individuals to cope with stressors. Therefore, despite the lack of support for the 'buffering hypothesis', there appears to be a great deal of consistent evidence that suggests that social support (and in the case of Bliese & Britt's study, social environments) can play an important role in improving employee well-being (Ganster, 1995). What Ganster, (1995) asserts is that evaluation research is lacking in this area, which is disappointing as the underlying evidence suggests that the benefits of social support are strong. Dormann and Zapf's (1999) findings are similar, as following a review of the empirical literature on social support they also found surprisingly little evidence from longitudinal studies on the moderating effect of work-related support.

Looking at team-working as a potential form of social support, Carter and West (1999) maintain that whilst there is evidence that team working is beneficial on team member mental health, the impact that working in a team has on individual well-being is still under investigation by the Institute of Work Psychology, University of Sheffield. In this regard, the Institute of Work Psychology (2003) reports that their surveys to date show that whilst teamwork is one of the most widespread types of work organisation, with 55% of UK manufacturing companies reporting using team working in the 1990's (Parker & Williams, 2001), its effectiveness is highly variable. In this respect, comparative and change studies of teamwork are ongoing (Institute of Work Psychology, 2003). Parker and Williams, (2001) assert that although team working might be a way of reducing work-related stress, there is a danger that flexible work practices like team working may worsen employee stress levels, for example through increasing work pressure.

The first step in stress prevention is diagnosis, often carried out through a stress audit (International Labour Organization, 2000; see also Sutherland & Cooper, 2000; Cartwright et al., 1995). In this respect, Cherniss (1980) states that *"[w]hatever is done to alleviate burnout in a setting should be based on empirical analysis and the most plausible theory"* (p.158). As organisation-level interventions aimed at preventing or limiting stress generally involve organisational development, implementation can prove disruptive, or expensive, therefore stress audits can provide both justification for their necessity and a baseline measure from which to evaluate their effectiveness (Cartwright et al., 1995). Additionally, sources of stress have been shown to vary among different occupational groups, different institutions, and between different status groups and subcultures within the same organisation (Cartwright et al., 1995). Therefore, *"[t]ailoring action to suit the assessed needs of the organization is likely to be more effective than any "broad brush" approach"* (Cartwright et al., 1995, p.225). The stressful characteristics of work identified by Cox et al (2000) and others (see Table 2) provide a useful framework for effectively directing resources by answering the questions: what are the existing level of stress within the organisation? Are some areas better in terms of job satisfaction and physical and psychological health better than others? How does the organisation compare with other populations or groups?; if so, what are the stressors, and are they department specific or organisation wide? (Cartwright et al., 1995). *"Following*

stress assessment and problem identification, interventions need to be designed, installed and evaluated" (Cartwright et al., 1995, p.229). However, no systematic evidence is available to show that the process of carrying out stress audits works, although in principle Briner (2000) asserts that there are reasons to believe that stress audits may be effective depending of course, on what precisely is done in a stress audit. In this respect Briner (2000) asserts that the self-reporting of stress is problematic and that audits done at one point in time only give a snapshot of peoples' feelings and perceptions at that particular moment. However, it makes sense that some form of initial assessment should be done to inform stress management interventions, and in this respect, *"[s]tress audits are extremely useful where they are reliable, valid and provide some evidence about cause and effect"* (Briner, 2000, p.14). Briner (2000) recommends using measures that ensure reliability and validity; collecting other more objective data, such as absence and turnover; by gathering information over time; and looking for patterns and changes.

Workplace stressors, in risk assessment terms, represent a hazard which can be understood in relation to the exposure to stress (perceived level of the stressor) and the consequences, in terms of negative outcomes (Clarke & Cooper, 2000; Cox & Griffiths, 1996). However, given that any aspect of work labelled as hazardous must be shown to carry the potential for harming employees exposed to it, the *"act of* relating *the appraisal of hazardous events to health outcomes is therefore an important part of the assessment procedure"* (Cox & Griffiths, 1996, p.133). Using a measure such as the Occupational Stressor Indicator, the perceived level of stress can be measured, and the consequences would represent indicators such as mental and physical well-being, or job satisfaction, allowing the calculation of correlations between the stressor and some stress outcomes (Clarke & Cooper, 2000). Clarke and Cooper (2000; see also Cox & Griffiths, 1996) warn against using subjective measures of both stressors and stress outcomes, because of common method variance, and recommend that more objective data, such as absenteeism or turnover levels are collected from employee records simultaneously. However, without normative values, determining what represents low or high risks is problematic, therefore, to be effective a generic stress audit would need to be used to allow comparison between work-sites, departments and organisations, and also against external norms (Clarke & Cooper, 2000). It is therefore unsurprising, that Briner (2000) found little evidence as

to whether this approach to the assessment and management of stress is effective, with Cox and Griffiths (1996) asserting that many of the questionnaire-based surveys are inadequate for the purpose of applying the risk assessment paradigm to the issue of work related stress. In this respect, triangulation is recommended as a method to combat some of these issues (Cox & Griffiths, 1996).

Cox and Griffiths (1996) recommend that assessment is carried out in four phases, comprising: familiarisation with the organisation; in-depth interviews with a sample of employees, leading to; a questionnaire based survey of both psychosocial hazards and the health status of employees; and an audit of existing management controls, whilst Cox et al (2002) add the fifth step of data analysis and interpretation. An example of a health-profile in this respect (see Cox et al., 2002) measures: feelings of being worn out or tense; high absence, low job satisfaction, intention to leave the job and musculoskeletal pain. In studies, the health profiles of individual groups were found to be different (Cox et al., 2002).

Key principles of risk assessment include: working with defined groups; focusing on work rather than individuals; focusing on the 'big issues'; the use of reliable measures; confidentiality of information and risk reduction as a goal. These principles were recently applied to a risk management approach, as developed by the Institute of Work, Health and Organisations at the University of Nottingham, which was carried out to tackle work stress in hospital staff (Cox et al., 2002). Cox et al (2002) found that a number of the subsequent interventions that were developed were creative, unremarkable, and effective, with the most positive interventions being those that were built through consultation with employees. This report highlights the importance of translating the evidence gathered into *"agreeing what needs to be done, how it will be achieved, by whom and when, whether others need to be involved, what resources are required, and importantly, how it will be evaluated"* (Cox et al., 2002, p.9). In this respect, evaluating this impact of the interventions was the most challenging part of the process, leading to the development of new methods of evaluation (Cox et al., 2002). Cox et al (2002) highlight how the risk management for work-related stress, is an action-led process, focused on intervening to reduce the experience of stress at source. Cox et al (2002) found, in their study of hospital staff, that most of the groups involved in the risk management process improved their

working conditions, and employees' reactions to the interventions were generally favourable, with little evidence of problems worsening as a result, although in many of the case studies the impact of interventions on employee well-being was modest. However, Briner and Rick (1999) have identified a number of problems with the risk assessment approach, namely that before defining something as a hazard there must be reason to believe that it has the potential to cause harm. Risk is defined as the chance that somebody will be harmed by the hazard, however, whilst for a physical hazard such as a toxic chemical risk can be assessed, there are difficulties in translating this approach to the psychosocial environment. Reasons for this include the fact that: we cannot determine the way heavy workloads might cause specific harms; the effects of exposure to psychosocial hazards, for example a traumatic event may remain latent for some time; psychosocial hazards effects can sometimes be negative and sometimes positive (e.g. autonomy – having too much may indicate little management support or a lack of role clarity); and finally, psychosocial hazards are determined by how people perceive them (Rick & Briner, 2002). Despite these problems, Briner (2000) still asserts *"there are good reasons to continue developing risk management approaches to stress as they have the potential to be highly focused and very practical"* (p.15). In this respect, Briner (2000) recommends that the risk management model ought to be adapted so that it fits better with psychological risks, and that advances in the causal links between work hazards and well-being are needed to improve our ability calculate risk.

Recently, health promotion literature includes models of health needs assessment (Dugdill, 1996). *"The philosophy behind most of the models is that of engaging the community or individuals involved in the process of identifying their health priorities, as a vehicle for empowerment"* (Dugdill, 1996, p.3). Ideally, a health needs assessment should use as wide a range of information as possible, using both qualitative and quantitative data, to inform the process. This process should ultimately inform *perceptible* action if continued commitment is required (Dugdill, 1996).

The research that has been published on stress management interventions has often had methodological limitations, which Nytro et al (2000) summarise as being:

> *"weaknesses in research design (particularly the scarcity of longitudinal studies), unclear links to theoretical models, excessive emphasis on intervention at the level of the individual employee, inappropriate data analysis strategies, inattention to the effects of differences in intervention processes and insufficient recognition of contextual differences"* (p.213/214; see also Cox et al., 2000b; Briner & Reynolds, 1999).

Furthermore, there is reason to believe that many unsuccessful interventions are never actually reported in journals (Nytro et al., 2000; Briner & Reynolds, 1999) and that many stress reduction interventions fail (Saksvik et al., 2002). Briner (2000) contends that the way forward involves a move away from using stress as an umbrella term, as it can cause more confusion than clarity. Alternatively, terms covering *precise* work conditions (e.g. demands, control or support), employee health (both physical and mental) and performance behaviours (e.g. absence events) should be used. Briner (2000) further advocates the adoption of 'evidence-based' practice, i.e. being clear about what the problems are and drawing on the best possible evidence to support whatever interventions are chosen. Finally, Briner (2000; see also International Labour Organization, 2000) recommends approaching stress management in a systematic way, by *"identifying "stress" problems, looking closely for evidence about cause and effect, making informed decisions about interventions and building in some forms of evaluation"* (p.17). In this respect, to be effective, most effective interventions will involve a certain amount of organisational change (International Labour Organization, 2000). Moreover the evaluation of *all* stress management interventions is problematic, as there is limited evidence on which to draw (Briner, 2000), with Kompier (1996) concluding that the 'how well, and why, do they work?' questions cannot yet be answered. Subsequently, the jury is still out on the effectiveness of most stress interventions (Briner, 2000; Cox et al., 2000).

After looking at interventions to manage stress in the workplace, key findings are that the available evidence looking at interventions to reduce work stress appears to be limited at best (Shannon et al., 2001; Nytro et al., 2000; Kompier et al., 2000; Briner, 2000; Parkes & Sparkes, 1998), with Kompier et al., 2000 asserting that work stress prevention programmes are predominantly individually biased and reactive, with a lack of organisation-level interventions studies acting as a barrier to progress in

reducing work-related stress (Kompier et al., 2000; Cox et al., 2000b). Cox et al (2000b) conclude that the literature *"suggests that organisational-level interventions (or at least, intervention programmes that target the organisation as well as the individual employees) may be the most beneficial for both individuals and organisations"* (p.120). However, most interventions have been found to be weak, targeting only the individual, and very few are adequately designed or evaluated in scientific terms (Cox et al., 2000b). As a result, the available evidence suggests that some of the attempts to manage stress to date have been unsuccessful and others may be effective only in certain conditions or contexts (Briner, 2000). Furthermore, the crucial issue of *how* to assess the way that work can and does impact negatively on people and, in terms of risk assessment, how the link between hazards and harm can be identified (Rick & Briner, 2002). Nytro et al (2000) claim that:

> *"limited success may be attributed to a failure to assess employees' perceptions of the need for change, and whether the proposed intervention(s) is regarded as suitable for the identified problem (e.g. reducing acute responses) or future challenges (e.g. promoting enhanced well-being)"* (p. 222).

Parkes and Sparkes (1998) conclude that the most encouraging results were found in the few studies that employed strong designs, focused on a significant work stress problem, and used a range of different types of outcome measure. In this respect, success was seen in two separate studies of workload reduction, which used experimental designs, and a programme implemented to enhance communication between workers and management following a merger announcement. Parkes and Sparkes (1998) recommend that researchers; focus on one, or a few stressors; adopt a clear conceptual framework to facilitate and design and analysis process; investigate options for experimental design; use both objective and subjective outcome measures of individual outcomes; use carefully chosen, established psychometric measures with acceptable reliability and validity; use times of transition to introduce stress reduction interventions; maximise response rates; repeat waves of data collection to assess the effects of the intervention; use independent consultants and researchers; and the use of qualitative methods to evaluation PAR studies.

Shannon et al (2001) state that rigorous evaluation of the changes is critical and suggest that where possible researchers should try to conduct randomised projects, using quasi-experimental designs. However, Griffiths (1999) says that quasi-experiments are rarely used, because although they are possible in many fields of social science, they are extremely challenging with functioning organisations. Furthermore the dominant experimental paradigm in research, which emphasises causal connections, often focuses on the outcome at the expense of the process (Griffiths, 1999). Griffiths (1999) asserts that interventions should be examined in terms of macroprocesses (conceptualisation, design and implementation), microprocesses (the detail of the nature of change, e.g. how control or support actually affects individuals) *and* outcomes. *"The power of the practical example is its demonstration that a given intervention is possible and has the intended effect"* (Kristensen, 2000, p.293)

2.11 The process of managing stress management interventions in the workplace

Nytro et al (2000) assert that the *process* in the implementation of occupational stress interventions can be as important as the contents of the occupational stress intervention itself (see also Saksvik et al., 2002; Griffiths, 1999). Nytro et al (2000) claim the outcomes may have less to do with the content of the intervention, but the way the intervention has been initiated. For this reason, *"good intentions do not necessarily guarantee good outcomes"* (European Commission, 1999, p.49). Therefore Griffiths (1999) urges careful documentation of the implementation process, as without it even positive results fail to make clear what role the intended processes played in bringing about the outcome. Additionally, much of the literature on change management gives the impression that as long as an organisation sticks to recommended recipes then change is a relatively simple endeavour (Saksvick et al., 2002). However, interventions that are poorly implemented or mismanaged can potentially lead to increased, rather than reduced stress. This highlights the need for interventions to be well planned and comprehensive, a process which requires monitoring and evaluation as critical factors for success. Cahill et al (1995) state that whilst changing individual behaviour is tough, changing organisations to improve

employee health is even more difficult. Kristensen (2000; see also Cox et al., 2002) outlines some of these obstacles, as follows:

- Organisational interventions are time-consuming and can be expensive
- Organisational interventions are difficult to describe, control and evaluate
- Despite the fact that management may participate in a research project, they could dislike the idea of an intervention study because they see the organisation of the workplace as their responsibility
- Management may fear that possible mistakes or unpopular actions taken during the intervention will be made public to the employees or to the media. In this respect the political nature of organisational interventions can make them difficult to affect
- Workers may be opposed to some organisational interventions, as may the unions, because they may feel they could interfere with the collective bargaining system of the workplace organisational interventions may raise workers expectations and may increase job dissatisfaction if those expectations are not met
- If the intervention is a failure, internal as well as external difficulties may be caused

Nytro et al (2000) also add that the language barriers, between the interventionists and the stakeholders can hinder change, especially in terms of the effectiveness of the information provided and whether there is *"an adequate understanding of local norms, values and use of language"* (p.219). Furthermore, at times of change, workers can cling to traditional organisational processes and practices for security reasons, consequently unless organisational members are willing to give up what they have clung to in order to make life predictable and controllable, change will not occur (Nytro et al., 2000). Nytro et al (2000) further assert that:

> *"if employees are accustomed to untrustworthy behaviours, and learn to expect them from management, it is unlikely that fresh initiatives to develop healthy modes of organizational functioning will be met with enthusiasm and commitment"* (p.220).

Because of these barriers, and the fact that workplace participants may feel that researchers have lost interest once they have collected the data they need, Kristensen (2000) suggests that, *"[b]efore starting an organizational intervention project it is a good idea to have a formal agreement in which the obligations and rights of all participants are clarified"* (p.302).

These obstacles highlight how the concept of stress and the process of managing change in the workplace are highly intertwined (Schurman & Israel, 1995). Cartwright et al (1995) state that organisations, like individuals, tend to resist change, and that *"this inertia is reinforced by the belief among many managers that the work environment does not contribute to employee distress"* (p.230). Additionally, the nature of complex bureaucratic organisations, such as public sector bodies, is such that *"the major "objective" features of the immediate work environment are "overdetermined", that is, the system has multiple mechanisms for reproducing desired behaviour and resisting change"* (Schurman & Israel, 1995, p.239). In such organisations, policy changes are almost always made at the highest level of manager (Schurman & Israel, 1995). Therefore, the most important step in making healthy organisational change is for the top management within organisations to be seriously committed to both making and sustaining the changes (Cahill et al., 1995), with Shannon et al (2001; see also Nytro et al., 2000) adding that the participation and backing of union leadership is also essential in this respect. However, research still needs to ascertain exactly *what* makes managers committed to a healthy workplace, and whether or not, for example, 'healthy work awards' are potentially more effective than policies or legislation (Shannon et al., 2001). Additionally, managers need to be aware of the cultural barriers to change and how to overcome them (Shannon et al., 2001). Yet, many stress prevention studies:

> *"are under-powered and have relatively limited duration of follow-up, which might be too brief for a real change in workplace culture to occur and hence incapable of detecting any health effect"* (Shannon et al., 2001, p.325).

Principles involved in the establishment of job organisation improvements, highlighted by Theorell (1999) include: the fact that job changes require a

considerable amount of time (see also Shannon et al., 2001; Cahill et al., 1995), with social changes requiring months and years; needs formulated by workers are more likely to be successful than top-down processes (see for example Brodie & Dugdill, 1993); group feedback and discussion are important mechanisms in the change process (see also Nytro et al., 2000); there are bound to be conflicting opinions regarding solutions, which require mental preparation; that concomitant work must take place between the organisation and individual workers; and the completion of a cost benefit analysis (Nytro et al., 2000). Nytro et al (2000), assert that three 'prerequisites' should be in place before introducing organisational interventions. Firstly, learning from failure, which requires reliable empirical reasons why many apparently well-designed organisational change efforts fail to achieve their intended results. Whilst at the same time, uncertainties about the failure of similar projects, and realistic expectations of success should be discussed at the outset of the project. Secondly, involvement and negotiation, which involves taking into account the influence exerted by powerful groups within the organisation. And finally, cultural maturity, which involves the organisation being competent enough in managing the change process to realise the full potential of an intervention, therefore a managers attitude towards change and their way of communicating may be key factors in understanding how organisational process influence the success of occupational stress interventions (Nytro et al., 2000).

Clarke & Stewart (2000) use the term 'wicked issues' to discuss problems for which there is no obvious or easily found solutions, claiming that *"they are likely to be resolved not directly but through an iterative process – learning, trying and learning"* (p.377/378). These type of problems challenge existing patterns of organisation and management requiring a participatory style of working, which both learns from and works with people to inform changes which need to be owned by the people involved (Clarke & Stewart, 2000). Requirements include: holistic thinking to see the bigger picture, including interrelationships of issues, organisations and people; thinking and working across organisational boundaries; and a willingness to think and work in new ways (Clarke & Stewart, 2000).

Once data has been collected, the next stage, called the *translation* phase *"involves identifying the priorities, investigating options for action, assessing the resource*

implications of various courses of action, and planning the implementation of change" (Cox et al., 2002, p.53), thus bridging the gap between the results of the risk assessment and interventions, whilst at the same time identifying the major problems that are *also* associated with poor health. Translating the assessment results into concrete intervention plans is one of the most daunting, and challenging aspects of the risk management process. Cox et al (2002) emphasise the importance of staff feeling that they 'own' the results and the intervention design process. To aid this process, the 'six step' approach to intervention design was developed, as follows:

Table 4: The 'Six Step' approach to intervention design (Cox et al., 2002)

The 'Six Step' approach to intervention design	
The 'ideas phase'	
Step 1	The identification of underlying issues/organisational pathology
Step 2	Making decisions about what can be achieved
Step 3	Select the appropriate and practicable intervention strategy
The 'action planning phase'	
Step 4	Identify the agency (who would implement the plan) and target (who would be receiving the intervention)
Step 5	Planning implementation
Step 6	Setting timescales and milestones

Cox et al (2002) found that the implementation of action plans for risk reduction needed to be carefully and thoughtfully managed, as effectively they are change processes, and recommend establishing a steering group to oversee and facilitate each risk management project. Likewise, the process of action planning must be methodically observed and discussed, and provision made for the evaluation, not only of the outcomes, but also of the implementation process, to allow for both strengths and weaknesses to be assessed (Cox et al., 2002; see also Dugdill & Springett, 1999; Dugdill & Springett, 1995). Criteria for evaluating the efficacy of health promotion strategies include: change in indicators of health and behavioural risk factors of employees; psychosocial conditions at the workplace; accident rates; absenteeism; staff turnover; productivity; satisfaction and well-being of the workforce; and changes in health care costs (European Commission, 1999). Cox et al (2002) describe the evaluation of work stress interventions, as *"an emerging discipline"* (p.87), and in

this respect have outlined a number of specific evaluation criteria, which are discussed in more detail below. However, Dugdill and Springett (1994) found, looking at that the literature on evaluation of actual interventions that few studies took a multi-level approach to evaluation. A key theme arising from the literature is how complex and difficult the evaluation of health promotion programmes actually is, because whilst people spend a long time at work, it is not the only factor affecting well-being (Dugdill & Springett, 1994). As a result, Dugdill and Springett (1995) developed guidance in the form of a practical framework for evaluating workplace health programmes, aimed at health practitioners in the UK. However, Shannon et al (2001) emphasises the need for researchers to determine *which* incentives are effective in motivating companies to be involved in evaluations of interventions.

Nytro et al (2000) sum up the three most important factors in promoting organisational change as being: visible management support and commitment; preparing for successful change; and encouraging employee participation. Additionally, Kompier et al (2000) conclude that *"stress prevention thus relates to both content and process variables, which often are intertwined"* (p.386). In this respect, by combining both content and process factors, Kompier et al (2000) identify five factors in stress prevention: a stepwise and systematic approach; adequate diagnosis or risk analysis identifying risk factors and risk groups; a package of interventive measures that address the problems identified, combining both work-directed and person-directed measures; a participatory approach involving both employees and management; and the sustained commitment of top management.

2.12 The costs and benefits of preventing stress in the workplace

The development of competence, social capital and enhanced opportunity to make decisions, according to the European Commission (1999), represent, not only important determinants of health, but also important investments for organisational health, success and future prospects. However, given that the evidence on the effectiveness stress management interventions is equivocal, as discussed above (see for example Brinner & Reynolds, 1999) it is unsurprising to find that in seeking to evaluate the costs and benefits of stress prevention there is limited evidence (see also Cox et al., 2000b). In fact, Van der Hek and Plomp (1997) found only 37 stress

management interventions, out of 342, which referred to some kind of evaluation research, and of these 7 were based on anecdotal comments from participants. As one of the main purposes of evaluation is to assess the cost effectiveness of programmes, the lack of research in this area clearly represents a significant gap in the research.

There is relatively more published data available on the cost benefits of secondary or tertiary level intervention programmes than there is on organisational level programmes, with some evidence that these types of interventions can temporarily make a difference in reducing the experience of stress (Cooper et al., 1999). Although Briner and Reynolds (1999) argue that there is little clear evidence to suggest that these techniques have a positive impact on objective work variables such as performance and absence. However, as the focus of this thesis is primarily on organisational level interventions to reduce stress, the costs and benefits of secondary and tertiary interventions will not be addressed at this time.

As discussed above, organisational-level strategies are relatively rare, with the focus in the UK generally being on secondary and tertiary level interventions, therefore, costs benefit analyses of organisational level interventions are rarer still. One UK publication aimed at addressing this gap was produced by the European Foundation for the Improvement of Living and Working Conditions in 1996, however, it concluded that there are methodological difficulties in establishing convincing evaluative evidence (Cooper et al., 1996), asserting that:

> *"Since the fundamental problem – how the financial consequences of stress for private and public companies are quantified and analysed in the company's financial routines – has not been solved, there is no basic data available that could guide the measurement of financial consequences of the stress programmes for the companies, either"* (p.78).

As a result, Cooper et al (1996) claim it is would be better to investigate *how* to obtain the basic data for calculations, or quantify the consequences of stress, rather than focus on individual cost-benefit analyses. Whilst issues of measurement may be complex, Cooper at al., (1996) state that they still need to be addressed and incorporated in the evaluation of any strategy. Therefore it is important for an

organisation to know its starting point, or baseline, in order to assess any benefits derived (Cooper et al., 1996). However, where primary level interventions have been evaluated, what little evidence exists has been consistently positive, particularly in showing long term beneficial effects (Cooper et al., 1996). For example, Ganster et al (2001) conducted a 5-year study of control and job stress in a sample of nurses, and found that higher control predicted a lower use of medical services (assessed from health insurance medical records). Cox et al (2000b) suggest in this respect, that organisational-level interventions have significant advantages and represent the best way forward. However, Briner and Reynolds (1999) hold that there is little evidence to support enthusiasm for the success of stress management interventions, highlighting a statement made by Cox et al (2002), which states that *"[t]o date, such conclusions are based more on moral and strategic reasoning that on empirical data, although the data that do exist are supportive"* (p.127). Briner and Reynolds, (1999) claim that the combination of eagerness and optimism on the part of job stress researchers has drawn attention away from the basic questions of why and how organisational level stress interventions work. In this respect what is required are: more longitudinal studies; multiple self-report and objective measures; an assessment of extra-organisational influences on behaviours and attitudes, for example labour market conditions; and study designs that highlight links between *"changes in objective job conditions, changes in subjective perceptions of those job conditions, and changes in employee well-being* [that] *can be clearly examined and the causal relationships between them explored"* (Briner & Reynolds, p.659).

However, where quantitative benefits are useful for measuring for example personnel costs, in order to measure the organisation's capacity or health, it would be more appropriate to use qualitative methods. This calls for a number of varied indices to be used to assess the outcome of stress reduction strategies, in order to reflect the diversity of the impacts of stress upon individual and organisational functioning. However difficulties can arise because assessing costs and benefits in 'words' does not neatly fit into the paradigms of business economics or accounting conventions (Cooper et al., 1995).

In summary, whilst there is optimism that primary level interventions *could* produce positive benefits for both individuals and organisations and represent the best way

forward, what is lacking is a large body of evidence to support this. This is primarily due to the lack of baseline data, primary level interventions, longitudinal studies, and the methodological difficulties in evaluating the multiple causes and consequences of stress, together with the large number of moderating and mediating variables involved. In this regard, more research, as outlined above, is needed to address this gap.

2.13 A participatory action research approach to creating change

Having considered the process of managing stress related interventions in the workplace, a participatory action approach (PAR) using focus groups will now be considered as an approach to creating change in the workplace. Although this section could be considered as part of the methodology part of the thesis, it was felt that as the concept of stress and the process of managing change in the workplace are highly intertwined (Schurman & Israel, 1995; see also Kompier et al., 2000) it is more appropriate for these issues to be discussed concurrently.

The majority of approaches to stress reduction which seek to change employees' perceptions of the work environment through strategies such as increasing participation, communication and social support, enhancing control, and reducing role ambiguity and conflict adopt PAR methods to identify stressors in the work environment and devise ways of alleviating them (Parkes & Sparkes, 1998). In this respect, action research has been designed specifically for bridging the gap between theory, research and practice. PAR involves a cyclical process of reflection and action whereby the stakeholders identify aspects of the system they wish to change; analyse the causes of these dysfunctions; create and implement action plans; develop a plan to evaluate these interventions; identify lessons learned from their experiences; and consolidate their learning into general knowledge that benefits others, or into revised actions (Schurman & Israel, 1995). PAR is therefore a process of *"scientific enquiry that shifts to varying degrees the involvement in and control of the research process to those who experience the problem investigated"* (Loewenson et al., 1999, p.247). Research (see for example HSE, 2002) together with practical experience

strongly suggests that interventions that are designed with the involvement of staff are the most likely to be effective in the long-term.

> *"Staff involvement...encourages enthusiasm, and creativity and can yield extremely effective interventions"* (HSE 2002, p.55). *"Research and practical experience strongly suggests that those interventions that are designed with the involvement of staff are the most likely to be the most effective in the long-term"* (Cox et al., 2002, p.54).

In this respect Bond and Bunce (2001) used a PAR intervention to increase people's job control, and found that *"that the PAR intervention significantly improved people's mental health, sickness absence rates, and self-rated performance at a 1-year follow up"* (p.290). Participation should be genuinely empowering and emancipating for those involved, thereby serving the shared interests of both researchers and researched (Beresford & Evans 1999; Springett & Dugdill, 1999; DeKoning & Martin 1996; Karlsen 1991).

There are four broad approaches in action research which have given rise to different orientations: these are experimental approaches associated with Kurt Lewin in the 1940s and his followers; the organisational approach associated with the Tavistock Institute; the empowering approach which arises from community development; and the professionalising approach which can be seen in education and nursing (Hart & Bond, 1995). However, the focus of this research is on PAR, which is a more radical form of organisational action research rooted in psychoanalysis and social psychology and drawing on the later work at the Tavistock Institute.

PAR conceptualises the production of knowledge as itself an outcome of social relations, as opposed to traditional forms of organisational level interventions that rely on 'expert knowledge'. Therefore, PAR recognises the knowledge of ordinary people, challenging this 'expert knowledge' which often negates the experience of the majority (Loewenson et al., 1999). Karlsen (1991) asserts that to achieve the best, or most rational, solution, open discussions need to be held in which all participants are viewed as having equal rights. These non-hierarchical relationships contrast to the society we live in, where 'politically influential' knowledge conventionally is in the

form of statistically or theoretically based generalisations, which are established by experts and promoted through organisational power hierarchies (Winter & Munn-Giddings, 2001). In this respect, the philosophy of action research is associated with Postmodernism, which rejects a single 'grand narrative', asserting that truth is culturally relative (Winter & Munn-Giddings, 2001). Additionally, the 'pragmatist' tradition stresses practically effective knowledge and enquiry as a communal enterprise (Winter & Munn-Giddings, 2001). The important elements in both of these arguments is the *"rejection of a correspondence theory of truth"* (p.257), which means that statements made cannot be claimed to be true because they 'correspond to' an objective reality external to the language, because we have no way of referring to such a reality except through that very language (Winter & Munn-Giddings, 2001). Therefore it is argued that the truth of each statement depends on its 'coherence' with other statements, as in the action research process where eventual agreement is reached concerning *"the generally shared truth"* (Winter & Munn-Giddings, 2001, p.259).

Contrasts between conventional social enquiry and action research create real and practical problems (Winter & Munn-Giddings, 2001). In this respect, reports risk being rejected, *"as merely partisan or sentimentally idealistic, as mere voices of dissent or exercises in raising morale, as simply lacking the validity and reliability of 'proper research'"* (Winter & Munn-Giddings, 2001, p.255). Similarities exist between these issues and the debates about the validity and reliability of qualitative data that has been and taking place over the last few decades (DeKoning & Martin, 1996). Whilst acknowledging that truth is culturally and 'locally' relative, in order to address issues of validity or credibility of qualitative data a variety of methods can be used, such as member checking, or *"opening the research process to a kind of validation through consensus"* (Karlsen 1991, p.155), using a mix of research methods (see for example Hugentobler et al., 1992), or meeting with peer groups from the same community (DeKoning & Martin, 1996).

As outlined above, interventions aimed at reducing stress in the workplace have a chequered track record. Whereas PAR as an approach to system-level interventions has proven itself an effective means of *"linking knowledge of the setting with a conception of how to introduce change"* (Schurman & Israel 1995, p. 236). Results

of many recent studies (see for example Aparicio, 2002; European Agency for Safety & Health at Work 2002, Kuhn 2002; Bond & Bunce, 2001; Cox, Griffiths & Rial-Gonzalez, 2000; Levi & Levi, 2000; Mikkelsen et al., 2000; The Sainsbury Centre for Mental Health, 2000; Griffiths 1999; Hugentobler et al., 1992; Karasek, 1990; Chernis, 1980) indicate that PAR and participatory processes which involve active or empowerment learning, can significantly improve people's mental health, sickness absence rates, and performance and are critical for developing effective interventions (Goldenhar et al., 2001). Therefore, philosophically PAR is an important approach if one is interested in a bottom-up approach to health in the workplace (Springett & Dugdill, 1999). Kompier et al (1998) reviewed 10 Dutch projects from several branches of industry aimed at reducing work stress, physical workload and sickness absenteeism and concluded that one of the key factors for success was a participative approach. This approach enables 'context-specific' solutions to be found in stress prevention initiatives (for example see case studies from The European Agency for Safety & Health at Work, 2002). Research has shown that participation is particularly important during times of organisational change (see for example Landsbergis et al., 1999). Whitehead et al (2003) agree stating that *"action research is fast emerging as an important method for health-related research activity, and particularly as a method for supporting organisational change"* (p.6). In this respect participation can protect employee's health:

> *"by providing a sense of control and self-esteem and helping to remove uncertainty, frustration and anxiety...staff participation is a means of enhancing the success of change programmes"* (Donaldson, 2002, p.28).

However, Shannon et al (2001) caution that participatory action strategies can only be applied to a tiny fraction of workplaces, requiring substantial time commitment from the researchers.

However, whilst Mikklesen et al (2000) report that participatory interventions had a positive effect on work-related stress, job characteristics, learning climate and management style in a public sector organisation in Norway, the positive effects were short-lived. This could be because the intervention period was too short to implement new working methods successfully, or because of the 'Hawthorne' effect, which can

be particularly likely when participants know that they are involved in a study, and when the follow-up observation point occurs soon after the intervention has ended (Jackson, 1983). However, no negative effects were reported and the most positive feedback reported by the employees was *"appreciation of the opportunity to participate in identifying and solving problems, that the problems addressed were taken seriously by the management and that steps towards solutions were put on an action plan"* (Mikklesen, 2000, p. 168).

Whilst the majority of published accounts of action research are 'success stories' (Gomm et al., 2000), Waterson (2000) published a 'behind the scenes' account that reported a number of problems, such as *"issues of inheriting a project, multiple agendas, changes in key organizational staff, problems of how to present findings, and dilemmas about dissemination and feedback* [which] *created predicaments for the researcher and distorted the balance between action and research"* (p.506). To reduce these limitations Waterson (2000) recommends the use of an independent mentor, more proactive contact with senior management, and the establishment of a steering group. Despite the limitations of this research, Waterson (2000) still felt that the research was useful for the staff involved, reporting that *"the process sharpened their thinking and analytical skills, encouraged them to be more confident in valuing their opinions and experiences and to co-generate meaning and ideas for the future"* (p. 505).

Within social services 'professional-bureaucratic role conflict' (Cherniss, 1980) can occur, resulting in staff feeling helpless because they know little about how the system works and have not acquired the skills to negotiate it. In this respect, skills such as organisational problem solving can be acquired during PAR (Cherniss, 1980). Dockery (1996) reflects on some of the problems of promoting and facilitating participatory processes within non-participatory systems such as public sector bureaucratic organisations, i.e. the number of changes faced by these organisations; how the research population is identified; what methodology is used to conduct the research; the time and money involved; the gradual progression from disempowerment to empowerment; and how a bureaucracy that is hierarchical by nature and in practice can respond to participation. Dockery (1996) suggests that

whilst we may aim for the 'ideal', it is important to acknowledge the above constraints on achieving the ideal in bureaucratic public sector bodies.

Further difficulties of action research include; lack of willingness to participate, lack of access or domination by certain individuals that may lead to bias in both the interpretation of the findings and in the interventions; difficulties in demonstrating cause-effect relationships without clear baseline and outcome measures or some kind of experimental control group, problems with 'external validity' and in the generalisability and sustainability the findings (Gomm et al., 2000; Loewenson, 1999). In this respect, *"[t]he selection of the study base and of the subjects determines the representativeness of the findings"* (Loewenson, 1999, p.248). However, although there are limitations in the scientific 'rigour' of PAR, these can be counterbalanced by the 'relevance' of the findings (Loewenson, 1999).

Notwithstanding the above, as a strategy for redesigning work systems to reduce or eliminate the onset of stress-related health problems (primary prevention) PAR deserves serious attention (Schurman & Israel, 1995). Not least because of the:

> *"increased complexity of working life, the need to access shop floor knowledge of work and organisational processes, increased emphasis on stress and other subjectively experienced conditions, the increasing recognition of multifactorial illness and the need to determine illness in early stages has motivated a greater recognition of the subjective experience and the involvement of workers as central to inquiry and intervention* (Loewenson et al., 1999, p. 241).

Winter and Munn-Giddings (2001) assert that action research is a way of addressing some of the real philosophical difficulties inherent in all forms of social enquiry, including large-scale surveys, theoretical analyses, randomised control trials or local development projects.

The key issue when using the PAR approach to create change is to determine which aspects of working conditions are amenable to change, and how such context-specific interventions may practically be achieved. This follows recommendations for recruitment and retention in the public sector put forward by the Audit Commission

(2002) who urge employers to *"fully understand the work experience from the perspective of your staff, and take action to create and sustain a working environment in which people can make a difference"* (p.61). Donaldson (2002) adds that participative change results in greater staff commitment to the changed system, increasing the likelihood that employees will ensure its future success.

Schurman and Israel (1995) assert that successful PAR interventions should result in: increased use of data to guide planning and decision making; the development of new, more egalitarian structures and decision-making processes that are more participatory, leading to increased opportunities for positive social interaction and social support; the institutionalisation of these new structures and processes into the 'normal' behaviour patterns of the system; and increased scientific knowledge about organisational change and behaviour and the process of (in this case) organisational stress.

2.14 Focus groups in participatory action research

One way of involving staff in a participative way is to use focus groups. A focus group is:

> *"an interactive strategy to gain insight into the perceptions, beliefs and opinions of 8-12 representatives of an intended audience about specific issues, programs, or services through a 60- to 90-minute guided and taped discussion led by a skilled moderator"* (Goldman & Schmalz, 2001, p.14).

In this way, employees' on-the-job experiences can be used as a vital resource in identifying both problems and solutions (European Agency for Safety & Health at Work, 2002). Focus group methods have become an increasingly popular approach to data collection in the social and health sciences, for example to understand employee perceptions of stress (see for example Gillespie et al., 2000), in the development of interventions and in evaluation research (see for example HSE, 2002; MacDougall & Fudge, 2001; Kidd & Parshall, 2000; Health Education Authority, 1999), and as a health needs assessment, to ascertain workplace health proprieties from the perspective of the worker (Dugdill, 2001).

Barbour (1999) asserts that *"focus groups can bridge the gap between 'traditional' organizational research and 'new' organizational theory, which draws on the models of social constructionism and negotiated order"* (p.113). The history of focus groups, which it is not possible to address here, suggests that they were not originally conceived as a stand-alone method, but that focus group methods were an early instance of triangulating qualitative and quantitative data from the same participants (Kidd & Parshall, 2000). Barbour and Kitzinger (1999) agree, stating that focus groups can be combined with quantitative methods (structured research instruments), especially in the latter stages of a project where they can help to tease out the findings. In this respect, *"[g]roup work can not only complement data collected via other methods, but may actually challenge how such data are interpreted"* (Barbour & Kitzinger 1999, p.7). Focus groups are also particularly useful as a way of involving staff in organisational change programmes (Donaldson, 2002; Kutek, 1998). Additionally, focus groups can be used as a means of summative evaluation of a range of interventions or social action programs, to make final judgements about their worth (Wilkinson, 1998).

The aim of the focus group is less about measurement and more about gaining in-depth knowledge about certain areas of interest to acquire in-depth qualitative data (Barbour & Kitzinger, 1999; Jinks & Daniels, 1999). Like PAR, focus groups are seen as a relatively 'egalitarian' method of conducting research, as the number of participants simultaneously involved in the research interaction inevitably leads to a reduction in the researcher's power or control (Wilkinson, 1998). This makes it somewhat impossible for the researcher to impose his or her own agenda in the group context, enabling participants to have a greater opportunity to set their own research agenda and develop themes most important to them (Wilkinson, 1998).

2.15 Summary

The volume of organisational stress research has grown markedly in recent years and as a result it has only been possible to discuss the key themes that have arisen from the literature, pertinent to the aims of this study. Within these themes, there are conflicting paradigms and where possible the debate has been discussed in detail, although in some cases it has been outside the scope of this thesis to do so. In these instances, the evidence has been carefully weighed up to reach the stance that has been adopted. In this regard, a transactional model of stress has been accepted, which sees stress as a negative psychological state, involving characteristics of both emotion and cognition and leads to the definition which sees *"stress as a psychological state, which is both part of and reflects a wider process of interaction between the person and their (work) environment"* (Cox et al., 2000b, p.56). Given that the person interacts with their work environment, it follows that the amount of stress is affected by the nature of the person who is exposed to it. However, the body of literature available recommends that combating the risks at source, and adapting the work to the individual rather than the individual adapting to work is the approach that is required.

Stress is estimated to be affecting approximately 563,000 in Britain (HSE, 2002c) and the Confederation of British Industry have estimated that stress related absence in the UK accounts for the loss of 187m working days per year, costing approximately £12 bn (The Guardian, 17th March, 2001). Similarly, in Europe, stress is reported to be affecting more than 41 million Europeans, resulting in millions of days off sick each year and lost earnings. As a result, strategies have been launched, both here in the UK, and in Europe to try to reduce the number of working days lost and promote well-being at work. These strategies are largely based on the body of evidence which points to ten different job characteristics, work environments and work organisation which have been identified as potentially stressful (see Cox et al., 2000). Guidelines to reduce absenteeism have been produced by the European Foundation (1997), advocating four types of intervention: procedural measures for monitoring and controlling absenteeism; preventative work-oriented measures aimed at reducing the discrepancy between workload and capacity; preventive person-oriented measures to improve the capacity of individuals; and reducing return-to-work barriers. However,

despite this, in social services the main focus is on procedural measures, with no evidence of *any* preventative work-oriented measures.

There is now considerable evidence that perceived stress at work is associated with ill health, including: emotional reactions; cognitive reactions; behavioural reactions; and physiological reactions. Additionally, unhealthy coping behaviours may lay early foundations for subsequent diseases such as CHD, which may be irreversible. Under a number of Acts, employers have a statutory duty to carry out risk assessments regarding both physical and psychosocial hazards and manage these risks as far as reasonably practicable. However, recently the Court of Appeal has ruled that employees also have a duty to inform their employers if they feel under stress, in order to give them the opportunity to do something about it, and/or to make a decision not to carry on in the same job if they find it stressful. Stress has also been shown to negatively impact on organisations by resulting in: increased complaints from clients; less committed staff; an increase in accidents; increase in staff turnover; increased absenteeism; reduction in performance and compensation claims for stress-related illness.

There are a number of stressors, which are associated with working in the public sector, primarily the escalation in the rate and scale of change that has been taking place since the 1980s. This has resulted in organisations either being privatised or subjected to pressures to increase the effectiveness of their management, along with increasingly stringent financial review. As a consequence six factors have been identified as underpinning people's decision to leave, namely:

> *"the sense of being overwhelmed by bureaucracy, paperwork and targets; insufficient resources, leading to unmanageable workloads; a lack of autonomy; feeling undervalued by Government, managers and the public; pay that is not 'felt fair': and a change agenda that feels imposed and irrelevant"* (Audit Commission, 2002, p.22).

Additionally research has found that in the public sector job satisfaction levels are lower than the private sector; pay is relatively lower; and public sector workers are reporting an increase in measured stress.

Social services have similarly been subjected to massive changes over the past few decades. For social workers, stressors identified in the literature include: lack of resources, staff and time; poor perceptions of social work by the public; fear of making mistakes; poor pay; overwork, necessitating unpaid overtime; and organisational change. Again low levels of job satisfaction and high levels of stress have been found amongst this group. Change amongst homecare workers has meant that there has been a shift from domestic care to personal care, because more dependent people are staying at home longer. Violence is a further concern amongst social service staff, with women being more vulnerable than men.

In SSDs the overall level of vacancies has fallen in most employee groups between 2000-2001 although nearly half of the authorities in the Social Services Workforce Study (2002) reported difficulties recruiting field social workers to work with children and families. However, over half of the workforce is aged over forty, and fewer younger people are being attracted to work in the public sector, resulting in UK SSDs recruiting abroad, with disastrous consequences for the welfare systems in the countries affected. Salary levels and the status afforded to social work by society are two factors reported to influence the recruitment of social workers (Gibelman, 2003). In this respect, it would appear that compared to the effort that staff in social services report they are putting in, this is not being rewarded by the appropriate pay and benefits (including public recognition). Despite the obvious consequences of high turnover and difficulties recruiting staff, less obvious effects could include: absenteeism; unpleasant emotional states; higher risks of psychosomatic health complaints; job dissatisfaction; and physical health symptoms.

Stress management interventions fall broadly into three categories, primary, secondary and tertiary, which fall into two main approaches, organisation-oriented and individual-oriented. Recent recommendations urge employers to try to eliminate the root causes of work-related stress, i.e. organisation-oriented approaches, with individual-oriented approaches seen as augmenting organisational approaches. Individual-level approaches are criticised because they focus on the outcomes of stress, rather than the causes, however, despite this, individual level approaches are the most common. However, there is a lack of well-designed and evaluated organisational approaches to manage stress, leading to equivocal results.

