

Work related stress and European policy – A comparative exploration of contextual stressors in the rehabilitation sector in five European countries

JOHN WELLS, MARGARET DENNY, & JENNIFER CUNNINGHAM

Department of Nursing, Waterford Institute of Technology, Waterford, Ireland

Abstract

Background. Dealing with work related stress is a declared priority of European Union mental health policy. A particularly under-researched sector in this regard is the community vocational support sector for people with mental health and intellectual disability problems.

Aims. To report on the organisational profile of the vocational support and rehabilitation sector for people with mental health and intellectual disabilities as this relates to occupational stress, in five European countries (Austria, Ireland, Italy, Romania and UK).

Methods. A sector profile questionnaire was distributed to representative organisations in five countries and a short face-to-face survey was conducted with 25 local managers (five from each country) to draw up a profile and facilitate a comparative description and analysis.

Results. It was found that there is no national and European data collected at any level in this sector upon which to base effective policy interventions to combat occupational stress specific to professionals working in this sector. Results indicate that the sector in a number of the countries sampled does not have effective mechanisms in place to deal with occupational stress.

Conclusion. Developing effective transnational occupational stress management policy that supports staff working in this sector and measuring its success is greatly impaired by a failure to effectively define the purpose of the sector and collect and collate national data to support it.

Keywords: *Stress, occupational stress*

Introduction

It is reported that up to 28% of the European Union workforce experience work-related stress (Health and Consumer Protection Directorate-General, 2005). Consequently, the European Union emphasises dealing with work-related stress as a policy priority and issued guidelines as to the type of policies and services that should be developed by member states and employers in the workplace (European Commission, 2005; Health and Consumer Protection Directorate-General, 2005; WHO Europe, 2008; the European Parliament, 2008; The European Framework Directive, 1989; Boorman, 2009). The European Parliament (2008) called on the European Commission to publicise positive examples of local work place emotional and mental well being policies and actions as a means of disseminating good practice.

Correspondence: Professor John Wells, PhD, MSc, BA(Hons), PGDip, RPN, RNT, Head of Department of Nursing, Waterford Institute of Technology, Ireland. Tel: +003535184442. E-mail: jswells@wit.ie

The focus of this paper

With reference to this pan European policy perspective on work-related stress, this paper reports on the results of a scoping study conducted in five European countries (Ireland, UK, Italy, Austria and Romania) to explore the degree to which this European policy priority for employing organisations to promote the mental well being of employees and to deal with work-related stress is reflected in the experience of workers in the vocational and rehabilitative support sector for people with mental health and intellectual disabilities. The paper focuses on structural and organisational issues as these have been found to be a significant cause of work-related stress for individual employees, particularly in health and social care settings (Department of Health, 2010). Organisations in the vocational and rehabilitative support sector are the subject of this examination for five reasons.

First, there is little information on the provision and quality of occupational health responses and policy implementation within a European context in relation to work-related stress in the social care sector. For example, it is only very recently that research has started to look at this within the United Kingdom within the health care sector (Harvey et al., 2009; Williams et al., in press;). Second, it is recognised that working in the field of mental health and intellectual disabilities can be particularly challenging in terms of work-related stress (Harvey et al. 2009; Jenkins and Elliott, 2004). Third, the emphasis on the recovery model in a number of European countries (for example Ireland, the UK and Italy) combined with greater emphasis on community-based interventions to support people with mental health and intellectual disabilities means that the rehabilitative and vocational support sector is considerably important in terms of service delivery in a way it was not in the past.

Fourth, this sector, unlike its hospital-based counterparts, is often staffed by a range of personnel from non-clinical backgrounds, such as trades and education. As such these personnel may not be formally equipped with a knowledge specific to the client group in relation to their psychological problems and management. Most studies on work-related stress in the mental health and intellectual disability sector have focussed on clinical settings and clinicians (see for example, Edwards & Burnard 2003; Jenkins & Elliott, 2004). Some studies have looked at work-related stress in community mental health settings, though not vocational support, where high levels of 'emotional exhaustion' have been found to be a significant (Carson et al., 1995; Marine et al. 2007; Prosser et al., 1996). However, published research on the experience of stress in rehabilitative and vocational support settings, particularly comparative European studies in this sector are notable for their absence, possibly because in the past this sector was an 'invisible' part of service provision with little policy significance.