Consequently it is recommended that stress management should be carried out in a systematic way, by identifying stress problems, looking for evidence about cause and effect, making informed decisions about interventions and rigorous evaluation. Similarly, there is a lack of process evaluations of occupational stress interventions, with is of critical importance, as even positive results can fail to make clear what role the processes played in bring about the outcome. This dearth of substantive evidence means that there is just as little evidence in the UK on the costs and benefits of preventing stress in the workplace.

PAR is one approach to creating change in the workplace designed to bridge the gap between theory, research and practice. This process involves: the stakeholders identifying the aspects of the system they want to change; analysing the causes of these dysfunctions; creating and implementing action plans; evaluating these interventions; identifying lessons learned from their experiences, and consolidating their learning into knowledge that benefits others, or into revised actions. Research has indicated that interventions that are designed with the involvement of staff are likely to be the most effective in the long-term, and in this respect, focus groups are a way of involving staff in this process. Using this process, the results from many recent studies, indicate that PAR can significantly improve people's mental health, sickness absence rates, and performance.

This research aims to address some the gaps highlighted above and add to the growing body of literature on stress management by developing an understanding of *what* stressors impact on social service staff in order to work out an effective intervention/range of interventions in a participatory way, using focus groups, from a grounded research baseline. This course of action can be subjected to process evaluation and can subsequently be followed up with an evaluation study to assess the effectiveness of the interventions applied.

In this respect, the key research questions are:

- What stressors impact on social services staff?
- By what means can these stressors be reduced or eliminated?

- What services would staff like to be provided by their occupational health service?
- How successful will the future interventions (to be developed with the participants) be in reducing or eliminating stress?

CHAPTER THREE – THE RESEARCH FRAMEWORK

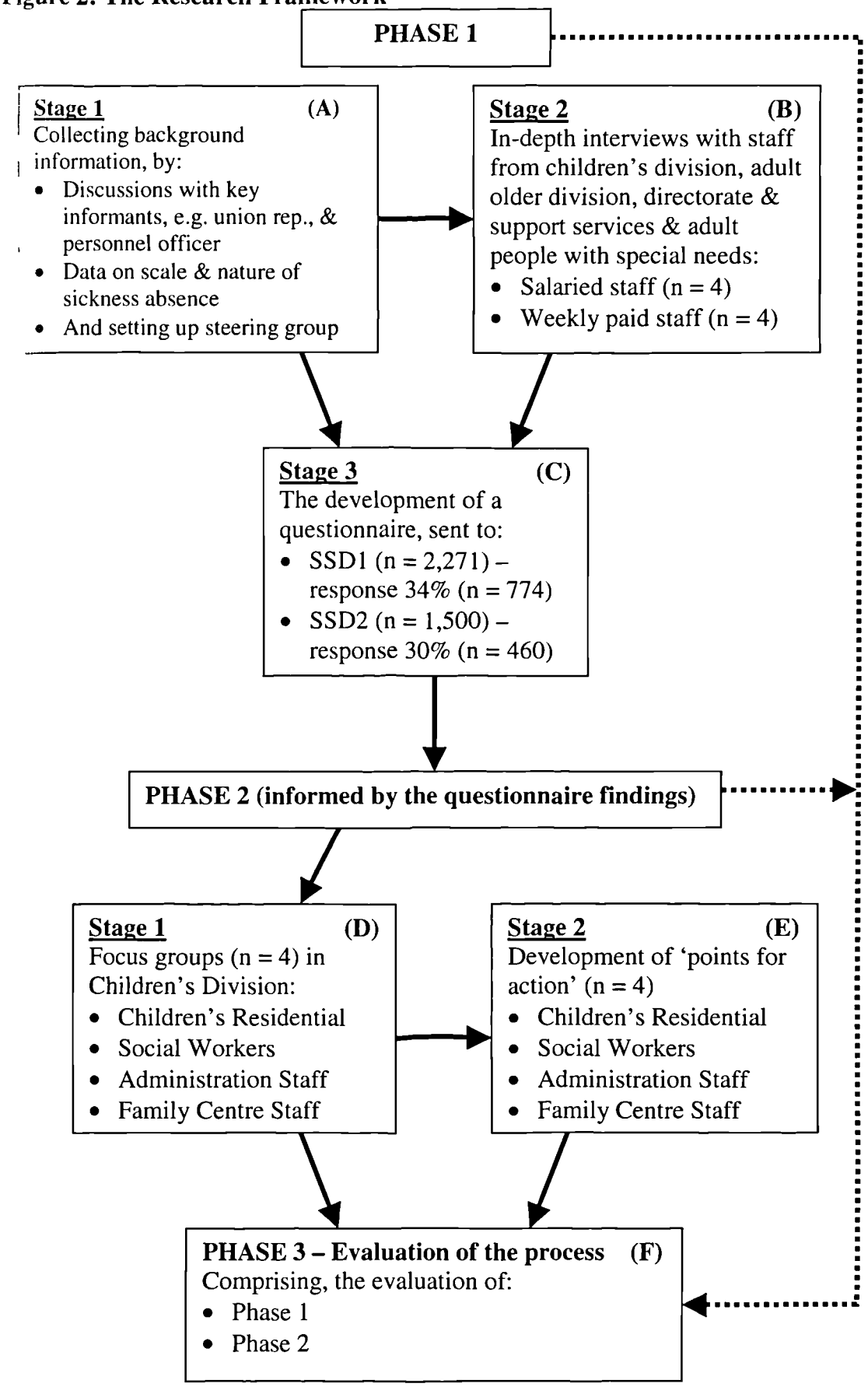
3.0 Research Framework

The aims of this research were:

- To assess the stressors impacting on social service staff
- To identify how these stressors can be reduced or eliminated
- To ascertain what services staff would like to be provided by their occupational health service
- To determine how successful the future interventions (to be developed with the participants) would be in reducing or eliminating stress.

Rather than include a complete methodology chapter for the entire piece of work at this stage, the thesis has been designed to consider each phase of the research process separately and therefore the relevant methodology will be discussed under the appropriate sections (see Figure 2 below). However, an overview of the main features of the research framework will be undertaken to discuss: the type of study conducted; triangulation; and measurement issues.

Figure 2: The Research Framework



3.1 Methods overview

3.1.1 Type of study

This study fits the transactional model of stress (see Cox et al., 2000), as it sought to measure the more structural features of peoples' interaction with their work environment (e.g. job demands and organisational constraints), whilst at the same endeavouring to measure levels of job satisfaction and well-being to reflect psychological states. This study was also analytical, and used both the positivist/empiricist paradigm, which underlie quantitative methods and the constructivist/phenomenological paradigm, which underlie qualitative methods (Tashakkori & Teddlie, 1998). Mixed methods can enhance the ability to make stronger inferences or conclusions from the data (Francisco et al., 2001). Within the positivist paradigm, experimental research is designed to predict outcomes and reveal causal relationships (DePoy & Gitlin, 1994). In this respect, the two most common ways of generating data are through controlled experiments and surveys (Dometrius, 1992). The controlled experiment relies on the researcher's ability to control the conditions of the experiment and manipulate the stimulus received (ibid). However, Griffiths (1999) states that it is:

> *"unrealistic to expect the natural science paradigm to explain highly complex, constantly changing systems such as organizations and to predict the specific effects on individual behaviour and health"* (p.593).

When the stimulus cannot be manipulated, as in this piece of research, surveys are used as a source of information to examine existing attitudes or characteristics (ibid). *"Surveys can be used to study causal processes, to develop and test explanations for particular associations or social patterns"* (Hakim, 1987, p.47). Because this study seeks to investigate the 'relationship' between characteristics of working life within social services and levels of job satisfaction, control, constraints and mental well-being it therefore fits into the positivist paradigm. Additionally, *"well designed and implemented surveys can provide both baseline data and a profile of the existing work environment"* (Lansbergis & Cahill, 1994, p.123).

However, there are limits to the natural science paradigm within organisational research, and in this respect, qualitative methods may be useful to *"generate and explore hypotheses about the micro-mediating processes involved in interventions"* (Griffiths, 1999, p.593). Within the constructivist paradigm, description is used to *"recite the characteristics of a person, object or event"* (Dey, 1993, p.31). In this respect, this study also attempts to explore the multiple interacting factors that contribute to stress amongst social service staff and explore what could be done to lessen some of the difficulties staff are facing, and therefore simultaneously falls within the constructivist paradigm (DePoy & Gitlin, 1994). Griffiths (1999) asserts that qualitative approaches may provide a useful addition to quantitative approaches for the following reasons: they are useful to examine the richness and significance of people's (context-dependent experience); they are helpful in the generation of new theories; and they are useful in the early stages or problem analysis and project design. However, Griffiths (1999) highlights the reluctance in academia to use qualitative methods in organisational interventions.

These two paradigms have often been thought of as conflicting in important conceptual issues, such as the 'nature of reality', however, many theorists (e.g. Tashakkori & Teddlie, 1998; Howe, 1988) have adopted a paradigm, known as 'pragmatism', which allows for the use of mixed methods in social and behavioural research. This method rejects the forced choice between constructivism and positivism in respect of logic, methods, and epistemology, embracing both points of view (Tasakkori & Teddlie, 1998).

> *"These are studies that are products of the pragmatist paradigm and that combine the qualitative and quantitative approaches within different phases of the research process"* (Tasakkori & Teddlie, 1998, p.19).

Instead of searching for metaphysical truths, pragmatists consider 'what works' to be the truth. This method is considered to 'work' within this piece of research, as statistical information gained from the questionnaire can illustrate the scope of the phenomenon, and provide baseline information. Whilst more in-depth qualitative information, gained from the interviews (Figure 2, Box A) and focus groups (conducted in Phase 2) can unearth problems, identify indicators and formulate further

research questions (Dey, 1993). This follows recent recommendations by Cox et al (2002b), which assert that questionnaire data can be supported by a large group, whereas more qualitative methods (e.g. interviews) yield more useful information for smaller groups.

3.1.2 Triangulation

Triangulation involves the combination of methodologies to study the same phenomena (Cox et al., 2000; Tasakkori & Teddlie, 1998; Ivancevich & Matteson, 1988; Hammersley & Aitkinson, 1983; Denzin, 1970). The idea is to use more than one method in the validation process to ensure that the variance reflected is that of the phenomenon and not of the method (Ivancevich & Matteson, 1988). However, Denzin (1970) warns that 'consentuality' in the findings will never be complete, because each different method will reveal different aspects of the reality being studied. *"Methods are like the kaleidoscope, depending on how they are approached, held, and acted toward, different observations will be revealed" (Denzin, 1970,* p.298). Moreover, observations made at different points in time will be different from any other set of observations, as will different researchers' interpretations of observations (Denzin, 1970). Denzin (1970) puts forward four basic types of triangulation, which are data, investigator, theory and methodological. Data refers to data collected over time, space or about individuals, collective groups of people (e.g. organisations), or interactive groups of people (e.g. families); investigator refers to single vs. multiple observers of the same object; theory refers to multiple vs. single perspectives in relation to the same objects; and methodological refers to whether there is within-method or between-method triangulation. Therefore, data can by triangulated by methodology, or by data sources (Denzin, 1970).

A basic feature of methodological triangulation is that two or more different research strategies will be used in the study of the same issue, with researchers choosing methods for their theoretical relevance (Denzin, 1970).

> *"More generally, data-source triangulation involves the comparison of data relating to the same phenomenon but deriving from different phases of the fieldwork, different points in the temporal cycles occurring in the setting, or*

as in respondent validation, the accounts of different participants (including the ethnographer) involved in the setting" (Hammersley & Aitkinson, 1983, p.198).

Similarly, Hugentobler et al (1992) claim that multiple sources of data can strengthen the process of programme planning, needs assessment, intervention and evaluation and that the combined use of qualitative and quantitative data can increase confidence in research findings.

"The robustness of triangulation rests on the premise that the weaknesses in a single method will be compensated by the counter-balancing strengths of another" (Ivancevich & Matteson, 1988, p.202).

3.1.3 Measurement issues

Denzin (1970) highlights the *"inherent difficulties of generating valid sociological data"* (p.313), which arise because of the ever-changing nature of the empirical world, together with the unique bias that arises from theories, methods and observations, which can largely be overcome by employing multiple strategies of triangulation as outlined above. Dewe et al (2000) agree, stating that future researchers may wish to consider a more balanced approach and look for measures of process in qualitative as well as quantitative terms. Ivancevich and Matteson (1988) therefore urge researchers to study organisationally relevant problems, whatever measurement procedures are used.

Considering measurement procedures, in occupational stress research, individual level studies are pervasive, because the impact of stressors is generally believed to be the greatest at the individual level (Bliese & Jex, 2002). However, *"the main limitation with individual-level analyses is that they fail to explicitly consider the role of higher-level context on individual-level processes"* (Bliese & Jex, 2002, p.266), thereby discounting the effect of social systems which are likely to impact on all aspects of the stress process from perceptions of stressors to reactions to stressors. In this respect Bliese and Jex (2002) caution against collecting data from individuals nested within groups, without taking group membership into account in the analysis, because

of the high variability shown by individuals in perceptions and reactions to potential work stressors. Similarly, Sutherland and Cooper (2000) recommend that a successful stress management package should operate from more than one level. Group level analysis is characterised by all variables being modelled at the group level, for example using individual-level variables that have been combined using group means or other summary statistics, which allow detection of relationships that could be obscured by individual-level analyses (Bleise & Jex, 2002). In occupational health research

> *"analyses based on group means may detect relationships that have both statistical and practical significance because the aggregation process creates group-level variables that are sensitive to small, systematic effects that might otherwise go undetected"* (Bleise & Jex, 2002, p.269).

However, generally group-level results cannot be used to make individual inferences, although resources could logically be targeted at groups at risk based on group level analyses, without being able to use this information to predict which individuals in the groups would benefit from the targeted resources (Bleise & Jex, 2002).

Stress as a concept is difficult to measure because *"its dimensions, or exposures, do not form a distinct, defining set and cannot be measured with reasonable consensus among investigators"* (Amick & Kasl, 2000, p.284). Furthermore, difficulties arise, because the term 'stress' has been used in several fundamentally different ways, as outlined above, although the available evidence indicates that stress is a psychological state which is both part of and reflects a wider process of interaction between the person and their environment (Cox et al., 2000b). This 'relationship' between the person and their environment will not be static, but continually changing. In this respect, *"[t]he study of stress has traditionally presented methodological and conceptual challenges to scientists and professionals in every discipline"* (Ivancevich & Matteson, 1988, p.200).

There are a number of factors which play a significant role in determining what is stressful for one person and not for another, which include: life experiences; genetic inheritance; conditioning; health status; and personality types, affecting how people

react to stressful situations (Raymond, 2000). Therefore, a single method, such as a questionnaire, however 'client centered' can never tap the whole of a respondent's 'world view' or experience, because they are based on a set of 'a priori' categories (Shipley & Orlans, 1988). In addition, although the reliability of self-report measures can be established in terms of overall structure, or performance over time, their validity cannot (Cox et al., 2000b). In this respect, 'triangulation methods' as discussed above assert that more than one method should be used to study the same phenomenon (Cox et al., 2000b; Ivancevich & Matteson, 1988). This 'multi-level' mode of measurement has been adopted within this piece of research, to add to the reliability and validity to the methodology.

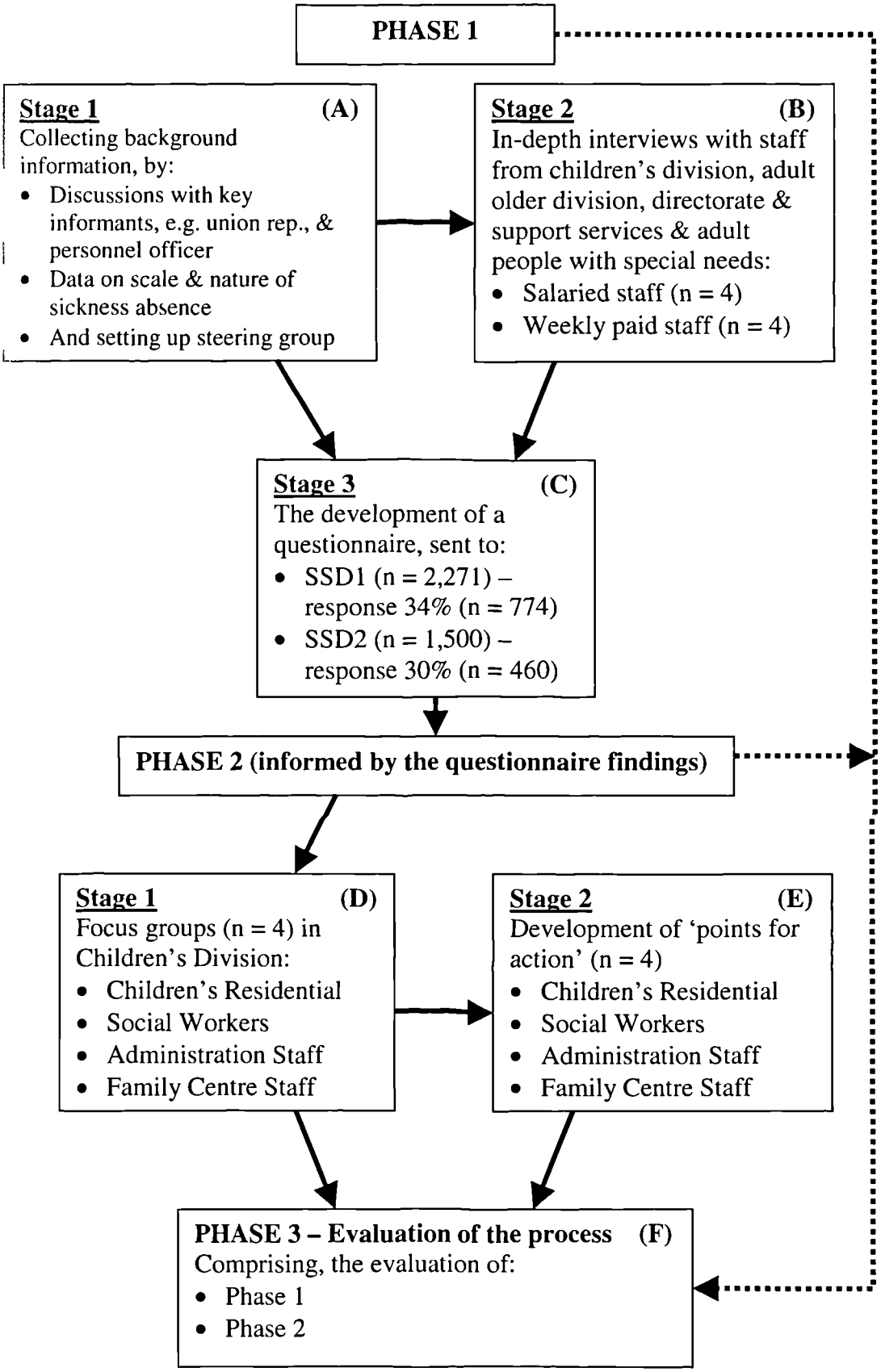


Figure 2a: The Research Framework (Phase 1)

4.0 Phase One - Stage One (Figure 2 – Box A)

Phase one of the investigation was carried out in three parts (Figure 2). Following the conceptual model into 'intervention research in occupational safety and health' developed by Goldenhar et al., (1998) and adopted by, for example, Cox et al (2000a) and Cox et al (2000b), the first stage involved gathering background information to clarify the scope of the project. In order to do this informal discussions were held with key informants, e.g. the Union Representative and Personnel Manager and baseline data on absenteeism, together with pre-existing data within the organisation relevant to occupational health needs were collected. This data consisted of: absence data over a twelve month period; sickness data and analysis, which highlighted the major causes of sickness absence by month, grade and division; SSD1's Code of Practice for Managing Absence, setting out the Council's policies and procedures in relation to sickness absence; and an internal report on 'Improving Levels of Sickness Absences in Social Services – A Feasibility Study (2000).

4.1 The Steering Group

Following Cox et al (2002; see also Dugdill, 1996; Cahill et al., 1995), because of the size and nature of the project in both social service departments a steering group or working group was established at the outset to oversee and facilitate the project. Cox et al (2002) assert that it is important for the steering group to have both authority and credibility and be kept to no more than seven or eight people. In this respect the steering group met these criteria. It is important for three groups to be represented:

- Senior and line management
- Occupational health, or health and safety management
- Trades unions, staff associations or employee representatives (Cox et al., 2002)

Again, these criteria were met.

Dugdill (1996) further asserts that the group should have:

- A broad understand of the issues that surround health and work, and not just in terms of health and safety
- An overview of the organisation
- Be in a position to adopt the process and results from the health needs assessment to future projects

4.2 Phase One - Stage Two (Figure 2 – Box B)

In-depth interviews were carried out on a pilot sample of staff from SSD1 (n = 8) to inform the questionnaire by investigating any issues which employees felt affected either their working lives, or their health. These staff were all female, and consisted of weekly-paid (n = 4) and salaried staff (n = 4) from each of the four divisions. The respondents were identified by SSD1 and contacted by letter to inform them of the nature and purpose of the interviews. Although agreement to the interview was on a voluntary basis, the issue of consent was reiterated at the outset of the interview and the participants were given the following note to read:

> *'Thank you for agreeing to take part in this discussion. Please feel free to stop at any time, and for any reason, if you do not want to continue with this talk.*
>
> *The purpose of this discussion is to talk about your job and how it may affect your health, either positively or negatively. This information will be used to develop a 'health needs assessment questionnaire', which will be distributed at a later date.*
>
> *Any information given will be strictly confidential, and no details will be reported which could identify or link any of the people who take part'*

Open-ended questions were used to enable respondents to formulate their own answers (de Vaus, 1996) and the interviews were tape-recorded to allow content

analysis at a later date in order to draw out key themes (Gomm et al., 2000). The interviews typically lasted between 45 minutes and 1 hour and focused on asking open questions on the ten stressful characteristics of work previously identified (Table 1, p.18).

"The essence of qualitative data analysis of any type is the development of categories or themes that summarise a mass of narrative data" (Tashakkori & Teddlie, 1998, p119; see also Gomm et al., 2000). In this respect following a system devised by Glaser and Straus (1967, cited in Tashakkori & Teddlie, 1998) using inductive logic the data was grouped into themes, which have emerged from the data, rather than being determined a priori. This type of analysis, known as thematic content analysis, seeks to find a limited set of ideas which are relevant to the research topic and constitute a common framework in terms of which the data originating from different respondents can be described (Gomm et al., 2000). This data was used to inform the questionnaire development, which is a method commonly used by researchers, for example, loosely structured interviews informed the development of the Health and Lifestyle Questionnaire used by Cox et al in 1987 (Gomm et al., 2000).

4.3 Phase One – Stage Three (Figure 2 – Box C)

4.3.1 Participants and Sample Size

The target survey population was the entire staff of two UK social service departments (SSD1: n = 2,271, SSD2: n = 1,500). This population comprised 80% female staff and 20% male staff. Two main staffing groups worked in these departments, salaried staff (higher grades) and weekly paid staff (hourly rate of pay). The SSDs comprise four main Divisions, all of which included both salaried and weekly paid staff: Children's Division; Adult Services Division; Directorate & Support Services Division and Adult People with Special Needs Division. The population was split into the above sub-groups because research has shown (see for example Bliese & Jex, 2002; Mullarkey et al., 1999; McLean, 1999; Bacharach & Bamberger, 1992) that different grades and occupations experience different pressures within the workplace. Bliese and Jex (2002) highlight how organisational behaviour is increasingly being viewed from a 'levels perspective', which looks at how the

various levels or hierarchies within an organisation can influence both individual and organisational behaviour, including occupational stress.

4.3.2 Cross-sectional surveys

The advantage of using a survey design was that it was possible to target all of the staff within both social service departments with a fairly low expenditure and numerous variables could be measured using a single instrument (DePoy & Gitlin, 1994). Further advantages include the fact that the survey could be repeated with the entire department, or with sub-groups, after any interventions were put in place to reduce stress, and in this respect could be used as an 'evaluation tool'. Similarly, this survey could be repeated in different social service departments as a comparative study. Survey designs are also useful because the methods and procedures used can be made accessible and visible to other parties in order that the implementation and overall research design can be assessed. However, Parkes and Sparkes (1998) claim that for adequate representation of the employee group involved in a study it is important to aim for a response rate of 60% or more, as lower response rates inevitably cast doubts on the representativeness of the findings. In this respect, Parkes and Sparkes (1998) recommend that the extent to which the sample is representative of the wider employee group should be reported. Kish (1979) describes how measurements can be made in the *"'natural settings' of actual populations"* (p.70). However, a major weakness of surveys is the *"lack of control necessary to distinguish covariation from cause and effect"* (Daly et al., 1992, p.8). A further problem is that the processes of quantification and categorisation impose the researcher's assumptions and concepts onto the field of study. However, despite the fact that this method lacks the control of the experimental approach, the broad range of questions and contexts to which it can reliably be applied mades it the most practical and suitable approach for this field-based study.

The measurement of stress must primarily be based on self-report measures, which focus on the appraisal process and on the emotional experience of stress (Cox et al., 2000b). Therefore, the third stage of the investigation involved the design of a questionnaire as a research instrument after completion of the pilot interviews and discussions with key informants (for a copy of the questionnaire see Appendix 2).

This follows an 'interventionist perspective', as put forward by Shipley and Orlans (1988), which argues that stress should be self-defined by the client. The questionnaire was designed to be easy to read, pleasant to the eye, and with a sequence of questions which was easy to follow (Kumar, 1996). The questionnaire was also designed to be unambiguous, because, as it was mailed, there was no one available to explain the meaning of the questions to the respondents, although a contact telephone number and e-mail address was included in the letter attached to the questionnaire in case anyone wanted further information (see Appendix 3).

The questionnaire, called the Healthy Work Questionnaire (HWQ) formed the basis of a 'needs assessment' (Cox et al., 2000a; Dugdill, 1996). Predominantly 'close-ended' questions were used, in order to produce answers that could be easily compared (Dometrius, 1992). Data produced are expressed quantitatively for the purposes of categorisation and comparison (Daly et al., 1992). However, several open-ended questions were included to give people the opportunity to express more in-depth views on the subject. This addresses one of the disadvantages of using questionnaires, namely spontaneous responses not being allowed for (Kumar, 1996). An advantage of these open-ended questions is that they yielded qualitative data, to assist in describing and classifying phenomena and see how concepts interconnect (Dey, 1993).

The open-ended questions included in the questionnaire were as follows:

- Please list what could be done to improve working conditions in your current job
- Which of the above do you consider to be the most important?
- What is the most difficult aspect of your job?
- What do you think could be done to make that difficulty less of a burden?
- What is the best part(s) about your job?
- If attempts were made to develop an occupational health service, which you could use, what would you like to see included in such a service?
- Any other comments?

'Response bias' is considered the most serious problem with mail surveys (Shaughnessy & Zechmeister, 1990). This is one drawback of this type of survey because respondents with literacy problems, or those of poor educational backgrounds may be intimidated by the questionnaire and subsequently decide to exclude themselves. A further potential problem is that staff can either be too busy or not interested enough to respond, which results in a biased sample (Shaughnessy & Zechmeister, 1990). In order to minimise this limitation the questionnaires were attached to individual staff member's payslips, rather than being included in the internal mail system. If staff were absent from work or failed to pick up their payslips after two weeks, then they were mailed to their home addresses.

There are a large number of individual self-report scales available to assess a wide range of specific job stressors (Hurrell et al., 1998). Subsequently questions were formulated by linking the themes generated by the pilot interviews and discussions with key informants to a number of these scales. These included the:

- Job Content Questionnaire (JCQ) (Karasek, 1979)
- Organisational Constraints Scale (Spector & Jex, 1997)
- Job Satisfaction Measure (Warr, Cook, & Wall, 1979)
- General Health Questionnaire-12 (GHQ-12) (Goldberg, 1972)

Those themes, raised through the interviews, and which were not addressed by the above measures, were listed separately (see Question 17 of the questionnaire in Appendix 2) and a five-point Likert scale, ranging from 'never' to 'rarely', 'sometimes', 'quite often' and 'very often', was used. This was to allow subjects to place themselves on an attitude continuum for each statement (Oppenheim, 1992) to enable data analysis to ascertain whether these issues were only relevant to the pilot group interviewed, or whether, and to what extent, they affected the entire social services department.

4.3.3 Questionnaire Measures – Overview

Andrews and McKennell (1979) highlight how research on attitudes infers that they include at least two fundamental components, i.e. cognition and affect. Cognition refers to the rational aspect of a person's response, whilst affect refers to the emotion components (Andrews & McKennell, 1979). Subsequently measures of subjective attitudes, e.g. well-being, can be expected to reflect combinations of both cognitive and affective elements.

4.3.3.1 The Job-Demand-Control Model (JDC)

The JDC, also known as the job strain model is one of the most influential models in research on work and health (Van der Doef & Maes, 1999; Kompier, 1996) and the JCQ (Job Content Questionnaire, based on the JDC model) is currently thought to be the most widely used job-stress assessment instrument (Hurrell et al., 1998). The model (see Figure 3 below) uses a number of scales to identify crucial aspects in the work situation: job demands; job control (Van de Doef & Maes, 1999); and social support (Kristensen, 1995). These scales can be used for

> *"microlevel, job characteristic analytic purposes, such as assessing the relative risks of individuals' exposure to different work settings to predict job-related illness development"* (Karasek et al., 1998, p.323).

Job demands refer to work load, and are operationalised mainly in terms of role conflict and time pressure (Karasek, 1985 cited in Van der Deof & Maes, 1999). *Job control*, sometimes known as *decision latitude* refers to the person's ability to control his or her work activities (Van der Doef & Maes, 1999). Decision latitude is made up of two components in the scale, skill discretion and decision authority (Van der Doef & Maes, 1999).

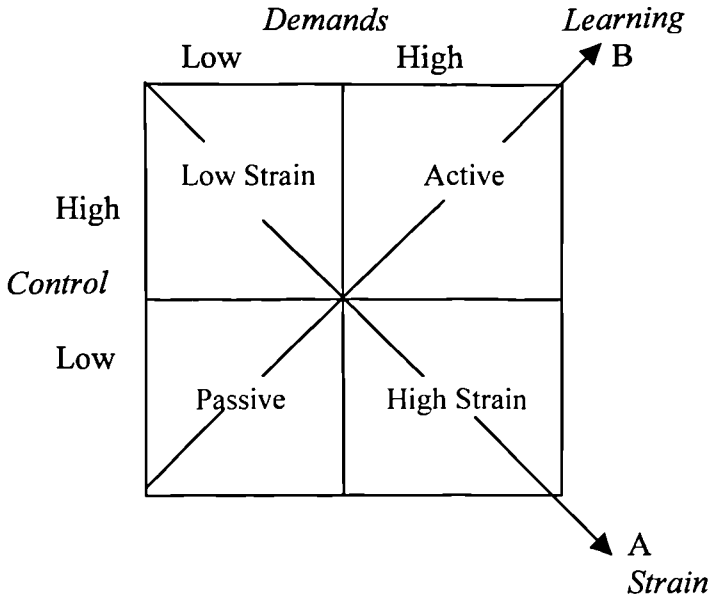


Figure 3: The Job-Demand-Control model (adapted from Karasek, 1979)

This model predicts that, following the strain diagonal, when psychological demands are high and the workers decision latitude is low, that the most adverse reactions of psychological strain will occur (Van der Does & Maes, 1999; Karasek et al., 1998). However:

> *"following the 'learning' diagonal, a second hypothesis states that high demands in combination with high control lead to increased learning, motivation and development of skills"* (Van der Doef & Maes, 1999, p89).

Control by the worker over his/her own job is measured by using the sub-scales 'skill discretion' and 'decision authority' (Karasek et al., 1998). Jones and Fletcher (1996) point out that these measures, which are highly correlated, are wider than the popular meaning of control. However, high internal consistency, using Chronbach's Alphas, is only a valid indicator of reliability for unidimensional scales, rather than distinguishing between different aspects of control (Jones & Fletcher, 1996). According to the JDC control can buffer the potentially negative effects of high demands on health and well-being (Van der Doef & Maes, 1999). However Spector (2002) claims that although this model implies that control can improve the negative effect of job stressors on health and well being, the supporting evidence is equivocal. This could be a result of: the different methodologies used, which mainly rely on self-

report questionnaires; the lack of understanding of the exact role of control and the mechanism through which it operates; and the lack of intervention studies investigating the effects of programmes designed to improve control (Spector, 2002).

The JCQ also measures 'social support', which is considered to be a crucial factor in modelling sickness absence, with evidence (Unden, 1994 cited in Kivimaki et al., 1997) indicating that:

> *"those employees who perceived social support at work as high reported fewer sickness absences and psychosocial symptoms than those who perceived support as unsatisfactory"* (p.859).

However, Bourbonnais et al (1996) found that although social support at work was significantly associated with psychological distress, it did not modify the association between job strain and psychological distress. The JDC has been criticised for its failure to take individual differences into account in susceptibility and coping potential (Cox et al., 2000).

Van der Doef and Maes (1999) conclude, after reviewing 20 years of empirical evidence on the JCQ, that:

> *"the strain hypothesis of the JDC model, which states that the most negative psychological well-being is found in employees working in high demands – low control jobs is supported in a considerable number of studies"* (p.107; see also Bourbonnais et al., 1996).

In this respect, Bourbonnais et al (1996) found, consistent with other studies that the association between job strain and psychological distress remained, even after adjusting for age, employment status, gender, occupation, cynicism, social support at work and non-work social support, hostility, domestic load and stressful life events during the last 12 months. However, Platt et al (1999) concluded that whilst the available evidence supports the JDC, it only does with people who have a high sense of self-efficacy in their work. As a result, increasing control among people with low(er) self-efficacy may exacerbate the stress of demanding jobs.

Later empirical findings do not consistently support a moderating pattern of influence for job control and stressful characteristics of work (Sauter, 1989 cited in Elavainio et al., 2000; Karasek & Theorell, 1990). However, the importance of job control as a factor protecting against health problems has repeatedly been demonstrated (Kivimaki et al., 1997; Landsbergis et al., 1994).

> *"Working in a high-strain job appears to be associated with lower general psychological well-being, lower job satisfaction, more burnout and more job-related psychological distress"* (Van der Does & Maes, 1999, p.107).

Their study suggests that males and females may be affected differently by high-strain work, although this could be the result of gender differences in other characteristics, such as work preferences, i.e. full or part time, or different values attached to work in relation to other aspects of life (Van der Doef & Maes, 1999, p.107).

Theoretically, the JCQ integrates the strengths of multiple disciplines. In this respect the *"JCQ is sociological in that it presumes existence of socially "objective" environments that systematically affect individual well-being and behaviour"* (Karasek et al., 1998, p.326). It uses sociological questionnaire assessment methods in order to collect valid data on social environments (Karasek et al., 1998), although Amick and Kasl (2000) assert that the job strain model *"pays insufficient attention to the broader issues of social inequality"* (p.302). At the same time the JCQ has a psychological focus, in that it looks at the *"behavioral basis for emotion-driven psychological distress, psychosomatic illness development, and changes in microlevel behaviour related to social situations"* (Karasek et al., 1998 p. 327). Thus it presumes that psychological experiences are major determinants of health and well-being (Karasek et al., 1998).

In most studies where scale reliability is reported, coefficient alpha for job decision latitude and job demands is above .70 (Schnall et al., 1994).

4.3.3.2 General Health Questionnaire – 12 (GHQ-12)

The GHQ-12 (Goldberg, 1972, cited in Payne & Morrison, 1999) was included in the questionnaire to measure psychological distress or mental health. The GHQ-12 is a well established mental health screening tool which measures 'strain' and is often used as a psychiatric screening instrument being the most widely version of the GHQ used in occupational settings measure job-stress (Spurgeon & Cooper, 2001; Mullarkey et al., 1999; Hurrell et al., 1998). It covers feelings of depression, strain, inability to cope, lack of confidence, anxiety-based insomnia, and other psychological problems (Spurgeon & Cooper, 2001; Mullarkey et al., 1999). Age, gender or education has no effect on the validity of GHQ-12 (Goldberg 1972, cited in Elovainio et al., 2000). *"Questionnaire scores have been shown to be significantly correlated with clinical assessments and other self-report measures of symptoms of anxiety and depression* (Hurrell et al , 1998, p.376). Amongst the advantages of using this method, one is the fact that the instrument was developed for a British population (Hurrell et al., 1998). This scale can be measured either by the 'Likert method' or 'GHQ method' (Mullarkey et al., 1999). There is little difference with regard to internal reliability between the two methods (Mullarkey et al., 1999). GHQ-12 using the GHQ scoring method is used to identify whether or not an individual would be classified as suffering from minor psychiatric disorder on the basis of psychiatric assessment, the threshold for case classification being either greater than 3 or greater than 4 (Mullarkey et al., 1999). Goldberg (1972) suggests that a score of 3 or more indicates 'minor psychological distress', however, in recent studies of hospital workers in the UK scores for ancillary workers were about 14%, and for women managers as high as 43% (Borrill et al., 1996). The Likert method of scoring:

> *"uses more of the information in the response-scales and produces a less skewed distribution than the GHQ method, which makes its use more appropriate in studies employing parametric statistics* (Mullarkey et al., 1999, p.36).

Gardner and Oswald (2001) state in respect of the GHQ-36, using the Likert scale *"medical opinion is that healthy individuals score around 10-13 on the test. Numbers near 36 are rare and usually indicate depression in a formal clinical sense"* (p5). For

the purposes of this study, the results of the GHQ-12 will be analysed using both scoring methods, to yield the greatest amount of information.

4.3.3.3 Job Satisfaction

This measure was developed by Warr, Cook and Wall (1979) and is described as a *"robust instrument which is easily completed by employees at all levels and which is psychometrically sound"* (Mullarkey et al., 1999, p.11). The job satisfaction questionnaire is a 15-item instrument, which can be scored one of two ways. Firstly as a single index of overall job satisfaction (all 15 items), or secondly, as separate indices of intrinsic (7 items) and extrinsic job satisfaction (8 items) (Mullarkey et al., 1999). Extrinsic job satisfaction covers external features to the work itself (e.g. the way the firm is managed, pay), whereas intrinsic job satisfaction addresses people's affective reactions to features integral to the work itself (e.g. autonomy, variety). Overall job satisfaction was measured in a Local Authority sample (n=4,442), and yielded a coefficient alpha of .88 and a mean of 4.35 (Mullarkey et al., 1999). Intrinsic job satisfaction by Local Authority sample (n = 4,446) scored a coefficient alpha of .85, and a mean of 4.40, and similarly extrinsic job satisfaction (n = 4,450) scored a coefficient alpha of .73, and a mean of 4.31. Intrinsic and extrinsic job satisfaction scores tend to be positively intercorrelated (Warr, 1987a).

4.3.3.4 Organisational Constraints Scale

The Organisational Constraints Scale (OCS) is a 'stressor scale' based on the work of Peters and O'Connor (1980), who listed 11 areas of constraints, e.g. incomplete information, or conflicting job demands (Spector & Jex, 1998). It is designed to identify situations or things that *"prevent employees from translating ability and effort into high levels of job performance"* (Spector & Jex, 1998, p.357). Payne (1999) asserts that an environment high on constraints is more likely to cause psychological distress. Each area is assessed with a single item, ranging from 1 (less than once per month) to 5 (several times a day) and high scores represent high levels of constraints (Spector & Jex, 1998). As the OCS is a causal indicator scale, internal consistency is not relevant, however, the coefficient alpha reported by Spector and Jex (1998) is .85, with a possible range or 11-55 and a mean of 21.3 (n=1,746).

4.3.3.5 Absenteeism

In this study absenteeism records were obtained from both SSDs and absenteeism was also measured using two self-report questions, have you been away from work because of your own sickness or injury in the last six months? and were any of your absences in the last six months caused either by injuries sustained at work or by you being affected by your working conditions (if yes, details were sought)? Potential limitations associated with both sources of absenteeism data are discussed in detail below.

Those themes which were not addressed by any of the above measures but were raised through interviews/discussions, e.g. is appropriate cover provided when staff are sick, were listed separately and a five-point Likert scale, ranging from 'never' to 'rarely', 'sometimes', 'quite often' and 'very often', (Coffey, 2001; Coffey, 2002). This was to ascertain whether these issues were only relevant to the pilot group interviewed, or whether, and to what extent, they affected both social service departments.

4.4 Evaluation of self-report job stressor measures

A common problem with many of the measures is that they tend to focus on only one dimension of the stressor being assessed (from a range that includes: work-related environmental conditions; worker's psychological and physiological reactions to such exposures; and the negative health states thought to result from exposure to job stressors) (Hurrell et al., 1998). In this respect, and to counteract this particular problem, several scales were chosen. A further problem can be that scales can be quite remote from a worker and their job environment (Hurrell et al., 1998). Again, to address this limitation, 29 questions were included in this research instrument, which had been identified by the pilot in-depth interviews (see Question 17 of the questionnaire).

Self-report bias is a potential problem when assessing job strain using questionnaires completed by the study participants (Schnall et al., 1994). Similarly, the reliance on self-report data on both stressors and outcomes makes definitive conclusions difficult (Spector et al., 1988). There are a number of issues concerning self-report data.

Karasek et al (1998) and Spector et al (1988) question whether self-reported data corresponds to 'objective reality'. In this respect, *"self-reports may be inaccurate descriptions of job characteristics, or may be biased by personality traits such as negative affectivity"* (Schnall et al., 1994, p.397). Similarly Spector et al (1988) query whether employee perceptions of their job conditions are representative and what other variables cause them. In this respect, Jex and Beehr (1991) claim that *"80 or 90% of the variance in self-report measures is not due to the objective environment"* (p350). Other factors reported to effect perceptions independent of the work environment include cognitive processes; social cues; attitudes; transient mood states and stable dispositions (Jex & Beehr, 1991). Jex and Beehr (1991) therefore recommend when using self-reports that they either be used in conjunction with more objective measures of the work environment, or without the assumption that they represent the objective work environment.

Harrison and Shaffer (1994) highlight the disadvantages of relying on archival records of absenteeism as a single type of measure, warning that:

> *"[b]ecause archival records are generated and kept for an organization's purposes rather than for a researcher's, both reliability and construct validity are weakened, especially when absences are categorized by type, that is, according to some imputed motive for missing work"* (p.240).

Van Poppel et al (2002) found that the sensitivity of questionnaires for detecting episodes of sick leave was very low, with little agreement on the duration of the episode between the data in company records and the questionnaire data. Similarly, Johns (1994) having reviewed forty-three studies presenting self-reported absence data in terms of their psychometric properties of reliability, validity and accuracy, found that: very little attention has been paid to the reliability of self-reports of absence data; the correlation of self-report absence data with records-based measures was shown in 11 of the studies, with validity coefficients ranging from .30 to .92; and there was a tendency for underreporting absence. Possible explanations for underreporting include: the demands that self-reports make on the absentee's memory, especially in terms of the causes of such illnesses; the negative connotations attached to absence behaviour; and common method variance, although most studies

use formats that are typically different from the formats used to measure attitudes or opinions elsewhere in the questionnaires (Johns, 1994). Johns (1994) concluded that more research is needed in the case of self-reported absenteeism, especially in terms of reliability, validity and accuracy. Additionally, more attention should be spent trying to find out more about the conditions under which people are more or less honest in their self-reported absence (Johns, 1994).

Looking at correlations between self-reported stressors and self-reported strains, common method variance, i.e. correlations reflecting sources of bias common to a method of instrumentation, rather than true relations between constructs, can also be a source of bias (Jex & Beehr, 1991). However, following a review of the literature, Jex & Beehr (1991) conclude that common method variance *"is clearly not pervasive enough to use as a basis to dismiss all correlations between self-report measures"* (p.352). Nevertheless, they recommend only using scales that are psychometrically sound and that further research on the measurement of work stress variables is needed (Jex & Beehr, 1991).

Negative affectivity (NA) is a personality variable, or trait, which has been given much attention by work stress researchers as a potential biasing influence in self-report measures of job stressors and job strains (Cooper, 2000; Cox et al., 2000; Jex & Beehr, 1991). Individuals with high NA tend to concentrate on the negative aspects of everything, experiencing distress in a number of situations, therefore NA could potentially affect not only a worker's perception of their work environment, but also their appraisal of their own health and well-being, thus becoming a confounding variable (Cox et al., 2000). Authors (see for example Cooper, 2000; Judge et al., 2000; Payne, 2000; Spector et al., 2000) highlight the complex role of NA in the job stress process although the research literature is divided as to what extent NA distorts the assessment of the stress-strain relationship (Cox et al., 2000). Some researchers use partialling to control for the possible biasing effects of NA, although Spector et al (2000) *"consider the use of partialling in this way to be a mistake, because it is not in any way clear that NA has only a biasing effect"* (p.81). Smith (2000b) found that *"[t]he results from the cohort study suggested that the effects of stress could not be solely attributed to the personality trait of negative affectivity"* (p.215). The controversy appears to be over whether high NA people lie about their perceptions,

reporting a stressful job when actually it is not, or that low NA individuals lie, not wanting to admit to negative perceptions? (Spector et al., 2000). The issue is complex and largely outside the scope of this thesis, however it draws attention to the weakness of relying entirely on self-assessments to measure stress (Cox et al., 2000). In this respect, in order to help to overcome the problem of NA, 'triangulation' (as discussed above) has been used within this study, as *"[t]he triangulation of evidence overcomes the potential problems of NA to some extent"* (Cox et al., 2000, p.58).

Despite criticisms of self-report analysis scales, they continue to be used by job stress researchers, for the following reasons. Firstly these measures make data collection relatively easy and secondly *"self-reports represent incumbent perceptions, and perceptions represent an important mediating process in the occupational stress process* (Spector & Jex, 1998, p.359). In addition, psychological job strains involve attitudes and emotions, therefore the only way of measuring them, is to ask individuals how they feel (Spector & Jex, 1998). Furthermore, the use of questionnaires to establish employee attitudes to health promotion and occupational health care has been reported (Ritchie & McEwen, *1994*). This practice of obtaining employees views is an accepted component in health needs assessment. Consequently, *"[w]hen planning occupational health services, it is appropriate to determine employee health concerns, their priorities for* occupational health care and *the level of interest in a number of health promotional activities"* (Ritchie & McEwen, p.81). The usefulness of self-report measures in reflecting perceptions can be enhanced by pairing them with objective indicators such as sick days or health care claims (Hurrell et al., 1998; Spector & Jex, 1998), as is this case with this study.

> *"The investigation of job-related stress involves studying the relationship between stressful aspects of jobs (normally termed* stressors) *and the reputed results of stressor exposure (normally termed* strains) (Spector & Jex, 1998, p.356).

In this respect, the GHQ-12 measures 'strain' (Mullarkey et al., 1999). Similarly the JCQ focuses on 'job strain', hypothesising that the combination of high job demands and low decision latitude will lead to negative physical health outcomes (Schnall et al., 1994), whilst the OCS measures 'stressors' (Spector & Jex, 1998). *"The choice of*

a particular stressor assessment instrument is clearly dependent on the purpose of the investigation and the theoretical orientation of the investigator" (Hurrell et al., 1998, p.373). In this respect a number of 'stressor assessment instruments' were used to gain the widest possible insight into the nature of work within the different sections of both SSDs. It was anticipated that, because of the diverse nature of work within the Departments, ranging from domestics, to administrative staff or social workers, that a variety of instruments would prove the most appropriate for this purpose.

4.5 Questionnaire Results

Table 5: Survey respondents

	Overall	SSD1	ssd2
Response rate	**33%** (n = 1,234)	**34%** (n = 774)	**30%** (n = 460)
Male	**19%** (n = 228)	**18%** (n = 137)	**20%** (n = 91)
Female	**81%** (n = 1,000)	**82%** (n = 633)	**80%** (n = 367)
Aged 50+	**29%** (n=357)	**29%** (n = 228)	**28%** (n = 129)
Full time	**61%** (n = 749)	**57%** (n = 433)	**69%** (n = 316)
Part time	**39%** (n = 475)	**43%** (n = 332)	**31%** (n = 143)
Salaried	**62%** (n = 719)	**64%** (n = 470)	**59%** (n = 249)
Weekly paid	**38%** (n = 439)	**36%** (n = 262)	**41%** (n = 177)

Note: (Overall: 6 staff did not identify their gender; 76 staff did not identify whether they were salaried or weekly paid; and 10 staff did not identified whether they worked full or part time).

31% of the weekly paid staff who identified themselves (n = 135) worked full time, whilst 69% (n = 300) worked part time. 81% of the part time weekly paid staff worked either with in Adult Older Division, or with Adults with Special Needs, and although it was not possible to determine exact roles from the questionnaire, it is considered that a large percentage of this group were probably homecare workers, because 48% (n = 224) of them worked in Adult Older Division, whose primary

function was to provide home help for older people. Conversely, 79% of salaried staff who identified themselves (n = 564) worked full time, with only 21% (n = 153) reporting that they worked part time.

Both qualitative and quantitative results from the surveys are reported below. With respect to organisational constraints, job satisfaction, mental well-being, psychological job demands, control and total social support, no statistically significant main effects were found between title (salaried or weekly paid), study (SSD1 & SSD2) or Division (Children's Division, Adult Older Division, Directorate & Support Services, and Adult People with Special Needs Division) using 3-way ANOVA ($p > .05$), therefore the following analyses were carried out on the whole sample. Also, because of the small number of weekly paid staff in Directorate & Support Services Division differences between job grades were carried out using Independent Samples t-tests and differences between Divisions were tested using one-way ANOVA.

The open-questions in the questionnaire generated a vast amount of data on the following topics: what is the most difficult part of your job; what could be done to make this difficulty less of a burden; what is the best part of your job; what services would you like to see provided by your occupational health unit; and any other comments. However, due to the amount of data generated, it was only possible to undertake a very brief discussion of the main themes that arose at this time (for a full discussion see Coffey, 2002; Coffey, 2001).

4.5.1 Organisational constraints scale

Table 6: Mean Levels of Organisational Constraints (Spector & Jex, 1998) by Division and Grade

ORGANISATIONAL CONSTRAINTS SCALE					
	OVERALL	WEEKLY PAID STAFF		SALARIED STAFF	
	Mean Score	No.	Mean Score	No.	Mean Score
Total Sample (n = 1,019)	22.41	336	18.85	637	24.37
Children's Division (n = 240)	24.67	31	23.00	194	25.07
Adult Older Division (n = 313)	20.12	197	17.58	106	24.66
Directorate & Support Services (n = 154)	22.81	5	15.40	141	23.38
Adult People with Special Needs (n = 297)	22.83	97	20.39	180	24.17

The overall level of reported organisational constraints was significantly higher for salaried staff than weekly paid staff, ($t(961) = .862$, $p<0.001$). There was also a significant effect of Division ($F(3, 1138) = 7.390$, $p<0.001$). Post-hoc Tukey tests showed that reported levels of constraints were significantly higher in Children's Division than Adult Older Division, who reported levels of constraints significantly lower than all of the other Divisions ($p<0.05$). Overall, Children's Division reported the highest levels of constraints in both groups of staff, and Adult Older Division staff reported the lowest mean level of constraints. In terms of the specific constraints reported to be particularly problematical, interruptions by other people was reported to affect 34.1% of staff several times per day, followed by conflicting job demands (13.5%), lack of equipment or supplies (8.2%) and poor equipment or supplies (7.6%). Additional open-ended questions were responded to as follows:

4.5.2 *What is the most difficult aspect of your job?*

In response to this open question there were a substantial number of different replies, which were grouped into themes. The largest number of responses by far indicated that the most difficult aspect of social service staff's jobs was the lack of time and rigid timescales in which to do the job properly.

> *"Time factor – trying to juggle pending workload with urgent tasks and feeling guilty and stressed for not giving pending workload the attention it needs"* (SSD 1 - female, weekly-paid, part-time member of staff from Adult Older Division)

> *"Impossible to do the job at a practical level and do the paperwork as well. The fear that when things go wrong, the paperwork will not be done, and I'll be hung out to dry (scapegoat)"* (SSD 2 – 55 year old male, salaried, full-time member of staff from Adult People with Special Needs Division.

This was followed by the interface with service users – issues around their various needs, especially in terms of challenging behaviour, abusive/demanding clients, dealing with life/death situations, taking people's liberty away etc.

> *"Coping with the demands of so many families with complex needs. I worry about missing something wrong with the child (as in child protection)"* (SSD 2 – 57 year old female, salaried, full-time member of staff from Children's Division).

> *"Abuse, violence, noise, behavioural problems, people wanting your attention constantly, never being able to finish one job before there is maybe an outburst etc."* (SSD 1 - 48 year old female, weekly paid, part-time member of Adult People with Special Needs Division.

Staff reported further pressures because of a lack of staff to cover the workload:

> *"Clients not getting cover because I'm on holiday and coming back to twice the work and the clients are uptight"* (Study 1 – 36 year old female, weekly paid, part-time member of Adult Older Division)

> *"Lack of trained staff, permanent anxiety re. finding appropriate staff is a major area of concern the work still has to be done and we have responsibilities to fulfill, however the department doesn't always appreciate these difficulties"* (Study 2 – 50 year old female, salaried, full-time member of Children's Division).

4.5.3 What could be done to make this difficulty less of a burden?

A substantial number of different responses were received to this question, of which the largest number by far indicated that the way to ease their difficulties was to employ more staff, especially trained, permanent, competent staff and to replace staff who leave as quickly as possible:

> *"More staff/workload to be lessened so that things can be done in the time allotted that are of importance to the service user's needs"* (SSD 1 – 28 year old female, weekly paid, part-time member of Adult People with Special Needs Division)

> *"To have permanent staff so we could organise things better, as there have been too many staff changes of late"* (SSD 2 – 56 year old female, weekly paid, part-time member of Adult Older Division).

This was followed by more support and understanding of working conditions and the nature of the job - recognition and appreciation of hard work:

> *"Provide more support. Managers cannot support staff when they are under immense pressure re. sickness absence/best value etc."* (SSD 2 – 31 year old female, weekly paid, part-time member of Adult Older Division).

"For management to realise what we have to deal with on a daily basis, especially when things are going wrong and there is no support and you are making decisions that you have not been trained for" (SSD 1 – 36 year old female, weekly paid, part-time member of Adult People with Special Needs Division).

Staff also wanted more training, both internal and external, including management training, especially *before* new procedures are implemented:

"I feel that I have too much responsibility and I am asked to undertake tasks that I have had little or no training in, causing me to feel stressed" (SSD 2 – 27 year old female, salaried, full-time member of Children's Division).

"Staff to be pre-trained and not be left unaccompanied before commencing work with different service users" (SSD 1 – 56 year old male, weekly paid, part-time member of Adult People with Special Needs Division).

4.5.4 Job satisfaction

Table 7: Job Satisfaction (Warr, Cook & Wall. 1979) by Division and Grade

Client Group	JOB SATISFACTION SCORE								
	OVERALL			INTRINSIC			EXTRINSIC		
	TOTAL	W/P	S	Total	W/P	S	Total	W/P	S
n	**1,096**	**376**	**652**	**1,149**	**396**	**682**	**1,143**	**396**	**675**
Total Sample	4.19	4.08	4.24	4.22	4.14	4.27	4.16	4.07	4.20
Children's Division	4.24	4.28	4.24	4.33	4.42	4.33	4.14	4.21	4.14
Adult Older Division	4.10	4.13	4.04	4.11	4.15	4.05	4.11	4.14	4.04
Directorate & Support Services	4.32	4.62	4.28	4.34	4.51	4.33	4.31	4.72	4.25
Adult People with Special Needs	4.17	3.89	4.33	4.20	4.00	4.30	4.17	3.85	4.33

W/P = weekly paid staff, S = salaried staff

Previous research in Local Authorities (n=4,442), reported an overall mean Job Satisfaction level of 4.35 (Mullarkey et al., 1999). Levels of job satisfaction were therefore poorer in this study.

Using an Independent Samples t-test, salaried staff reported significantly higher levels of overall job satisfaction than weekly paid staff ($t(1,026) = 11.52$, $p<0.05$). One-way ANOVAs revealed no significant differences between Divisions (Intrinsic JS, $F(3, 1127) = 2.37$, $p>0.05$, Extrinsic JS, $F(3, 1123) = 1.52$, $p>0.05$, Overall JS, $F(3, 1076) = 1.93$, $p>0.05$). The lowest levels of job satisfaction were reported in Adult Older Division and Adult People with Special Needs Division. Using a Paired Samples t-test, extrinsic job satisfaction was found to be significantly higher than intrinsic job satisfaction ($t, (1,097) = -22.54$, $p<0.01$).

4.5.5 *What is the best part(s) of your job?*

The vast majority of staff indicated that spending time with the service users and developing relationships with them, and the sense of camaraderie of being in a team with friendly work colleagues provided their greatest sources of job satisfaction.

> *"Working with people to make their lives better. I love my job and the challenges that I face on a daily basis"* (Female, full-time, SSD2, Children & Families Division, Salaried)

> *"Camaraderie between colleagues...supportive colleagues"* (Male, part-time, SSD1, Adult Services Division, weekly paid)

4.5.6 *GHQ-12*

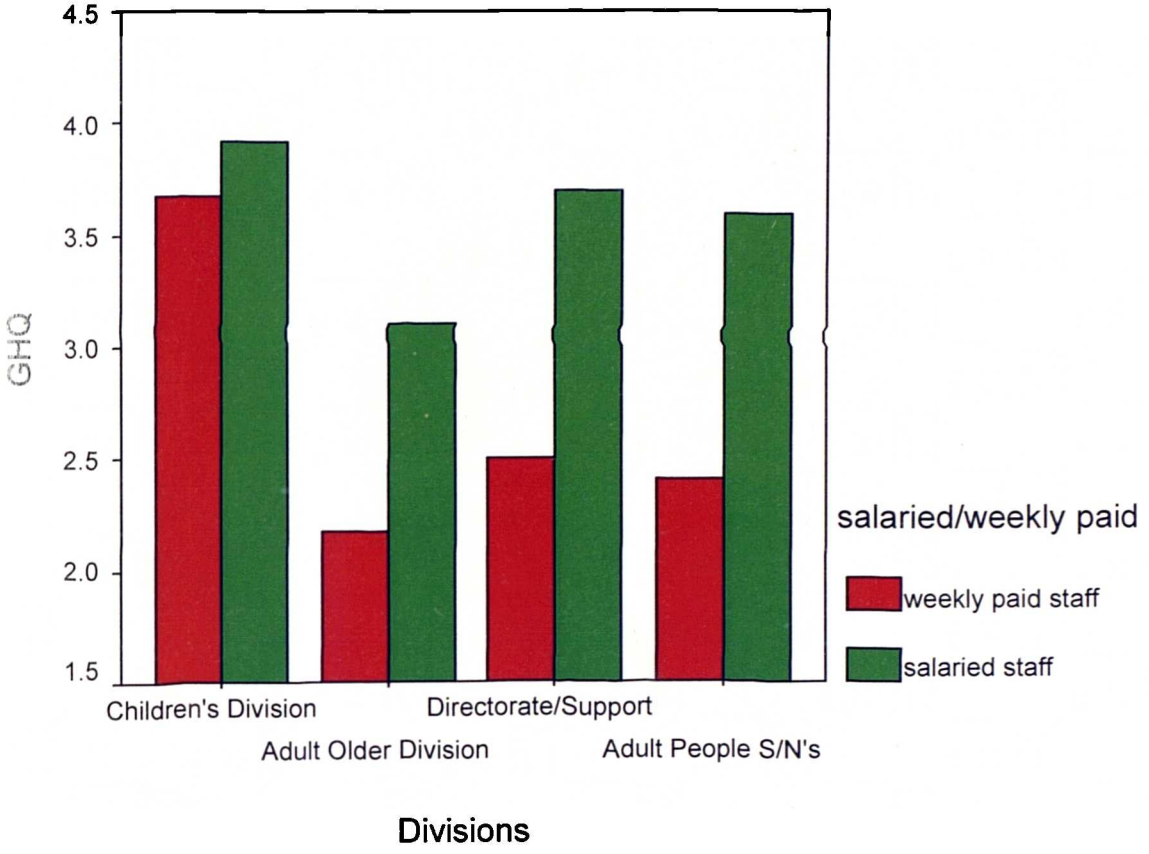
Table 8: Mean levels of mental well-being (Goldberg, 1972) by Division and Grade

CLIENT GROUPS	GHQ – 12 SCORE (GHQ SCORING METHOD)					
	Overall		Weekly Paid Staff		Salaried Staff	
	n	mean	n	mean	n	mean
Total Sample	1,159	3.18	405	2.39	689	3.62
Children's Division	264	3.90	34	3.68	209	3.92
Adult Older Division	369	2.54	241	2.18	116	3.10
Directorate & Support Services	170	3.46	10	2.50	151	3.70
Adult People with Special Needs	339	3.20	114	2.40	203	3.59

Salaried staff reported significantly higher GHQ scores than weekly paid staff ($t(1089) = 24.71$, $p<0.001$). A one-way ANOVA indicated a significant difference between the Divisions ($F(3, 1138) = 7.39$, $p<0.001$). Post-hoc Tukey tests showed there was a significant difference between Children's Division and Adult Older

Division, and Adult Older Division and Directorate. Staff in Adult Older Division had the lowest GHQ scores throughout the Department, whilst staff Children's Division had the highest.

Figure 4: Mean levels of Mental Well-being by Division and Grade



4.5.6.1 GHQ-12 'Cases'

Table 9: GHQ-12 'Cases' by Division and Grade

GHQ-12 'CASES' WITH SCORES OF 4 OR OVER									
	CHILDREN'S DIVISION		ADULT OLDER DIVISION		DIRECTORATE & SUPPORT SERVICES		ADULT PEOPLE WITH SPECIAL NEEDS		TOTAL
	W/P No.	S No.	W/P No.	S No.	W/P No.	S No.	W/P No.	S No.	
Total	**14**	**87**	**63**	**41**	**2**	**65**	**37**	**83**	**392**
No.	34	209	241	116	10	151	114	203	1,078
%	**41%**	**42%**	**26%**	**35%**	**20%**	**43%**	**32%**	**41%**	**36%**

Table 9 indicates that overall, 36% of the respondents in this study would be considered as 'cases', or suffering from mental distress, using the GHQ scoring method. The highest proportion were found amongst salaried staff, with weekly paid staff generally reporting lower levels of caseness, except for the 41% staff identified as such in Children's Division.

4.5.7 Absenteeism

Table 10: Absenteeism by Division and Grade

CLIENT GROUPS		ABSENCE FROM WORK (IN THE PREVIOUS 6 MONTHS) DUE TO ILLNESS			ABSENCES FROM WORK (IN THE PREVIOUS 6 MONTHS) DUE TO WORK-RELATED INJURIES		
		TOTAL	W/P	S	Total	W/P	S
Total Sample	%	49%	43%	52%	17%	17%	17%
	n	**1,220**	**434**	**711**	**790**	**275**	**457**
Children's Division	%	54%	54%	52%	17%	10%	17%
	n	**263**	**35**	**207**	**180**	**29**	**134**
Adult Older Division	%	42%	42%	41%	15%	16%	15%
	n	**389**	**252**	**123**	**248**	**162**	**75**
Directorate & Support Services	%	52%	27%	53%	18%	25%	19%
	n	**180**	**11**	**159**	**113**	**4**	**102**
Adult People with Special Needs	%	52%	43%	37%	20%	24%	18%
	n	**370**	**130**	**215**	**235**	**74**	**141**

W/P = weekly paid staff, S = salaried staff

Table 10 indicates that more salaried staff reported being absent from work in the previous 6 months due to illness than weekly paid staff, (χ = 8.21, $p<0.01$). Children's Division reported the highest levels of sickness absence from work amongst the Divisions. Absences from work-related injuries were much less prevalent, with the highest levels reported by Adult People with Special Needs Division. Stress-related absence accounted for the biggest cause of work-related absenteeism, followed by infections caught at work and back problems. Overall, 50

(4.3%) staff reported being off work due to stress-related illness, of whom 34 (4.9%) were salaried and 16 (3.95%) were weekly paid.

4.5.8 Job Content Questionnaire

Table 11: Mean Levels of Decision Latitude, Psychological Job Demands and Total Support (Job Content Questionnaire (JCQ) Karasek, 1979) by Division and Grade.

CLIENT GROUPS	JOB CONTENT QUESTIONNAIRE					
	Psychological Job Demands		Decision Latitude 'control'		Total Social Support	
	W/P	S	W/P	S	W/P	S
Total Sample (n=1,234)	31.73	36.17	64.53	70.34	22.66	23.66
	Men					
Overall (n = 207)	32.12	35.45	65.49	71.64	22.65	23.73
Children's Division	35.67	35.70	70.00	73.03	24.00	23.73
Adult Older Division	31.50	38.50	63.00	69.00	22.77	22.38
Directorate & Support Services	31.50	33.48	62.50	71.42	22.20	23.69
Adult People with Special Needs Division	31.25	34.62	67.09	72.09	21.86	24.78
	Women					
Overall (n = 872)	31.62	36.39	64.37	69.96	22.68	23.64
Children's Division	33.85	37.69	65.50	70.24	22.93	24.10
Adult Older Division	31.13	36.48	63.93	69.41	22.76	22.58
Directorate & Support Services	30.80	35.81	61.00	69.82	25.17	23.84
Adult People with Special Needs	32.01	35.50	64.84	70.19	22.12	23.52

There were no significant differences between male and female staff in respect of psychological job demands (t, (1079) = .004, p>0.05), or total social support (t, (1,094) = .215, p>0.05). However, in respect of control, men reported significantly more control than women (t, (1,059) = 7.97, p<0.01).

4.5.8.1 Psychological Job Demands

Psychological Job Demands for salaried staff are significantly higher than weekly paid staff (t (1,021) = 122.43, p<0.001). There is a main effect of Title on levels of psychological job demands (F (1, 1,011) = 37.07, p<0.001). There is no significant effect of Division (F (3, 1011) = 2.60, p>0.05) or Study (F (1, 1011) = .268, p>0.5), nor any significant interactions.

Previous research (n=16,601), comprising 38% female and 62% male population, reported mean psychological job demands of 31.91 for men, and 32.50 for women (Karasek et al., 1998). However, the Table 11 indicates that in this study for both men and women *all* salaried staff reported levels of job demands considerably higher than the published norms. Generally weekly paid staff reported psychological job demands close to the published norm, except for Children & Families Division where levels of psychological job demands are higher than the published norms for both men and women.

4.5.8.2 Decision Latitude 'Control'

Salaried staff in all Divisions reported significantly higher levels of control than weekly paid staff (t (1,000) = 76.22, p<0.001). There is a main effect of Title on level of control (F (1, 989) = 19.35, p<0.001). There is no significant effect of Division (F (3, 989) = .453, p>0.5) or Study (F (1, 989) = .903, p>0.05). However, there was significant interaction between Study and Title (F (1, 989) = 7.62, p<0.05), and Study, Title and Division (F (3, 989) = 2.85, p<0.05).

Previous research (n=16,601), which consisted of a 38% female and 62% male population, reported mean levels of control of 69.82 for men, and 64.99 for women (Karasek et al., 1998). Therefore, again we can see that levels of control for salaried

staff in respect of both men and women are considerably higher than the published norms. For weekly paid staff, generally control is slightly lower than the published norms for both men and women, except again in Children & Families Division, where control for both men and women is higher than the published norms.

4.5.8.3 Total Social Support

Weekly paid staff report significantly lower levels of support than salaried staff ($t(1,030) = 14.36$, $p<0.001$). There were no significant main effects of Title ($F(1, 1020) = .68$, $p>0.05$), Study ($F(1, 1020) = .024$, $p>0.5$), or Division ($F(3, 1020) = 1.99$, $p>0.05$). However, there was a significant interaction between Title and Division ($F(3, 1020) = 3.0$, $p<0.05$).

Previous research (n=16,601), which consisted of a 38% female and 62% male population, reported mean levels of total social support at 24.48 for men, and 24.83 for women (Karasek et al., 1998). In this study however, overall, levels of support were lower than the published norms for both men and women and salaried and weekly paid staff.

Table 12 - Intercorrelations between tested variables, their means and standard deviation

Variables	M	SD	1	2	3	4	5	6	7	8	9	10	11
1. Age	43.40	9.46	-										
2. Working in organisation	10.52	7.05	.396**	-									
3. Psychological Job Demands	34.48	6.53	-.014	.109**	-								
4. Decision Latitude ("control")	68.12	10.38	.039	.084**	.166**	-							
5. Supervisor Support	11.06	3.05	-.069*	-.094**	-.083**	.327**	-						
6. Coworker Support	12.24	1.94	-.102**	-.062*	.013	.183**	.299**	-					
7. Total Social Support	23.32	4.05	-.099**	-.104**	-.061	.342**	.888**	.704**	-				
8. Organizational Constraints Score	22.41	8.72	-.078*	.073*	.496**	-.036	-.259**	-.214**	-.294**	-			
9. Intrinsic Job Satisfaction	29.58	8.50	.019	-.017	-.216**	.498**	.504**	.278**	.520**	-.421**	-		
10. Extrinsic Job Satisfaction	33.29	8.40	-.044	-.075*	-.301**	.299**	.504**	.325**	.532**	-.469**	.787**	-	
11. Overall Job Satisfaction	62.81	15.89	-.029	-.062*	-.264**	.422**	.538**	.321**	.557**	-.468**	.945**	.945**	-
12. GHQ Likert score	13.88	6.72	.012	.094**	.394**	-.086**	-.233**	-.168**	-.267**	.462**	-.433**	-.456**	-.475**

** Pearson's correlation is significant at the 0.01 level (2-tailed) p<.01, * Correlation is significant at the 0.05 level (2-tailed) p<.05

Pearson's correlations were carried out (see Table 12) between the main outcome measures of: psychological job demands; decision latitude; social support; organisational constraints; job satisfaction; and GHQ-12 (Likert score). Total social support represents an aggregate of supervisor support and co-worker support, and similarly, overall job satisfaction represents the aggregate of intrinsic and extrinsic job satisfaction. In both these instances, only the aggregate scores will be discussed. Also included were the demographic variables of age and length of time working in the organisation.

Given the large sample size (n = 1,234) only p values of $p<0.01$, rather than $p<0.05$ will be discussed. Where effects are reported, they follow Cohen's (1992) recommendations, which are that small, medium and large effects are respectively .10, .30. and .50. Looking at the main outcome variables in turn:

- Psychological job demands were found to be positively correlated to length of time working in the organisation ($r = .109$, $p<.01$) and decision latitude ($r = .166$, $p<.01$) both of which represent a small effect size. Additionally, psychological job demands were found to be positively correlated to organizational constraints ($r = .496$, $p<.01$) and GHQ Likert score ($r = .394$, $p<0.01$), with a medium effect size. Negative correlations were found between psychological job demands and overall job satisfaction ($r = -.264$, $p<0.01$), with a medium effect size.

- Decision latitude was found to be *positively correlated to length of time* working in the organisation ($r = .084$, $p<0.01$), and psychological job demands ($r = .166$, $p<0.01$), with a small effect size. Whilst, positive associations were found in respect of both total social support ($r = .342$, $p<0.01$) and overall job satisfaction ($r = .422$, $p<0.01$), with medium effect sizes. A negative correlation was found between decision latitude and GHQ Likert score ($r = -.086$, $p<0.01$), with a small effect size.

- Total social support was found to be negatively correlated to age ($r = -.09$, $p<0.01$), length of time working in the organisation ($r = -.104$, $p<0.01$), with

small effect sizes, and organizational constraints score (r = -.294, p<0.01), and GHQ Likert score (r = -.267, p<0.01), with medium effect sizes. Positive correlations were found between total social support and overall job satisfaction (r = .557, p<0.01), with a large effect size.

- Organisational constraints were found to be positively correlated to psychological job demands (r = .496, p<0.01) and GHQ Likert score (r = .462, p<0.01) with large effect sizes. Whereas organizational constraints score was found to be negatively associated with total social support (r = -.294, p<0.01), with a medium effect size, and overall job satisfaction (r = -.468, p<0.01), with a large effect size.

- Overall job satisfaction was found to be negatively correlated to psychological job demands (r = -.265, p<0.01) with a medium effect and organizational constraints score (r = -.468, p<0.01), with a large effect and positively associated with decision latitude (r = .422, p<0.01), and total social support (r = .557, p<0.01) with large effects.

- GHQ Likert score was found to be positively associated with length of time working in the rganisation (r = .094, p <0.01), with a small effect, and psychological job demands r = .394, p<0.01), with a medium effect. Whilst negative associati ns were f und between GHQ Likert score and decision latitude r = -.086, p< 01 , with a small effect size, total social support (r = -.267, p<0 01 , with a medium effect size, and overall job satisfaction (r = -.475, p<0 01 , with a large effect size.

Looking at the main trends between outcome measures where large effects were found Table 12 , these included positive associations between: social support and overall job satisfaction r = .557, p<0.01 ; organisational constraints and psychological job demands r = .496, p<0.01 ; organisational constraints and GHQ Likert Score r = .462, p<0 01 , and overall job satisfaction and total social support r = .557, p<0 01 And negative associations between: organisational constraints and

overall job satisfaction ($r = -.468$, $p<0.01$); and GHQ likert score and overall job satisfaction ($r = -.475$, $p<0.01$).

4.5.9 What would you like to see included in an occupational health service?

Overwhelmingly, the top service which staff would like to see provided by their occupational health service was counselling that is easy to access and available by self-referral. This was followed by: access to stress management training; a preventative/proactive health promotion service, which would involve regular medical checks (e.g. blood pressure checks) and advice regarding diet, smoking cessation etc.; availability of 'alternative therapies' including, relaxation, acupuncture; reflexology, massage; and the availability of free or subsidised leisure facilities.

4.5.10 Any other comments?

There was an extremely wide variety of themes in this section, with a lot of comments about the number of changes there had been, highlighting how disruptive change was for both clients and staff, and suggesting that in future change should be communicated better. Staff reported that there had been a number of questionnaires however there had been no recognisable improvements because of them. Additionally staff asked that they be listened to more, have more input into decision making and be supported and recognised more for their hard work. There were also comments about poor management attitudes, with managers seeming not to 'care' and a lack of harmony/communication between managers, staff and clients. Staff also talked about a culture within SSD1 that accepts having a 'sicky' now and then, and asked for better sickness absence policies in this respect. Pressure of work, tight deadlines, poor pay and a shortage of staff were also commented on, especially in SSD2. Staff also commented on the stigma that is attached to using the occupational health service, which they asked to be addressed.

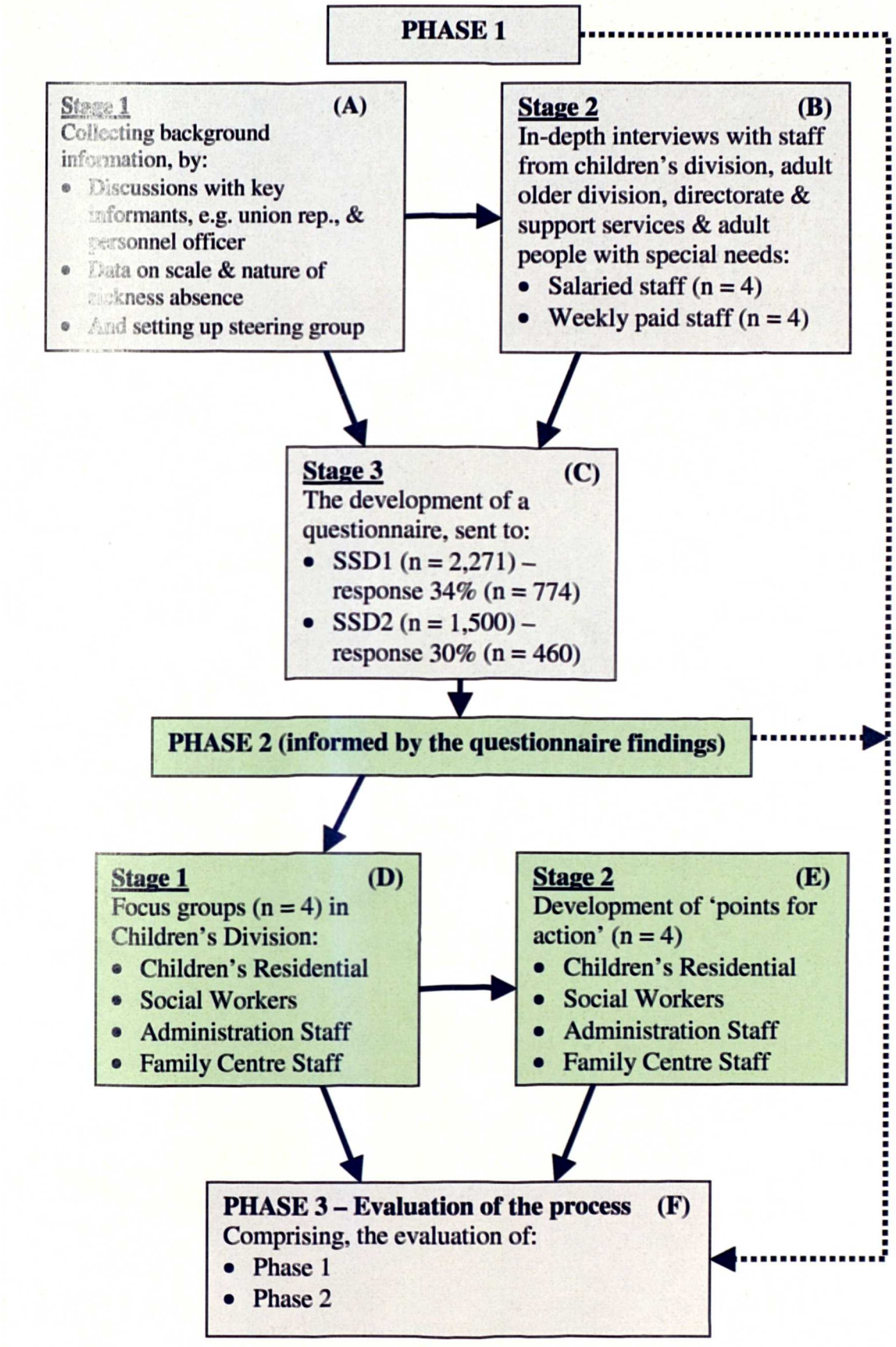


Figure 2b: The Research Framework- (Phase 2)

5.0 Phase Two

The next phase of the research followed an action-research paradigm (see for example Whitehead et al., 2003; Loewenson et al., 1999; Schurman & Israel, 1995; Kitzinger, 1994; Karlsen, 1991), as outlined above. Pilot interventions were developed initially in Children's Division because of their reported highest levels of organisational constraints, highest levels of distress across the Division and highest levels of sickness absence. Moreover, recruitment and retention difficulties appear to be having more of an impact on this Division (Employers Organisation, 2002), and also because a number of questions from the current study indicated that this group reported more difficulties than others across the department, and were thinking of leaving the organisation 'fairly soon', more than any other group within the department.

The key issue when using the PAR approach to creating change is to determine which aspects of working conditions are amenable to change, and how such interventions may practically be achieved (Schurman & Israel, 1995). To address this issue, focus groups were carried out Children & Families Division in order to gain a more in-depth 'emic' knowledge of the particular 'stressors' of each group and to develop an action plan aimed at reducing/eliminating them. Data from these groups was compiled into 'points for action', fed back to the group for their approval and passed to the appropriate body for implementation. Each intervention can be considered a 'pilot study' in its own right. By following this process different sources of stress could be identified and distinct interventions applied within a range of settings and work groups. These interventions can subsequently be evaluated from the grounded research baseline already established, and if successful, rolled out across the department.

5.1 Stage One - Participants and sample size (Figure 2, Box D)

Four focus groups were selected randomly from a list of all the different work units (i.e. residential homes, day centres) within Children & Families division. The only exception to this was the children's residential home, which was selected by the Manager of Children & Families Division because it was felt that the number of

changes currently taking place in other homes within the Division would make developing a plan of action difficult, whereas the home that was chosen was considered relatively stable. Numbers included in the groups ranged from three individuals to eight. Demographic details of the focus groups are given below:

Table 13: Focus Group Participants

Staff Groups	Accommodation	No.	Male	Female
Children's Residential	On site	5	2	3
Administration	On site	5		5
Social Workers	Off site	3	2	1
Family Centre	On site	6		6
Total		**19**	**4**	**15**

5.2 Methods

The main questions that acted as a framework for discussion in the focus group interviews were:

1. Do the summary of 'main findings' from the Healthy Work Report reflect your concerns/issues working in Children & Families Division
2. Within your Division where are the main areas workplace stress?
3. What is the source of these stressors?
4. What actions could be taken to reduce or eliminate these stressors?

The researcher aimed to put people at their ease when conducting the focus group interviews, so that they would feel comfortable with expressing honest and open answers. Permission to tape-record the interviews was requested at the outset (Rubin & Rubin, 1995) and in all cases the participants willingly agreed. Confidentiality was assured, although anonymity could not be due to the small number of staff employed in each of the chosen areas. In all cases staff volunteered to take part in the research. Accommodation was generally on-site and away from participant's work areas in order to avoid interruptions. The exception to this was the social workers, where

work-site accommodation was not available, therefore accommodation was provided off-site. Where focus groups were conducted during lunch-times, refreshments were provided by the organisation, as a gesture of appreciation for the time staff were sacrificing.

At the beginning of each meeting, following ethical guidelines (see for example Fogg, 1988) participants were informed of their rights, as follows:

- To be fully informed of the purpose of the research
- To be able to terminate their involvement in the group at any stage
- To confidentiality
- To ask for information to be changed or recalled to them as the group progressed
- To know who the audience of the research project will be
- To have comments or any information safeguarded
- To have their views objectively reflected
- To express their opinions on the research
- To discontinue the tape recordings at any stage in the discussion
- To negotiate the content of the interview (adapted from Fogg, cited in Hart & Bond 1995)

Ground rules were established, to ensure that confidentiality within the group was respected throughout the discussions and that every individual was given the opportunity to speak without interruption. Staff were advised of the proposed format of the meetings, which were anticipated to number four in total, as follows:

1. To consider the summary findings of the HWQ for Children & Families Division, identify the main sources of stress within the division and any gaps in the findings
2. Explore the main areas of concern arising identified in the first meeting, and consider interventions that could be developed aimed at their reduction or elimination.

3. Agree and finalise the points for action prior to their submission to the Departmental Management Team for implementation
4. Evaluate the success or otherwise of any interventions arising from the focus groups.

The 'ideal' number of participants is often stated as being 8 – 12, however focus groups in practice can work with as few as three (Kitzinger, 1999). The number of groups in a given study will depend on the research question, the range of people included, together with time and resource limitations (Barbour & Kitzinger, 1999). Discussions between participants are generally audio-taped, transcribed and subjected to some variety of content analysis or thematic analysis to analyse the data (see for example Frankland & Bloor, 1999; Barbour & Kitzinger, 1999; Kitzinger, 1999; Wilkinson, 1998; Kitzinger, 1994; Hammersley & Aitkinson, 1983; Krippendorff, 1980). Audio-taping the discussion allows for the results to be analysed systematically, rather than selectively (Frankland & Bloor, 1999). Rubin and Rubin (1995) assert that *"some interviewees appreciate being recorded because they see the tape as a symbol of your ability to get their message out accurately"* (p.126). Disadvantages of using tape recorders, include the mechanics of the recording equipment in terms of the requirements for; fresh batteries; changing tapes mid-interview; ensuring the microphone is turned on; volume is turned up; problems with background noise or tapes breaking (Rubin & Rubin, 1995). One method of limiting these difficulties is to note-take in addition to tape-recording, which allows the researcher to jot down further questions to ask later in the focus group, or keep track of where they are up to in the interview (Rubin & Rubin, 1995). A further disadvantage is the length of time that transcribing tapes takes, approximately four to six hours per one hour tape (Rubin & Rubin, 1995).

Ideally, the room used for the focus group needs to be quiet, comfortable, protected from observation by those not participating in the research and free from interruptions (Barbour & Kitzinger, 1999). Heterogeneity among group participants can often be illuminating, however for the purposes of this research, homogeneity was considered appropriate and pre-existing groups were considered the best way to answer the research objectives. Barbour and Kitzinger (1999) assert that although pre-existing groups are not a prerequisite for successful focus group research:

> *"the sorts of issues likely to be raised in the research session and the 'naturally-occurring' group is one of the most important contexts in which ideas are formed and decisions made"* (p.9).

When participants know each other this has an impact on the dynamics of the focus group (Reed & Payton, 1997). One impact can be that formal and informal power relationships are already established therefore they are difficult to control, which can result in some members dominating the conversation, despite the facilitator's best efforts (Reed & Payton, 1997). Agar and MacDonald (1995) agree, stating that *"moderator control is inevitable"* (p.78) because of the presence of moderators alien to the group with questions on their mind, which are taken seriously by the group and orient their discussion. Agar and MacDonald (1995) assert that this makes focus group similar in some respects to a meeting, where a manager leads discussions/questions. In this respect, they assert in their research on LSD users, only prior qualitative work made interpretation of the results possible (Agar & Macdonald, 1995).

Kidd and Parshall (2000) recommend that preferably no fewer than two members of the research team should be present at every focus group interview, because if the discussion gets lively several people may speak at once making it impossible to reproduce a session completely accurately. Further recommendations are that some form of member checking should be done in real time, i.e. when the focus group is running, by presenting *"any tentatively identified issues to the members for confirmation or clarification"* (Kidd & Parshall, 2000, p.299). In this respect, data analysis (which is more fully discussed in the following section) begins while the focus group is still underway (Rubin & Rubin, 1995). Analysis should be done as quickly as possible after a session, because otherwise much of the rich information from the session will be forgotten within a day or two (Carey, 1995).

This method of collecting data is dependent upon the leader or moderator establishing rapport and trust with the group, through identifying the commonality of experience (Kidd & Parshall, 2001; Carey, 1995). The researcher needs to ensure that they do not present themselves as 'expert'; be non-judgemental; ensure that they do not make assumptions; know when to intervene and when to keep quiet; be able to think on

their feet; clarify ambiguous statements; encourage everyone to participate, and promote interaction between research participants and research (Barbour & Kitzinger, 1999; Wilkinson, 1998). In this respect, skill in conducting focus groups increases exponentially with experience (Barbour & Kitzinger, 1999). However, Barbour and Kitzinger (1999) assert that focus group discussions can be attempted by novice researchers if the topic is straightforward, safe and of obvious interest to the research participants. Prior knowledge of the particular groups with whom one is working is crucial for both group facilitation and subsequent data interpretation (Barbour & Kitzinger, 1999). Although, there is no 'correct' persona for focus group facilitation, it is crucial to consider how the researcher's persona influences the data collected, e.g. how is your identity, dress accent and behaviour perceived; are you perceived as an insider/outsider; or as being related to the institution under study? (Barbour & Kitzinger, 1999; Hammersley & Atkinson, 1983).

Looking at issues of validity and reliability, statistical 'representativeness' is not the aim of most focus group research, rather 'qualitative sampling' is generally employed, guided by the particular research questions being addressed (Kitzinger & Barbour, 1999). However, Carey (1995) asserts that:

> *"when several sessions have been conducted for each segment of the target population and no new information is discovered, then one can cautiously generalize to similar groups"* (p.489).

In respect of reliability, Kidd & Parshall (2000) consider reliability in the conventional terms of stability, equivalence and internal consistence. Stability is an issue if the group meets on more than one occasion, especially in terms of members being present at each occasion (Kidd & Parshall, 2000). Equivalence refers to moderator experience and styles, particularly when more than one moderator or coder is used (Kidd & Parshall, 2000). Internal consistency refers to coding the data, which Kidd and Parshall (2000) assert is enhanced if one individual has the primary responsibility for conducting the analysis, participates in as many groups as possible, and communicates with other team members through the analysis process. In terms of validity, *"the emergence of a substantively similar viewpoint on some issue in multiple focus groups, especially if they are geographically dispersed, will tend to*

support content validity" (Kidd & Parshall 2000, p.303). Other methods can include; secondary analysis, or comparison with themes or theory in existing literature (Kidd & Parshall, 2000).

> *"Similar findings derived from multiple sources increase confidence in the validity of constructs and the theoretical generality of relations between them"* (Kidd & Parshall, 2000, p.304).

"Participation is one means to uphold an ethical principle that individuals and groups under investigation should retain control over their lives" (Baker & Hinton, 1999, p. 80). Although the ethical issues of informed consent and confidentiality can pose difficulties when conducting focus groups (Barbour & Kitzinger, 1999). It is impossible to ensure complete confidentiality, as members of the group may 'gossip' to people who are not involved in the research. Additionally, it is difficult to establish how 'informed' consent actually is when gate-keepers are used (Barbour & Kitzinger, 1999). Informing the group prior to session and advising participants that they are under no pressure to take part, along with setting 'ground rules' can help to address these issues (Barbour & Kitzinger, 1999).

There are several limitations to using focus groups. Firstly, censoring and conformity occurs within groups, as members can withhold potential comments for a number of reasons, such as a lack of trust in other members of the group, or the leader, or concerns about the confidentiality or use of the data collected (Kidd & Parshall, 2001; Carey, 1995). Secondly, 'groupthink' can lead group members' opinions to be influenced by the other members in the group, especially if the group has members of different status or prestige (Carey, 1995; Kitzinger, 1994). This is especially pertinent when using pre-existing groups, as it is likely that they will have established their own norms as to what can and cannot be said, along with hierarchies within the groups (Barbour & Kitzinger, 1999). One way of addressing this limitation, is to provide the participants with the opportunity to talk one-to-one with the facilitator after the group, or by telephone (Barbour & Kitzinger, 1999). Thirdly, there are often limitations in achieving full participation, which can arise from power hierarchies and external factors (Baker & Hinton, 1999). This can lead to organisations requiring researchers to produce information to a timescale and ultimately the funders are in control of

completing the cycle of research, in terms of which interventions are carried out and evaluated (Baker & Hinton, 1999).