There is nevertheless some evidence that work-related stress may be a considerable problem for this specific work force. For example, an unpublished Irish survey found staff turnover in the National FAS Supported Employment Programme was 47%, with work-related stress, a significant cited factor (National Co-ordinators Forum 2005, unpublished).

Finally, bearing in mind the policy directives at a European level, it is perhaps important to assess whether services which focus on social and employment integration of people with psychological problems are themselves engaged with policies that promote the mental well being of their staff. In this context, comparative referencing of services across the European Union may be useful in relation to calls to disseminate not only good practice but also where practice needs to be improved in a context of work mobility across the Union.

Defining work-related stress, its causes and manifestations through a European policy perspective

Though there are a range of nuanced definitions of work-related stress (see for example Cox et al., 2000; Sarafino, 2005), for the purposes of this study, the definition used by the European Commission was adopted. This states that work-related stress is, ‘the emotional, cognitive, behavioural and physiological reaction to aversive and noxious aspects of work, work environments and work organizations’ (Levi, 2000). The guidance goes on to state that work-related stress is characterised by people feeling distressed and unable to cope at work (Levi, 2000).

The European Social Partners Framework agreement, (European Social Partners, 2004), echoing earlier work by the European Agency for Safety and Health at Work (Cox et al., 2000) states that work-related stress can be caused by physical and psychosocial factors such as work content, work organisation, work environment, poor communication in the workplace, organisational norms and culture as these relate to the individual worker’s role and career development and decision latitude in day-to-day work.

Whilst it is recognised that experience of work-related stress and responses to it are highly dependent individual factors such as personal background, personality and coping styles, general organisational indicators include high absenteeism or staff turnover, frequent interpersonal conflicts or complaints by workers (Department of Health, 2010). At the individual level, workplace stress can result in various emotional, cognitive, behavioural and physiological reactions (Sarafino, 2005). A literature review conducted by Michie and Williams (2003) on work-related psychological ill health and sickness absence in health care settings indicated that key work factors associated with psychological ill health and sickness absence in staff were long hours worked, work overload and pressure, and the effects of these on personal lives; conflicting demands; poor social support at work; unclear management and work roles; interpersonal conflict and conflict between work and family demands.

The European legislative context

The legislative frameworks of all EU countries consider work organisations to be a source of health and safety risks (Levi, 2000). Although the regulatory framework of most EU countries does not refer to stress directly, there are often regulations that refer to the causes of stress. This can be seen in the European Commission’s Directive on the Introduction of Measures to Encourage Improvements in the Health and Safety of Workers at Work, 1989. Transpositions from this EU directive can be seen at national level in the UK-Management of Health and Safety at Work Regulations, 1999 and Health; in Ireland in the Safety, Health and Welfare at Work Act, 2005; in Italy in the Safety at Work Charter, 2000; in Austria in the Health and Safety at Work Act, 1995; and in Romania in the health and safety law under the Romanian Labour Code, 2005. Consequently, all member states, and specifically the ones examined in this study should at an organisational level be compliant with their national legislation with regards work-related stress and be implementing supportive policies on the ground to deal with it.

Methods

Qualitative survey instruments (a questionnaire and face-to-face interviews) were used to gather data through a convenience and purposeful sampling strategy. Both qualitative instruments were designed to gather data on the profile, national and local, of vocational and

rehabilitation centres for mental health and/or intellectual disability service users. The questions were based on what the literature identified as significant organisational issues and contributors to work-related stress as these were referenced to current European Union policy.

The questions were divided into sections which sought information on the nature of service provision, service funding, work-related stress policies, staff qualifications and training and career pathways. These questionnaires were sent to senior managers of five representative national organisations in five countries (Austria, Ireland, Italy, Romania and the United Kingdom). The countries were not chosen randomly but were selected on the basis of the location of organisations who had agreed to participate in the research at the time of application for funds to the European Union.