Further limitations can include practical difficulties arising in the co-ordination of respondents in terms of meeting times and venues (Barbour & Kitzinger, 1999). Using established meeting slots, offering some form of reimbursement of expenses, or choosing a venue which is easily accessible to participants can go some way towards addressing these issues (Barbour & Kitzinger, 1999). Focus group research is also dependent on gate-keepers to aid access and recruitment issues, which can result in line managers in an organisation trying to exclude potential critics (Barbour & Kitzinger, 1999).

5.2.1 Analysis of Focus Group Data

Typically focus groups are characterised by the interaction of group participants with each other as well as with the researcher/moderator, and it is this interaction which distinguishes the focus group from one-to-one in-depth interviews (Wilkinson, 1998). Advantages of interaction between participants are that: they highlight respondents' attitudes, language, priorities and framework of understanding; encourage a variety of communication from participants; help to identify group norms; provide insight into group/social processes; and can articulate open conversation about embarrassing subjects, ideas and experiences that might be left underdeveloped in the interview (Kitzinger, 1994).

Consequently, *"[t]he analysis and interpretation of focus group data require a great deal of judgement and care, just as any other scientific approach"* (Stewart & Shamdasani, 1990, p.102). However, there is no one best or correct approach to the analysis of focus group data (Kidd & Parshall, 2000; Kreuger, 1998; Catterall and Maclaran, 1997; Morgan, 1997; Powell & Single, 1996; Stewart & Shamdasani, 1990), with different views as to the degree to which group interaction between the group members is analysed and reported. Moreover, *"there is very little guidance in the literature with respect to how differences between group and individual discourse impact the analysis and interpretation of focus group data"* (Kidd & Parshall, p.293; see also Myers & Macnaghten, 1999; Powell & Single, 1996; Carey, 1995). This

lack of guidance may in part explain why *"[t]he fundamental differences between a focus group and an individual interview are often only briefly discussed in pragmatic, rather than theoretical terms, suggesting that the status of the data and approaches to analysis are unproblematic"* (Reed & Payton, 1997, p.765; see also Carey, 1994).

As a result of this lack of guidance, one of the issues to be considered when conducting focus groups is how to analyse the data arising (Myers & Macnaghten, 1999; Kreuger, 1998; Morgan, 1997; Stewart & Shamdasani, 1990). The main consideration when looking at the type of analysis that is appropriate is what kind of report the project will produce? (Kreuger, 1998; Morgan, 1997; Carey, 1995; Stewart & Shamdasani, 1990). The purpose of focus groups can be wide ranging, for example, they can be used to explore topics in order to gain understanding, to clarify content domains, to obtain natural vocabulary for instrument development, for outcome evaluation, or in contrast in some forms of market research (Carey, 1995). In this respect, consideration needs to be given as to whether or not the focus groups are a set of self-contained focus groups, whether they have an 'applied purpose' (e.g. evaluation), or if they are part of a larger project (e.g. preliminary exploratory techniques to generate content for a survey questionnaire) (Morgan, 1997).

In applied research the end result is often a 'final report' that must meet the needs of those who commissioned the project. Because of the nature of applied research projects, they generally investigate predetermined research issues and use a more structured approach to gathering, analysing and reporting data (Morgan, 1997). This approach to applied research holds true in this study, where the framework for the focus group interviews had largely been pre-determined by the findings of the survey, consequently, in keeping with the framework of the study, the main aim of the focus groups was not at generating theory, but at gaining illuminative, descriptive data about these predetermined areas in order use this information to develop recommended points for action, in the form of a report, for senior management within the social service department.

Morgan (1997) asserts that more structured approaches to analysis and reporting are generally used *"when each group discussion covers more or less the same topics in more or less the same order, then the main business of the analysis and reporting will*

be to address these topics" (p.59). This allows for the reporting of comparisons across different segments (Morgan, 1997). One such method, (see for example Frankland & Bloor, 1999; Henderson, 1995) is analytic induction. Following this method, analytic techniques for focus group data require transcription of the interview (Stewart & Shamdasani, 1990). The best method of gaining data that is both retrievable and accurate, is to use tape-recorders, and transcribe the tapes verbatim (Rubin & Rubin, 1995). Perakyla (1997) asserts that as the tapes and transcripts are the 'raw material', equivalent to field notes in the context of ethnography, their quality has important implications for the reliability of the data. In this respect, tape recordings and the transcripts based on them can provide for highly detailed and accessible representations of social interaction (Perakyla, 1997).

Following transcription, the process of analytic induction involves reading and re-reading the transcripts thoroughly to familiarise the researcher with their content, recurring patterns or themes of interest (Frankland & Bloor, 1999). One method of defining codes is to focus on the content of what people have said, and the topics which they discussed, which can then be developed into categories (Reed & Payton, 1997). These categories can then be labelled, indexed, or coded (Frankland & Bloor, 1999). This coding or indexing is essentially inductive, with categories emerging both from the researcher's absorption in the text and recollection of the events of the focus group itself (Frankland & Bloor, 1999). By the time indexing is complete the researcher will have a good idea of the main focus of the analysis, and themes and patterns can be modified to reflect all indexed items, including those which appear to contradict the analysis scheme (Frankland & Bloor, 1999). Frankland & Bloor, (1999) assert that using the analytic method ensures that the data is analysed systematically, allowing for the inclusion of *all* themes arising, thus guarding against a selective approach. However, this method has been criticised (see for example Myers & Macnaghten, 1999; Reed & Payton, 1997; Carey, 1994; Kitzinger, 1994) because this type of analyses loses much of the context (and content) of the interaction. In this respect, Carey (1994) recommends that *"because the interaction within the group will affect the data elicited, an appropriate description of the nature of the group dynamics is necessary to incorporate in analysis for example, heated discussion, a dominant member, little agreement"* (p.488). Kitzinger (1999) agrees, recommending that researchers should aim to strike a balance between *"looking at the*

picture provided by the group as a whole and recognizing the operation of individual 'voices' within it" (p.16). Agar and MacDonald (1996) similarly illustrate how detailed conversational analysis can highlight who dominates a group, which parts were interview-like, conversation like, and meeting like, which topics were lively or flat, and how well ratified topics were by the group as whole.

Kitzinger (1999) asserts that *"analysis will involve, at the very least, drawing together and comparing discussion of similar themes and examining how these relate to the variation between individuals and between groups"* (p.16). Practical examples, which adhere to these criteria, are highlighted by Kreuger (1998), who discusses methods used by 'experts' on focus group analysis, as follows. Casey (1998) reports that she types an abbreviated transcript after each group, transcribing only the comments which she feels may be useful in analysis. After several groups have been completed, Casey (1998) reports that she begins systematic analysis, which often involves merging the computer files of the transcripts, and moving all the answers to each question from all the groups to the same place, ending up with a 'master transcript', which contains all the relevant responses. Following this, Casey (1998) writes a paragraph summarising each theme. Stewart & Shamdasani (1990) assert that this 'cut and paste' technique, using colour coded brackets or symbols to mark different topics within the text, is one of the most common analytic techniques. They state that whilst the material coded may be phrases, sentences, or long exchanges between individual respondents, *"the only requirement is that the material be relevant to the particular category with which it has been identified"* (p105).

Kinzey (1998) reports that his basic responsibilities are *"1) to find out what my participants think and feel about those issues outlined in the guide and 2) to report what they said"* (p.86). Kinzey (1998) argues that the first duty of a moderator is to report what people *say* about their attitudes and behaviours, rather than trying to be psychoanalysts and interpret what they were *really* thinking, as *"any speculation I might offer on "what they were really thinking" is just that: speculation"* (p.85). Likewise, Rausch (1998) summarises her steps in analysis as follows: read through transcripts, highlighting key findings and potential quotes; write a rough draft of detailed findings; and go back to transcriptions to pick verbatim quotes to illustrate the findings.

Following the above recommendations, key stages in analysing the focus group data for this study involved:

- Transcribing the focus group tapes verbatim
- Recording a description of the dynamics of the group's interaction
- Summarising the main points of the focus group to enable member checking by the group
- Reading and re-reading the transcripts to fully understand and absorb both the content and context
- Re-reading the transcripts, using the highlighter facility on Word to identify and highlight different themes using the fifteen different colours available
- Cutting and pasting each coloured theme into a separate document, ending up with a master document containing comments from each of the groups collected together under common themes

The cut and paste technique, whilst very useful, relies heavily on the judgement of a single analyst, which can provide opportunity for subjectivity and potential bias (Stewart & Shamdasani, 1990). However, this approach shares many of the characteristics of more sophisticated and time-consuming approaches, e.g. computer packages such as NUD*IST, or conversation analysis (Stewart & Shamdasani, 1990). Furthermore, as highlighted above, the type of analyses used is dependant on the purpose of the research.

In this study a pre-understanding of the key themes had been identified by both a large-scale survey and a number of in-depth interviews, therefore the purpose of these groups was to firstly develop a better understanding of the stressors affecting each group; and secondly to use this information to develop interventions aimed at reducing stress. In this respect, given that the aim of the focus groups was not at generating theory, but at gaining illuminative, descriptive data about largely predetermined areas, the cut and paste technique was considered the most appropriate method of analyses.

Future research would benefit from a thorough exploration of the impact of different methods of analysis on focus group findings. This could perhaps be achieved by using some of different methods outlined above to analyse the same transcript, then comparing the results. This would help to provide more practical guidance to researchers facing the dilemma of how to analyse their focus group data.

5.3 Results - Focus group findings – Stage One

Agar and MacDonald (1995) assert that:

> *"many focus groups are drawn together through networks,* [and] *that they are products of institutional processes that powerfully shape them. Such histories belong in the focus group data for, without them, it's difficult to evaluate the scope of what was learned"* (p79).

Therefore, in order to contextualise the findings, it is important to look at the dynamics of each focus group.

5.3.1 Children's Residential

There were five members of this group, including the manager of the children's home, who met during the weekly team-meeting time-slot in the dining room of the children's residential home. There were no interruptions, as the children were in school during the day. In this group, the manager dominated the conversation, despite the facilitators best efforts (see Reed & Payton, 1997), which was of concern to the researcher, who felt that other members of the group may have been intimidated by the managers presence. Notwithstanding this, the rest of the group appeared to be speaking freely, and seemed unconcerned about disagreeing with their manager, although this rarely happened. However, following the first meeting, as a precaution, the author posted individual summaries of the meeting to each group member with a stamped addressed envelope, asking them if they had any further comments they wished to add. None of the group took advantage of this and at the following meeting the summaries were agreed with only a few minor changes, therefore it would appear that the managers' presence did not unduly affect the discussion.

One drawback with this group was that, due to shift patterns, the same people were not always present at each of the three meetings, although there were three core members who where present throughout. This meant that at the outset of each meeting the process had to be explained to the new members, which was time consuming, and the dynamics of the group changed slightly. However, before the

points for action were agreed it was decided amongst the group that it was important for *all* members of the children's residential home to agree them, therefore the resulting points for action were considered a true reflection of the entire groups wishes. Throughout the process stamped addressed envelopes were left in the office, along with the author's contact details, so that group members could contact the author if they felt there were comments they wished to add, but could not openly discuss at the meetings.

5.3.2 Administration Staff

There were five members of this group, who met at lunchtimes in a counselling room, which was quiet, undisturbed and away from the main office. This group remained relatively stable throughout the three meetings, although occasionally one member was on holiday, or off sick. Again, there was one group member who tended to dominate the conversation, although she was not in a more senior position that the other group members, who seemed happy to disagree with her if they felt it necessary. This group seemed fairly cohesive and appeared to agree on most matters during the meetings, however, they seemed fearful of management, or potential repercussions. In this respect, when it came to agreeing both the summary and the points for action, they were very hesitant and took a considerable amount of time to come to agreement. The author feels that although the group was happy to *air* their grievances, they were reluctant to *report* them. To help this process an electronic version, initially of the summary of the first focus group meeting, was e-mailed to the group in order that they could amend it as they wished, and subsequently an electronic copy of the points for action. However, the group still found it difficult to agree on certain matters, asserting that they did not have enough time to meet as a group and reach agreement. This resulted in a statement being added to the focus group report to this effect, which is discussed in more detail below. The author feels that these difficulties may have arisen, because, being administration workers, this group was less autonomous that the other three groups, and generally on lower pay scales.

5.3.3 Social Workers

This group was the smallest group, consisting of three social workers from one team, who met during lunch-times in a different building than the one they worked in, as there were no facilities there that were quiet and free from interruptions. Two of the group had been on long term sick leave having suffered from stress, and additionally one member had been off sick for approximately six week due to back problems, reportedly caused by a faulty chair. One member of the group was in a slightly more senior position to the other two members, although this did not seem to have any obvious impact on the discussions. Within this group, none of the members dominated the conversation, and there appeared to be a high level of respect and cohesion. This group felt happy to both discuss their problems and put them in writing, with only a few minor changes made in each instance. Additionally, because they were only a small representation from the social work team (due to pressure of work), they requested that they share the summaries and the points for action with their colleagues to obtain their agreement before they were submitting to the Departmental Management Team. Therefore, it is felt that despite the small number of participants in this group, the findings are a good representation of all social workers within SSD2. The only drawback with this group, was pressure of work, which led to a number of meetings being cancelled, as if only one member was unavailable, there was little point in holding the meeting.

5.3.4 Family Centre Workers

This was the largest group, consisting of six family center workers, including the manager at the first meeting, although she was not present at subsequent meetings. Meetings took place during regular meeting time-slots, in a quiet, comfortable room which was free from interruptions. In this group, during the first meeting the manager was the most dominant speaker, however, there appeared to be considerable consensus in this group as to what difficulties they were experiencing, and group members seemed comfortable disagreeing with their manager, if they felt they needed to. Again, following the first meeting, as a precaution, the author posted individual summaries of the meeting to each group member with a stamped addressed envelope, and left her contact details, asking them if they had any further comments they wished

to add. None of the group took advantage of this and at the following meeting the summaries were agreed with only a few minor changes, therefore it would appear that the managers' presence did not unduly affect the discussion. Although the manager was not present at the following two meetings, she was given the opportunity to read the summaries and points for action, and few amendments to either were made. Meetings with this group never had to be cancelled, as despite being busy, *pressure of* work did not force them to call off any meetings.

5.4 Sources of stress

The main purpose of the initial focus group meetings was to consider the summary findings of the HWQ for Children & Families Division and to identify the main sources of stress within each particular workplace and identify any gaps in the findings.

Considering these in turn, all four groups were very interested in the summary findings from the HWQ. Both the Administration and family centre staff reported that the results were reflective of their working conditions:

> *"I didn't fill it in* [the questionnaire] *but I think having worked here for 8 or 9 months, that covers it"* (Administration)

However, staff from Children's Residential and Social Workers felt that the findings did not fully reflect their working conditions:

> *"80% report that cover for staff sickness is never rarely provided. We have got to provide it, so that is like a major difference"* (Children's Residential)

> *"I thought there would be more on timescales"* (Social Workers)

> "[job satisfaction] *is not low here, I don't think we represent all of the children's residential division. I think if you went and interviewed other*

people, especially just at this moment in time, it would be very low" (Children's Residential)

"knowing my staff team, I don't think there are any of us thinking of leaving fairly soon, so I wouldn't say that's representative" (Children's Residential)

The HWQ provided a 'pre-understanding' of stressors within social services however the purpose of the focus groups was to get a more in-depth understanding of these issues. In this respect, a number of key themes emerged from the focus group discussions, namely: workload; staffing levels; lack of recognition/loyalty; communication; changes; sickness levels and general stressors, as follows:

5.4.1 Workload

Social workers and Administration staff reported that their workload was unmanageably high, and were concerned at the levels of pressure and stress this put them under:

"It's hard enough at the best of times to keep it up, if everyone's here as it should be. So if somebody is off as well you're under extra pressure, and if the counter is very busy and you're up and down to the counter and interruptions, you can turn around at the end of the day and think 'exactly what I have done today what have I got to show for all I've done'...and you haven't stopped" (Administration)

"I think paperwork and all, I think quite rightly so I mean we need to detail every contact we make with everybody phone calls, every visit em it is not always possible to do and that has came back and bitten me quite big style. Because you're under that much pressure if someone makes a complaint again and you know you've made a decision after discussing it with your manager but because you haven't followed procedure, you haven't got anything written down and that is just because of time

constraints, it is not because a decision wasn't made and I don't think that's right" (Social Worker)

Staff reported that they pushed themselves because of the nature of the work:

"basically, you push yourself to try and do it - the nature of social services, you know, that it is children and you just have that commitment" (Administration)

"our initial assessments are supposed to be brief, but your frightened in case you miss any information. You miss any information and then something happens it's 'why didn't you put that in your initial assessment'?" (Social Worker)

There was a feeling of frustration that despite the best efforts of staff, it was impossible to do the job well:

"I think most people in our team would say 'I enjoy my job, I love working with people, I love going out, doing what you do, but it becomes most un-enjoyable because you can't actually address the needs of people properly sometimes, because there is pressure on you to get this assessment written up, even if you haven't got enough information get in what you've got, and it's really dissatisfying" (Social Worker)

"'I've got all this to do, so I'll stay an extra hour at night, or I'll stay a bit longer, 'cos it's quiet, there's no phones going' ..... 'cos you want to go home with an easy conscience" (Administration Worker)

"and you actually care about the people's lives you're involved in...it's not good enough sometimes, you know...and you go home and...I wake up at night thinking, God I should have done that, I must do that...and you never manage to reach the end of your mental list because other stuff is coming in. But I think it is just our business is people and that just adds to the pressure. You can just shut your drawer at the end of the night..." (Social Worker)

The general feeling seemed to be that it was the *constant* pressure that was the most difficult aspect of the job. This pressure is as a result of the timescales associated with the national performance assessment framework, which require than when a referral comes in social work staff have only got twenty-four hours to decide on best course of action, if this is an assessment, then this must be completed within seven days. Meeting these time targets is a performance indicator for the authority. Adhering to these timescales impacts similarly on the Administration staff, who have to input the information, again within the required time-frame:

> *"You know, you want to make an appointment on this day, because if you do, it gives you four more days to finish your assessment. You've got to see the parent, see the child, you know make agency checks with health, education, police, whoever you need to make a check to, and reach an assessment. For example if you don't get to see the parent until the 5th day, you are down to 2 days do you know what I mean?"* (Social Worker)

> *"and you can sort of push yourself for so long, I think, to try and cope with it all, but if it goes on for a very long time you just get tired yourself, don't you, and it starts to effect you...you can't do it forever, you can do it for so long and manage, but not infinitum you can't"* (Administration Worker)

> *"I've had enough. It's like being on the dole for me - I'll equate it to being on the dole. Right, on the dole for three weeks is all right, on the dole for two months* [makes a face], *on the dole for six months, on the dole for a year... two year... is hard work. I remember a Tory MP in the 70' coming up North and living on the dole for a week and saying it was easy. Yes it is, we can all work to them timescales for a week, or two weeks, but when you're doing it constantly it grinds you down"* (Social Worker)

Children's Residential reported that, although they were busy, they felt that the workload was within their capabilities. However, staff at the family centre reported that they were 'struggling' working nine to five, and were concerned about the forthcoming introduction of shifts:

"you wonder how they are actually going to manage those shifts, because we're struggling to manage our nine to five now, so how do you actually fit in weekends and evenings if you've got no more staff to do the other hours?" (Family Centre Worker)

5.4.2 Staffing Levels

The difficulties that staff faced in dealing with the heavy workload and tight timescales was reported to be exacerbated by a minimum of staff, again predominantly affecting social work and administration staff:

"with a minimum of staff, if we were all here for every day when we should work, we could possibly get through the work, but we're all entitled to our holidays. If someone goes off ill, or there's training needed because they're introducing IIP...the whole thing just falls to pieces, because there's not a soul who can step in and help you out" (Administration Worker)

"we have got no money for extra staff and we are all conscious of that and we are aware of that" (Social Worker)

"We call in cold on you don't know what and that's a stress in itself...I know it will be said well the policy is ... that there should be two people going ... but the reality is ...you haven't got two people to cover all the work" (Social Worker)

During particularly busy times in the Administration Office temporary staff are employed to help reduce the backlog of work, however, staff reported that this was frustrating for two reasons. Firstly, because of the time taken to train the temp and secondly because the fact that these workers are on a six months temporary contract means that as soon as they are trained, or find a permanent job, they leave:

"do you remember the time when we advertised for a 6 month post...we had a girl came in for six months and just after Christmas she was told she was no longer needed, that her post was for 6 months...that was a nice girl...she

was really good...she really was interested, she wanted to do the job, but then she was finished up...a month later they advertised for another 6 months post" (Administration Worker)

"it would possibly be cheaper for them in the long run to get another member of staff" (Administration Worker)

In the Family Centre, the proposed changes will lead to a reduction in staff:

"the three of us managers have over 100 years experience between us, which will just go they're happy to get rid of us, that's the way I feel" . "It suits Best Value you see, it suits them to amalgamate places, it's cheaper isn't it, to amalgamate buildings" (Family Centre Worker)

5.4.3 Lack of recognition/loyalty

Overall staff perceived that there was little or no recognition from senior management, either for doing their jobs well, or for the pressure they were working under. Staff felt that this lack of appreciation/recognition was perceptible in a number of ways, i.e. poor wages, criticism for failing, not listening to or acting on what staff said, and poor office equipment:

"does anyone ever come here and say you're doing really well, you know...working well and is getting results and stuff?" (Children's Residential)

"there's a whole new breed of service managers...They've all got a smile, but they're all ruthless...absolutely ruthless. Is all they care about is performance indicators, this that and the other, not the shop floor workers, you know, who cares about them" (Family Centre Worker)

"It's about valuing the staff, isn't it really, and you know, saying you are doing a good job and rewarding staff, you know, not only with pay, but that

they're actually listening to staff and acting on that, that is very important" (Administration Worker)

"I think the overall result for social workers is that you feel that...I'm not doing a good job, because you're constantly being criticised for failing, or not getting through enough work" (Social Worker)

"Him [the Assistant Director] *and the Director are supposed to be going to make 3 monthly visits to visit the troops, 'cos they're after investors in people status. I had a thing on the wall about investing in people - I ripped it up and put in the bin. That was after one incident at the beginning of the year. But we're going to go for the status, well I'll have gone by then, so it's as well, 'cos they won't invest in their staff, and do it properly, you know they haven't got a clue"* (Family Centre Worker)

5.4.4 Communication

Staff talked about different types of communication, i.e. between their own team and between their team and senior management. Where staff discussed communication between their own team, especially within Children's Residential, it was considered extremely good, and a contributory factor in both the smooth running of the home and their levels of job satisfaction:

"...communication is so good. Now that's down to the team being honest and open and feeling able that they can say things – it's also down to additional strategies we've put in place to ensure that everybody knows what is going on with a particular child. We all discuss how we're going to work with that child, therefore we're all coming from the same direction and I think that's why it works so well" (Children's Residential)

However, perceptions of communication in Children's Residential and the Family Centre between staff and management/senior management was reported to be problematic in a number of ways, namely: 'social work speak'; too much/irrelevant

information being communicated; lack of sharing of information; inconsistent information; information being intentionally withheld;

> *"we've got an excellent boss who would tell us everything she knows, but she's not getting told either, so she feels like she's failing us because we keep asking her questions that she doesn't know the answers to"* (Family Centre Worker)

> *"people were moaning they didn't get informed of anything that was happening, so now you get told everything, and you could spend all day going through the masses of information that you then filter out because of what's relevant to your team"* (Children's Residential)

> *"It's a power thing, and some people don't want to give information because they lose power, they're losing some power over something, don't they?"* (Family Centre Worker)

5.4.5 Changes

The changes that were taking place at the time of the focus group meetings affected staff at the Family Centre more than the other groups, as they were being amalgamated with the other family centres and their roles were changing from Family Centre Workers, to Family Support Workers. The ultimate outcome of these changes was that the staff were losing their boss; were required to change their working hours to incorporate a degree of shift work (if needed); were undertaking new roles within the organisation; and had to get used to working with new colleagues. These changes were causing a considerable amount of stress amongst this group of employees:

> *"the biggest thing that's happening is all the big changes coming in with Best Value and I think that's causing staff stress, 'cos they don't really know what people will be doing, well you know for a certain extent but it's the change isn't it, which is stressful anyway and it sort of gets thrust upon you"* (Family Centre Worker)

"we used to be community based and we all quite enjoyed doing that – it was hard work wasn't it? And we did a lot of good preventative work then...we had job satisfaction then, didn't we?...we had all sorts of groups and we used to do courses and everything, but now we've just gone child protection. So it's the heavy ended stuff and that's very stressful" (Family Centre Worker)

"we'll say for instance they explained to everybody concerned what was going to happen and what they expected of you and what the changes were going to be, then you could make a decision as to whether you could cope with those changes, because at the end of the day if you decide you can't cope with those hours and it's not feasible, then not only what are you *going to do, but what are* they *going to do as a service when they haven't got anybody working for them, and you know why isn't anybody looking at this...why isn't anybody looking at the fact that half the staff have left?"* (Family Centre Worker)

5.4.6 Sickness levels

There was little consensus about sickness absence within the Division. On the one hand, Children's Residential felt that long-term sickness absence was being abused by a cohort of staff, who were perhaps not suited to their jobs and caught in a financial trap because of the extra pay staff in this area get for night shifts, weekend work etc.

"you'd find it would be the same people that would be off sick, off long-term sick, mostly...and I would go as far as to say possibly more highly represented in children's residential than anywhere". "I would say each unit has got identified people that do that regularly" (Children's Residential)

"perhaps they shouldn't be doing the job perhaps they're not getting fulfilled...I believe in residential, probably more than the field, you get caught in a financial trap...those people would not be employed on the same rate of pay of unqualified people in the private sector, and I think that is one

of the big sticky points within children's residential" (Children's Residential)

However, conversely, both the Administration Staff and Social Workers considered that levels of sickness absence were low, surprisingly low given some of the reported difficulties:

"we've no time to be sick, have we?" (Administration Worker)

"I'm actually surprised that more people are not off. I think more people aren't off because they are committed and I think sometimes we lose that view" (Social Worker)

5.4.7 General stressors

In addition to the stressors identified above as affecting more than one group, there were a number of stressors that impacted on individual groups, rather than across the groups. These arose because of: the nature of the service users; shift changes in children's homes; conflict between field social workers and children's residential workers; lack of IT training and equipment; lack of budgetary control; having to change jobs in order to be promoted; lack of support from management; lack of NVQ training; the responsibility of doing assessments; fear of 'getting it wrong', especially with regard to child protection issues; naming and shaming of staff who don't meet their targets; taking the job home with you, both mentally and physically; and lack of partnership working between agencies with regard to corporate parenting;

"we take on children that are normally statemented with emotional and behavioural disorders that are deemed unsuitable to be fostered that's the type of kid we're dealing with." (Children's Residential)

"we're the initial people that they see when they come in, we're front line staff, so if you've got someone that's exceptionally upset, someone who comes battered and bruised, someone that's looking for somebody and

pretending, you know, someone who's aggressive, ready to throw a chair through the window...we are front line staff" (Administration Worker)

"I mean we're often at loggerheads in this with field workers, even though you're coming from the same side and fighting the same corner, at the end of the day you're fighting for what's right for the kids. I think we all find ourselves at some stage not agreeing with a social worker's decision" (Children's Residential)

"I think the organisation, as a larger thing is a stress factor - it's probably one of my worst" (Children's Residential)

"Two years we've been trying to get the staff trained in IT skills and I've just got one person through after 2 years. But they are asking you to produce typed reports - they're asking you to produce booklets. We've got to have booklets for the home, we've got to have all these things, but they don't give you the training that's appropriate to use, when they gave you the equipment, so you're just hoping that somebody can work the equipment so that you can produce the things you've got to" (Children's Residential)

"I've got a full staff team, at least 4 kids, usually 5 kids, £50 a year budget for stationary, now is that realistic?... a cartridge for the photocopier is £80, and we laughed didn't we the first stationary order we put in was £119 and my budget's £50." (Children's Residential)

"*even if you go to your line manager there's no support, because you are told 'what do you expect me to do my hands are tied I can't do anything', so it's pointless even discussing anything"* (Administration Worker)

"*staff are terrified of missing something, they really are, and they're not trained social workers, they're nursery nurses, and I keep saying that they're nursery nurses"* (Family Centre Worker)

"Social Worker: We get dumped on by everybody and it's us that take the can for everything.
Facilitator: by everybody, as in?
Social Worker: as in hospitals, health visitors, schools...it's supposed to be a corporate parenting approach to young people. We're supposed to facilitate that. If it's child protection we're supposed to facilitate that, however everybody has a responsibility to the child. I don't think people have taken that on. I don't think there is ways that we challenge that and I don't think there's areas where we, or forums where we can actually...well there are forums, but there needs to be more for me, for people to take on this responsibility, because it is always us." (Social Worker)

"and sometimes they keep things in-house that shouldn't be in-house. They make a referral and you say why didn't you make a referral earlier...we're dealing with it in-house. But it's child protection I've got a child at risk of harm, why aren't we hearing about it...we were trying to brush it under the carpet, or we wanted to give this information, but we don't want to make a referral" (Social Worker)

Following the initial focus group, each tape was transcribed verbatim and a summary of the main findings of each group was developed. This summaries were presented to each group at the outset of the second meeting, as a form of member checking (Kidd & Parshall, 2000), or validation through consensus (Karlsen, 1991) and as a starting point from which to discuss and develop any proposed interventions. These proposed interventions are described as 'points for action', rather than 'action plans', as within the Council, action plans have to include time-scales, along with the names of who is responsible for the action.

5.5 Stage Two - Focus Group 'Points for Action' arising (Figure 2, Box E)

The process of developing points for action from the summaries of main findings, took between 2 to 8 weeks for a number of reasons, for example: lack of time; differences in opinions within the groups; or staff absence. Due to the number of ways in which the groups both contacted the author during this period and amended their points for

action (i.e. telephone, e-mail, mail) it is outside the scope of this thesis to discuss how each individual point for action was arrived at, however, agreement of *all* of the group members was a requirement in their development.

Not surprisingly, due to the diverse nature of the groups and the range of difficulties they experienced, there were a large number of proposed points for action. In this respect the focus group report that was developed contained both a summary of main findings and points for action in respect of each of the groups, together with an overall synopsis of the main points affecting all or most of the groups and a summary of recommendations (see Coffey, 2003). The main points arising out of the focus groups and recommendations are discussed below:

5.5.1 Workload

It was recognised that reducing the workload was impractical, as work is usually dictated by the needs of clients, rather than by the organisation. However, one way of reducing the workload 'per person' would be to increase the number of staff available, therefore the majority of comments concerning the level of work are dealt considered under the next heading of 'staffing levels'.

5.5.2 Staffing levels

- A review of staffing levels needs to be undertaken, especially amongst Social Workers and Administration Staff

- A review of the use of temporary agency staff in Administration

- Ways of retaining staff and attracting graduate social workers need to be considered, for example by providing mileage allowance

- The method of calculating case numbers per social worker needs to be revised to take account of the work involved *after* an assessment is completed

- A survey of Family Support Workers to ascertain any potential difficulties staff may have in coping with new shift patterns.

- A bank of staff to be available, when needed.

- More permanent staff

5.5.3 Lack of recognition/loyalty

Staff felt that there should be 'tangible' benefits to prove that their efforts are valued and appreciated by the organisation. Additionally, this system (or a similar one) could be used as a bonus for those staff who have exemplary attendance records. In this respect, suggestions included:

- 'Points for prizes' e.g. *points* being collected for each month without absence, then being translated into prizes (perhaps vouchers or bonuses) coming up to Christmas time, when they would be most appreciated.

- Discounted access to leisure facilities

- Senior management *actively* showing appreciation of work well done

- Staff felt that the organisation could show its commitment to staff by attending to the 'points for action' developed by each group, and responding to each in writing

- A review of Administration wages and grading system

5.5.4 Communication

In respect of communication, there were a number of suggestions made, including:

- The removal of 'social-work speak' and abbreviations from correspondence

- A list of issues/questions needing clarification was included in the Family Centre's points for action

- The development of a newsletter which discussed current issues and forthcoming changes, which could be circulated on a monthly basis, with a tear-off slip at the bottom, which staff could use to ask for written clarification of any issue, if necessary.

- Regular meetings

5.5.5 Changes

In respect of Social Workers, Children's Residential and the Administration staff, it was felt that there was no action that could be taken which could reduce the number of changes taking place, as a lot of changes are driven by Government and therefore outside the Department's control. However, in the case of the Family Centre Workers whose roles were changing to Family Support Workers, better methods of managing change were suggested as follows:

- Setting up a 'support group' with the other family support workers from different centers.

- A Manager should be regularly available to answer queries

- More consultation about forthcoming changes and regular meetings with senior management

5.5.6 Sickness levels

In respect of the difficulties with long-term sickness absence experienced in Children's Residential, suggestion to improve the situation included:

- the development of different policies for dealing with persistent long-sickness and occasional short spells of absence

- Payment protection and more regular re-deployment opportunities being offered to encourage staff who are persistently on long-term sick leave to move jobs.

No action points were developed in relation to sickness absence amongst the other groups, who felt absence levels to be low.

5.5.7 General stressors

Further suggestions put forwarded, included:

- The introduction of some sort of appraisal system to pick up on poor work performance in Children's Residential
- Better availability of training and equipment, including IT (personal laptops and internet access) and NVQ training for Administration Workers
- Better control of budgets in Children's Residential
- That the highlighting of names of Social Workers not meeting their timescales, be done in a more sensitive way
- A regularly updated directory of 'resources' available for Social Workers
- On-going training involving all partners in 'corporate parenting'
- More advice and policy guidance in respect of potentially violent situations
- That Social Worker's work environments be appraised and improved where necessary
- For Administration Workers that hours that cannot be claimed back via flexitime, can be carried forward or payment made in lieu

These 'points for action' were presented to the Departmental Management Team in January 2003. At times the discussion was lively as managers defended their positions, pointing out where staff had got things wrong, for example, the reported highlighting of names of social workers who had not met their targets, which the

manager claimed was not longer carried out. However, during the course of the discussion the researcher pointed out that as stress is a *perception*, even where staff where under misapprehensions, these could still be a source of stress and as such needed to be dealt with, even if this only involved clarifying the issues. The Departmental Management Team, took the 'points for action', to go back to the staff where appropriate, and develop 'action plans'. This stage took from January – June, a period of nearly six months.

The Departmental Management team presented draft action plans the Steering Group, in June 2003, which represented the translation of the 'points for action' into proposed actions, to be agreed with Senior Management (for a sample copy of an Action Plan, see Appendix 4). At this meeting the managers responsible for each of the four focus groups reported that following the presentation of the points for action they had gone back to the groups to clarify some of the points arising. In this respect the managers reported that they felt the points for action were a useful starting point for these meetings. The managers reported that in some cases, points for action had arisen because staff were misinformed, or not aware that these issues were already being addressed, and consequently once the issues were explained to staff, staff no longer felt that further action was required, e.g. that the Recruitment and Retention Working Group had already been set up to look at staffing levels. At these meetings, the points for action were prioritised, and, where possible some issues, for example, ordering Dictaphones for the Social Workers, were dealt with immediately.

Managers reported that they felt that the focus groups had been productive because: issues had been brought to their attention, which, in some cases, they were previously unaware of; they were able to clarify misconceptions; staff could talk and be listened to by an independent person; and they enabled managers to improve staff morale by dealing with some of the issues straight away, although some matters would inevitably take longer to sort out. However, they were concerned about: how the project could be rolled out to other areas within the division without an independent person to facilitate it; that some staff used the meetings to air their personal grievances, which could skew the results; that staff may have exaggerated problems; that some of the major issues (e.g. lack of staff) could not be dealt with in the short-term; and that staff would always find something to grumble about.

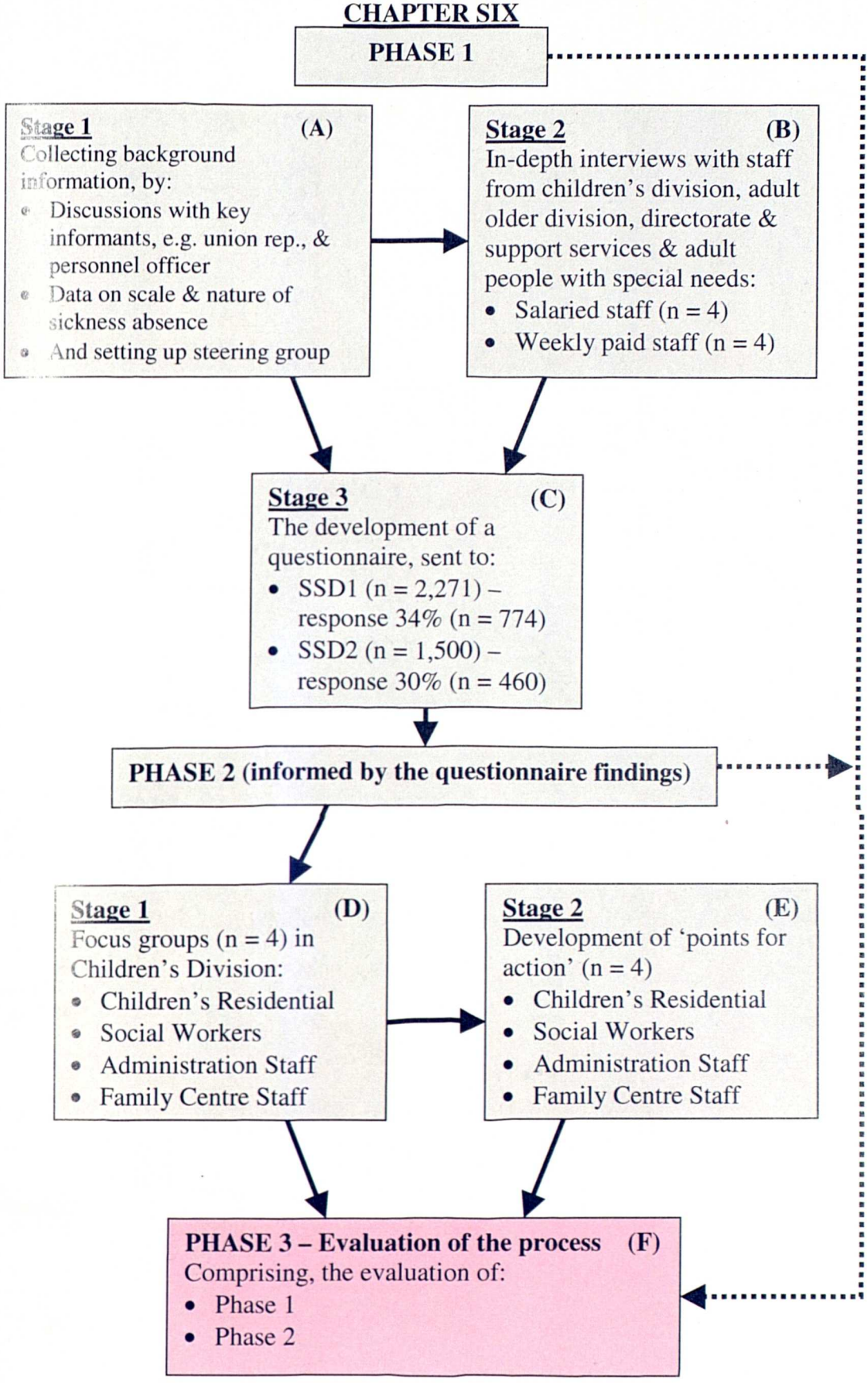


Figure 2c: The Research Framework – (Phase 3)

6.0 Phase Three – Evaluation of the Process (Figure 2, Box F)

Increasingly there is a demand for evaluation work funded by public agencies to become more focused on demonstrating effectiveness (Wimbush & Watson, 2000). *"Evaluation is about collecting information to inform action"* (Springett, 2001, p.144). The World Health Organisation recommends that a mixture of process and outcome data is used to evaluate all health promotion initiatives. In this respect, the process can be seen as important as the content of health intervention itself (Saksvik et al., 2002; Goldenhar et al., 2001). However, despite these recommendations, Baranowski and Stables (2000) assert that process evaluations are infrequently conducted. *"Understanding the process of an intervention ... is of great importance in its own right, but is also essential to build the evidence on which 'success' is determined"* (Nutbeam, 1998, p.39). Process measures can highlight what worked well and what did not, and in what context and therefore can be reflective (Parry-Langdon et al., 2003; see also Hulscher et al., 2003; Saksvik et al., 2002; Baronowski & Stables, 2000; Israel et al., 1995). Combining quantitative and qualitative techniques to answer different research questions is therefore important. It is only through this understanding that the conditions which need to be created to achieve successful outcomes can be identified (Nutbeam, 1998). Otherwise it would be impossible to identify whether a programme failed because it was the wrong programme, was badly implemented, or whether it was a success in ways not anticipated (Parry-Langdon et al., 2003; Hulscher et al., 2003; Nutbeam, 1998). In this regard, Hulscher et al., (2003) found that many features of interventions are not fully described in publications, or not provided at all. Nutbeam (1998) asserts that key questions which can be asked in this respect are:

- Did the programme reach all (or an optimal number) of the target population?
- Is the programme acceptable to the target population?
- Was the programme implemented as planned?
- Did the programme work?
- Can the programme be repeated/refined?
- Can the programme be widely reproduced?

Baranowski and Stables (2000) add further components to this list, including; explaining the context of the programme; barriers to implementing the programme; the recruitment and maintenance of participants; and the resources available to the programme. For example, key findings in a process evaluation of seven different individual and organisational interventions in Norway, identified some key 'learning' points. There was a tendency for lots of new projects to be initiated, with very few follow-up measures and further assessment, leading to 'project fatigue'. Generally, there were negative associations with previous intervention experiences. Additionally there were cultural barriers which resulted in employees seeing the manager as being responsible for improving things, whilst they sat in judgment or complained about the lack of effort. Managers' preferences were for individual, rather than organisational interventions, whilst: the bureaucratic nature of the organisation; reorganisation within the organisations; and lack of resources available to implement interventions led to managers feeling that the project was a waste of time (Saksvick et al., 2002). In this study, the effects of the interventions to reduce stress were found to be modest with Saksvick et al (2002) asserting that ongoing structural changes, together with the complexity of the modern working environment made the longitudinal studies difficult. To improve intervention effectiveness they recommended taking advantage of ongoing changes within the organisation to conduct natural experiments, using mixed methodologies to evaluate the results.

There are many different interpretations of what constitutes success and value in health promotion programmes, including the perspective of the population who are to benefit from the intervention that may place considerable value on how the programme is conducted, particularly whether it is participatory and it addresses the priorities they have identified (Nutbeam, 1998). Baranowski and Stables (2000) assert that each component of an evaluation can be thought of as having both qualitative and quantitative aspects, with Nutbeam (1999) adding that *"the most compelling evidence of effectiveness comes from studies that combine different research methodologies quantitative and qualitative"* (p.100; see also Saksvick et al., 2002; Springett, 2001). In this respect, focus groups can be used to inform the qualitative aspect of process evaluations and are useful as a component in triangulation. Benefits of using focus groups include their ability to: develop specific procedures for components of an intervention; measure acceptability of a programme

amongst the target group; explore the reasons for participation or non participation; identify barriers to effective implementation; and explore the role of the programme implementers (Mitchell & Branigan, 2000). Additionally case studies can be used, which involve the detailed analysis of selected sites or clients, and ethnography which relies on observation and unstructured interviews (Harrell et al., 1996). Qualitative designs for evaluation include experimental and quasi-experimental designs (Harrell et al., 1996).

Whilst the emphasis in health promotion is on results, given the complex and distant relationship between the usual health promotion activities and health outcomes (Parry-Langdon et al., 2003), together with the scarcity of evidence, it is important to focus on change in three different types of health promotion outcomes (Nutbeam, 1998). These include: improved health literacy (e.g. knowledge relevant to the problem of interest, self confidence, empowerment or participation in health promotion programmes); changes to policies and organisational practices; and changes to social norms or actions, which can increase people's control over the determinants of health. Within this framework, two key questions can be asked - whether change can be seen and whether this observed change can be attributed to the intervention.

In summary, process evaluation seeks to find out how well (or not) an intervention works and why the intervention or aspects of the intervention were successful, or otherwise (Parry-Langdon, 2003; Baranowski & Stables, 2000). However, the literature on process evaluation establishes that carrying out process evaluations is far from straightforward (Saksvik et al., 2002). *"Process evaluation data is most useful when it is collected and analyzed in conjunction with outcome data"* (Israel et al., 1995, p.369). Unfortunately it is impossible to answer all of the process evaluation questions raised above at this time, as SSD2 will only be in a position to implement the action plans in July, 2003. Consequently any evaluation of the success or otherwise of the interventions is outside the scope of this thesis, because a period of at least six months would need to elapse before any potential changes could be appraised. Not withstanding this, key *process* evaluation questions which can be addressed at this time include: did the programme reach all (or an optimal number) of the target population?; what barriers were encountered in reaching the participants

and implementing the programme?; what was the context of the programme?; was the programme acceptable to the target population?; what were the resources available?; was their evidence of any health promotion outcomes?; and was the programme implemented as planned? (Parry-Langdon et al., 2003; Baranowski & Stables, 2000; Nutbeam, 1998). The answers to these questions will be discussed below.

6.1 Results – Evaluation of the Process

Put simply, evaluation is about measuring the *worth* or *value* of something.

> *"In the context of health and health promotion, evaluation allows professionals to reflect on all aspects of a programme to judge is merits and service against a standard of baseline of acceptability"* (Kenny et al., 1998).

Coghan & Brannick (2001) assert that in action research engagement with others yields data, in other words:

> *"asking an individual a question or observing him at work is not simply collecting data but is also generating learning data for both you, the researcher and the individual concerned"* (p.90).

In this respect, Saksvik et al (2002) detailed the steps they included in their process evaluation: (1) pre-intervention study; (2) pre-intervention interviews; (3) interventions; (4) observations and participation in the interventions by researchers and instructors; (5) post-intervention survey; (6) post-intervention interviews; and (7) follow-up studies. Consequently, following Coghlan & Brannick (2001) and Saksvik et al (2002) the process evaluation of this study involved a combination of: pre-intervention interviews and pre-intervention data collected via the HWQ; observations and participation in the interventions by the researcher; and the focus group meetings (which were considered to be the interventions).

Within the HWQ there were several 'open questions' relating to working conditions within the unit. The final question was 'any other comments' which was included to

allow staff to comment freely on any issue they chose, and in this regard a number of respondents used this opportunity to comment on the research process. The responses to this question were coded in terms of themes (Gomm et al., 2000) and those themes which are considered relevant to the process evaluation are discussed under the relevant evaluation questions, as follows:

6.1.1 What was the context of the programme?

The background to the project has been discussed above, with staff reporting that the most difficult aspects of their job were: too much work to do in too little time; challenging behaviour from service users; and a lack of staff. However under the 'any other comments' question, further issues brought up relating to the context of the interventions, were: the number of changes that the organisation was undergoing; the fact that whilst changes are taking place, it can cause distress to both staff and service users; the lack of trust and blame culture within the organisation; and a call from staff for more support at times of change.

> *"The Department is constantly changing everything. How can they put out a questionnaire about wanting to improve staff morale when they have caused so much distress to staff"* (Male, full-time, Adult Services Division – SSD2)

> *"Local government is undergoing rapid and significant change. Organisations and the managers are, in these circumstances, severely challenged to be successful without serious damage to employee's health"* (Male, full-time, Adult Older Division, SSD1)

> *"All staff are unsure as to how the changes with SSD will affect their individual jobs...not sure how this will affect me. As a single parent obviously the financial implication is a major concern for me"* (Female, full-time, Directorate & Support Services, SSD2).

"I've never know an authority like this that tries to control your every move – doesn't trust and doesn't listen" (Female, full-time, Directorate & Support Services, SSD2).

"Consultation and communication I feel are generally well adhered to at grass roots level...however, this is not always the case with Senior Management who are all too willing to apportion blame and appear to have very little understanding of the difficulties the job entails" (Male, full time, weekly paid, Adult Services Provision, SSD2).

"The current climate in [SSD1] *is in my view very unhealthy. Staff are being made the subject of bullying and blame/harassment. This is affecting stress levels and creating a dangerous environment where people are frightened to admit mistakes and client's needs are lost due to focus on procedures and resources issues"* (Female, full-time, Children & Families Division, SSD1).

6.1.2 Did the programme reach all (or an optimal number) of the target population?

The overall response rate to the questionnaire was 32.7% (n = 1,234), comprising 81% female staff (n = 1,000), and 19% male staff (n = 228), therefore, the survey did not reach the optimal number of the target population. Possible reasons for the low response rate are discussed below. Four groups (n=19) took part in the focus groups, two of the groups (n=6 & n=5) took place during regular meeting slots, and two groups took place during lunch times (n=5 & n=3), with sandwiches provided by the Department.

6.1.3 What barriers were encountered in reaching the participants and implementing the programme?

Considering *why* there were problems in reaching the participants with the questionnaire, again issues were highlighted in the 'any other comments' question. Key themes that arose in this respect were; that staff were skeptical about any

difference that filling in the questionnaire would make; had no time to fill in the questionnaire; and that questionnaires had been filled in previously without any obvious resulting changes.

> *"I have struggled with whether or not to complete this questionnaire, as all I feel is that I complete these questionnaires and fail to receive any feedback"* (female, full-time, adult services provision, SSD2)

> *"If this survey is simply about establishing that staff in the organisation are stressed, dissatisfied and unhappy then it is a waste of time and effort. It must translate into some realistic, specific achievable outcomes otherwise it will be just another survey dismissed as a Unison backed whinge about how hard done to their members are"* (Male, full-time, Children & Families Division, SSD1).

> *"I am confident that this will have no useful outcome for individuals working for the department. It is just another paper exercise"* (female, part-time, Children & Families division, SSD2)

> *"No time to complete this part got to go to court"* (Male, full-time, no division stated, SSD1

> *"Taking time to fill in questionnaires is an addition I could do without!"* (Female, part-time, Adult Older Division, SSD1)

Additionally, the questionnaire was eight pages long and required both time and a reasonable level of literacy to complete. Given the pressure of work experienced within the department, and the fact that some staff were in positions requiring minimal literacy skills, these factors almost certainly contributed to the low response rate.

Looking at the implementation process, in both organisations the actual implementation of the surveys was unproblematic. Questionnaires were attached to payslips and circulated throughout the Departments. However, translating the results of the surveys into actions and implementing subsequent interventions was more

problematic and is discussed below under the heading 'was the programme implemented as planned'.

During the focus group phase of the research, where focus group meetings took place during weekly meeting times, as was the case with two of the groups, there were few barriers encountered in reaching the participants, other than where pressure of work, or lack of staff, dictated that the meetings could not take place. However, where staff were giving up their lunch times it was sometimes more difficult, as in addition to pressure of work, or lack of staff, personal commitments (such as shopping, especially towards Christmas) sometimes took precedence over attending the meetings. Consequently, there were frequent cancellations, necessitating the re-arrangement of meeting times, which meant that a total twelve focus group meetings took nearly three months to conduct.

6.1.4 Was the programme acceptable to the target population?

Discussions with key stakeholders and staff in SSD1 indicated that some sort of stress audit would be extremely welcome, because of the high levels of stress-related absence within the Department, with staff reporting that they would value the chance to be involved in such a project. Additionally, responses to the 'any other comments' question indicated that a number of staff were pleased to be taking part in the survey and looking forward to receiving feedback, although some respondents felt that the questionnaire was not precise enough:

> *"Very pleased these have been sent out. Hope it makes social services aware staff are not as happy in their jobs as they make out and a lot could be done to improve job satisfaction"* (Female, part-time, Adult Services Provision, SSD2)

> *"Thanks for a comprehensive questionnaire I hope it results in a change of attitude by senior managers towards the lower scale staff"* (Female, full-time, Directorate & Support Services, SSD1)

"I hope we get some feedback on this questionnaire" (Female, full-time, Children & Families Division, SSD2)

"I would like to know the outcome of this survey" (Female, part-time, Adult/People with Special Needs Division)

"A totally undifferentiated questionnaire is not precise enough to deal with specific problems...in order to address important issues you need to know where they are coming from and who is raising them" (Female, part-time, adult assessment and case management, SSD2)

"Some of these questions do not lend themselves to an understanding of constraints experienced by staff in trying to fulfill social service roles/tasks" (Male, full-time, Adult Older Division, SSD1).

Therefore, the low response rate may indicate that whilst a percentage of staff were interested enough to completing the survey, others may not have been. Moreover, the means of assessment i.e. the questionnaire may not have been entirely suitable, given the reasons outlined above.

The focus groups, generally seemed much more acceptable to the target population, with groups making time to attend the meeting, despite their extremely heavy workloads. One support workers commented after our second meeting:

"Even this is support for us. We know you're listening to us and you're helping us to get it together as to where to go really and how to put it across." (Female, support worker, Children & Families Division)

However, one group found it extremely difficult agreeing what they wanted to include in their action plan, primarily because they did not have the time to spend discussing it as a group, outside the time that we spent in meetings, which were actually their official lunch times (see Coffey 2002a). This group was also extremely concerned about any potential repercussions that could have result because of their negative

comments. As a result, they wanted the following statement included in their action plans.

> *"Whilst we appreciated the opportunity to take part in this piece of work, we had actually found it very stressful in itself. Whilst we had been given time and cover of our posts to undertake the meetings with Margaret Coffey, we were not able to get together to work on the feedbacks.*
>
> *The final feedback session was extremely difficult as we were working at the same time, answering the counter, phones and dealing with Social Worker's problems. We actually felt very guilty at doing this work when we knew we were needed to do our jobs. No-body complained, but we felt we were letting them down, and we knew people were wondering what we were doing.*
>
> *Whilst we were given to understand that this exercise had the support from the highest level of the organisation, there were occasions when there was limited evidence of that support on a local basis, and this in itself created additional stress and guilt on the staff undertaking the task" (27th January 2003).*

6.1.5 What were the resources available?

£15,000 was secured by SSD1 from Merseyside Health Action Zone to support the project for a two year period. An additional £5,000 was secured by SSD2 from the same source, to carry on the project for a further twelve months in order to develop interventions from the grounded research baseline that was established. These funds were expressly to cover the researcher's bursary throughout the three-year period, although in this respect they were insufficient and the university supplemented the shortfall. Moreover, within both SSDs, no specific resources were set aside to implement the interventions. Mindful of this, the 'points for action' that were developed in SSD2, focused as far as possible on interventions involving minimal costs, although at the same time issues such as staff shortages were highlighted.

Additionally, very little time was actually allowed for the focus group meetings. Two of the groups used their lunch times (although sandwiches were provided by the department), while the other two groups used regular meeting slots. The general lack of budgetary and time resources were major limitations of the research, since where issues were identified as being stressful to staff (e.g. lack of IT equipment) funds were not available to address them, and time to discuss the issues was limited. In this respect, some staff within SSD2 reported that resources were extremely scarce within the department, resulting in: poor equipment and equipment maintenance; and cutbacks in the services.

> *"IT systems, equipment and repair are very poor. Often we have no printers, staff cannot access equipment and nothing seems to change. Every development, review or change is done as a no cost exercise – this is unrealistic and should be addressed before we commit to making changes"* (Female, full-time, salaried, Adult Assessment and Care Management, SSD2)

> *"Social services for families of children with disabilities have been drastically reduced resulting in family breakdowns and parents under stress. This results in front-line staff being burdened with their problems without any support from 'above'. This team feel totally undervalued and social workers have left in droves, resulting in total chaos for families and remaining staff. We are now expected to take extra responsibilities (without training) and for no extra pay."* (Female, part-time, salaried, Children & Families Division, SSD2)

> *"It's sad that my last month of work is seeing it all go down hill. It used to be a happy department, but lack of money has seen it all go. Nobody seems to thinking of the old folk that we serve"* (Female, part-time, Adult Assessment and Care Management, weekly paid, SSD2)

However, given that resources are *habitually* scarce in the public sector, one of the strengths of this project lies in the fact that the areas most in need were identified by the survey, therefore future spending could be targeted more efficiently.

6.1.6 Was there evidence of any health promotion outcomes?

As stated above, health promotion outcomes can include improved health literacy; changes to policies and organisational practices and changes to social norms or actions, which can increase people's control over the determinants of health (Nutbeam, 1998). In this respect, the author feels that working closely with senior management, the Health Unit, and the Sickness Absence Monitoring Committee was influential within SSD2. The author had the opportunity to address the issue of feedback to the staff, although the feedback was limited to raising awareness of the services available from the Health Unit (see Appendix 5). This was in response to the open question - 'A Health Unit providing occupational health and safety has been set up. What services would you like to be available?' The response to this question highlighted the limited knowledge that staff had about the Unit, which the feedback sought to address:

"Don't know enough about services available to comment"

"Firstly what are they there for? No information about what is available"

"Leaflets telling people what the health unit is and what is provided there"

Additionally, the researcher was instrumental in instigating a 'leaver's questionnaire' (see Appendix 6), which was developed following recommendations from the Employers Organisation for Local Government (2002) and Audit Commission (2002) which urged authorities to use exit interviews and leavers questionnaires as an aid to improve recruitment and retention. The author identified Oxfordshire County Council (OCC) as having received a best practice award for their Leaver's Questionnaire (Joint Reviews, 2000) and following discussions, OCC very kindly made the questionnaire available for our use. In conjunction with the Steering Group, this questionnaire was subsequently tailored to meet SSD2's needs, and adopted for use within the Council in April 2002. This represents a change, albeit a modest one, to policies and organisational practices within the organisation, which the author anticipates will result in a feedback or loop system, whereby issues within certain

areas of the Department, such as bullying or poor working practices, can be picked up and acted upon quickly.

The author also feels that in terms of improving knowledge relevant to the problem of interest, i.e. health literacy, within the project it was possible to raise awareness amongst key figures in SSD2 about issues such as: using problem diagnosis (either by questionnaire, or focus groups) to inform stress management interventions; using participatory action research; or using best practice guidelines to inform actions (e.g. leaver's questionnaires). However, it is difficult to assess whether 'social norms' were influenced as a result of the programme.

6.1.7 Was the programme implemented as planned?

In SSD1 phase one of the project, which incorporated the development of the questionnaires, their distribution, and subsequent analysis went according to plan and a report on the 'healthy work' questionnaire was presented to the Assistant Director, and Steering Group in May 2001 (11 months after the project was begun). However, the 'translation phase', which involved: the identification of priorities; investigation of options for action; and assessment of resource implications did not.

The primary reason for this was that the Director of Social Services was not directly involved in the project, although *reportedly* he was aware of its existence and gave it his full support, and when the Assistant Director went on long-term sick leave responsibility for the project was passed to the Service Manager for whom the project was not a priority. Disappointingly, the remaining members of the Steering Group did not have sufficient power to translate the assessment results into concrete intervention plans, despite a considerable amount of pressure from the Union and University alike. The reason for the lack of support from the Director was never openly discussed, as throughout this difficult period we were assured of his support, although these verbal assurances never materialised into actions. However, it seems likely that as the tone of the report was generally negative, highlighting the difficulties that staff were experiencing, it could potentially be seen as damming, therefore *politically* it may not have been in the Directors best interest to publicise these results to the Elected Members. It is interesting to note at this stage that the Union

Representative had warned at the outset that any negative findings would be 'buried', and in a subsequent telephone conversation, said *"I didn't want to say 'told you so', but I'm not surprised"*.

As a result of the inability to move past the baseline report in SSD1 the University and the researcher contacted SSD2, with whom they had worked previously. At this stage the 'problem diagnosis' tool was already developed, and the researcher was able to provide an example of the type of report that the Department would be getting. This enabled the researcher to reassure the Director that although the results would most likely be negative, this information could be used in a positive way to inform actions to reduce or eliminate some of the stressors and target resources within the Department. The author, having reflected on the limitations of the previous project was careful to be more precise about the exact nature and potential outcomes of the project and ensured at an early stage that the Director of the Department was fully aware of all aspects of the process. An added advantage was that HAZ funding was still in place, so the survey and subsequent report could be carried out at no charge to the Department. Additionally, a large amount of HAZ funding had already been obtained by the Department to fund an internal Health Unit, whose terms of reference were to improve the health of the workforce. Therefore in this instance the Steering Group was already in place and active within the organisation, which provided an existing framework which the project fit in well with.

Following the survey and presentation of the 'Healthy Work Report' in June, 2002, SSD2 was keen to translate the findings into actions. In this respect, they secured additional funding so that focus groups could be set up within Children & Families Division to work in a participatory way with the researcher to develop intervention plans aimed at reducing or eliminating stress. Four areas of Children & Families Division were chosen, with three focus group meetings proposed in each instance (as outlined above). This phase of the programme implementation went to plan, although progress was slow because of difficulties getting all the group members together for meetings, due to pressure of work.

A draft report of the focus groups 'points for action' was presented to the Director of Social Services and the Steering Group in early February, 2003. At this stage the

implementation programme was going to plan, however, again, the 'translation' of these 'points for action' into 'action plans' was extremely slow. As a result, the implementation of any proposed interventions was set for July 2003 and therefore evaluation of their success or otherwise will not be feasible to conduct until early 2004, which is outside the scope of this thesis.

The two main reasons for this phase of the project being so slow have been firstly (according to one of the senior managers) because *"things move slowly around here!"* This seems to be the nature of public sector bureaucracies, however, the author feels that given the nature of the focus group results, which were generally unfavorable of the organisation, an alternative explanation could be that it might have been difficult for managers to take on board and act on what may have seemed like *criticisms*. Secondly, the Union (who are particularly militant) did not want the focus group report to be acted upon, because they said the focus groups had been set up without their agreement or without prior consultation, which was not the case. This gave the Departmental Management Team an excuse to delay taking action, and it was only following lengthy discussions with the Director of Social Services, that the Departmental Management Team were advised to act on the results of the focus groups. It is difficult to fully understand what led to this chain of events. The Union had been fully appraised of the plans to conduct focus groups when they were given a presentation of the Healthy Work Report (and indeed given a copy of the PowerPoint presentation to take away). Additionally, any interventions arising out of the focus groups were in the interests of the staff (mostly union members), which makes it hard to understand *why* the Union would take such a stance. The only explanation that can be put forward at this point is that perhaps the Union felt that their collective bargaining system had been compromised by the researcher (Kristensen, 2000), and in some way felt threatened enough to jeopardise any potential interventions arising out of the previous twelve months work.

CHAPTER SEVEN - DISCUSSION

7.0 Introduction

This study was carried out in three phases. Firstly, the baseline survey was used to identify what stressors were impacting on social service staff and the potential impacts these were having in terms of mental well-being and job satisfaction. This phase also sought to identify which groups, if any, were worst affected by these stressors. The second phase used focus groups in the most severely affected division in order to work out an effective intervention/range of interventions in a participatory way from the research baseline already established. The third phase of this research was a process evaluation, which was used to identify: what worked well, what did not and in what context; to inform the literature on change management, which tends to give the impression that change is relatively simple, as long as an organisation sticks to recommended recipes; to identify any successes that were not anticipated; and finally, to build evidence concerning the conditions which need to be created in order to achieve successful outcomes and improve intervention effectiveness. This systematic process follows recommendations which call for approaches to stress management that seek to identify stress problems, look for evidence about cause and effect, make informed decisions about interventions, and evaluate the results (see for example, Briner, 2000; International Labour Organization, 2000). As the research was carried out in three phases, it is considered appropriate to discuss each theme separately, drawing the overall findings together in the conclusion.

7.1 Discussion of the survey results

The results indicate that stressors impact differently on salaried and weekly paid staff, and between the four major Divisions within the two SSDs. Looking firstly at why there may be differences between salaried and weekly paid staff, one of the major differences between these two groups is that the majority of weekly paid staff in this study worked part time (69%), compared to the majority of salaried staff (79%) who worked full time. In this regard, full time working has been found to be uncommon amongst weekly paid homecare staff, whilst almost all managers and field social work staff have been found to work full time (Balloch & McLean, 1999). Levels of pay

and education may also be a contributory factor, although findings in this respect are equivocal, with the Bristol Health at Work study concluding that those earning more than £20,000 pa reported significantly *more* stress than those earning below this level (see also Bourbonnais et al., 1996), whilst Gardner and Oswald's (2002) research claims that higher levels of earnings seem to contribute to *lower* levels of mental stress in later life.

Additionally, social services is a highly fragmented industry, operating in different settings, for different providers, with users ranging from small children to the very elderly (Eborall & Garmeson, 2001). As a result, there are a wide variety of different types of jobs carried out within each of the four separate divisions, the most obvious distinction being between homecare workers, and social work staff. In this respect, the literature highlights that the main difficulties reported by social workers are the fact that social work is reported to be in a state of crisis, being both under-funded and understaffed (Postle, 2002; Davies, 1998), resulting in: a lack of resources (Postle, 2002; Jones, 2001; Storey & Billingham, 2001; Bradley & Sutherland, 1995); time pressures, including bureaucracy and paperwork, which often have to be done at home; the difficulties dealing with child protection cases (Cresswell & Firth-Cozens, 1999; Bennet et al., 1993; Jones et al., 1991); fear of getting it wrong (Eborall & Garmeson, 2001); poor pay levels; (Taylor, 2000); poor public perceptions, and negative media coverage of social work (Eborall & Garmeson, 2001; Storey & Billingham, 2001) and low job satisfaction (Eborall & Garmeson, 2001). Additionally, staff in management positions are likely to have a greater degree of responsibility for others, which is a critical factor identified as being a potential source of stress, especially in public sector organisations (Cooper, 1996; Bacharach & Bamberger, 1992). Homecare workers, on the other hand, report difficulties due to; working in unsafe homes; the significant shift in responsibilities from domestic care to personal care (Community Care, 2003c; Unison, 2001; Bradley & Sutherland, 1995); poor pay; working in isolation; often having to deal with difficult clients without support; and the high level of emotional involvement with highly dependent clients (Bradley & Sutherland, 1995), which Zapf et al (2002) found to be predictive of all burnout variables.

This study is unique, as the organisational constraints scale, which had not previously been used within social services, was used to ascertain the nature and level of constraints negatively impacting on task performance. Findings indicated that salaried staff reported significantly more constraints than weekly paid staff, at 24.37 compared to 18.85. For salaried staff, levels of constraints are high, at 24.37, as norms published by Spector (1998) report 21.30 as an average level of organisational constraints. Conversely for weekly paid staff levels of constraints are lower than the published norms, at 18.85. Both salaried and weekly paid staff working with Children and Families reported the highest levels of organisational constraints within the two SSDs, at 25.07 and 23.00 respectively. This could be a factor contributing to the increasing levels of turnover and recruitment difficulties amongst this group (Employers Organisation, 2002; Social Services Workforce Study, 2002). For both salaried and weekly paid staff the most reported constraint throughout both SSDs was 'interruptions by other people', affecting over one third of staff 'several times per day', followed by 'conflicting job demands', affecting 14% of staff 'several times per day', and 'poor equipment or supplies', reported to be affecting 8% of staff 'several times per day'. Looking at these in turn, Zijlstra et al (1999) found that interruptions were generally found to have a negative impact on the state of the person, in the sense that *"the emotional feeling became less positive and well-being diminished"* (p.183). In addition, their research found that interruptions caused an increase in 'effort expenditure', therefore when the number of interruptions grow, levels of effort rise and time taken to re-start a task become longer, leading to decreasing motivation and growing mental fatigue.

Conflicting job demands are one of the critical factors identified in the literature as being a major source of potential stress (Cooper, 1996; Spurgeon & Barwell, 1995). The Workforce studies found that role conflict and control were frequently associated with stress, with staff receiving contradictory instructions, having responsibility without power, or being overwhelmed by users' problems and disagreement about good practice (McLean, 1999). Additionally, given that the biggest single reason for people joining the public sector is to make a difference, social care workers may understandably feel a sense of divided loyalty, or conflict, no longer being clear whether they serve the needs of a bureaucratic organisation or the individuals in their care (Postle, 2002). This places staff in a moral dilemma, and is highly frustrating

(Eborall & Garmeson, 2001; Jones, 2001). It is perhaps predictable however that conflicting job demands reportedly affected so many staff, as the public sector is characterised as having a broad range of stakeholders, with sometimes conflicting interests and complex objectives, i.e. not being driven by a single goal such as profit, being substantially influenced by politics and having groups of professionals working within them who demand relatively autonomous working conditions, e.g. social workers (Lawler & Hearn, 1995).

Poor equipment or supplies may well be a result of the drive towards efficiency, effectiveness and economy which characterise the changes that have taken place in the public sector over the last two decades, including Best Value (Bennett, 2002; Lawler & Hearn, 1995). In previous studies, lack of resources, was the most cited stressor amongst social workers (see above) and inadequate or broken tools or equipment have been found to lead to direct impairment of job performance and execution (Fay & Sonnentag, 2002). This study has contributed to this body of knowledge by ascertaining that poor equipment or supplies are affecting 8% of staff in social services several times per day.

Related to this were the comments provided to the open question, 'what was the most difficult aspect of your job'? The most difficult aspect reported was 'lack of time and rigid timescales in which to do the job properly', followed by the interface with service users 'issues around their various needs, especially in terms of challenging behaviour, abusive demanding clients, dealing with life/death situations, taking people's liberty away etc'., and 'lack of staff to cover the workload'. Lack of time to do the job properly, or work overload, is one of the main causes of stress identified throughout a wide range of occupations (Burbeck et al., 2002; Tudor, 2002; Gillespie et al., 2001; Spurgeon & Cooper, 2001; Cox et al., 2000; Smith et al., 2000b; Cooper, 1996; Spurgeon & Barwell, 1995), including social services (Pousette & Hanse, 2002; Eborall & Garmeson, 2001; Jones, 2001; Bradley & Sutherland, 1995). In this respect, in this study psychological job demands were found to be significantly positively correlated to GHQ-12 score ($r = .394$, $p<0.01$), demonstrating a positive relationship between high job demands and poor well-being. Previously, significant correlations between depression levels and levels of stress caused by overwork were reported amongst staff dealing with child protection issues (Cresswell & Firth-

Cozens, 1999). Moreover, unmanageable workloads, together with a sense of being overwhelmed by bureaucracy, paper work and targets were among the six main factors identified by the Audit Commission (2002) underpinning people's decisions to leave, which is worrying, given the recruitment retention difficulties the public sector is facing.

The interface with service users was found to be the second most reported difficulty in both SSDs, with social work, by its very nature, involving crisis situations demanding immediate attention. These findings support recent research which highlights four main reasons for this, including; the development of consumerism and threat of complaints or litigation; the blurred boundaries between health and social services; the increase in violence and abuse towards staff; and the stricter eligibility criteria which means that service users are presenting with more difficult and problems than was previously the case (Postle, 2002; Eborall & Garmeson, 2001; Jones 2001; Balloch 1999a; TUC, 1999; Balloch 1996).

Lack of staff was also a key concern amongst staff in both SSDs, which is undoubtedly at the root of the work overload reported above. In this respect, throughout the public sector recruitment and retention difficulties have been highlighted (Audit Commission, 2002) with social services reporting an average vacancy rate of 9.4%, whilst about two thirds of their employees are aged over 40 (Social Services Workforce Study, 2002). However, vacancy rates have reportedly fell between 2000-2001 by between .5% and 5%, *except* in children's residential manager and supervisor posts where the vacancy rate increased by over 2%. Additionally for care employees working in children's residential establishment the turnover rate was 15.3%, compared to a turnover rate of between 8% and 13% for the other occupational groups, and the worst affected group in terms of recruitment and retention were field social workers who work with children and families (Social Services Workforce Study, 2002). The pressure exerted by BV to be competitive and efficient may well be exacerbating problems with heavy workloads and lack of staff, as highlighted by these findings.

In order to address these difficulties, the respondents suggested that: more staff should be employed; there should be more support and understanding of working conditions

and the nature of the job; and that more training should be available to help staff in their roles. The findings in these two SSDs indicate that the main difficulties reported, together with the solutions put forward to lessen these burdens, all basically reduce down to one main problem, i.e. lack of resources.

These issues, coupled with the high level of constraints would seem to be affecting levels of job satisfaction, which were considerably lower than mean job satisfaction levels in a large survey of local authorities (n = 4,442), at 4.19 in this study compared to 4.35 (Mullarkey et al., 1998). These results were also considerably lower than mean job satisfaction levels reported in the Workforce Studies, which were 4.65 for social service staff in England (McLean, 1999). Job satisfaction and dissatisfaction are dependent on factors to do with the workplace, in addition to factors to do with the individual (Spurgeon & Barwell, 1995). Looking at the results of this study, salaried staff reported significantly higher levels of overall job satisfaction than weekly paid staff, with the lowest levels of job satisfaction found in Adult People with Special Needs Division and Adult Older Division, which would seem to be a reflection of the fact that 89% of weekly paid staff work in these two divisions (n = 386). These findings indicate that throughout both SSDs levels of job satisfaction are low, however, *"[a] quality service requires committed staff who obtain satisfaction from their work"* (McLean, 1999, p62). Whilst previous studies had found that most social service staff experienced *high* levels of job satisfaction from their work, (McLean & Andrew, 2000: McLean, 1999; Jones et al., 1999), this study did not. In fact these findings suggest that job satisfaction has actually worsened, which is supported by Gardner and Oswald (2001) who reported that job satisfaction had fallen in the public sector over the past 10 years, at the same time as well-being has worsened.

By using the Job Satisfaction Scale (Warr, 1979) it was possible to advance the knowledge on job satisfaction within social services, by finding out *which* aspects of their jobs staff were very/extremely dissatisfied with. These were found to be: the way the firm is managed; chance of promotion; rate of pay; industrial relations; and recognition for good work. In this respect, intrinsic job satisfaction which refers to people's affective reactions to features integral to the work itself (i.e. chance of promotion and recognition for good work) was found to be significantly lower than extrinsic job satisfaction ($p<0.01$), which covers features external to the work itself

(i.e. the way the firm is managed, the rate of pay and industrial relations). In terms of wages, the public sector has fallen behind the private sector, as years of pay restraint under the Conservative government have been followed by two years in which wages have been held back under Labour (Schifferes, 2002). Gibelman (2003) claims that these pay differences are due to continued patterns of discrimination, with a recent study by NASW (2003) finding evidence that the more a profession is dominated by women, the lower the worker's average salary.

By using a variety of scales it was possible to carry out unique correlations between the different measures in order to contribute to the current body of knowledge on job satisfaction within social services. In this respect, overall job satisfaction was found to be significantly *negatively* correlated to length of time working in the organisation; psychological job demands; and organisational constraints, and significantly *positively* correlated to: decision latitude (control); supervisor support; and co-worker support. Previous research indicates that job satisfaction is a powerfully predictive concept, with a large body of evidence suggesting that job satisfaction with pay, prospects, colleagues, physical working conditions, the running of the section and the way one's abilities are used are significantly associated with low levels of work stress (Smith, 2000b). This study supports these findings, with GHQ-12 scores found to be negatively associated with all aspects of job satisfaction ($p<0.01$), indicating that reported high job satisfaction is correlated with better well-being (lower GHQ-12 scores). Lack of job satisfaction has also been reported to affect performance, morale and commitment (McLean & Andrew, 2000; McLean, 1999). Whilst Spurgeon and Barwell (1995) found length of service to be positively associated with job satisfaction, with those who disliked their jobs tending to change them, in this study the opposite result was found, with length of service found to be negatively correlated to job satisfaction ($p<0.05$). A possible explanation for this, could be the lack of marketability of social work skills (Taylor, 2000), which has been cited as a possible reason for the 'increasingly dispirited worker' to retreat into ill-health. However, despite the low levels of job satisfaction, in response to the open-question, 'what is the best part(s) of your job', the vast majority of staff indicated that spending with the service users and developing relationships with them, and the sense of camaraderie of being in a team with friendly work colleagues provided their greatest sources of job satisfaction. Similarly, Penna et al (1995) found that working with people in a caring

situation, together with the satisfaction of seeing improvements in their clients, were sources of job satisfaction amongst local authority residential care workers in the North West of England.

The GHQ-12 was used to identify those who were experiencing mental distress. The high levels (mean for this study is 3.18) and proportion of staff 'at risk' (36%) compares unfavourably to the results of the Workforce studies (see McLean, 1999) where the overall rate in England between 1994/95 was 2.16. Gardner and Oswald (2001) found that mental strain among British workers rose in the 1990s, with public sector workers reporting a pronounced increase in measured stress, relative to private sector employees. Likewise, amongst health care managers, stress (measured the GHQ-12) was reported to be higher than managers in the British Household Panel Survey, at 32.8%, compared to 21.3% (using 3/4 caseness cut-off) (Borrill & Haynes, 1999; see also Wall et al., 1997, Mullarkey et al., 1998), although amongst salaried staff in this study, the rate was 40% using a caseness cut-off of 4, which is considerably worse. In the current study, it was salaried staff who reported significantly higher levels of mental distress than weekly paid staff. These findings are similar to the Workforce studies, where managers and field social worker staff reported levels of GHQ at 3.57 and 3.24 respectively, compared to homecare and residential workers who reported levels of 1.71 and 2.67 respectively. Highest levels of mental distress were reported in Children's Division, with both salaried and weekly paid staff reporting mean levels of 3.92 and 3.68 respectively. This is comparable to findings from the Workforce Studies where the evidence is that those working with children and families had higher GHQ-12 scores than staff working with older people (Balloch et al., 1999b). This evidence is further supported by a study of social workers carried out by Bennett et al (1993), which reported:

> *"that those employed in childcare services had significantly higher stress outcomes, greater perceived stress from a variety of sources, and were less able to distance themselves from these stresses than other groups"* (p.41).

This trend seems to be reflected in the overall (self-reported) figures for absenteeism, with salaried staff reporting more absence through illness than weekly paid staff, and Children's Division reporting the highest levels of sickness absence overall.

However, the wording of this question seemed to confuse a large number of the respondents, and as a result a lot of the responses did not make sense, therefore, although absence data was analysed descriptively, it was not possible to carry out correlations between absence variables and the main outcome variables. However, the most recent report from the Employers Organisation (2003) on Local Government indicates that nationally sickness absence was 4.5%, which had risen by around .3% from 2000/01, however, in the North West these figures were 6.3% for manual occupations, compared to 4.5% for non-manual occupations, although conversely in this study, it is the non-manual, or salaried, occupations that reported significantly higher absence levels than the manual, or weekly paid occupations.

Looking at the job content questionnaire (Karasek, 1979), psychological job demands, control, and support were found to be significantly higher for salaried staff, than weekly paid staff ($p<0.01$). Job demands refers to work load, which is mainly operationalised in terms of role conflict and time pressure (as discussed above), whilst job control refers to the person's ability to control his or her work activities (Van der Deof & Maes, 1999). In this respect, the perception of control is reported to be one of the most important elements in the occupational *stress* process (Spector, 2002), as it enables staff to deal with demands by taking personal action (Karasek, 1979). Research indicates that, job satisfaction, mental health, and life satisfaction are reportedly best predicted by a combination of job demands and decision latitude (control) (McLean, 1999; Payne, 1999). Additionally, control is reported as being important in stress, as well as new episodes of coronary heart disease (Bishop et al., 2003; Burbeck et al., 2002; McLean 1999). In this study, men reported having significantly more control than women, even in an organisation comprising 81% women, which is comparable to Karasek et al's (1998) findings. This could be an indication that women still tend to occupy less senior jobs then men, resulting in lower levels of control in their jobs (Li & Wearing, 2002; The International Labour Organisation, 2001); alternatively it could be a reflection of men's *perception* of their levels of control. According to the JCQ control can buffer against the potentially negative effects of high demands on health and well being (Van der Doef and Maes, 1999), although the results are equivocal (Spector, 2002). In this respect, in this study, control was found to be higher amongst salaried staff than the published norms and negatively correlated to GHQ-12 scores ($p<0.01$), and psychological job demands

were also found to be higher than published norms and positively correlated to GHQ-12 scores ($p<0.01$). However, given the rate of caseness amongst salaried staff (40%), it would seem that whilst the high levels of control may have had *some* buffering effect on well-being, they do not appear to have been protective enough given: the high psychological job demands; low levels of support; high organisational constraints and low levels of job satisfaction reported.

Overall, support was found to be lower than the published norms throughout both SSDs, although weekly paid staff reported significantly lower levels of support than salaried staff. This may have been due to the large number of weekly paid staff working part time, possibly as homecare workers, who are often isolated in their work. The body of literature has shown that support from colleagues, and immediate superiors, has been found to be associated with significantly lower levels of perceived work stress (Levi & Levi, 2000; Smith, 2000b; Cooper, 1996; Spurgeon & Barwell, 1995). Additionally, low social support at work has been found to be associated with elevated heart rates during the daytime, with the effect persisting throughout the evening after work (Evans & Steptoe, 2001), and sickness absence (Kivimaki et al., 1997). In this study support was found to be negatively correlated with GHQ-12 scores ($p<0.01$), indicating that support is positively associated with well-being.

These survey results have highlighted that salaried staff have: higher organisational constraints; higher levels of job satisfaction; higher psychological job demands; higher levels of control, and higher levels of support than weekly paid staff, although they have poorer levels of well-being. In this respect, correlations between GHQ-12 score and the reported scale outcome variables highlight that: length of time working in the organisation; high psychological job demands and high organisational constraints were associated with poorer well-being. However, overall, those working in Children & Families Division reported the highest levels of organisational constraints, poorest levels of well-being, highest levels of reported absence through illness, with weekly paid staff from this division also reporting the highest levels of psychological job demands and decision latitude (control) of their weekly paid counterparts. These results indicate that interventions are necessary to support and retain these much needed staff.

This 'problem diagnosis' stage was crucial to identify *where* particular problems existed, to *what* degree staff were being affected, and *who* was being affected. Combined with the results of the open questions, this information provided a good level of baseline knowledge, which was essential in order to develop and target ways of improving the current situation. Additionally, this phase of the research has contributed to academic knowledge by exploring the situation in social services *since* the implementation of Best Value, which was aimed at improving local government. In this respect, these results have indicated that within social services, especially amongst salaried staff, the situation appears to have *worsened* rather than improved. One example of this is job satisfaction, which was found to be negatively correlated to length of time working in the organisation and to have *deteriorated* since the Workforce Studies (especially amongst weekly paid staff working with older people). A further example was mental well-being, which again was reported to have *worsened* since the Workforce Studies (McLean, 1999). The organisational constraints scale indicated that salaried staff were suffering high levels of constraints (together with weekly paid staff in children's division). This scale, which had not previously been used in social services, combined with the other scales in the questionnaire, allowed unique correlations to be made between the main variables, which add to the literature by providing a greater understanding of the precise nature of the difficulties faced by social service staff. However, despite using a number of open questions in the survey, this data could only provide a limited understanding of the issues causing stress and in order to capture what was behind the facts and figures, qualitative research, using focus groups were carried out in the worst affected division, i.e. Children and Families Division (discussed below).

7.2 Discussion of the Focus Group Results

Focus groups have become an increasing popular way of gaining insight into employees' experiences and can be used as a vital resource in identifying both problems and solutions (European Agency for Safety & Health at Work, 2002; Gillespie et al.. 2000). In this way focus groups are a particularly useful way of involving staff in a participatory way in organisational change (Donaldson, 2002; Kutek, 1998).

Four focus groups took part in this study, and ranged in size from three to six participants, which equated with Kitzinger's (1999) assertion that in practice focus groups can work with as few as three members. The groups were homogenous, as pre-existing groups were considered the best way to answer the research objectives (Barbour & Kitzinger, 1999). One of the primary reasons for the small group numbers was time and resource limitations (see Barbour & Kitzinger, 1999). The HWQ provided a pre-understanding of the stressors within SSD2 therefore the purpose of the focus groups was to get a more in-depth 'emic' understanding of these issues. In this respect, focus group methods can be combined with quantitative methods, such as questionnaires, especially in the latter stages of a project to help tease out the findings (Barbour & Kitzinger, 1999). The aims of the focus groups were to, firstly to consider the summary of findings of the HWQ for Children & Families Division, identify the main sources of stress within the division and any gaps in the findings. Secondly, to use the findings from to first meeting as a basis to consider what interventions, or 'points for action', could be developed in order to reduce or eliminate the stressors. Finally, to agree and finalise the 'points for action' before their submission to the Departmental Management Team for implementation.

Using focus groups to collect data is dependent upon the facilitator establishing rapport and trust within the group, through identifying the commonality of experience (Kidd & Parshall, 2001; Carey, 1995). In this respect, at the outset the researcher gave the participants a copy of the executive summary showing the main findings of the HWQ in respect of their division. This level of prior knowledge of the particular groups with whom one is working is crucial for both group facilitation and subsequent data interpretation (see Barbour & Kitzinger, 1999; Agar & MacDonald, 1995). The

researcher considers that because of this pre-understanding of the issues, and the fact that the findings from the HWQ highlighted problems within Children & Families Division, which *verified* the researcher's awareness of the issues, this helped the group to see the researcher as someone who was on their side, and impartial, and consequently helped to build up a rapport. As a result, interaction with the researcher and between the groups was found to be relaxed and insightful.

Generally, the focus group participants were in agreement with the summary of main findings, except where there were issues that were chiefly pertinent to the individual groups, for example, staff sickness was reported as being never or rarely provided across Children & Families Division, however this was not the case in children's residential, as it is mandatory for certain levels of cover to be in place at all times. Likewise, social workers thought there would be more mention of tight timescales, however, again, this is mostly applicable to the social work team therefore it was unlikely to be an issue for the whole division that was captured by the questionnaire.

The focus group participants already knew each other, which can have an impact on the dynamics of the focus group (Reed & Payton, 1997). One impact can be that formal and informal power relationships are already established therefore they are difficult to control, which can result in some members dominating the conversation, despite the facilitator's best efforts (Reed & Payton, 1997). This was a feature of the focus groups, which could potentially have lead to 'group think' on the part of the participants, which is a possibility when using pre-existing groups, especially if this includes members of different status (Barbour & Kitzinger, 1999; Carey, 1995; Kitzinger, 1994). In an attempt to address this limitation, each of the participants was given the opportunity to talk or correspond with the researcher, although as individuals they did not avail of this opportunity (Barbour & Kitzinger, 1999). However, with regards to the Administration group there were a number of telephone conversations, e-mails and mailed changes made to the points for action prior to their presentation of the Departmental Management Team. This seemed to be because staff were fearful of potential repercussions, which may be indicative of authoritarian management, which has been highlighted as one of the causes of occupational stress that can lead to low job satisfaction and poor communication (Stevenson, 2000; HSE, 2000). Low job satisfaction has been reported to affect staff performance, morale and

commitment (McLean & Andrew, 2000; McLean, 1999) which is reported to have fallen in the public sector over the past 10 years (Gardner & Oswald, 2000). Additionally poor relationships with supervisors have been identified as potential sources of stress (Payne, 1999; Cooper, 1996; Jones & Fletcher, 1996).

There were a large number of diverse issues that came to light during the focus group meetings, however for the sake of brevity, only the key themes that arose will be discussed at this time (for a full discussion see Coffey, 2003). These themes were developed inductively (Frankland & Bloor, 1999) following thematic content analysis of the transcripts of the initial focus group meetings (Gomm et al., 2000). This method of analysis was adopted (see above) because the aims of the groups were to gain illuminative, descriptive data about largely predetermined areas, rather than at generating theories. Morgan (1997) states that when each group discussion covers more or less the same subjects, then the main issue of analysis and reporting will be to address these topics. Consequently the issues that came up across all or most of the groups included: the heavy workload; lack of staff; insufficient recognition/loyalty; poor communication; lots of change; sickness levels; and a number of stressors, applying only to *individual groups.*

Social Workers and Administration staff reported that their workload was unmanageably high, and were concerned about the amount of pressure this put them under, which is one of the six main factors identified by the Audit Commission (2002) underpinning people's decision to leave in the public sector (see also Pousette & Hanse, 2002; Storey & Billingham, 2001; Bradley & Sutherland, 1995). Moreover, heavy workloads, or work overload has been identified in the occupational stress literature as being one of the main causes of stress throughout a wide range of occupations (Burbeck et al., 2002; Tudor, 2002; Spurgeon & Cooper, 2001; Gillespie et al., 2001; Cox et al., 2000; Smith et al., 2000b; Cooper, 1996; Spurgeon & Barwell, 1995). Social Workers and Administration staff reported that because of their commitment to their job and the nature of the work, they pushed themselves constantly. In this respect, one of the main reasons that people report joining the public sector for is to make a difference for service users and local communities (Audit Commission, 2002).

The main difficulties reported by Social Workers were the pressures associated with: lack of time, necessitating working late, or taking work home; excessive paperwork (Pay and Workforce Research, 2003; Postle, 2002; Storey & Billingham, 2001); fear of missing something or getting it wrong, especially with regard to child protection cases (Cresswell & Firth-Cozens, 1999); not being able to properly address service users' needs (Taylor, 2000); and the tight timescales dictated by the national performance assessment framework. In this respect, the degree of responsibility one has for others, especially in public sector is one of the critical factors identified as being major sources of potential stress (Cooper, 1996; Spurgeon & Barwell, 1995; Bacharach & Bamberger, 1992). Administration workers similarly reported tight timescales which were causing them to work extra hours. This would seem to be a reflection of those difficulties put forward by the Social Workers, as in effect, Administration work is generated by Social Workers and therefore subject to the same time pressures associated with the national performance assessment framework, which is a performance indicator for the authority. Although both Administration and Social Workers reported that they were under pressure, the most difficult aspect of this appeared to be the chronic, unrelenting nature of this pressure, which they felt unsustainable in the long-term. Additionally, fear of getting it wrong in child protection cases, has been found to place considerable emotional demands on health care professionals (Cresswell & Firth-Cozens, 1999; Bennett et al., 1993; Jones et al., 1991). This issue seems to be exacerbated because whilst head-teachers, doctors, or health visitors also have child protection responsibilities, the 'buck' stops with the social worker. In this respect, Cresswell and Firth-Cozens (1999) found significant correlations between depression levels and levels of stress, associated with working with children. However, this degree of pressure did not appear to be felt in either the Family Centre, or the Children's Residential Home, although they reported being busy and in the Family Centre there was concern about the potential impact of the adoption of shift work patterns.

Administration and Social Workers reported that pressure of work was exacerbated, if not caused, by a shortage of staff, especially when staff were off sick, or training was taking place. Both groups felt that lack of resources was the main reason for staff shortages, which has been found in the literature to be one of the most frequently cited stressors amongst social workers (Postle, 2002; Storey & Billingham, 2001; Bradley

& Sutherland, 1995). Lack of staff is a major difficulty throughout the public sector (Audit Commission, 2002), however within social services, field social workers from Children & Families Division, are reportedly the worst affected group, with 48% of local authorities reporting that they were experiencing recruiting difficulties (Social Services Workforce Study, 2002). However, the Administration and Social Worker teams in this study were not actively recruiting therefore lack of resources, rather than recruiting difficulties, was the main concern amongst these groups. Consequently, it would seem that staffing levels are being *purposely* kept to a minimum, perhaps in order to satisfy one of the criteria of Best Value (BV), which is to compete by ensuring that in-house services are comparable to external competition. Within the social work team, the lack of staff appeared to be impacting on safety, with Social Workers reporting that instead of going to a residence in pairs, they were going in 'cold' by themselves. This is extremely worrying, given the risk of violence associated with social work (Community Care, 2003a; European Foundation, 2003) more so because Government strategies are actively aiming to reduce the figures on violent incidents by 25% over three years, a strategy that was launched in 1999 (Community Care, 2003a).

Overall staff perceived that there was little or no recognition from senior management, either for doing their jobs well, or for the pressure they were working under. Staff considered that this lack of recognition manifested itself in: poor wages; criticism; not listening or acting on what staff said; and poor office equipment. Considering these in turn, NASW (2003) found evidence that the more a profession is dominated by women (80% of staff in the public sector), the lower the worker's average salary, which Gibelman (2003) argues is due to continued patterns of discrimination. This inequity between wages received and efforts put in has been found to be associated with absenteeism (De Boer et al., 2002), turnover intention (Guerts et al., 1999), unpleasant emotional states (Adams, 1965), psychosomatic health complaints, job dissatisfaction and physical health symptoms (Van Vegchel et al., 2001; Hendrix et al., 1999; Adams, 1965). Not listening to or not acting on what staff say, together with criticism for failing, equates to factors such as lack of participation and effective consultation or poor communication, which are management styles frequently associated with causing stress (Smith, 2000b; Cartwright et al., 2000; Levi & Levi, 2000; Cooper, 1996). However, communication

within teams, rather than between teams and senior management was found to be considered good. Focus group participants reported that there was a lack of IT and NVQ training, and equipment. In this respect, inadequate or broken tools have been identified as stressors leading to direct impairment of job performance and execution (Fay & Sonnentag, 2002), whilst poor mental well-being has been found to be directly related to unpleasant work conditions (Cooper, 1996; Spurgeon & Barwell, 1995).

Changes were reported to be affecting the Family Centre more than the other groups, as their roles were changing and their team was being amalgamated with other newly created family support worker teams. These changes were reportedly as a result of the introduction of BV. In this respect, the rate and scale of change has been considerable throughout the 1980s and 1990s, with BV being introduced in order to: challenge traditional approaches to the service; consult local people and key stakeholders and monitor customer satisfaction on services; benchmark their services against other councils and providers; and compete by ensuring that services are subjected to external competition (The Guardian, 12th March, 2001). Staff reported being very concerned with the way that the changes were being managed. In this respect Donaldson (2002) asserts that badly managed changed can cause irreparable damage to employee well-being and organisational culture. In this study this would seem to be borne out, as at the time of writing four out of the six staff from this Centre who took part in the focus groups had resigned, leaving SSD2 with vacancies to fill an area plagued with recruitment difficulties.

Looking at sickness levels, Children's Residential reported that there were some members of staff who abused the system, whilst both Administration and Social Workers considered that sickness absence was low. Workers who abuse this system could possibly indicate that sickness absence may be a social phenomenon, with absences taken in accordance with what is allowed by culture or norms (Xie & Johns, 2000; Gellatly & Lauchak, 1998; Johns & Xie, 1998; Sanders & Hoekstra, 1998; Brooke & Price, 1989). Low sickness absence amongst the other groups, would appear to be evidence of their commitment to their jobs, and their willingness to 'make a difference' (Audit Commission, 2002).

The nature of the service users was also found to be causing difficulties. This aspect of working for social services seems unlikely to improve, and may even worsen, given the ever stricter eligibility criteria that is resulting in service users presenting with more difficult and complex problems than was previously the case, and the shift in care from the NHS to social service departments (Postle, 2002; Balloch, 1996). Shift changes were also reported to be problematic in the Children's Residential home. This could potentially negatively impact on family care, which appears to magnify the impact of stress on women (International Labour Organisation, 2001; Ganster & Schaubroeck, 1991), especially given that job stress is more strongly associated with the impact of the job upon one's family life (Smith, 2000b). Staff reported a lack of support from management, which has been found to be significantly associated with perceived work stress (Smith 2000b; Levi & Levi, 2000; Cooper, 1996; Spurgeon & Barwell, 1995). Additionally, Children's Residential staff reported problems because they lacked budgetary control. Control is considered to be an important factor (Karasek, 1979) because it enables staff to deal with demands by taking personal action, and is considered to be important for well-being (Warr, 1987).

It would appear from the above findings that the issues causing most distress to staff were due to organisational factors, such as: the heavy workload, lack of staff, insufficient recognition; poor communication and too many changes, rather than the intrinsically stressful nature of the job. In this respect, even in seemingly stressful jobs, such as the police (Hart et al., 1995) or teaching occupations (Hart, 1994) research indicates that organisational factors such as communication and administration, rather than factors intrinsic to the job, were the main predictors of psychological distress (Clarke & Cooper, 2000).

As a result of these findings the focus group members drew up a set of points for action (Coffey, 2003). The main points were:

- Workloads to be reviewed, especially the way that case numbers per social workers are considered

- Staffing levels to be addressed by: reviewing current staffing levels, with a view to increasing the number of permanent staff; a review of the use of temporary/agency staff; improved recruitment and retention measures;

- Tangible benefits to show recognition and appreciation of the effort put in by staff, possibly in the form of 'points for prizes' or discounted leisure facilities;

- Improved communication, including the removal of 'social-work speak', regular meetings and the development of a monthly newsletter;

- More support at times of change, with improved consultation and the setting up of a support group for the family center workers;

- And the development of policies to deal with persistent, long-term sickness absence.

The focus group findings, together with the points for action arising, highlight how the participants were able to identify the aspects of their situation that they wished to change, analyse the cause of these problems, and create 'context specific' action plans to deal with the problem (European Agency for Safety & Health at Work, 2002; Schurman & Israel, 1995). In this respect, the literature strongly suggests that interventions that are designed with the involvement of staff, i.e. participatory action research (PAR), are the most likely to be effective in the long term (Cox, 2002; HSE 2002). Additionally, PAR has been found to increase people's job control (Bond & Bunce, 2001) and to empower those involved (Beresford & Evans, 1999; DeKoning & Martin, 1996; Karlsen, 1991). This process meant that in this study those who were affected by the problem were able to work towards a solution, highlighting how PAR recognises the value of ordinary people's perspectives, and challenges 'expert knowledge' (Loewenson et al., 1999). However, Winter and Munn-Giddings (2001) warn that reports produced in this way can be rejected as partisan, idealistic, or as mere voices of dissent and in this respect lacking the validity and reliability of proper research. In this respect, managers did appear to reject some of the findings, asserting

that staff were misinformed, or that the results were skewed by people airing personal grievances.

PAR and participatory approaches have reportedly proven themselves as a means of reducing stress in the workplace (Aparicio 2002; European Agency for Safety & Health at Work, 2002; Kuhn, 2002; Bond & Bunce, 2001; Cox et al., 2000; Mikkelsen et al., 2000; The Sainsbury Centre for Mental Health, 2000; Levi & Levi, 2000; Griffiths, 1999; Hugentobler et al., 1992; Karasek, 1990; Chernis, 1980). In this study, it was not possible to carry out an outcome evaluation on the proposed interventions informed by the points for action because of the length of time it took for managers to develop 'action plans'. However, a process evaluation was carried out and is discussed below. Despite the lack of outcome evaluation, staff reported that they appreciated the opportunity to take part in these meetings, and have the chance for problems to be taken seriously and addressed by management (see Mikklesen, 2000). This is particularly important in the public sector because the bureaucratic nature of the organisation can lead to staff feeling helpless and lacking the skills to negotiate the system (Cherniss, 1980). In this respect, the focus groups enabled the participants to acquire the skills to negotiate the system, although Dockery (1996) warns that trying to promote participatory processes within non-participatory systems can be difficult.

This phase of the research has demonstrated how, even in a complex bureaucratic organisation, pre-existing groups can come together to: provide a more in-depth understanding of survey results; verify the results of the survey; pinpoint any gaps in the findings; identify more 'local' issues that may not have been exposed by the survey; and develop context specific solutions to these problems. For this to happen, prior knowledge of the issues was considered a crucial aspect in the development of trust between the researcher and the participants.

The main themes that came out of the focus groups included: a heavy workload; lack of staff; insufficient recognition/loyalty; poor communication; lots of change; and sickness levels. These themes have previously been highlighted by the literature, however, these findings further academic knowledge by demonstrating that the introduction of both national performance assessment framework and Best Value have

not helped the situation and would actually appear to be contributing to the difficulties faced by staff working with children and families. Moreover, it would seem that staffing levels are being *purposely* kept to a minimum, perhaps in order to satisfy one of the criteria of Best Value (BV), which is to compete, by ensuring that in-house services are comparable to external competition.

This research has established that participants were able to, given to chance, address these problems by developing largely *practical* solutions at a local level to tackle a number of these stressors. Despite the fact that a quick fix is unlikely in the case of heavy workloads and lack of staff because of the resource implications, the focus groups were able to highlight these problems; discuss their implications; and bring them to the attention of Senior Management, with the result that staffing levels and case allocation methods are being reviewed (see Appendix 4). The focus groups also benefited management, by giving them the opportunity to show the groups how they were dealing with some of the issues, for example the recruitment and retention action group was already in existence, although staff were unaware of it. As a result it would seem that these groups were empowering, not only for the participants, but also for their managers, as they improved both groups' knowledge and set up new lines of communication within a complex bureaucratic organisation.

7.3 Discussion of Process Evaluation Results

The process of implementing occupational stress interventions can be as important as the contents of the intervention itself (Saksvik et al., 2002; Goldenhar et al., 2001; Nytro et al., 2000; Griffiths, 1999). As result, careful documentation of the intervention process was carried out through this project (Griffiths, 1999). The process evaluation was conducted, firstly, to highlight what worked well, what did not and in what context (Parry-Langdon et al., 2003; Saksvik et al., 2002; Baronowski & Stables, 2000; Nutbeam, 1998; Israel et al., 1995); secondly, to inform the literature on change management, which tends to give the impression that change is relatively simple, as long as an organisation sticks to recommended recipes (Saksvick et al., 2002); thirdly to identify any successes that were not anticipated; and finally, to build evidence concerning the conditions which need to be created in order to achieve successful outcomes and improve intervention effectiveness.

Throughout the course of this research, there were a number of aspects which went well, although disappointingly there were also setbacks. Before looking at these aspects however, it is important to consider the context in which this study was taking place. Both SSDs were undergoing major changes throughout the course of this research. These changes are the result of the Government's modernisation agenda, including the introduction of Best Value in 1999, which is aimed at getting councils to: challenge traditional approaches to their service; consult with local stakeholders and monitor customer satisfaction; compare their services against other councils and providers and compete against external competition (DETR, 1999; The Guardian, 12th March, 2001).

In the survey these changes were found to be causing considerable distress to a number of staff, in some cases leading to concerns about job security. Additionally, there appeared to be a feeling of little trust between the council and its staff, reported by some of the respondents. This lack of trust seems to have been a factor influencing the survey response rate, as staff reported that they felt it was unlikely that their efforts in completing the questionnaire would result in any action on the council's part (Nytro et al., 2000). These comments would seem to indicate 'project fatigue', which Saksvick et al (2002) highlight as being the result of lots of new initiatives with very few follow-up measures, together with generally negative associations from previous intervention experiences. Moreover, pressure of work, as highlighted above, would restrict the amount of time that staff had to complete the questionnaire, and the overall lack of resources (both time and money) within the Department would undoubtedly cause staff to question *how* any worth while any potential 'no-cost' changes could be.

Considering that these comments were made by those who actually took the time to fill in questionnaire, it seems reasonable to assume that a mixture of skepticism, lack of interest, pressure of work or literacy problems (Shaughnessy & Zechmeister, 1990) must have played a considerable part in the non-completion of the questionnaire and account, at least in part, for the low response rate. A response rate of 33% must therefore cast doubts about the representativeness of the findings, with Parkes and Sparkes (1998) asserting that a 60% response rate or more is important for adequate representation. This highlights one of the most serious problems associated with mail surveys, known as 'response bias' (Shaughnessy & Zechmeister, 1990), although

despite this, 1,234 staff still took part in the survey, which made it worthwhile. A number of staff indicated that they were pleased to have had a chance to take part in the survey and were anxious to see changes and receive feedback as a result of their efforts. However, one of the common problems associated with using questionnaires, namely that they are not specific enough to capture the world view of the participants (Hurrell et al., 1998) was also raised, although the open questions included in the questionnaire were an attempt to limit this drawback as far as possible.

Lack of available resources was one of the major drawbacks of the project, and within the focus groups, whilst staff may have felt that more staff, or better IT equipment, would be the most beneficial 'interventions' to reduce stress, they were aware that there was little or no chance of these issues being addressed. However, the project did raise awareness of these issues, and helped to pinpoint specific areas within the two SSDs that were reporting the most difficulties, thereby helping the Department to target future resources more appropriately. This is one of the main strengths of using a problem diagnosis tool, such as the one used within this research, as by identifying problems, informed decisions can be made about future interventions (Cox et al., 2002; Briner, 2000; Cartwright et al., 1995).

Raising awareness equates with health literacy, one of three potential health promotion outcomes highlighted by Nutbeam (1998). Health literacy is associated with improving knowledge, self confidence, empowerment or participation, and in this respect, knowledge about the scale, causes and consequences of stress within both SSDs was raised with the steering group, management and the unions throughout the programme, and was therefore achieved. In terms of self confidence, empowerment and participation, in SSD1 this outcome was not realised, due to the inability to translate the findings from the Healthy Work Questionnaire into actions, which is considered to be one of the most challenging aspects of the risk management process (Cox et al., 2002). Previous findings highlight that one of the most important steps in making healthy organisational change is for the top management within the organisations to be seriously on board (see for example Nytro et al., 2000; Cahill et al., 1995). However, establishing that top management is fully committed is not always easy, as in SSD1 were the Director was not accessible to the researcher and his *reported* support was being passed on through a third party. Perhaps if some sort of

formal agreement, in which the obligations and rights of the participants were clarified, (Kristensen, 2000) had been drawn up at the outset of the project, some of these difficulties could have been avoided.

Although the inability to translate findings into actions in SSD1 was a setback, it provided invaluable experiences on which the author could reflect in order to improve the programme (Nytro et al., 2000). As a result more care was taken to ensure that commitment from senior management was assured at the outset of the second study (Nytro et al., 2000; Cahill et al., 1995). Additionally, more realistic expectations were discussed at the outset of the second project, which equated to one of the pre-requisites for the introduction of organisational interventions put forward by Nytro et al (1995). These factors seemed to benefit the second programme, and in this respect SSD2 was keen to translate the findings of the survey into actions, which resulted in the focus groups being set up.

As well as improving health literacy, comments from the focus groups (SSD2) indicated that improvements in self-confidence, empowerment and participation (Nutbeam, 1998) were, to some degree, achieved. However, again the translation of the focus group findings into action plans proved slow and challenging (Cox et al., 2000; Nytro et al., 2000). In this respect, Cartwright et al (1995) assert that change, particularly in large bureaucratic organisations such as public sectors is particularly problematic, because of the ability of this type of organisation to resist change. The author fears that the length of time this phase is taking, although anticipated (see for example, Shannon et al., 2001; Kristensen, 2000; Theorell, 1999), may result in the benefits of taking part in the focus groups being negated, as staff could feel that their efforts were in vain, which was one of their original concerns at the outset of this project. In this respect, Kristensen (2000) asserts that interventions may raise workers expectations, and increase job dissatisfaction if these expectations are not met, which may have happened in SSD1, and potentially could still happen in SSD2. Again, perhaps some sort of contract drawn up at the outset, which included time-scales may have benefited in this respect.

Nutbeam (1998) includes changes to policies and organisational practices as health promotion outcomes, because of the complex and distant relationship between the

usual health promotion activities and health outcomes. In this respect, the author's involvement in the development of the exit questionnaire was an unanticipated and welcome aspect of the programme. This should benefit SSD2 by providing ongoing information about working conditions within the Department and the reasons why staff are leaving, which has the potential to improve working practices and inform recruitment and retention policies on an ongoing basis (Audit Commission, 2002; Employers Organisation, 2002). Additionally, the author was asked to join the Sickness Absence Monitoring Task Group, the Health Unit Steering Group and take part in a number of Departmental Management Meetings, which led to a number of awareness raising opportunities. It is felt that the development of the exit interviews is a good example of improved health literacy within the Department, as it equates to diagnosing problems to inform interventions, which was the author's philosophy throughout the project.

Programme implementation within both SSDs was problematic in a number of ways. Translation of the findings into actions (Cox et al., 2002) proved to be the most challenging aspect, firstly in SSD1 following the survey results, and secondly in SSD2 following the focus group results. Problems seem to have arisen due to the predominantly negative findings, which could have been seen as criticisms of the way management ran the organisation. Kristensen (2000) warns that managements' fear of possible mistakes being made public to the employees or the media can be an obstacle to organisational change in this regard. Opposition by management was however anticipated, although the resistance shown by the Union to the focus group report being adopted was not. The only possible explanations that the author can put forward for this resistance are; firstly that the union may have felt their collective bargaining powers were compromised by the research (Kristensen, 2000) and; secondly, that there was inadequate understanding of local norms and values on behalf of the researcher (Nytro et al., 2000). Consequently, although the backing of union leadership is considered essential (Shannon et al., 2001; Nytro et al., 2000), in the case of SSD2 their involvement was a limitation, rather than a strength. Additionally, in the case of SSD1, the union did not have sufficient power to persuade management to carry the project through, therefore again their contribution to the programme was disappointingly limited. This lack of ability (SSD1) or willingness

(SSD2) on behalf of the Unions to help their members through this programme was an unexpected negative outcome of this research process.

Evaluating the processes involved in this study has contributed to the body of academic literature by highlighting a number of conditions that would seem necessary in order for potentially successful interventions to be achieved, namely; commitment of top management (preferably in writing); a culture of trust within the organisation; an assurance by management to staff that where possible findings will inform actions; the existence of a steering group (who have preferably been established prior to the programme); an assurance by management that sufficient resources are available to carry out, at least, some interventions; a realistic expectation of findings/outcomes discussed at the outset of the programme; sufficient time allowed for staff to take part in the survey; an assurance of feedback from management; a supportive union; and a contract drawn up at the outset to confirm time scales and intentions to act on the survey results. However, despite the fact that some of these conditions were absent during this project, health promotion benefits were achieved, namely improved health literacy, changes to organisational policies and practices (Nutbeam, 1998), and the development of a grounded research baseline, which can inform the targeting of resources/interventions to improve health.

Whilst changing individual behaviour is tough, changing organisations to improve employee health is even more difficult (Cahill et al., 1995). The findings from this study support this, together with the fact that complex bureaucratic organisations have multiple mechanisms for resisting change (Schurman & Israel, 1995). Notwithstanding this, the benefits of carrying out this process evaluation are that: it has enabled the identification of what worked well, what did not, and in what context; it has informed the literature of some of the difficulties associated with managing change; it has identified unanticipated successes; and finally, it has informed the literature on some of the conditions which need to be created in order to achieve potentially successful outcomes and improve intervention effectiveness.

CHAPTER EIGHT – CONCLUSIONS AND RECOMMENDATIONS

8.0 Conclusion and Future Recommendations

The overall aim of this research was to develop an understanding of *what* stressors impact on social service staff, in order to develop an effective intervention/range of interventions from a grounded research baseline, which could then be followed up with an evaluation study to assess the effectiveness of the interventions applied. This approach to managing stress is a form of 'primary prevention' which, despite being recommended (see for example Cox et al., 2000b; European Foundation, 1996) is still comparatively rare, with the majority of action taken by EU member states being aimed at modifying the stress response or the stress-related health outcome.

Additionally, research shows that very few stress management interventions are adequately designed or evaluated in scientific terms (Cox et al., 2000b; Burke & Richardson, 2000; Springett & Dugdill, 1995). Consequently, although there is considerable evidence that perceived stress at work is associated with ill health, the lack of well-designed and evaluated organisational approaches to managing stress means that the available evidence looking at interventions to reduce work stress appears to be limited at best. Therefore by adopting this 'systematic approach', as recommended by Cox et al (2000b), NIOSH (1999), and the European Foundation (1997) it is anticipated that the results of this research will add to the body of literature by providing some of the lacking evidence, which is of paramount importance, firstly, because of the scale of occupational stress, which is reportedly affecting up to 5 million workers in the UK (Smith, 2001; HSE 2000a), with recent data suggesting that up to 563,000 individuals in the UK are actually suffering from work related stress, depression or anxiety (HSE, 2002c). Secondly, because of the cost of occupational stress, which is estimated to be accounting for the loss of 187m working days per year, costing the UK approximately £12 billion pa (The Guardian, 17th March, 2001). Thirdly, because public sector workers are reporting a pronounced increase in measured stress, relative to private sector workers, and have cited stress as the biggest single factor in their decision to leave (Audit Commission, 2002). Whilst, at the same time the public sector is facing an imminent staffing crisis, because young people no longer want to work in it and nearly a third of its workforce are over 50

years of age, a situation which the Audit Commission (2002) describes as a potential *"demographic time bomb"* (p.2).

This research therefore sought to ascertain: what stressors were impacting on social service staff; by what means could these stressors be reduced or eliminated (which included finding out what services staff would like to see provided by their occupational health service); and how successful these interventions would be at reducing/eliminating stress. To answer these questions, following the systematic approach advocated in the literature, this study was carried out in three phases.

The first phase was a baseline survey, informed by discussions with key stakeholders and in-depth interviews with a number of staff, which was carried out in both SSDs. This was considered the best way, given the large study population, of identifying what stressors were impacting on social service staff and the potential impacts that these were having in terms of mental well-being and job satisfaction. This phase also sought to identify which groups, if any, were worst affected by these stressors.

A unique range of scales were used in this large-scale survey, enabling correlations to be carried out between the main outcome variables, which highlighted a number of stressors that appeared to be negatively impacting on the mental health of the workforces of two SSDs in the North West of England. Salaried staff in particular reported high levels of organisational constraints, high levels of psychosocial job demands and high levels of mental distress. Overall, those working in Children & Families Division reported the highest levels of organisational constraints, poorest levels of well-being, highest levels of reported absence through illness, with weekly paid staff from this division also reporting the highest levels of psychological job demands and decision latitude (control) of their weekly paid counterparts. In addition, staff throughout all Divisions reported low levels of job satisfaction, stating that they had too little time to do their jobs properly, difficulties with service users and insufficient staff to cover the workload.

The respondents suggested that to make these difficulties less of a burden, more staff, more training and more support were needed. This stage of the research also found that the services that staff would most like to see being provided by their occupational

health service was *overwhelmingly* counselling that was easy to access and available by self-referral, followed by: access to stress management training; a preventative/proactive health promotion service; the availability of 'alternative therapies; and free or subsidised leisure facilities. Although, this was not discussed in detail within this thesis, this information was passed on to the occupational health units in both SSDs to inform their service development.

This phase of the research is original in as much as it has used a purposely developed questionnaire to explore a wide variety of potential stressors in social services *since* the introduction of Best Value and the national performance assessment framework. Moreover, this 'problem diagnosis' was a crucial step in identifying *where* particular problems existed, *how* and to *what* degree staff were being affected, and *who* was being affected. Combined with the results of the open questions, this information provided a good level of baseline knowledge, which was essential in order to develop targeted interventions aimed at improving the current situation.

Children & Families Division was chosen for pilot interventions, because of the number of difficulties highlighted by the survey and the recruitment and retention difficulties that are most pronounced in this area. Focus groups were chosen for this phase of the research, because they have been found to be a particularly useful way of involving staff in a participatory way, to develop context-specific solutions to their own problems. In this respect, the literature strongly suggests that interventions that are designed with the involvement of staff, i.e. participatory action research, are the most likely to be effective in the long term. The main issues that came up across all, or most, of the groups were: the heavy workload; lack of staff; insufficient recognition/loyalty; poor communication; lots of changes; and high sickness levels. These difficulties were predominantly *organisational*, rather than intrinsic to social care work, with lack of resources seeming to be responsible for the main problems associated a heavy workload, which is presumably caused, or at least contributed to, by the lack of staff.

However, whilst resource issues are more difficult for public sector organisations to address, the benefit of carrying out this kind of exercise, is that future resources can be targeted *appropriately* where needs have been identified. During the course of the

focus groups staff devised 'points for action', which outlined the interventions they would like implemented to reduce some of the difficulties highlighted. The main points were: workloads to be reviewed, especially the way that case numbers per social workers are considered; staffing levels and the use of temporary/agency staff to be reviewed; tangible benefits to show recognition and appreciation of the efforts put in by staff; improved communication, involving regular meetings and the development of a monthly newsletter; more support at times of change, with improved consultation with staff; and the develop of separate policies to deal with persistent, long-term absence.

These suggestions were passed to the Departmental Management Team, to be translated into 'action plans'. In this regard, the managers initially went back to the focus groups to clarify some of the points raised, before developing appropriate action plans. Regrettably, it took almost six months for these action plans to be developed, which meant that an evaluation of the interventions was outside the scope of the thesis.

As a result, the third phase of this research comprised a process evaluation of all aspects the programme, because the process can be seen as important as the content of the health intervention itself (Sakswik et al., 2002; Goldenhar et al., 2001), and because process evaluations are rarely conducted (Baronowski & Stables, 2000). The process evaluation was conducted to highlight; what worked well, what did not and in what context; to inform the literature on change management, which tends to give the impression that change is relatively simple as long as an organisation sticks to recommended recipes; to identify any successes that were not anticipated; and finally, to add to the body of evidence concerning the conditions which need to be created in order to achieve successful outcomes and improve intervention effectiveness.

The process evaluation highlighted the areas where the programme implementation was challenging in both SSDs. In SSD1, following the presentation of the survey results, the translation phase (which involved the identification of priorities; investigation of options for change; and assessment of resource implications) did not take place. The main reasons for this were that the Director of Social Services was not directly involved in the project, although *reportedly* he gave it his full support.

Additionally, the Assistant Director of Social Services, who had overall responsibility for the project, went on long-term sick leave, leaving an Acting Assistant Director for whom the project was not a priority. Regrettably, neither the Steering Group nor the Union, despite pressure from the University, had the power to translate the findings into concrete intervention plans.

Whilst this was disappointing, it emphasised how crucial it is to have senior management *actively* on board any stress management programmes at the outset. It also demonstrated how, in the face of findings that could be perceived as critical of the workplace, or the way it is managed, an organisation can withdraw from the project and essentially seek to bury the findings. One possible way of reducing the potential for this happening again, would be to discuss realistic outcomes with senior management at the outset of the project and draw up some form of contract, detailing the research process and confirming their commitment to act on the findings. In this respect, realistic outcomes were discussed with the Director of SSD2 at the beginning of the programme and his commitment to act on the findings was assured from the outset. However, even with this assurance the actual process of translating the focus group findings into action plans proved to be a very lengthy procedure. Possible reasons for this were, again because some of the findings could be perceived as critical of the way the firm was managed, and also because the Union did not support the focus group work, perhaps because in some way it threatened their collective bargaining powers, or that there was inadequate understanding of local norms and values on the part of the researcher. Further limitations of the programme included: the lack of available resources for the project, which no doubt resulted in 'project fatigue' on the part of the respondents, as they reported that any potential interventions would most likely need to be on a 'no-cost' basis.

There are many different interpretations of what constitutes success and value in health promotion programmes and given the complex and distant relationship between the usual health promotion activities and health outcomes Nutbeam (1998) highlights the importance of focusing on three different types of health promotion outcomes. These include: improved health literacy; changes to policies and organisation practices; and changes to social norms or actions, which can increase people's control

over the determinants of health. Looking at these outcomes, health literacy equates with improving knowledge, self confidence, empowerment or participation and in this respect the level of knowledge was raised amongst the steering group, management, focus groups (in SSD2 only) and unions throughout the programme and was therefore achieved. Additionally, an unexpected outcome of the process was that the author was asked to be involved in a number of groups within this organisation, and subsequently became involved in the development of an exit interview, which will benefit the organisation by providing ongoing information about problems which may be causing staff to resign. This is of critical importance given the recruitment and retention difficulties highlighted above. Moreover, despite the length of time the action plans have taken, the focus groups were successful in: getting their voices heard, highlighting the sources of their stress; and developing context-specific solutions to reduce these stressors.

Finally the process evaluation highlighted a number of conditions which would seem necessary in order for potentially successful interventions to be achieved, including: commitment from top management; an assurance that where possible they will act on findings; a culture of trust within the organisation; an influential steering group; sufficient resources; a realistic expectation of the findings/outcomes discussed at the outset of the programme; agreed timescales by both the research team and management; sufficient time for staff to take part in the project; an assurance of feedback to staff from management; and a supportive union. Whilst these conditions would undoubtedly improve the potential for successful interventions to be implemented, it must be noted that Best Value also seeks, through 'continuous improvement', to enhance the quality of local government services. However, the overall findings of this study were that the main issues of concern to staff, i.e. pressure of work and lack of staff, could not be addressed by the organisations concerned because of BV performance indicators, which compel local authorities to compete, resulting in restricted resources.

As action research is an ongoing cyclical process, there comes a time when the researcher has to leave and hand the project over to the organisation concerned. Therefore, once the points for action were developed, these were passed to management for translation into action plans to be implemented within Children &

Families Division. The organisation concerned now has the opportunity to implement these interventions and repeat this process in any other areas of the Department which appears to be having problems. In this respect, in order to further add to the body Of literature on the effectiveness of stress management interventions, it is recommended that these interventions are rigorously evaluated, in a participatory way, from the research baseline already established.

References

Adams J.S., (1965) Inequity in Social Exchange. *Advances in Experimental Social Psychology, Vol. 2,* 267-299

Agar M., & MacDonald J., (1995) Focus Groups and Ethnography. *Human Organization, Vol. 54, No. 1,* 78-86

Amick B., & Kasl S., (2000) Work Stress. In McDonald C. (Ed.) *Epidemiology of Work Related Diseases.* 2nd Edn., BMJ Books, London

Andrews F.M., & McKennell A.C., (1979) Measures of Self-Reported Well-Being: Their Affective, Cognitive, and other Components. *Social Indicators Research 8,* 127-155

Aparicio J.C., (2002) Workplace Stress – a growing problem. *Working on Stress. Magazine of the European Agency for Safety & Health at Work, No. 5* http:/ europa.eu.int

Arola H., Pitkanen M., Nygard C.-H., Huhtala H. & Manka M.-L. (2003) The connection between age, job control and sickness absences among Finnish food workers. *Occupational Medicine, Vol. 53,* 229-230

Audit Commission (2002) *Recruitment and Retention: A public service workforce for the twenty-first century.* Audit Commission, London. http://www.lg-employers.gov.uk/advice recruitment.html

Bacharach S., & Bamberger P., (1992) Causal Models of Role Stressor Antecedents and Consequences: The Importance of Occupational Differences. *Journal of Vocational Behaviour, Vol. 41,* 13-34

Baker R., & Hinton R., (1999) Do focus groups facilitate meaningful participation in social research? In Barbour R.S., & Kitzinger J., (Eds.) *Developing Focus Group Research: Politics, Theory & Practice.* Sage Publications, London

Balloch S., Andrew T., Ginn J., McLean J., & Williams J., (1995) *Working in the Social Service.* National Institute for Social Work Research Unit, London

Balloch S., & McLean J., (1999) The changing nature of work. In Balloch S., McLean J., & Fisher M. (Eds.) *Social Services: Working under pressure.* Policy Press, Bristol

Balloch S., Burglass D., & McConkey (1999a) Introduction. In Balloch S., McLean J., & Fisher M. (Eds.) *Social Services: Working under pressure.* Policy Press, Bristol

Balloch S., Fisher M., & McLean J., (1999b) Conclusions and Policy Issues. In Balloch S., McLean J., & Fisher M. (Eds.) *Social Services: Working under pressure.* Policy Press, Bristol

Baranowski T., & Stables G., (2000) Process Evaluations of the 5-a-Day Projects. *Health Education and Behavior, Vol. 27, No.2,* 157-166

Barbour R.S., (1999) Are focus groups an appropriate tool for studying organizational change? In Barbour R.S., & Kitzinger J., (Eds.) *Developing Focus Group Research: Politics, Theory & Practice.* Sage Publications, London

Barbour R.S., & Kitzinger J., (1999) *Developing Focus Group Research: Politics, Theory & Practice.* Sage Publications, London

Barraclough K., (2000) "I'm suffering from work related stress, doctor". *BMJ, Vol. 321:519, 19th August*

Baruch-Feldman C., Brondolo E., Ben-Dayan D., & Schwartz J., (2002) Sources of Social Support and Burnout, Job Satisfaction, and Productivity. *Journal of Occupational Health Psychology, Vol. 7, No. 1,* 84-93

Bellman S., Forster N., Still L., & Cooper C.L., (2003) Gender differences in the use of social support as a moderator of occupational stress. *Stress and Health, Vol. 19, Issue 1, 2003,* 45-58

Bennett H., (2002) Employee commitment: the key to absence management in local government? *Leadership & Organization Development Journal, Vol. 23, No. 8,* 430-551

Bennett P., Evans R., & Tattersall A., (1993) Stress and Coping in Social Workers: A Preliminary Investigation. *British Journal of Social Work, Vol. 23,* 31-44

Beresford P., & Evans C., (1999) Research Note: Research and Empowerment. *British Journal of Social Work, Vol. 29,* 671-677

Bishop G.D., Enklemann H.C., Tong E.M.W., Why Y.P., Diong S.M., Ang J., & Khader M., (2003) Job Demands, Decision Control, and Cardiovascular Responses. *Journal of Occupational Health Psychology, Vol. 8, No. 2,* 146-156

Bliese P.D., & Britt T.W., (2001) Social support, group consensus and stressor-strain relationships: social context matters. *Journal of Organizational Behaviour, Vol. 22,* 425-436

Bliese P.D., & Jex S.M., (2002) Incorporating a Multilevel Perspective into Occupational Stress Research: Theoretical, Methodological, and Practical Implications. *Journal of Occupational Health Psychology, Vol. 7, No. 3,* 265-276

Bond F.W., & Bunce D., (2001) Job Control Mediates Change in a Work Reorganization Intervention for Stress Reduction. *Journal of Occupational Health Psychology, Vol. 6, No. 4,* 290-302

Borrill C.S., Wall T.D., West M.A., Hardy G.E., Shapiro D.A., Haynes C.E., Stride C.B., Woods D., & Carter A.J., (1998) *Stress amongst staff in NHS Trusts.* Institute of Work Psychology, University of Sheffield & Psychological Therapies Research Centre, University of Leeds.

Borrill C., & Haynes C., (1999) Health Service Managers. In Firth-Cozens J., & Payne R.L. (Eds.) *Stress in Health Professionals.* John Wiley & Sons, Chichester.

Bourbonnais R., Brisson C., Moisan J., & Vezina M., (1996) Job strain and psychological distress in white-collar workers. *Scandinavian Journal of Work Environment & Health, Vol. 22,* 139-45

Bradley J., & Sutherland V., (1995) Occupational Stress in Social Services: a Comparison of Social Workers and Home Help Staff. *British Journal of Social Work, Vol. 25,* 313-331

Bridges S., & Mumford K., (2001) Absenteeism in the UK: A comparison across genders. *The Manchester School, Vol. 69, No. 3,* 276-284

Briner R., & Reynolds S., (1999) The costs, benefits, and limitations of organizational level stress interventions. *Journal of Organizational Behavior,* Vol. 20, 647-664

Briner R., & Rick J., (1999) How different are psychosocial and physical hazards? Implications for psychosocial assessment at work. *Paper presented at the Occupational Psychology Conference of the British Psychological Society, Blackpool, 5-7 January, 1999*

Briner R., (2000) Stress management 2: effectiveness of interventions. *Employee Health Bulletin, No. 18, December*

Brodie D., & Dugdill L., (1993) Health Promotion at Work. *Journal of the Royal Society of Medicine, Vol. 86, December,* 694-696

Brooke P.P., & Price J.L., (1989) The determinants of employee absenteeism: An empirical test of a causal model. *Journal of Occupational Psychology, Vol. 62,* 1-19

Bryson N., (2003) Trade Union Trends: Focus on union legal services for injury victims. *Trades Union Council (TUC) (03 02).*

Burbeck R., Coomber S., Robinson S.M., & Todd C., (2002) Occupational stress in consultants in accident and emergency medicine: a national survey of levels of stress at work. *The Emergency Medicine Journal, Vol. 19,* 234-238

Butterfoss F.D., Francisco V., & Capwell E., (2001) Stakeholder Participation in Evaluation. *Health Promotion Practice, Vol. 2, No. 2,* 114-119

Cahill J., Landsbergis P.A., & Schnall P.L., (1995) Reducing Occupational Stress: An Introductory Guide for Managers, Supervisors and Union Members. *Job Stress Network* http://www.workhealth.org/

Carey M.A., (1995) Comment: Concerns in the Analysis of Focus Group Data. *Qualitative Health Research, Vol. 5, No. 4,* 487-495.

Carter A.J. & West M.A., (1999) Sharing the Burden: Teamwork in Health Care Settings. In Firth-Cozens J., & Payne R.L. (Eds.) *Stress in Health Professionals.* John Wiley & Sons Ltd., Chichester

Cartwright S., Cooper C.L., & Whatmore L., (2000) Improving communications and health in a government department. In Murphy L.R. & Cooper C.L. (Eds.) *Healthy and Productive Work: An international perspective.* Taylor & Francis, London

Casey M.A., (1998) Analysis – Honoring the Stories in Analyzing & Reporting Focus Group Results. In Krueger E.A. (Ed.) *Focus Group Kit 6.* Sage Publications Inc., California

Cartwright S., Cooper C.L. & Murphy L.R., (1995) Diagnosing a Healthy Organization: A Proactive Approach to Stress in the Workplace. In Murphy L.R., Hurrell J.J. Jr., Sauter S.L., & Puryear-Keita G., (Eds.) *Job Stress Interventions.* American Psychological Association, Washington.

Caterall M., & Maclaran P., (1997) 'Focus Group Data and Qualitative Analysis Programs: Coding the Moving Picture as Well as the Snapshots'. *Sociological Research Online, Vol. 2, No. 1,*
http: www.socresconline.org.uk/socresonline/2/1/6.html

CBI (2002) Workplace Absence hits 14-year low but costs rise by £1 billion – New Survey. *CBI News Release, 24th April,* http://www.cbi.org.uk

Chadwick-Jones J.K., Nicholson N., & Brown C., (1982) *Social Psychology of Absenteeism.* Praeger Publisher, New York

Cherniss C., (1980) *Staff Burnout Job Stress in the Human Services.* Sage Publications, Inc., California

Clark A.E., & Oswald A.J., (1995) *Satisfaction and Comparison Income.* www.oswald.co.uk

Clarke M., & Stewart J., (2000) Handling the Wicked Issues. In Davies C., Finlay L. & Bullman A., (Eds.) *Changing Practice in Health & Social Care.* Sage Publications, Inc., California

Clarke S.G., & Cooper C.L., (2000) The risk management of occupational stress. *Health, Risk & Society, Vol. 2, No. 2,* 173-187

Coffey M., (2001) *Report on Healthy Work Questionnaire.* Unpublished

Coffey M., (2002) *Report on Health Work Questionnaire.* Unpublished

Coffey M., (2003) *Report on Healthy Work - Focus Group Report.* Unpublished

Coghlan D., & Brannick T., (2001) *Doing Action Research.* Sage Publications, London

Cohen J., (1992) A Power Primer. *Psychological Bulletin, Vol. 112, No. 1,* 115-159

Cohen M.B., & Garrett K.J., (1999) Breaking the Rules: A Group Work Perspective on Focus Group Research. *British Journal of Social Work, Vol. 29,* 359-372

Community Care (2003a) Knowing the Risks. *Community Care, January 9th,* www.communitycare.co.uk

Community Care (2003b) Director urges councils to joint up efforts to reduce staff shortages. *Community Care, March 6th,* www.communitycare.co.uk

Community Care (2003c) Home care case studies. *Community Care, April 24th,* www.communitycare.co.uk

Cooper C.L., (1996) Stress in the workplace. *British Journal of Hospital Medicine, Vol. 55, No. 9*

Cooper C.L., Liukkonen P.L., & Cartwright S., (1996) *Stress Prevention in the Workplace: Assessing the Costs and Benefits to Organisations.* European Foundation for the Improvement of Living and Working Conditions, Luxembourg

Cooper C.L., & Cartwright S., (1997) An intervention strategy for workplace stress. *Journal of Psychosomatic Research, Vol. 43, No. 1,* 7-16

Cooper, C.L., (2000) Introduction: A discussion about the role of negative affectivity in job stress research. *Journal of Organizational Behavior, Vol. 21,* 77

Cox T., & Cox S., (1993) *Psychosocial & Organizational Hazards at Work – Control & Monitoring.* WHO

Cox T., & Griffiths A., (1996) Assessment of Psychosocial Hazards at Work In Schabracq M.J., Winnubst J.A.M., & Cooper C.L. (Eds.) *Handbook of Work & Health Psychology.* John Wiley & Sons, Chichester

Cox T., Griffiths A., Barlowe C., Randall R., Thomson L., & Rial-Gonzalez E., (2000a) *Organisational interventions for work stress: A risk management approach.* HSE Books, Crown Copyright, Norwich.

Cox T., Griffiths A., & Rial-Gonzalez E., (2000b) *Research on Work Related Stress.* The European Agency for Safety and Health at Work. Luxembourg. http://osha.eu.int

Cox T., Randall R., & Griffiths A., (2002) *Interventions to control stress at work in hospital staff.* HSE Books, Crown Copyright, Norwich.

Cresswell T., & Firth-Cozens J., (1999) Child Protection Workers. In Firth-Cozens J., & Payne R.L. (Eds.) *Stress in Health Professionals.* John Wiley & Sons, Chichester

Daly J.I., McDonald I., & Willis E. (Eds.) (1992) *Health Care – Designs, Dilemmas, Disciplines.* Routledge, London

Daniels K., & Harris C., (2000) Work, psychological well-being and performance. *Occupational Medicine, Vol. 50, No. 5,* 304-309

Davies A., & Thomas R., (2002) *Gender & Restructuring: Managerial Roles and Identities in the Public Sector.* Cardiff Business School, Cardiff University

Davies R., (Ed) (1998) *Stress in Social Work.* Jessica Kingsley Publishers, London

DeBoer E.M., Bakker A.B., Syroit J.E., & Schaufeli W.B., (2002) Unfairness at work as a predictor of absenteeism. *Journal of Organizational Behaviour, Vol. 23, No. 2,* 181-197

DeKoning K., & Martin M., (Eds) (1996) *Participatory Research in Health: Issues & Experiences.* Zed Books, London

Denzin, N.K., (1970) *The Research Act in Sociology: The Theoretical Introduction to Sociological Methods.* Butterworth & Co. (Publishers) Ltd., London

Department of Health (2001) Social Worker Recruitment Drive Set to be a Success. *Department of Health - Press Release.*
http:/ www.doh.gov.uk/scg/workforce/pressdec2001/htm

DePoy E. & Gitlin L., (1994) *Introduction to Research: multiple strategies for health and human services.* Mosby.

DETR (1999) *Achieving Best Value through Performance Review – Department of the Environment, Transport and the Regions.* February 1999
http://www.local.dtlr.gov.uk/research/bestva~paper5/02.htm

Dewe P., Leiter M., & Cox T., (2000) Coping with work: future directions from the debates of the past. In Dewe P., Leiter M., & Cox T., (Eds.) *Coping, Health & Organisations.* Taylor & Francis, London

Dey I., (1993) *Qualitative Analysis: A user-friendly guide for social scientists.* Routledge, London

De Vaus D.A., (1996) *Surveys in Social Research,* Fourth Edition. UCL Press Ltd, London

Diamantopoulou A., (2002) Europe Under Stress. *Working Under Stress, Magazine No. 5,* http://osha.eu.ent/ew2002/

Dockery G., (1996) Rhetoric or reality? Participatory research in the National Health Service UK. In DeKoning K., & Martin M., (Eds.) *Participatory Research in Health: Issues and Experiences.* Zed Books, London

Donaldson E., (2002) Surviving Organisational Change. *Occupational Health Review, September/October 2002*

Dometrius N.C., (1992) *Social Statistics using SPSS.* Harper Collins

Dugdill L., & Springett J., (1994) Evaluation of workplace health promotion: a review. *Health Education Journal, Vol. 53,* 337-347

Dugdill L., & Springett J., (1995) Workplace health promotion programmes: towards a framework for evaluation. *Health Education Journal, Vol. 54,* 88-98

Dugdill L., (1996) *NHS staff needs assessment: A practical guide.* Health Education Authority, London

Dugdill L., (2001) *Understanding Workplace Health Promotion: Programme Development and Evaluation.* PhD Thesis

Eborall C., & Garmeson K., (2001) *Desk research on recruitment and retention in social care and social work.* Prepared for COI Communications for the Department of Health, Business and Industrial Market Research

Eisenberger R., Fasolo P., & Davis-LaMastro V., (1990) Perceived Organizational Support and Employee Diligence, Commitment, and Innovation. *Journal of Applied Psychology, Vol. 75, No. 1,* 51-59

Elfering A., Semmer N.K., Schade V., Grund S., & Boos N., (2002) Supportive Colleague, Unsupportive Supervisor: The Role of Provider-Specific Constellations of Social Support at Work in the Development of Low Back Pain. *Journal of Occupational Health Psychology, Vol. 7, No. 2,* 130-140

Elovainio M., Kivimaki M., Steen N., & Kalliomaki-Levanto T., (2000) Organizational and Individual Factors Affecting Mental Health and Job Satisfaction: A Multilevel Analysis of Job Control and Personality. *Journal of Occupational Health Psychology, Vol. 5, No. 2,* 269-277

Employers Organisation (2000) *Social Services: Sickness Absence Survey 1998 99.* Employers Organisation, London

Employers Organisation (2002) *Identifying reasons for leaving: The use of Exit Interviews and Leavers Questionnaires.* Employment Relations Unit – Human Resources Advice, September

Employers Organisation (2003) *Sickness Absence in Local Government 2001 02.* Employers Organisation, London

European Agency for Safety and Health at Work (2000) *The State of Occupational Safety and Health in the European Union a pilot study.* http://agency.osha.eu.int/publications/reports/stateofosh

European Agency for Safety and Health at Work (2002) *Working on Stress: Prevention of psychosocial risks and stress at work and in practice.* European Agency for Safety & Health at Work http://europa.eu.int

European Agency for Safety and Health at Work (2003) Consultation of the social partners on stress and its effects on health and safety at work. *OSH Mail 18 – 2003,* http://agency.osha.eu.int

European Foundation for the Improvement of Living & Working Conditions (1997) *Preventing Absenteeism in the Workplace: Research Summary.* The European Foundation http://www.eurofound.eu.int

European Foundation for The Improvement of Living & Working Conditions (2000) *European Foundation for the Improvement of Living and Working Conditions: Third European Working Conditions Survey.* http://www.eurofound.eu.int/working/healtheffects.htm

European Foundation for The Improvement of Living & Working Conditions (2003) Violence and harassment at work is on the increase. *European Foundation Press Release, 25th February.* http://www.eurofound.ie/cgi-bin/pf/pf.cgi

Evans O., & Steptoe A., (2001) Social Support at Work, Heart Rate, and Cortisol: a Self-Monitoring Study. *Journal of Occupational Health Psychology, Vol. 6, No. 4.* 361-370

Fay D., & Sonnentag S., (2002) Rethinking the Effects of Stressors: A Longitudinal Study on Personal Initiative. *Journal of Occupational Health Psychology, Vol. 7, No. 3,* 221-234

Francisco V.T., Butterfoss F.D., & Capwell E.M., (2001) Key Issues in Evaluation: Quantitative and Qualitative Methods and Research Design. *Health Promotion Practice, Vol. 2, No. 1,* 20-23

Frankland J., & Bloor M., (1999) Some issues arising in the systematic analysis of focus group materials. In Barbour R.S., & Kitzinger J., (Eds.) *Developing Focus Group Research: Politics, Theory & Practice.* Sage Publications, London

Ganster D.C. & Scaubroeck J., (1991) Work Stress and Employee Health. *Journal of Management, Vol. 17, No. 2,* 235-271

Ganster D.C., (1995) Interventions for Building Healthy Organizations: Suggestions from the Stress Research Literature. In Murphy L.R., Hurrell J.J. Jr., Sauter S.L., & Puryear-Keita G., (Eds.) *Job Stress Interventions.* American Psychological Association, Washington.

Gardner J., & Oswald A.J., (2001) *What Has Been Happening to the Quality of Workers' Lives in Britain?* www.oswald.co.uk

Gardner J., & Oswald A.J., (2002) *How Does Education Affect Mental Well-Being and Job Satisfaction?* www.oswald.co.uk

Gellatly I.R., & Lauchak A.A., (1998) Personal and Organizational Determinants of Perceived Absence Norms. *Human Relations, Vol. 51, No. 8,* 1085-1102

Geurts S.A., Scaufeli W.B., & Rutte C.G., (1999) Absenteeism, turnover intention and inequity in the employment relationship. *Work & Stress, Vol. 13, No. 3,* 253-267

Gibelman M., (2003) So How Far Have We Come? Pestilent and Persistent Gender Gap in Pay. *Social Work, Vol. 48, No. 1,* January

Gillespie N.A., Walsh M., Winefields A.H., Dua J., & Stough C., (2001) Occupational stress in universities: staff perceptions of the causes, consequences and moderators of stress. *Stress & Work, Vol. 15, No. 1,* 53-72

Goldenhar L.M., Swanson N.G., Hurrell Jnr., J.J., Ruder A., & Deddens J. (1998) Stressors and adverse outcomes for female construction workers. *Journal of Occupational Health Psychology, No 3,* 19-32

Goldenhar L.M., LaMontagne A.D., Katz T., Heaney C., & Landsbergis P., (2001) The Intervention Research Process in Occupational Safety and Health: An Overview from the National Occupational Research Agenda Intervention Effectiveness Research Team. *Journal of Occupational and Environmental Medicine (JOEM), Vol. 43, No. 7,* 616-622

Goldman K.D., & Schmalz K.J., (2001) Focus on Focus Groups! *Health Promotion Practice, Vol. 2, No. 1,* 14-19.

Gomm R., Needham G., & Bullman A., (2000) *Evaluating Research in Health and Social Care.* The Open University, published in association with Sage Publications, London

Goldman C.B., & Waldman D.A., (2000) Modeling employee absenteeism: testing alternative measures and mediated effects based on job satisfaction. *Journal of Organizational Behavior, Vol. 21,* 665-676

Griffiths A., (1999) Organizational Interventions – Facing the limits of the natural science paradigm. *Scandinavian Journal of Work, Environment & Health, Vol. 25, No. 6,* 589-596

Grosch J.W., Alterman T., Peterson M.R., & Murphy L.R., (1998) Worksite Health Promotion Programs in the U.S.: Factors Associated with Availability and Participation. *American Journal of Health Promotion, Vol. 13, No. 1,* 36-45

Hakim C., (1987) *Research Design Strategies & Choices in the Design of Social Research.* Routledge, London

Hammersley M., & Atkinson P., (1983) *Ethnography: Principles in Practice* Routledge, London

Hanisch K.A., & Hulin C.L., (1991) General Attitudes and Organizational Withdrawal: An evaluation of a Causal Model. *Journal of Vocational Behavior, Vol. 39,* 110-128

Hardwidge C., (2002) Jobs in the Public and Private Sector. *Economic Trends, No. 583,* June 2002

Harper S., (2002) Common sense about stress. *General Insurance,* May/Early Summer

Harrell A., Burt M., Hatry H., Rossman S., Roth J., & Sabol W., (1996) *Evaluation Strategies for Human Service Programs: A Guide for Policymakers and Providers.* The Urban Institute, Washington D.C. http://www.bja.evaluationwebsite.org/html/documents/evaluation_strategies_p3_7.html

Harrison D.A., & Shafer M.A., (1994) Comparative Examinations of Self-Reports and Perceived Absenteeism Norms: Wading Through Lake Wobegon. *Journal of Applied Psychology, Vol. 79, No. 2,* 240-251

Hart E., & Bond M., (1995) *Action research for health and social care: A guide to practice.* Open University Press, Buckingham

Health Education Authority (1999) *Telling it like it is: Two workplace health case studies.* Health Education Authority, London www.hea.org.uk

HELA (2000) Sick Building Syndrome. *Local Authority Circular,* September, Health & Safety Executive Local Authorities Enforcement Liaison Committee (HELA) www.hse.gov.uk/lau/lacs 75-1.htm

Henderson N.R., (1995) A Practical Approach to Analyzing and Reporting Focus Group Studies: Lessons from Qualitative Market Research. *Qualitative Health Research, Vol. 5, No. 4,* 463-477

Hendrix W.H., Robbins T., Miller J., & Summers T.P., (1999) Effects of Procedural and Distributive Justice on Factors Predictive of Turnover. *Journal of Social Behavior and Personality, Vol. 13, No.4,* 611-632

HMSO (1995) *Disability Discrimination Act 1995.* Chapter 50, http:/ www.hmso.gov.uk/acts acts1995/1995050.htm Crown Copyright 1995

Holter I.M., & Schwartz-Barcott D., (1993) Action Research: what is it? How has it been used and how can it be used in nursing? *Journal of Advanced Nursing, Vol. 18,* 298-304

HSC (2002) *Health & Safety Statistics Highlights 2001 02.* Health & Safety Commission, HSE books, Sudbury, http://www.hse.gov.uk/statistics/overpic.htm

HSE (1999) Economic Impact: Revised data from the self-reported work-related illness survey in 1995 (SW195). *HSE Information sheet: 2/99/EMSU.* http://www.hse.gov.uk/statistics/2002/ecimpact.pdf

HSE (2000a) *The Scale of Occupational Stress: the Bristol Stress and Health at Work Study.* Health & Safety Executive, Contract Research, Report 265, http://www.hse.gov.uk/research/crr_pdf/2000/crr00265.pdf

HSE (2000b) Secondary analysis of the 1995 Self-reported Work-related Illness survey (SW195). *Information sheet: 4/00/EMSU* http://www.hse.gov.uk/statistics/2002/secan95.pdf

HSE (2000c) HSE publishes new research on occupational stress. *HSE Press Release E080:00* – 18th May. http://www.hse.gov.uk/press/e00080.htm

HSE (2001) Achieving the Revitalising Health and Safety Targets: Statistical Note on Progress Measurement. *Epidemiology and Medical Statistics Unit and Economic and Statistical Analysis Unit, June 2001* http://www.hse.gov.uk/statistics/statnote.pdf

HSE (2002a) *Priority Programme Plan Work related stress (year one, 2001-02).* Health & Safety Executive http: www.hse.gov.uk/research

HSE (2002b) *Interventions to control stress at work in hospital staff.* Health & Safety Executive, Contract Research Report 435/2002

HSE (2002c) Occupational Stress Statistics. *Information sheet: 4/02/EMSU:* December http: www.hse.gov.uk/research

HSE (2002d) *Health & Safety Statistics Highlights 2001 02.* http: www.hse.gov.uk/statistics overall/hssh0102.pdf

HSE (2004) Work Related Stress. *Stress Home Page* http: www.hse.gov.uk/stress index.htm

Hugentobler M.K., Israel B.A., & Schurman S.J., (1992) An Action Research Approach to Workplace Health: Integrating Methods. *Health Education Quarterly, Vol. 19, No. 1,* 55-76

Hulscher M.E.J.L., Laurant M.G.H., & Grol R.P.T.M., (2003) Process evaluation on quality improvement interventions. *Quality & Safety in Health Care, Vol. 12, No. 1,* 40-46

Hurrell J.J. Jr., & Murphy L.R., (1996) Occupational Stress Intervention. *American Journal of Industrial Medicine, Vol. 29,* 338-341

Hurrell J.J. Jr., Nelson D.L., & Simmons B.L., (1998) Measuring Job Stressors and Strains: Where We Have Been, Where We Are and Where We Need to Go. *Journal of Occupational Health Psychology, Vol. 3, No. 4,* 368-389

Institute of Work Psychology (2003) *ESCR Centre for Organisation and Innovation Guidelines.* http://www.shef.ac.uk/~iwp/current_research/coi/team.html#strat

International Labour Organinization (2000) Developing a workplace stress prevention programme. In *Focus Programme on Safety and Health at Work and the Environment* http://www.ilo.org

International Labour Organisation (2001) *Safework: What is workplace stress?* www.ilo.org/public/english/protection/safework/stress/whatis.htm

ISMA (2000) New technology not to blame as stress figures soar. *ISMA News Release, National Stress Awareness Day,* Wednesday 1st November

Israel B.A., Cummings K.M., Dignan M.B., Heaney C.A., Perales D.P., Simmons-Morton B.G., & Zimmerman M.A., (1995) Evaluation of Health Education Programs: Current Assessment and Future Directions. *Health Education Quarterly, Vol. 22, No. 3,* 364-389

Ivancevich J.M., & Matteson M.T., (1988) Application of the Triangulation Strategy to Stress Research. In Hurrell J. Jr., Sauter S.L., & Cooper C.L., (Eds.) *Occupational Stress Issues & Development in Research.* Taylor Francis, London

Jackson S.E., (1983) Participation in Decision Making as a Strategy for Reducing Job-Related Strain. *Journal of Applied Psychology, Vol. 58, No. 1,* 3-19

James P., Cunningham I., & Dibben P., (2002) Absence management and the issues of job retention and return to work. *Human Resource Management Journal, Vol.12, No. 2,* 82-94

Jex S.M., & Beehr T.A., (1991) Emerging Theoretical and Methodological Issues in the Study of Work-Related Stress. *Research in Personnel and Human Resources Management, Vol. 9,* 311-365

Jinks A.M., & Daniels R., (1999) Workplace health concerns: a focus group study. *Journal of Management in Medicine, Vol. 13, No. 2,* 95-104

Johns G., (1994) How Often Were You Absent? A Review of the Use of Self-Reported Absence Data. *Journal of Applied Psychology, Vol. 79, No. 4,* 574-591

Johns G., & Zie J.L., (1998) Perceptions of Absence from Work: People's Republic of China Versus Canada. *Journal of Applied Psychology, Vol. 83, No. 4,* 515-530

Joint Reviews (2000) *People Need People: Realising the potential of people working in social services.* Social Services Inspectorate & Audit Commission, October, http://www.joint-reviews.gov.uk/pdfs/peoppeop.pdf

Jones C., (2001) Voices from the Front Line: State Social Workers and New Labour. *British Journal of Social Work, Vol. 31,* 547-562

Jones F., Fletcher B (C), & Ibbetson K., (1991) Stressors and Strains amongst Social Workers: Demands, Supports, Constraints, and Psychological Health. *British Journal of Social Work, Vol. 21,* 443-469

Jones F., & Fletcher B (C), (1996) Job Control & Health. In Schabracq M.J., Winnubst J.A.M., & Cooper C.L., (Eds.) *Handbook of Work & Health Psychology.* John Wiley & Sons, Chichester

Judge T.A., Erez A., & Thoresen C.J., (2000) Why negative affectivity (and self-deception should be included in job stress research: bathing the baby with the bath water. *Journal of Organizational Behavior, Vol. 21,* 101-111

Karasek R., Brisson C., Kawakami N., Houtman I., Bongers P., & Amick B., (1998) The Job Content Questionnaire (JCQ): An Instrument For Internationally Comparative Assessments of Psychosocial Job Characteristics. *Journal of Occupational Health Psychology, Vol. 3, No. 4,* 322-355

Karlsen J.I., (1991) Action Research as Method: Reflections from a Program for Developing Methods and Competence. In W.F. Whyte (Ed.) *Participatory Action Research.* Sage publications, London

Kenny L.J., Dugdill L., & Springett J., (1998) *Doing Evaluation: A Framework for Action.* Institute of Health, Liverpool John Moores University

Kidd P.S., & Parshall M.B., (2000) Getting the Focus and the Group: Enhancing Analytical Rigor in Focus Group Research. *Qualitative Health Research, Vol. 10, No. 3,* 293-308

Kinsey R., (1998) Report Writing Without Guilt in Analyzing & Reporting Focus Group Results. In Kreuger E.A., (Ed.) *Focus Group Kit 6.* Sage Publications Inc., California

Kish L., (1979) Some Statistical Problems in Research Design. In Bynner J., & Stribley K.M., (Eds.) *Social Research: Principles and Procedures.* Longman

Kitzinger J., (1994) The methodology of Focus Groups: the importance of interaction between research and participants. *Sociology of Health & Illness, Vol. 16, No. 1,* 101-121

Kitzinger J., (1999) The challenge and promise of focus groups. In Kitzinger J., & Barbour R.S., (Eds.) *Developing Focus Group Research: Politics, Theory and Practice.* Sage Publications, London

Kitzinger J., & Barbour R.S., (Eds.) (1999) *Developing Focus Group Research: Politics, Theory and Practice.* Sage Publications, London

Kivimaki M., Vahtera J., Thompson L., Griffiths A., & Cox T., (1997) Psychosocial Factors Predicting Employee Sickness Absence during Economic Decline. *Journal of Applied Psychology, Vol. 82, No. 6,* 858-872

Kompier M.A.J., (1996) Job Design and Well-Being. In Schabracq M.J., Winnubst J.A.M., & Cooper C.L., (Eds.) *Handbook of Work & Health Psychology.* John Wiley & Sons

Kompier M.A.J., Guerts S.A.E., Grundemann R.W.M., Vink P., & Smulders P.G.W., (1998) Cases in Stress Prevention: The success of a Participative and Stepwise Approach. *Stress Medicine, Vol. 14,* 155-168

Kompier M.A.J., Cooper C.L., & Guerts S.A.E., (2000) A multiple case study approach to work stress prevention in Europe. *European Journal of Work and Organizational Psychology, Vol. 9, No. 3,* 371-400

Kreuger R.A., (1998) Analyzing & Reporting Focus Group Results. *Focus Group Kit 6.* Sage Publications, Inc., California

Krippendorff K., (1980) *Content Analysis: An Introduction to Its Methodology.* Vol. 5, The Sage COMMTEXT series. Sage Publications, USA

Kristensen T.S., (1995) The Demand-Control-Support Model: Methodological Challenges for Future Research. *Stress Medicine, Vol. 11,* 17-26.

Kristensen, T.S., (2000) Workplace intervention studies. *Occupational Medicine: State of the Art Reviews, Vol. 15, No. 1,* 293-305

Kuhn K., (2002) Managing stress by promoting health. *Working on Stress Magazine of the European Agency for Safety & Health at Work, No. 5* http://europa.eu.int

Kutek A., (1998) No Health, No Service... In Davies R., (Ed.) *Stress in Social Work.* Jessica Kingsley Publishers, London

Landsbergis P.A., & Cahill J., (1994) Labor union programs to reduce or prevent occupational stress in the United States. *International Journal of Health Services, Vol. 24, No. 1,* 105-129

Landsbergis P.A., Schnall P.A., Deitz D.K., Warren K., Pickering T.G., & Schwartz J.E., (1998) Job Strain and Health Behaviours: Results of a Prospective Study. *American Journal of Health Promotion Vol. 12, No. 4,* 237-245

Landsbergis P.A., Cahill J., & Schall P., (1999) The impact of lean production and related new systems of work organization on worker health. *Journal of Occupational Health Psychology, Vol. 4,* 108-130

Lawler J., & Hearn J., (1995) UK public sector organizations: The rise of managerialism and the impact of change on social services departments. *International Journal of Public Sector Management, Vol. 8, No. 4,* 7-19

Leontaridi R.M., & Ward M.E., (2002) Work-Related Stress, Quitting Intentions and Absenteeism. *IZA Discussion Paper No. 493,* May 2002. Institute for the Study of Labor, Germany

Lepore S.J., (1998) Problems and Prospects for the Social Support-Reactivity Hypothesis. *Annals of Behavioral Medicine, Vol. 20, No. 4,* 257-269

Levi L., & Levi I., (2000) *Guidance on work-related stress "Spice of Life – or Kiss of Death?"* European Commission, Directorate-General for Employment & Social Affairs http://europa.eu.int/comm/employment_social/h&s/publicat/pubintro_en.htm

Levi L., (2002) The European Commission's Guidance on work-related stress: from words to action. *TUTB Newsletter No. 19-20,* September http://www.europa.eu.int/comm/employment_social /h&s/publicat/pubintro_en.htm

Li C., & Wearing B., (2002) Between glass ceilings: female non-executive directors in UK quoted companies. *Working Paper No. 02/02* http://www.essex.ac.uk/AFM/research/working_papers/WP02-02.pdf

Loewenson R., Laurell A.C., & Hogstedt C., (1999) Participatory Approaches in Occupational Health Research. In Daykin N., & Doyal L., (Eds) *Health and Work: Critical Perspectives.* Macmillan Press Ltd., Basingstoke

Mikkelsen A., Saksvik P.O., & Landsbergis P., (2000) The impact of a participatory organizational intervention on job stress in community health care institutions. *Work & Stress, Vol. 14, No. 2,* 156-170

Mitchell K., & Branigan P., (2000) Using focus groups to evaluate health promotion interventions. *Health Education, Vol. 100, No. 6,* 261-268

MacDougall C., & Fudge E., (2001) Planning and Recruiting the Sample for Focus Groups and In-Depth Interviews. *Qualitative Health Research, Vol. 11, No. 1,* 117-126

McLean J., (1999) Satisfaction, stress and control over work. In Balloch S., McLean J., & Fisher M., (Eds.) *Social Services: Working under pressure.* Policy Press, Bristol

McLean J., & Andrew T., (2000) Commitment, Satisfaction, Stress and Control Among Social Services Managers and Social Workers in the UK. *Administration in Social Work, Vol. 23, No 3 4,* 93-117

Morgan D.L., (1997) Focus Groups as Qualitative Research. 2nd Edn., *Qualitative Research Methods Series 16,* A Sage University Paper, Sage Publications Inc., California

Morris L., (2003) Research into practice. *Community Care,* 12th June, www.communitycare.co.uk

Mullarkey S., Wall T.D., Warr P.B., Clegg C.W., & Stride C., (1999) *Measures of Job Satisfaction, Mental Health and Job-Related Well-Being A Bench-Marking Manual.* Sheffield: Institute of Work Psychology

Murphy L.R., (1999) Organisational Interventions to reduce stress in Health Care Professionals. In Firth-Cozens J., & Payne R.L., (Eds.) *Stress in Health Professionals.* (Eds) John Wiley & Sons Ltd., Chichester

Murphy L.R., & Cooper C.L., (2000) Models of health work organizations. In Murphy L.R., & Cooper C.L., (Eds.) *Healthy and Productive Work: An international perspective.* Taylor & Francis, London

Myers G., & Macnaghten P., (1999) Can focus groups be analysed as talk? In Barbour R.S., & Kitzinger J., (Eds.) *Developing Focus Group Research: Politics, Theory & Practice.* Sage Publications, London

Neidhammer I., Bugel I., Goldberg M., Leclerc A., & Gueguen A., (1998) Psychosocial factors at work and sickness absence in the Gazel cohort: a prospective study. *Occupational Environment Medicine, Vol. 55,* 735-741

NIOSH (1999) *Stress at Work.* National Institute for Occupational Safety & Health http://www.cdc.gov/niosh/atwork.html

North F.M., Leonard-Syme S., Feeney A., Shipley M., & Marmot M., (1996) Psychosocial Work Environment and Sickness Absence among British Civil Servants: The Whitehall II Study. *American Journal of Public Health, Vol. 86,* No. 3.

Nutbeam D., (1998) Evaluating health promotion – progress, problems and solutions. *Health Promotion International, Vol. 13, No. 1,* 27-44

Nutbeam D., (1999) The challenge to provide 'evidence' in health promotion. *Health Promotion International, Vol. 14, No. 2,* 99-101

Nytro K., Saksvik P.O., Mikkelsen A., Bohle P., & Quinlan M., (2000) An appraisal of key factors in the implementation of occupational stress interventions. *Work & Stress, Vol. 14, No. 3,* 213-225

OHR (1999) The Language of Absence - OHR editorial. *Occupational Health Review,* January/February

Oppenheim A.N., (1992) *Questionnaire Design, Interviewing and Attitude Measurement.* New Edition. Printer Publishers Ltd (first published in 1966 by Basic Books Inc.)

Oswald J., (2002) *London's Public-Sector Workers Need to be Paid 50% More Than Those in the North.* www.oswald.co.uk

Parker S.K., & Williams H.M., (2001) *Effective Teamworking: reducing the psychosocial risks.* Case studies in practitioner format, Health & Safety Executive, HSE books, Sudbury

Parkes K.R. & Sparkes T.J., (1998) *Organizational interventions to reduce work stress: are they effective? A review of the literature.* HSE Books, Crown Copyright, Sudbury

Parry-Langdon N., Bloor M., Audrey S., & Holliday J., (2003) Process evaluation of health promotion interventions. *Policy & Politics, Vol. 31, No. 2,* 207-216

Pay & Workforce Research (2003) *'NHS & Local Government Employees are the most stressed'.* – 13th March www.payandwork.co.uk

Payne R.L., (1999) Stress at work: a conceptual framework. In Firth-Cozens J., & Payne R.L. (Eds.) *Stress in Health Professionals: Psychological and Organisational Causes and Interventions.* John Wiley & Sons, Inc., New York

Payne R.L., & Morrison D., (1999) The Importance of knowing the affective meaning of Job Demands revisited. *Work & Stress Vol. 13, No. 3,* 280 – 288

Payne R.L., (2000) Comments on 'Why negative affectivity should not be controlled in job stress research: don't throw out the baby with the bath water. *Journal of Organizational Behavior, Vol. 21,* 97-99

Penna S., Paylor I., & Soothill K., (1996) *Job Satisfaction and Dissatisfaction: A study of residential care work.* National Institute for Social Work, London.

Perakyla A., (1997) Reliability and Validity in Research Based on Tapes and Transcripts. In Silverman D., (Ed.) *Qualitative Research: Theory, Method and Practice.* Sage Publications, London

Platt S., Pavis S., & Ankram G., (1999) *Changing labour market conditions and health: A systematic literature review (1993-98).* European Foundation for the improvement of living and working conditions, Dublin. http://www.eurofound.ie

Postle K., (2002) Working 'Between the Idea and the Reality': Ambiguities and Tensions in Care Managers' Work. *British Journal of Social Work, Vol. 32,* 335-351

Pousette A., & Hanse J.J., (2002) Job characteristics as predictors of ill-health and sickness absenteeism in different occupational types – a multigroup structural equation modelling approach. *Work & Stress, Vol. 16, No. 3,* 229-250

Powell R.A., & Singla H.M., (1996) Methodology Matters-V: Focus Groups. *International Journal for Quality in Health Care, Vol. 8, No. 5,* 499-504

Rausch M.J., (1998) Analyzing and Reporting Focus Group Results in Analyzing & Reporting Focus Group Results. In Krueger E.A. (Ed.) *Focus Group Kit 6.* Sage Publications Inc., California

Raymond C., (2000) Stress – The Real Millenium Bug. *Stress News, October 2000, Vol. 12, No. 4,* http://www.isma.org.uk/stressnews.htm

Reed J., & Payton Roskell V., (1997) Focus groups: issues of analysis and interpretation. *Journal of Advanced Nursing, Vol. 26, 765-771*

Rees C.J. & Redfern D., (2000) Recognising the perceived causes of stress – a training and development perspective. *Industrial & Commercial Training, Vol. 32, No. 4,* 120-127 http://www.emerald-library.com

Research Works Ltd. (2001) *Perceptions of Social Work and Social Care.* Prepared for COI Communications on behalf of the Department of Health. J.946, COI ref J 4876. London. all@researchworks.co.uk

Richardson V.,(2000) Teeth damaged by daily grind. *The Guardian,* Thursday 27th January

Rick J., & Briner R.B., (2002) Psychosocial risk assessment: Problems and prospects. *Occupational Health Review,* September/October

Ritchie K.A.,& McEwen J., (1994) Employee perceptions of workplace health and safety issues. Can a questionnaire contribute to health needs assessment? *Occupational Medicine, Vol. 44,* 77-82

Rubin H.J., & Rubin I.S., (1995) *Qualitative Interviewing: The Art of Hearing Data.* Sage Publications Inc., Thousand Oaks, London.

Sagie A., (1998) Employee Absenteeism, Organizational Commitment, and Job Satisfaction: Another Look. *Journal of Vocational Behaviour, Vol. 52,* 156-171

Saksvik P.O., Nytro K., Gensen C.D.-J. & Mikkelsens A., (2002) A process evaluation of individual and organizational occupational stress and health interventions. *Work and Stress, Vol. 16, No. 1,* 37-57

Sanders K., & Hoekstra S.K., (1998) Informal Networks and Absenteeism within an Organisation. *Computational & Mathematical Organization Theory, Vol. 4, No. 2,* 163(15).

Schifferes S., (2002) Why unions are militant. *BBC News Online,* 10th September, http://news.bbc.co.uk/1/low/business/2248045.stm

Schnall P.L., Landsbergis P.A., & Baker D., (1994) Job Strain and Cardiovascular Disease. *Annual Review of Public Health. Vol. 15,* 381-411. Annual Reviews Inc.

Schurman S.J., & Israel B., (1995) Redesigning Work Systems to Reduce Stress: A Participatory Action Research Approach to Creating Change. In Lawrence R., Murphy J., Hurrell J.R., Sauter S.L., & Puryear -Keita G., (Eds.) *Job Stress Interventions.* American Psychological Association, Washington

Senior K., (2001) Should stress carry a health warning? *The Lancet, Vol. 357, No. 9250,* www.thelancet.com

Shannon H.S., Robson L.S., & Sale J.E.M., (2001) Creating Safer and Healthier Workplaces: Role of Organizational Factors and Job Characteristics. *American Journal of Industrial Medicine, Vol. 40,* 319-334

Shaughnessy J.J., & Zechmeister E.G., (1990) *Research Methods in Psychology.* 2nd Edn., McGraw Publishing Company

Shipley P., & Orlans V., (1988) Stress Research: An Interventionist Perspective. In Hurrell J. Jr., Sauter S.L., & Cooper C.L., (Eds.) *Occupational Stress – Issues & Development in Research.* Taylor Francis, London

Sloan R.P., & Gruman J.C., (1988) Participating in Workplace Health Promotion Programs: The Contribution of Health and Organizational Factors. *Health Education Quarterly, Vol. 15, No. 3,* 269-288

Smith A., Brice C., Collins A., Matthews V., & McNamara R., (2000a) *The Scale of Occupational Stress: A further analysis of the impact of demographic factors and type of job.* HSE http://www.hse.gov.uk/research/crr_pdf/2000/crr00311pdf

Smith A., Davey- Smith G., Harvey I., Johal S., & Wadsworth E., (1998) The scale of occupational stress. *Occupational Health Review,* May/June

Smith A., Johal S., Wadsworth E., Smith G.D., & Peters T.,(2000b) *The scale of occupational stress: The Bristol Stress and Health at Work Study.* HSE Books, Her Majesty's Stationery Office, Norwich

Smith A., (2000) The scale of perceived occupational stress. *Occupational Medicine, Vol. 50, No. 5,* 294-298

Smith A., (2001) Perceptions of stress at work. *Human Resource Management Journal, Vol. 11, No. 4,* 74-86

Smith J., (1998a) An Employer's guide to Stress at Work Litigation (part one of a two-part article). *Stress News, July 1998, Vol. 10, No. 3,* http: www.isma.org.uk/stressnews.htm

Smith J., (1998b) Organisational Stress and Employee well-being: new perspectives' *Stress News, April, Vol. 10, No. 2,* http://www.isma.org.uk/stressnews.htm

Smulders P.G.W., & Nijhuis F.J.N., (1999) The Job Demands-Job Control Model and absence behaviour: results of a 3-year longitudinal study. *Work & Stress, 1999, Vol. 13, No. 2,* 115-131

Spector P.E., Dwyer D.J., & Jex S.M., (1988) Relation of Job Stressors to Affective, Health, and Performance Outcomes: A Comparison of Multiple Data Sources. *Journal of Applied Psychology, Vol. 73, No. 1,* 11-19

Spector P.E., & Jex S.M., (1998) Development of Four Self-Report Measures of JobStressors and Strain: Interpersonal Conflict at WorkScale, Organizational Constraints Scale, QuantitativeWorkload Inventory and Physical Symptoms Inventory. *Journal of Occupational Health Psychology Vol. 3, No.4,* 356-367

Spector P.E., Zapf D., Chen P.Y., & Frese M., (2000) Why negative affectivity should not be controlled in job stress research: don't throw out the baby with the bath water. *Journal of Organizational Behavior, Vol. 21,* 79-95

Spector P.E., (2002) Employee Control and Occupational Stress. *Current Directions in Psychological Science, Vol. 11, No. 4, August,* 133-136

Springett J., & Dugdill L., (1999) *Health promotion programmes and policies in the workplace: a new challenge for evaluation.* WHO, European Health Promotion Series, 7

Springett J., (2001) Appropriate approaches to the evaluation of health promotion. *Critical Public Health, Vol. 11, No. 2,* 139-151

Spurgeon P., & Barwell F., (1995) The quality of working life: occupational stress, job-satisfaction and well-being at work. In Bamford M., (Ed.) *Work & Health – An Introduction to Occupational Health Care.* Chapman & Hall

Spurgeon P., & Cooper C.L., (2001) *Working Time, Health and Performance in Well-being in Organizations: A reader for Students and Practitioners.* Cooper C.L., & Robertson I.T., (Eds.) John Wiley & Sons, Ltd., Chichester

Stansfeld S.A., Rael E.G.S., Head J., Shipley M., & Marmot M., (1997) Social support and psychiatric sickness absence: a prospective study of British civil servants. *Psychological Medicine, Vol. 27,* 35-48

Steers R.M., & Rhodes S.R., (1978) Major Influences on Employee Attendance: A Process Model. *Journal of Applied Psychology, Vol. 63, No. 4,* 391-407

Stevenson D., (2000) Stress the new 'British Disease'? *Health Education Journal, Vol. 12, No. 12*

Stewart D.W., & Shamdasani P.N., (1990) *Focus Groups: Theory & Practice.* Sage Publications, Inc., California

Storey J., & Billingham J., (2001) Occupational stress and social work. *Social Work Education, Vol. 20, No.6,* 659-670

Sutherland V.J., & Cooper C.L., (2000) *Strategic Stress Management: An organizational approach.* Macmillan Press Ltd., Basingstoke

Tashakkori A., & Teddlie C., (1998) *Mixed Methodology – Combining Qualitative and Quantitative Approaches.* Sage Publications, Thousand Oaks, London

Taylor A., (2000) Working till you drop. *Community Care,* 24th August, www.communitycare.co.uk

Terra N., (1995) The Prevention of Job Stress by Redesigning Jobs and Implementing Self-Regulating Teams. In Murphy L.R., Hurrell J.J. Jr., Sauter S.L., Puryear-Keita G., (Eds.) *Job Stress Interventions.* American Psychological Association, Washington

Terry D.J., & Callan V.J., (2000) Employee adjustment to an organizational change: a stress and coping perspective. In Dewe P., Leiter M., & Cox T., (Eds.) *Coping Health & Organisations.* Taylor & Francis, London

Terry D.J., & Jimmieson N.L., (2001) Work Control and Employee Well-being: A Decade Review. In Cooper C.L., & Robertson I.T., (Eds.) *Well-being in Organizations: A reader for Students and Practitioners.* (Eds) John Wiley & Sons, Ltd, Chichester

The Guardian (2002) *Campaign to recruit social workers is acclaimed success.* Wednesday, January 2nd

The Sainsbury Centre For Mental Health (2000) *Finding and Keeping: Review of recruitment and retention in the mental health workforce.* The Sainsbury Centre for Mental Health, London www.sainsburycentre.org.uk

Theorell T., (1999) How to deal with stress in organizations? – a health perspective on theory and practice. *Scandanaian Journal of Work, Environment and Health, Vol. 26, No. 6 (special issue),* 616-624

TUC (1999) *Violent Times: TUC report on preventing violence at work.* TUC Health & Safety Unit

Tudor O., (2002) Stress in Great Britain. *TUTB Newsletter, No. 19-20,* September

Ugon D.A., (2000) *Bibliography on the links between stress, violence, drug abuse, alcohol and tobacco in the workplace*
http: www.ilo.org public english/protection/safework/whpwb/biblio.pdf

Unison (2001) *Homecare: the forgotten service. Report on Unison's survey of Home Care Workers in the UK.* Written & researched by Mick Taylor, Consultant, Gowland Taylor Associates

U.S. Environmental Protection Agency (1999) *Indoor Air Facts No. 4 (revised): Sick Building Syndrome (SBS).* Office of Radiation & Indoor Air (6609J) April http://www.epa.gov/iaq/pubs/sbs.html

Van der Doef M., & Maes S., (1999) The Job Demand-Control(-Support) Model and psychological well-being: a review of 20 years of empirical research. *Work & Stress Vol. 13, No. 2* 87-114.

Van der Hek H., & Plomp H.N., (1997) Occupational stress management programmes: a practical overview of published effect studies. *Occupational Medicine, Vol. 47, No. 3,* 133-141

Van Poppel M.N.M., De Vet H.C.W., Koes B.W., Smid T., & Bouter L.M., (2002) Measuring sick leave: a comparison of self-reported data on sick leave and data from company records. *Occupational Medicine 52,* 485-490

Van Vegschel N., De Jonge J., Teijer T., & Hamers J.P.H., (2001) Different effort constructs and effort-reward imbalance: effects on employee well-being in ancillary health care workers. *Journal of Advanced Nursing, Vol. 31, No. 1,* 128-136

Wang J., & Patten S.B., (2001) Perceived Work Stress and Major Depression in the Canadian Employed Population, 20-49 Years Old. *Journal of Occupational Health Psychology, Vol. 6, No. 4,* 283-289

Warr P.B., (1987a) *Psychology at Work.* Third Edition, Penguin books

Warr P.B. (1987b) *Work, Unemployment and Mental Health.* Oxford University Press, Oxford

Waterson J., (2000) Balancing Research and Action: Reflections on an Action Research Project in a Social Services Department. *Social Policy & Administration, Vol. 34, No. 4,* 404-508

Whitehead D., Taket A., & Smith P., (2003) Action research in health promotion. *Health Education Journal, Vol. 62, No. 1,* 5-22

Wilkinson S., (1998) Focus Groups in Health Research: Exploring the Meanings of Health and Illness. *Journal of Health Psychology, Vol. 3(3),* 329-348

Wimbush E., & Watson J., (2000) An Evaluation Framework for Health Promotion: Theory, Quality and Effectiveness. *Evaluation, Vol. 6, No. 3,* 301-321

Winter R., & Munn-Giddings C., (2001) *A Handbook for Action Research in Health and Social Care.* Routledge, London

Xie J.L., & Johns G., (2000) Interactive effects of absence culture salience and group cohesiveness: A multi-level and cross-level analysis of work absenteeism in the Chinese Community. *Journal of Occupational and Organizational Psychology, Vol. 7, No. 1,* 31-52.

Zapf D., Seifert C., Schmutte B., Mertini H., & Holz M., (2001) Emotion work and job stressors that their effects on burnout. *Psychology and Health, Vol. 16,* 527-545

Job Descriptions for Social Care Staff

Dear M/s Coffey,

Please see the reply I received from our social care group reproduced below. This was in response to a similar question I received a while a go but would appear to be relevant to your request. The websites will have been updated since with the most recent information and publications.

"With regards to the enquiry that you have received about job descriptions and linked qualifications for social care staff, there are no set job descriptions for staff in social care in England - although some of the work done by certain staff is laid down by statute eg Approved Social Workers.

However, there are presently some national occupational standards for certain tasks that are undertaken in care (which are the basis of the NVQs for Care, Caring for Children and Young People, Promoting Independence and the Registered Managers (Adults) award) and these are increasingly being used as the basis of job descriptions. TOPSS are presently involved in developing additional national occupational standards for other areas of social care work (eg mental health).

The Training Strategy for Social Care Workers in England that TOPSS has produced, starts to outline the training and qualifications that staff need to undertake in order to do certain tasks. A copy of this document can be found on the TOPSS website: "www.topss.org.uk".

DH has also started to specify certain qualifications for some staff as can be seen in the Training Support Programme Grant 2001/02 Circular. A copy of this can be found on the DH website at: "www.doh.gov.uk/scg/training.htm".

The Care Standards Act 2000 is also the basis of legislation which includes the need for social care staff to undertake training and qualifications. Both the General Social Care Council (GSCC) and the National Care Standards Commission (NCSC) have been set up as a result of this Act. The GSCC will be bringing in registration for social care staff and this will be linked to particular qualifications.

The NCSC is producing National Minimum Standards for different care services which it will use for registration and inspection and these include standards on training and qualifications. Further information about both the NCSC and the GSCC can be found on the DH website at "www.doh.gov.uk/ncsc" and "www.doh.gov.uk/gscc"(I believe their website address has now changed to www.gscc.org.uk)."

I hope you find this helpful.

If you have any further query please contact me again.

David Ainsley
DoH
020 7972 5596

Healthy Work Questionnaire

APPENDIX 2

1. Are you male or female ☐ Male ☐ Female

2. What age are you? ☐ Years

3. How long have you been working for this organisation? ☐ Years

4. Do you have dependants (outside work) whom you are responsible for? ☐ Yes ☐ No

   If you have ticked yes, please state whether they are:

   Children under 12 ☐
   Adolescent children (13 or over) ☐
   Other (adults elderly relative etc.) ☐

5. What is the highest level of education that you have completed?

   No formal schooling or primary school ☐
   Completed secondary school ☐
   College or university ☐

6. Do you work full or part time? ☐ Full Time ☐ Part time

   How many hours is this per week? (include hours for all posts) Hours ☐

   Do you work flexitime? Yes ☐ No ☐

   Does this involve: day shifts only? ☐

   other shifts? ☐
   (please state which kind of shift) _____

7. Which group do you work with?

   Adult Assessment & Care Management ☐
   Adult Services Provision ☐
   Children & Families ☐
   Directorate & Support Services ☐
   (which includes: Central Service Pol Staff Pub. In Central Service Finance & Information Directorate, and Inspection & Quality Control)

8. Are you a Former Manual worker? ☐ A Former APT&C? ☐ Or other? ☐ please state) _____

9. How do you usually travel to work (public transport/car on foot/motorcycle/bicycle other), please state

   _____

   How long does it usually take you to travel to work each day?

   Less than 15 minutes ☐ Between 15 and 30 minutes ☐

   30 minutes to 1 hour ☐ More than 1 hour ☐

10. **Job Demands** (JCQ Karasek 1985)

	Strongly Disagree	Disagree	Agree	Strongly Agree
My job requires working very fast	☐	☐	☐	☐
My job requires working very hard	☐	☐	☐	☐
I am not asked to do an excessive amount of work	☐	☐	☐	☐
I have enough time to get the job done	☐	☐	☐	☐
I am free from conflicting demands that others make	☐	☐	☐	☐
My job requires long periods of intense concentration	☐	☐	☐	☐
My tasks are often interrupted before they can be completed, requiring attention at a later time	☐	☐	☐	☐
My job is very hectic	☐	☐	☐	☐
Waiting on work from other people or departments often slows me down in my job.	☐	☐	☐	☐

11. **Decision Authority**

My job allows me to make a lot of decisions on my own	☐	☐	☐	☐
On my job, I have very little freedom to decide how I do my own work	☐	☐	☐	☐
I have a lot of say about what happens on my job	☐	☐	☐	☐

12. **Skill Discretion**

My job requires that I learn new things	☐	☐	☐	☐
My job involves a lot of repetitive work	☐	☐	☐	☐
My job requires me to be creative	☐	☐	☐	☐
My job requires a high level of skill	☐	☐	☐	☐
I get to do a variety of different things in my job	☐	☐	☐	☐
I have an opportunity to develop my own special abilities	☐	☐	☐	☐

13. **Supervisor Support**

	I have no Supervisor	Strongly Disagree	Disagree	Agree	Strongly Agree
My supervisor is concerned about the welfare of those under him her	☐	☐	☐	☐	☐
My supervisor pays attention to what I am saying	☐	☐	☐	☐	☐
I am exposed to hostility or conflict from my supervisor	☐	☐	☐	☐	☐
My supervisor is helpful in getting the job done	☐	☐	☐	☐	☐
My supervisor is successful in getting people to work together	☐	☐	☐	☐	☐

14. **Coworker Support**

	Strongly Disagree	Disagree	Agree	Strongly Agree
People I work with are competent in doing their jobs	☐	☐	☐	☐
People I work with take a personal interest in me	☐	☐	☐	☐
I am exposed to hostility or conflict from the people I work with	☐	☐	☐	☐
People I work with are friendly	☐	☐	☐	☐
The people I work with encourage each other to work together	☐	☐	☐	☐
People I work with are helpful in getting the job done	☐	☐	☐	☐

15. **How often do you find it difficult or impossible to do your job because of:**
(OCS Paul L Spector and Steve M Jex 1997)

	Less than once per month or never	Once or twice per month	Once or twice per week	Once or twice per day	Several times per day
Poor equipment or supplies	☐	☐	☐	☐	☐
Organisational rules and procedures	☐	☐	☐	☐	☐
Other employees	☐	☐	☐	☐	☐
Your supervisor	☐	☐	☐	☐	☐
Lack of equipment or supplies	☐	☐	☐	☐	☐
Inadequate training	☐	☐	☐	☐	☐
Interruptions by other people	☐	☐	☐	☐	☐
Lack of necessary information about what to do or how to do it	☐	☐	☐	☐	☐
Conflicting job demands	☐	☐	☐	☐	☐
Inadequate help from others	☐	☐	☐	☐	☐
Incorrect instructions	☐	☐	☐	☐	☐

16. **Job Satisfaction** (Warr, Cook & Wall 1979)

Please rate how satisfied you are with each item by circling the number that corresponds most closely with how you feel.

I'm extremely dissatisfied	1
I'm very dissatisfied	2
I'm moderately dissatisfied	3
I'm not sure	4
I'm moderately satisfied	5
I'm very satisfied	6
I'm extremely satisfied	7

The physical work conditions (noise temp etc.)	1	2	3	4	5	6	7
The freedom to choose your own method of working	1	2	3	4	5	6	7

Your fellow workers	1	2	3	4	5	6	7
The recognition you get for good work	1	2	3	4	5	6	7
Your immediate boss	1	2	3	4	5	6	7
The amount of responsibility you are given	1	2	3	4	5	6	7
Your rate of pay	1	2	3	4	5	6	7
Your opportunity to use your abilities	1	2	3	4	5	6	7
Industrial relations between management and workers	1	2	3	4	5	6	7
Your chance of promotion	1	2	3	4	5	6	7
The way your firm is managed	1	2	3	4	5	6	7
The attention paid to suggestions you make	1	2	3	4	5	6	7
The hours of work	1	2	3	4	5	6	7
The amount of variety in your job	1	2	3	4	5	6	7
Your job security	1	2	3	4	5	6	7

17. **For each statement, please tick the box which best reflects your answer:**

	Never	Rarely	Sometimes	Quite Often	Very Often
Appropriate cover is provided when staff are sick	☐	☐	☐	☐	☐
I build up lieu time	☐	☐	☐	☐	☐
There is too much paperwork to do	☐	☐	☐	☐	☐
I am considering leaving this organisation fairly soon	☐	☐	☐	☐	☐
This organisation is 'family friendly'	☐	☐	☐	☐	☐
I have to work outside normal/rota hours at short notice	☐	☐	☐	☐	☐
I feel that being referred to Occupational Health is supportive to staff	☐	☐	☐	☐	☐
The organisation shows that it values its staff	☐	☐	☐	☐	☐
I feel part of this organisation	☐	☐	☐	☐	☐
I speak highly of this organisation to my friends	☐	☐	☐	☐	☐
I encounter verbal or physical violence in my job	☐	☐	☐	☐	☐
Occasionally I feel entitled to take days off sick	☐	☐	☐	☐	☐
The Unions help to support staff	☐	☐	☐	☐	☐
I am able to decide when to take lieu time owing	☐	☐	☐	☐	☐

	Never	Rarely	Sometimes	Quite Often	Very Often
I feel guilty taking time off even when I am ill	☐	☐	☐	☐	☐
I feel that my job security is good	☐	☐	☐	☐	☐
I am able to access the Employee Counselling Service if necessary	☐	☐	☐	☐	☐
I feel loyal to this organisation	☐	☐	☐	☐	☐
Supervision meetings happen when necessary	☐	☐	☐	☐	☐
I come to work when I should be off sick	☐	☐	☐	☐	☐
I feel that return to work interviews are supportive to staff	☐	☐	☐	☐	☐
There is a social life attached to this job, which gives me a chance to talk about non-work issues with my work-mates	☐	☐	☐	☐	☐
Issues at work affect my home life	☐	☐	☐	☐	☐
I work in isolation	☐	☐	☐	☐	☐
I feel that I can take a break if I need one	☐	☐	☐	☐	☐
I can determine my own work rate	☐	☐	☐	☐	☐
Issues at home affect my work life	☐	☐	☐	☐	☐
I feel that I drink or smoke more because of my job.	☐	☐	☐	☐	☐
I feel that if an allegation is made against me It will be handled well in the organisation	☐	☐	☐	☐	☐
I feel my prospects for career development and promotions are good	☐	☐	☐	☐	☐
I can determine the order in which my work is to be done	☐	☐	☐	☐	☐
I feel that I am aware of my staff entitlements (career break scheme/special leave scheme etc.)	☐	☐	☐	☐	☐
I feel I can take advantage of these schemes	☐	☐	☐	☐	☐
I feel able to claim lieu/flexitime back	☐	☐	☐	☐	☐

18. **General Health Questionnaire** (Goldberg 1972)

Please answer all the following questions by putting a circle around the answer that you feel is the closest to the way you feel at the moment, or have been feeling for the past few weeks.

Have you recently:

Been able to concentrate on whatever you're doing?	better than Usual	same as usual	less than usual	much less than usual

Lost much sleep over worry?	not at all	no more than usual	rather more than usual	much more than usual
Felt that you are playing a useful part in things?	more so than usual	same as usual	less so than usual	much less capable
Felt capable over making decisions about things?	more so than usual	same as usual	less so than usual	much less capable
Felt constantly under strain?	not at all	no more than usual	rather more than usual	much more than usual
Felt you could not overcome your difficulties?	not at all	no more than usual	rather more than usual	much more than usual
Been able to enjoy your normal day to day activities?	more so than usual	same as usual	less so than usual	much less than usual
Been able to face up to your problems?	more so than usual	same as usual	less able than usual	much less able
Been feeling unhappy and depressed?	not at all	no more than usual	rather more than usual	much more than usual
Been losing confidence in yourself?	not at all	no more than usual	rather more than usual	much more than usual
Been thinking of yourself as a worthless person?	not at all	no more than usual	rather more than usual	much more than usual
Been feeling reasonably happy all things considered?	more so than usual	same as usual	less so than usual	much less than usual

19. Are you a member of a Union? Yes☐ No☐

If so, which one? (please state) _____

20. Have you been away from work because of **your own** sickness or injury in the last six months?

Yes☐ No☐

Were any of your absences in the last six months caused either by injuries sustained at work or by you being affected by your working conditions?

Yes☐ No☐

If yes, please give details: _____

_____

21. Have you been away from work (exclude maternity paternity) because of **someone else's** sickness or injury in the last six months (that is through having to provide care for a child or relative)?

Yes☐ No☐

Would the availability of childcare or parenting cover have had an affect on your absence?

Yes☐ No☐

22. Please list what could be done to improve working conditions in your current job?

23. What is the most difficult aspect of your job?

24. What do you think could be done to make that difficulty less of a burden?

25. What is the best part(s) about your job.

26. A Health Unit providing occupational health and safety has been set up. What services would you like to be available?

27. Any other comments?

JMU
Liverpool John Moores University

Dear Colleague,

'Healthy Work'

We are writing to ask for your help in an initiative aimed at improving --------- Social Services (SSD2) as a place to work. In order to do this we need to find out about the experiences of people working within SSD2, and have asked an independent research body – Liverpool John Moores University – to find out the views of people working within the Department.

SSD2 are supported in this initiative by Unison and GMB and funded by Merseyside Health Action Zone to ensure that as an employer SSD2 promotes a health workplace and thereby contributes to the health and well being of its employees.

The attached questionnaire has been designed and developed to deal with issues that really matter to the people who work in SSD2. The questionnaire will only take a short time to complete and everyone's views are of interest to us. For this survey to be worthwhile, it is really important that as many people as possible complete and return the questionnaires. As researchers at Liverpool John Moores University are carrying out the research, all of the questionnaires will be returned directly to them in the attached pre-paid envelopes and will only be seen by research staff within the university. Confidentiality is assured, **no individuals can be identified**, and no questionnaires will be available to *anyone* within SSD2. The results of the survey, together with staff consultation, will be used to help inform the best ways to improve working conditions within SSD2.

Thank you for your help.

Margaret Coffey (BA) Hons
Researcher
Liverpool John Moores University

Director
---------- Social Services

If you need any more information, please do not hesitate to contact:

Margaret Coffey – Tel: ----------, e-mail: hummcoff@livjm.ac.uk

APPENDIX 4

HEALTHY WORK – FOCUS GROUPS ACTION PLAN

Issues identified	Actions identified	Comments	Actions / Timescales
1. Timescales – tight timescales are predominantly to do with an extremely large workload, a shortage of staff, and the nature of Framework Assessment. The Family Support Team are even more short staffed (in crisis), which means that cases are not reflected in the numbers of cases apparently allocated to each social worker. This situation is getting worse	▪ Staffing levels need reviewing	▪ The Assessment Team is currently fully staffed, and every effort will be made to ensure that this continues to be the case ▪ The Division recognises the issues of retention, and a number of options have been considered and actioned. ▪ Framework is constantly being evaluated and monitored, however, there is a feeling that the structure is not based on a true reflection of the work being undertaken, i.e. it does not reflect the complexity of the work, only the numbers ▪ The protocol currently in existence is placing a pressure on the Assessment Teams, which is out with the original evaluation of the work to be undertaken in this team and the criteria set. This is impacting on caseloads and timescales. ▪ The caseload weighting system originally set up for the Assessment Team does not work, and a new system has been developed and needs to be	▪ Recruitment and Retention working group is looking at the issues around recruitment (ongoing) ▪ Management Information has been lacking recently due to the change in the Department's computer system – this is being reviewed and will be resolved in the near future (01.04.03). This will assist in identifying the number of cases allocated, number of referrals / assessments dealt with etc. (ongoing) ▪ The protocol with FST is being reviewed and an end date will be agreed (current/ongoing). ▪ Continuing monitoring of

		implemented. There is a recognition that implementation of a caseload weighting system across the board will impact on the number of cases that can be allocated. ▪ The pressure of work is acknowledged within the Family Support Team, and it is recognised that this is a Divisional issue, however, the structure is not set up to take on additional work in other Services. ▪ Laming Report will impact on the structure and additional resources may be available in light of the recommendations and Green Paper	the issues surrounding the Family Support Teams (to be agreed). ▪ Implementation of new caseload weighting system for Assessment. (May / June 03)

2. Naming and Shaming of staff not meeting their targets rarely happens to staff in a group situation, although names are highlighted and circulated to certain members of staff	▪ This 'highlighting' of names could be done in a more subtle / sensitive way	▪ This may relate to the Daily Assessment Report, which is an important system to identify the assessment, which are due and overdue this is meant to be a supportive system for managers and staff. It is acknowledged as a supportive system. ▪ The Daily Assessment Report is currently produced by Planning and Development due to IT problems, but will be created in house in the near future. ▪ The Daily Assessment Report is circulated to managers – including Admin and individual sections are given to the relevant worker. ▪ This may relate to the Evaluation Report, which identifies how the various teams are performing. ▪ The focus group clarified this issue and identified a specific document, which had been highlighted in relation to specific workers and overdue assessments. This was discussed in a team meeting, and it was felt that this should have been done in a more sensitive way, and on an individual basis.	▪ Service Manager to meet with the South Assessment Team to clarify the meaning behind this issue, and to seek suggestions as to how this could be managed better (March/April 2003). ***Done*** ▪ Review of Daily Assessment Report system, and whom it is distributed to. (April 030 ▪ Any significant performance issues should be undertaken within the supervision setting. (ongoing) ▪ Clarification sought regarding Evaluation Report. (April 03)

3. Workload as with timescales, the workload seems to increasing. Part of the reason for this is the merging of offices, which means that there is a constantly high stream of work with no quieter periods in which to recover or catch up.	▪ Staffing levels and retention of staff issues need reviewing. In order to attract graduates leaving university, this SSD needs to be more attractive to work, e.g. by providing mileage allowance.	▪ Recognition that one Senior Practitioner and one manager were lost when the teams based in the South of the Borough were merged. Senior Practitioner's took on case responsibility, therefore the number of workers to allocate to was reduced. ▪ The number of referrals has not increased since the teams merged. ▪ Reduction in the number of assessments being undertaken by Family Centres (support for FST etc) increased the number of assessments to be done in Assessment. ▪ Acknowledged that Litherland and Bootle may have had different busy and 'slack' periods, and that the team is now consistently busy. ▪ Protocol with FST has impacted significantly ▪ The complexity of the cases does appear to have increased, and this is evidenced in the number of case conferences and LAC within Assessment, which was not anticipated as being as many in the original evaluation of work. This situation may change, and it does not follow that this is a constant, however, it is impacting on the team currently, as well as the division.	▪ Recruitment and Retention working group is addressing these issues, including students on courses. (ongoing) ▪ Recent new starting grade for SW's and related amendment to progression bar from spc 30 to spc 32. *Already in place* ▪ The issue of mileage is consistently on the 'agenda' and is a significant issue, where this SSD differs from other authorities. This is a Council issue, which is being looked at. (ongoing) ▪ The protocol with FST is being reviewed, and in light of the difficulties experienced by Assessment, an amendment or end date is required. Agreement reached to recruit additional staff to Assessment South against

		▪ Laming Report will impact on the structure and additional resources may be available in light of the recommendations and Green Paper	FST vacancies to support the additional work in Assessment. (current / ongoing)

4. Paperwork A paperwork review is being undertaken at the moment. However, staff still feel that there is a considerable amount of work for them to complete and because staff are trying to write up notes as quickly as possible, there are often problems with how legible the case notes actually are.	▪ Personal laptops would be very useful to overcome this problem. Notes could be typed up instead of written which would improve the quality of the case notes. ▪ Dictaphones could also help, especially if an additional 'admin' member of staff could be employed who was able to type from the tapes.	▪ There is an IT 5 year strategy, which will address the issues raised. ▪ The SWIFT development includes SW's inputting directly onto the computer, which will involve additional equipment being provided to all staff. ▪ SWIFT development will also place all forms on template format, and the information input would be utilised in other forms, which will decrease the amount of duplication and provide partially filled forms. ▪ I acknowledge that there is a shortage of computers, as the terminal based in the backroom was taken by Admin for core business. However, it was felt that this machine was not used consistently. ▪ Laptop allocated to SWIFT mentors could be used, however, this is currently being upgraded by IT in Merton House. ▪ WPO's have managed to reduce the backlog of work and are experienced in deciphering individual's handwriting. ▪ Dictaphones are a positive suggestion and WPO's have indicated that they are able and willing to type from tapes. ▪ Integrated Children's Systems will assist in relation to the paper work and hopefully will reduce duplication etc ▪ Ongoing discussions regarding the	▪ SWIFT Mentors laptop to be retrieved from IT at Merton House (immediately) ▪ Enquiries to be made about obtaining further laptops on loan / purchased for the team (immediately). ▪ Return the computer to SW team in VH from Admin. (April 03) ▪ Enquiries regarding templates being placed on computer to enable staff to type directly onto forms thus reducing work, and ensuring clear legible recording (immediately). ▪ For those members of staff who are not computer confidant or who do not type at any speed, Dictaphones to be purchased (2) (immediately) if this is successful, more can be obtained in the future. There is a problem in

		volume of recording has taken place, and mechanisms to reduce paper work / duplication etc	relation to the tapes used in the dictaphone, which do not fit the machine used by the WPO's. This is being addressed and will be resolved in the near future.

5. Computer – the new computer system, SWIFT is coming into effect in November and will obviously make a difference, although as yet staff are unsure about the ramifications of this. However, there is no internet computer available, which means that staff are unable to access a wealth of current, up to date information, e.g. about drugs or alcohol, and also information about local and national services which they may be able to access for service users.	▪ Staff would welcome at least one computer that was linked to the Internet.	▪ Following the Team Away Day, the issues relating to SWIFT were discussed. One of the biggest difficulties is the lack of SWIFT in the SW room. ▪ SWIFT developments will support and assist staff in the long term, although it is acknowledged that there have been a number of difficulties since it was introduced. ▪ The staff feel that it has been too long since their SWIFT training and they need refresher training, and a computer to practice on. ▪ Internet access is currently only with managers, however, the overall strategy will be to increase the access to Internet and intranet. ▪ Recruitment to the SWIFT project manager post will assist.	▪ To obtain a computer line in the Social Worker room to ensure easy access to SWIFT (currently making enquiries) ▪ To arrange refresher training for all staff (request to be made to SWIFT trainer immediately) ▪ To enquire about the possibility of Internet access on computer in SW room (April 03). ▪ SWIFT Mentors laptop to be retrieved from IT at Merton House (immediately) Return the computer to SW team in VH from Admin. (April 03)

6. More Staff – a pilot scheme was run prior to the introduction of Framework to establish how many referrals could be dealt with per person. However, although the system is evaluated, it is felt that the evaluation is incorrect, as it does not take into account the amount of work that is needed to tidy up an assessment once it has been completed. This includes securing and identifying services for the service users, along with attending the first meeting with them, which can take a considerable amount of time.	▪ The evaluation for Framework Assessment should be revised to take account of the work involved ***after*** an assessment is completed.	▪ The original pilot did take into account that some work would be required following the completion of an assessment, however, due to the difficulties in FST, this work is increasing reference protocol with FST, reduction in resources (commissioning of Family Centres to undertake assessments) etc has increased the work in Assessment. ▪ The reduction of a senior practitioner in Assessment, who previously undertook work, reduces the capacity to allocate. ▪ Clarification of work to be undertaken following assessment should be discussed in supervision and be taken into consideration when allocating further work. ▪ The caseload weighting system originally set up for the Assessment Team does not work, and a new system has been developed and needs to be implemented. There is a recognition that implementation of a caseload weighting system across the board will impact on the number of cases that can be allocated. ▪ Laming Report will impact on the structure and additional resources may be available in light of the	▪ Clarification with Jane Billows re what work was calculated into the current structure for Assessment Teams post assessment (immediately). ▪ Clarification re criteria and work being undertaken within Assessment teams, and to develop written document to evidence (April 03). ▪ Implementation of new caseload weighting system for Assessment (April / May) ▪ The protocol with FST is being reviewed and an end date will be agreed (current). ▪ Service Manager to discuss issues relating to loss of Senior Practitioner and impact on allocation – this has been an ongoing debate (April 03) ▪ Monitoring system / audit of work between end of assessment and closing/transferring the

		recommendations and Green Paper	case to be undertaken, and to discuss with Project worker regarding original pilot and structure etc. Work to be undertaken to cleanse the allocation and assessment records on SWIFT before this can be undertaken. (April / May 03) ▪ Potential re further resources in light of Laming recommendations and Green Paper (June 03?)

7. Changes – because changes are ongoing in the department, it was felt that no action could be taken which would have an effect on this	▪ No action identified	▪ Change is an inevitable part of the profession currently ▪ The pressures from Government and Elected Members from a national and local perspective must be recognised as being out with the Director and SM's remit or control ▪ IIP is addressing how change is managed and implemented, and staff have been part of this process, with positive comments at the last review. ▪ CSF is another change, which will impact staff, however, every effort will be made to ensure that staff are impacted as little as possible and will see the positive impacts of the change.	▪ To continue to advise staff and distribute information of change (ongoing) ▪ Ensure staff are trained in relation to legislative and procedural changes to limit the impact and support them in the change – PDLP's / ACPC (ongoing) ▪ To provide support to staff by attending meetings, facilitating away days etc to address issues of change. (ongoing) ▪ Director to continue to attend meetings (ongoing) ▪ Laming Report and Green Paper will also bring inevitable change – information, briefings, and training to be assured. (June 03?)

8. Resources - resource provision has changed considerably over the past two years, and staff find it difficult to keep up with the changes. The difficulties are compounded by the fact that some of the agencies e.g. Sure Start are unclear as yet about the services they will be offering. Resources appear to be shrinking, e.g. the availability of the 'positive parenting course' has been greatly reduced.	▪ A regularly updated handbook which outlined the different services available by all the agencies available to service users would be particularly useful. Each of the agencies involved could be asked to provide a monthly update in order that changes could be continually updated. ▪ More resources	▪ It is acknowledged that there have been a number of changes in relation to new organisations and initiatives, and that it is difficult to keep up to date. ▪ Due to the problems in Family Support, the commissioning of Family Centres to undertake assessments has reduced. ▪ CWD have significantly changed their criteria ▪ BV Reviews have impacted on the availability of resources ▪ Some services work under a criteria, which doesn't meet the services users we work with, or are unable / unwilling to take on responsibility for the case without SSD maintaining their involvement, e.g. YOT, CAMHS ▪ Other agencies are unable to take on work due to their own staffing / overload issues, e.g. Merseyside Centre for the Deaf. ▪ Lack of clarity about what the organisation is doing due to insufficient information, promotion, or time taken to set up the service. ▪ Handbook is a very good idea, although there is currently something similar produced by the Voluntary Organisations, but this is not updated as often as suggested.	▪ Clarification on what services are being offered by various establishments, agencies or organisations (April / May 03) ▪ Discuss with the Information & Publicity Officer re working with CVS on their handbook (April 03) ▪ Remind staff of the commissioning of services from Family Centres. (current/ongoing) ▪ Remind staff of organisations with whom we have a SLA – this could also be put into some form of information leaflet for staff – contracts and commissioning would have this information. (April / May 03)

		▪ Clarity of information is needed ▪ Focus group advised that this was mainly in relation to Sure Start and Family Centres.	

9. Corporate Parenting – staff feel that the principles of corporate parenting should be reinforced to all partners involved.	▪ On-going training may help with this, together with regular liaison with other agencies and other working groups (consisting of front line staff), in order to discuss multi-agency approach to child protection (working together). This needs to be a priority in light of the proposed merger with Education. It is essential that Headmasters get on board and 'own' the child protection process.	▪ This is a constant issue which is raised by SSD staff ▪ The issue of training is a positive suggestion and could be addressed via ACPC – this is topical currently given the Laming Report ▪ Targeting Head Teachers via CSF director would be productive, and could also include Governors. ▪ Information leaflet highlighting roles and responsibilities would be helpful, although it could not address every possible situation which may arise. ▪ CSF should address some of these issues, and current Access to Services Working Group would be supporting this work. ▪ Sub Groups around CSF may also assist.	▪ ACPC to consider developing a multi-agency training course around working together and corporate parenting (Christine to speak to Jenny Gibbs) ▪ Clarification regarding threshold criteria and roles and responsibilities (April / May 03) ▪ Information leaflet re roles and responsibilities in relation to CP / Corporate parenting (to be arranged)

10. Violence – the potential for violent situations occurring is part of the nature of the job. However, in terms of 'risk assessment' staff are unsure of which policies deal with this issue and what the rules and regulations are in this respect.	▪ The policies for attending potentially risky situations should be looked at and guidance drawn up for staff so that they are fully aware of the procedures involved.	▪ There is currently a working group addressing the issue of violence to staff and updating the policy and procedure. ▪ Health and safety procedures are already in place, also the procedure regarding recording someone as a hazard addresses the issues of violence. ▪ Custom and practice within teams will address risk assessments in relation to visits etc. All staff should be signing out to state where they are and when they expect to return. Use of mobile phones, access to managers, managers waiting for staff to return etc. ▪ There is a joint responsibility in relation to safeguarding staff whilst undertaking their work, and some basic good practice will address some of the issues.	▪ Request interim report from the Violence to Staff working group (April 03) ▪ Remind staff at team meetings of the policies and procedure in place (ongoing) ▪ Review risk assessment and other safeguarding practices within the office and ensure all staff are aware of what is expected of them (April / May 03)

11. Sickness – no action point was developed in relation to sickness absence, which is felt to be low amongst social workers working with children and families.	▪ No action identified	▪ Given that this was not raised by the Social Workers involved in the focus group, and in fact had a fairly positive comment to make, why was this included in their feedback? ▪ Team Managers are advised of the absence figures on a regular basis, and back to work interviews are discussed in supervision etc ▪ Additional information has been requested to identify trends, hot spots and other issues arising out of the absence returns.	▪ Continue to monitor absence returns, undertake back to work interviews, refer to Occupational Health etc. (ongoing)

12. Turnover – no action point was developed in relation to turnover, although it was felt that the fact that only two social workers are left out of seven who were involved in the pilot scheme should be noted, and considered when the scheme is being evaluated.	▪ No action identified ▪ Evaluation of structure re retention of staff.	▪ To seek clarification from team regarding comment on 2 members of staff being left who were involved in the pilot – there are currently 14 social work posts in Assessment, 9 of which are based in the South. Framework came into being in April 2001, and the pilot started December 2000. 8 Social Workers from the team (7 posts) were in this SSD at the time of the pilot, plus the Assistant Team Manager. Admittedly some were employed in other teams at the time, however, despite the turnover, the staffing in the Assessment Service has been consistently positive. ▪ The focus group advised that they had not included members of staff who had been in other teams at the time of the pilot of Assessment Framework, and acknowledged the above, in relation to the team as it stands now.	▪ To maintain staffing levels (ongoing) ▪ To address issues of retention of staff – Recruitment and Retention Working Group, Departmental initiatives, exit interviews – reports to be received on reasons for leaving the post, preferably by service. (ongoing)

13. Work Environment – the work environment, especially in terms of air quality, seating and work situations is poor, e.g. a chair which has already been deemed unfit by an ergonomics expert is still being used by another member of staff.	▪ Staff would like an independent inspection of the work environment and equipme4nt and that any changes that are needed are undertaken as soon as possible.	▪ Acknowledgement of the difficulties in relation to Vermont house – heating, windows. Everything that can be done is being done, however, it remains an ongoing problem ▪ Proposed move to another site, which will address some of these issues ▪ Need to acknowledge that unless moving to a purpose built site, there will be problems with most council owned buildings ▪ Some of the assessments re chairs etc have related to heath problems, therefore if a chair is deemed unsuitable for 1 member of staff, it doesn't mean that it is not suitable for others. ▪ Clarification was sought from the focus group, who advised that during a health assessment, the assessor advised that ergonomically, the chair was not suitable for staff who are spending a significant period of time at their desks. ▪ Consideration of independent review by Occupational Health and Health & Safety, also to include issues of computer work etc. Furniture is an ongoing problem, as staff feel that they are not given the appropriate items, which impact their working environment.	▪ Assurance that new site will address the needs of the staff re environment (ongoing to date of move) ▪ Write to Technical Services manager re heating issues (April 03) ▪ Request review of current environment and furniture by Health & Safety, IT and Occupational Health. (April 03)

14. Feeling Valued – staff don't feel particularly valued by the organisation	▪ Attention to some of the points outlined above would show the organisation's commitment to its staff and would go toward helping staff feel valued. In addition to this, tangible rewards e.g. discounted access to leisure services would be welcomed ▪ Staff would like a written response to these actions points as soon as possible	▪ IIP is addressing this and recent review stated that there was a positive response from staff. ▪ Clarification was sought from the focus group on what areas they were referring to and what further suggestions they wish to highlight. Specific issues raised were: - - Potential reduction in car mileage allowance - reasonable chairs, desks, equipment – computers, sufficient phone lines etc, working environment – adequate heating/air conditioning, car parking - positive terms and conditions in relation to access to council services at reduced rates – making This SSD a forward thinking authority, i.e. health is promoted, therefore reduced rates at baths and gyms etc. - acknowledgement of the volume of work and difficulties caused by protocols, which impact on job satisfaction and ability to do a job well, enjoyment factor. Staff feel overwhelmed, and often do not take toil or volunteer for courses as they can not afford to take time out of the working week due to their current	▪ Christine to meet with focus group to address further examples of not feeling valued by organisation – done ▪ Notify IIP Officer re the comments made and any further information arising from meeting. (April 03) ▪ Pursue issue of discounted access to leisure services. (DMM / DMT – as soon as possible) ▪ Produce action plan to address issues raised by focus group – done ▪ Away day to address issues of 'feeling valued', workloads, caseload weighting system and other such issues to be arranged for Assessment Service. Focus of the away day to be on positive suggestions rather than 'moans'. (May / June 03) ▪ Produce report for focus

		workloads. - Feeling that management information is constantly picking up problems, rather than recognising the positive work achieved etc. - The 'timing' of some reports could be produced in a more sensitive manner, i.e. recognising the other issues facing staff at a particular time. - Recognition that despite every attempt, staff may still feel dissatisfaction, and that this is an ongoing problem, which can not always be identified in a detailed way, and that this impacts on the ability of management to act. - Recognition that staff also have a responsibility to contribute to providing suggestions as to how things can improve. ▪ Suggestion of discounted access to leisure services is positive and will be addressed ▪ Work environment review / move may also assist. ▪ The focus group acknowledged that there will always be some staff who are prone to moan, and that moaning is natural on occasions, however,	group, Social Worker staff in general and DMM / DMT highlighting actions completed and work ongoing. (April / May 03)

		responses/action regarding reasonable moans would be appreciated. ▪ DMM agreed action plans and response in writing relating to the Healthy Work report and comments from the focus groups.	

HEALTHY WORK QUESTIONNAIRE

INTRODUCTION

SSD2 commissioned an independent research body (Liverpool John Moore's University) to find out about working conditions within the department. This research was undertaken using a questionnaire. It was anticipated that the anonymous results from this would identify any conditions impacting negatively on employee well being. The results of the questionnaire, which have been analysed by LJMU, will be fed back to staff at a later date.

In the meantime, one of the questions within the questionnaire asked staff what services they would like the Council's Health Unit to provide.

The top services requested by staff included:

- A totally independent, self referral counselling service
- Voluntary screening (all types, but especially well woman screening)
- Information regarding the Health Unit/ Balanced Occupational Health Service with 'no threat'
- Either free or subsidised regular personal medical checks (MOTs) e.g. cholesterol, blood pressure, etc.
- Stress management and advice
- Health Promotion and advice, e.g. smoking cessation, nutrition, etc
- Health and Safety advice
- Alternative therapies
- Leisure facilities (free/subsidised)

The purpose of this information sheet is to inform you of the services already provided by the Health Unit and to give guidance to enable you to access some of those that are not.

EMPLOYEE COUNSELLING

You can refer yourself or seek help through your manager or trade union representative or by making contact with staff at the Health Unit. Any issue, work-related or otherwise, including; bereavement, relationships, divorce, etc, that is affecting your well being can be a valid reason for referral.

The Employee Counselling Service exists to help employees to share and explore any problems or concerns they may have and to assist with coming to terms and resolving them. Effective use of the service is, therefore, beneficial to employees and the Council alike.

All assistance provided is on a strictly confidential basis except in circumstances where there are serious concerns about your well being or that of another person. Moreover, any proposed actions would be discussed with you first.

WELL WOMAN SCREENING

This is not something that the Unit can offer, however, we will endeavour to provide as much information as we can on Well Woman facilities within the Borough. The Health Unit can provide details of some of the medical centres based within Sefton that do offer this service as well as "well men clinics."

THE HEALTH UNIT

The Unit is led by the Health and Safety Manager and consists of experienced Health and Safety Advisers, Occupational Health Nurses and an Employee Counsellor. There is also a visiting Occupational Physician.

Referrals are made to assist employees with their absence, to ensure that appropriate rehabilitation is considered and undertaken and to identify what arrangements the employer needs to implement when employees return to work. The process is not intended to be threatening and the staff within the Unit use their professionalism and expertise to ensure the best possible outcome for all concerned.

The Unit offers a range of services (all of which are completely confidential and independent), including:

- Pre-employment Health Screening
- Assessment of individuals and provision of advice to managers and employees with regard to:
  - sickness absence
  - rehabilitation
  - disability issues
  - work-related health issues
  - general health issues

- Statutory medicals, health surveillance and health screening
- Health promotion services
- Advice on and the provision of inoculation, where appropriate
- Employee counselling (see section above)

Physiotherapy is not yet provided but there are proposals to develop this service at a later date.

HEALTH SCREENING AND MOTs

Social Services Adult Services Division is already involved in a health screening programme. This initially involves completion of a lifestyle questionnaire from which the Occupational Health Nurses will determine a priority screening regime. Not everybody will be invited for screening, as the questionnaire will determine whether or not this is necessary. However, every participant will receive a written response, advising them on any future action they may wish to consider to improve their lifestyles and whether future screening would be appropriate for them.

This programme is in the process of being rolled out to include all employees within SSD2. However, if you have particular concerns and would like to be screened earlier, then you can contact the Health Unit for a screening questionnaire.

In addition to this, the Unit is currently exploring the option of providing a voluntary screening programme in conjunction with one of the Primary Care Trusts.

STRESS MANAGEMENT AND ADVICE

The Council has a Stress Management Policy and each employee should have received a copy of the policy guidance. (If you have not received a copy please contact the Health Unit).

In addition, there is also an in-house (2 day) training course provided by Corporate Learning and Development Unit (CLDU) - "Managing Personal Pressures to Reduce Stress".

This course is aimed at all employees who wish to deal constructively with pressure whether it is work or home related.

For further details contact the CLDU on tel: xxxxxxxx.

HEALTH PROMOTION AND ADVICE AND INFORMATION

xxxxxxx is the Council's Health Promotion Nurse. Part of her role is to promote and co-ordinate health enhancing activities including, for example:

- Smoking cessation, Dietary advice/nutrition or Personal well-being

xxxxx is currently involved in the co-ordination of the health screening programme with the Social Services Department.

In addition to this screening programme, there is one for diabetes that is open to anybody who may be at risk from this disease. Staff will be identified for screening by response to a diabetes questionnaire. For further information contact xxxxxxx. Information on work and non-work based support services, support groups, etc., that employees may wish to use, can also be provided

HEALTH AND SAFETY ADVICE AND GUIDANCE

Health and Safety Advice is currently being offered by the Advisers based within the Health Unit.

Initial responsibility for addressing concerns with regard to health and safety lies with your supervisor and manager. However, should you need advice and guidance in addition to that provided by them you can contact the Unit who will assist wherever possible.

You can also use the Incident Report Form (supplies available on site) or initiate the Confidential Reporting Policy to report any problems or concerns that you feel are not being progressed. In addition, there are Harassment Support Workers (HSW) available in each department for any issues involving bullying and harassment. If you do not wish to contact the HSW within your own department you can contact one of the others within another department.

Further details are contained within the "Dignity at Work - Dealing with Harassment and Bullying" Policy. Alternatively contact Social Services Personnel Section on tel: xxxxxx or the Personnel Department on tel: xxxxxxx.

ALTERNATIVE THERAPIES

These are services that are unlikely to be provided by the Health Unit. However, subsidised sessions are available from:-

- The local college - tel: xxxxxxx

Examples of treatments available include:

- Reflexology - £5.00
- Back Massage - £2.50
- Full Body Massage - From £6.00
- Indian Head Massage - £3.50

Costs for these treatments are kept to a minimum because the students based within the college provide them. Sessions are generally available between 9am to 9pm Monday to Thursday and 9am to 4pm on Friday.

In addition xxxxxx College Hair and Beauty Students provide similar sessions although details of these are not be available until September 2002. For further information telephone the Hair and Beauty Salon on xxxxxxx.

LEISURE FACILITIES (FREE/SUBSIDISED)

Leisure Services Department is currently exploring options for the introduction of subsidised leisure facility usage. Nothing has been confirmed as the proposals are in the early stages. However, your requests for this service have been noted.

You should also be aware that the costs of gym facilities provided by the Council tend to compare favourably with those owned privately.

OTHER EVENTS AVAILABLE

Yoga - xxxxxxxxx every Tuesday 12.15pm to 1.15pm - £2.00 per person. This is organised by Education Department but run by an external Yoga Teacher and is open to all staff.

FREE LUNCHTIME WALKS :
Every Wednesday from xxxxxxxx. These are led by a qualified walk leader and are provided by the Leisure Services Department in conjunction with xxxx Primary Care Trust. Start time 12.00pm finishing at approximately 12.40pm.

Every Tuesday from the xxxxxxxxx. A Leisure Services Instructor leads these. Start time 12.30pm finishing at approximately 13.15pm.

For further details of any of the services outlined above, please contact the Health Unit

LEAVER'S QUESTIONNAIRE

APPENDIX 6

The purpose of this questionnaire is to enable SSD2 to examine the reasons why people leave the organisation and to identify any problems that need to be addressed. Your comments will not influence future reference or re-employment with the Council. Please be as frank as possible. The form will be analysed centrally and the results reported to the Departmental Management Team. All information will be treated in the strictest confidence, except in exceptional circumstances, where the Council's Confidential Reporting Policy will be applied.

ABOUT THE PERSON WHO IS LEAVING

1. Name: ..... 2. Job Title: .....
3. Last day of employment: .....
4. How long have your worked with Social Services: ..... years ..... months
5. Area of Work:

Community Care

- Divisional Management ☐ (01)
- Older People ☐ (02)
- Adult Mental Health ☐ (03)
- Hospital Services ☐ (04)
- Contract Unit ☐ (05)
- Asylum Seekers ☐ (06)

Disabilities

- Divisional Management ☐ (07)
- Learning Disabilities ☐ (08)
- Com & Care Mgt. - Phys. Dis. ☐ (09)
- Occupational Therapy Services ☐ (10)
- Sensory Impairment Services ☐ (11)

Adult Service Provision

- Divisional Management ☐ (12)
- Social Worker - Learning Dis. ☐ (13)
- Domiciliary Care ☐ (14)
- Res. Services - Elderly ☐ (15)
- Res. Services - Learning Dis. ☐ (16)
- Day Centres ☐ (17)
- Training Centres ☐ (18)
- Transport ☐ (19)

Children & Families

- Divisional Management ☐ (21)
- Assessment Teams ☐ (22)
- Family Placement ☐ (23)
- Youth Offending Team ☐ (24)
- Disability ☐ (25)
- Residential (children's homes) ☐ (27)
- Family Centres ☐ (28)
- Children Looked After ☐ (47)
- Family Support ☐ (48)
- Quality Assurance ☐ (49)
- Day Care Development Team ☐ (50)

Strategic Planning & Resources

- Divisional Management ☐ (30)
- Community Development Workers ☐ (31)
- Personnel Staff ☐ (32)
- Training Staff ☐ (33)
- Administration Staff ☐ (34)
- Directorate P.A.'s ☐ (46)

Resources

- Divisional Management ☐ (35)
- Finance Staff ☐ (36)
- Income & Assessment ☐ (37)
- Property Services ☐ (38)
- Hotel Services ☐ (39)
- Performance Information Unit ☐ (40)
- I.T. Team ☐ (41)

Regulation

- Divisional Management ☐ (42)
- Inspection Staff ☐ (43)
- Registration Staff ☐ (44)
- GAL Staff ☐ (45)

6. Are you:

Female ☐ (01) Male ☐ (08)

7. Ethnicity:

White

British ☐ (01)
Irish ☐ (02)
Other ..... ☐ (03)

Mixed

White and Black Caribbean ☐ (04)
White and Black African ☐ (05)
White and Asian ☐ (06)

Asian or Asian British

Indian ☐ (08)
Pakistani ☐ (09)
Bangladeshi ☐ (10)
Other ..... ☐ (11)

Black or Black British

Caribbean ☐ (12)
African ☐ (13)
Other ..... ☐ (14)

Chinese or other ethnic group

Chinese ☐ (15)
Other ..... ☐ (16)

8. Age Group:

Under 20 ☐ (01) 21-29 ☐ (02) 30-39 ☐ (03)
40-49 ☐ (04) 50-59 ☐ (05) 60+ ☐ (06)

EMPLOYEES OPINION ABOUT THEIR JOB/ORGANISATION

9. What is your opinion about the following aspects of your job and the organisation:

Aspect	Excellent	Good	Fair	Poor
Supervision quality				
Training				
Pay				
Pension				
Promotion prospects within the Department				
Working relationships with management				
Working relationships with colleagues, e.g. teamwork				
Hours of work				
Holiday entitlement				
Workplace Conditions, e.g. physical environment				
Communications, e.g. through line management				

10. What do you think could be done to attract people to this area of work? _____

_____

11. Any further comments on your job organisation? _____

_____

_____

12. What could be done differently to make your job more effective? _____

_____

_____

REASONS FOR LEAVING

13. In what way is your contract with Social Services ending? *Please tick one box only*

Resigned	☐ (01)	Resigned following maternity leave	☐ (05)
Retired (normal retiring age)	☐ (02)	End of temporary contract	☐ (06)
Retired (early retirement)	☐ (03)	Redundancy	☐ (07)
Retired (ill-health)	☐ (04)		

14 If you **resigned** or **retired early**, what were your **MAIN** reasons for leaving? *Please tick those that apply*

Career personal development	☐ (01)	Physical working environment	☐ (10)
Job satisfaction	☐ (02)	Home relocation	☐ (11)
Pay	☐ (03)	Parental caring responsibilities	☐ (12)
Employment conditions	☐ (04)	Job insecurity	☐ (13)
Working relationships - managers	☐ (05)	Harassment/bullying	☐ (14)
Working relationships - colleagues	☐ (06)	Travel problems	☐ (15)
Workload	☐ (07)	Other (please state)	☐ (16)
Workplace re-organisation	☐ (08)		
Health	☐ (09)		

15 If you have ticked more than one box, what was your MAIN reason for leaving:

_____

_____

_____

16 Please indicate if other reasons influenced your decision, or add further details relating to the above:

_____

_____

_____

17. What could have been done to make you stay? _____

_____

_____

18. What are you doing next?

New Job		**Other**	
Other local authority employer	☐ (01)	Study or training course	☐ (05)
Other public sector employer	☐ (02)	Full-time parent or carer	☐ (06)
Private sector employer	☐ (03)	Self-employment	☐ (07)
Voluntary sector employer	☐ (04)	Retirement	☐ (08)
		Unemployed, seeking work	☐ (09)
		Unemployed, not seeking work	☐ (10)
		Other (please state) _____	☐ (11)

19. Method of carrying out interview

Face to face	☐ (01)
Over the telephone	☐ (02)
Postal questionnaire	☐ (03)

PLEASE RETURN THE COMPLETED FORM TO xxxxxxxxx

If this questionnaire has been completed at an Exit Interview, please complete the next sections.

COMMENTS

20. Employee's comments, please use the space below to record any other relevant information:

21 Interviewer comments, please use the space below to record any other relevant information:

Employee's signature: ..... Date: .....

Interviewer's signature: ..... Date: .....

ABOUT THE PERSON WHO IS CARRYING OUT THE INTERVIEW

22. Name: .....

23. Date of Interview: .....

24. Job held: .....

CONFERENCES, PRESENTATIONS AND PUBLICATIONS

Conferences and presentations:

Women, Work and Health – Third International Congress in Stockholm, June 2 – 5, 2002- *Developing an Occupational Health Service in a Social Services Department: Understanding the Stressors.* Coffey M., Dugdill L., & Tattersall A. http://www.arbetslivsinstitutet.se/wwh/

Research Matters Conference – *Focus on Focus Groups* – Liverpool Hope University, 12th September, 2003

Institute of Electrical Engineers, Mersey & Western Cheshire Branch Events – *'Stress'* – Management Group Programme, 24th November, 2003

Publications:

Their Health: Our Wealth – (2002) Dugdill L., & Coffey M.

Stress in Social Services: Mental Well-being, Constraints and Job Satisfaction (in press) – British Journal of Social Work, Coffey M., Dugdill L., & Tattersall A.

Poster:

'Focus on Exercise': how can focus groups be used in the development of preadolescent children's physical activity interventions: a schematic model of 'serial' focus group methodology. Dugdill L., Porcellato L., & Coffey M. (2003) The Fourth International Interdisciplinary Conference, May 2nd – 5th, Canada