In addition to the distribution of this survey instrument to national bodies, the same bodies were asked to nominate English speaking managers of 25 vocational and rehabilitation centres at a local level (five from each country) who would be prepared to be interviewed. These managers were then asked to comment on these issues specific to the centre they managed. Ethical principles with regards confidentiality and anonymity were adhered to. The language used in the interviews was English.

All data, once transcribed, were entered into the computerised qualitative data analysis package NVivo 7 and analysed for common themes and negative cases by two of the research team.

Whilst it might be argued that the convenience and purposeful sampling strategy injects an element of bias in terms of selection, the research team felt that from a qualitative perspective the countries represented a sufficient range and typicality of member states to allow broader interpretative conclusions to be made from the data gathered (for example in terms of new and older accession countries, small and large populations, northern and southern states, wealth and less wealthy states and countries with well developed and less well developed mental health and intellectual disability policies).

Equally it might be argued that using a purposeful sample of nominated managers to comment on data supplied by their national organisations might also introduce bias, either withholding information or giving distorted information. However, this approach is perfectly acceptable within qualitative data gathering and what managers were being asked to was to provide their own personal day-to-day experience of the issues identified at a national level. As a check against over interpreting the data it should be noted that two members of the research team had management experience of this sector. This degree of familiarity on the part of researchers is well recognised within qualitative research as a check for the potential of exaggeration within the data. However, it is acknowledged that results which we report below may not be definitive but rather interpretative.

Results – service provision

Size of sector

Respondents were asked to report on the size of the sector in terms of number of clients served and the level of provision of occupational services. All countries reported that specific occupational support services to clients who experienced mental health problems and intellectual disabilities were available. However, precise data relating to such services at a national level were unavailable since governments do not collect it, both in terms of the nature of service provision, the numbers employed in the sector and the numbers of service users. For example, the UK and Austria could provide no accurate data even at a regional/organisational level as to the number of service users using the sector (it should be

noted that the Irish government has completed such a survey but at the time of writing has not published its results).

Thus data could only be provided by some respondents as this related to their specific organisations. This in itself, however, revealed some interesting variations. Thus in Italy there was an average of 20 service users at centres whilst in Romania 380.

Client services

In each country, a range of training and occupational activities are offered with most services offered in community settings, some still attached to hospitals or to larger residential care homes. Thus, in Austria residential and day services are offered, providing training and occupational activities including assisted living, mobile care, vocational training and workshops. In contrast, in Romania training and occupation is focused around centres for rehabilitation, residential institutions for assistance and long-term care, hospitals, elderly homes and day centres.

Managers at a local level were asked to describe the profile of their centres. In Austria and Romania managers reported that most clients are located in community home settings. In the UK, Ireland and Italy managers said clients went to day centres and lived at home.

Sources of funding

Respondents were asked to profile their respective countries in terms of principal sources of sector funding. All respondents reported that there were no figures available for the level of national funding for the sector. In all five countries, the sector was funded by a mixture of national and local funding, with in some cases, supplements from a fee for service or extra-national funding.

For example, in the UK funding is received directly from the Department of Health (for NHS provision) and from local authorities (for other provision). Alternatively, in Italy, a fee for service model predominates, supplemented with funding from the local regional authorities, with service users' families paying towards costs.

In Austria, services are funded from a variety of government, private and charitable providers. Private health insurance providing the largest source of income whilst government funding, accounting for just over a quarter. However, almost a third of funding is derived from direct payments by service users and their families.

In Ireland services are primarily funded by the State either by direct state provision of a service or transfer of funds to voluntary organisations. However, many of these voluntary organisations have to fundraise from the public to supplement their annual State provided budget.

In Romania, the sector receives some funding from the State and from local authorities. However, European Union funding is an important source (e.g. the pre-accession PHARE programme, the Social European Fund and the European Fund for Regional Development). Other funding is received from international donors (e.g. the World Bank and The European Commission Development Bank).

Local policies on work-related stress

Local managers were asked to comment on the degree to which the centre which they managed had policies in place that specifically dealt with work-related stress. In Austria, managers reported that there were no local policies on workplace stress, stress risk assessments or anti-bullying. Only one manager reported that there was a policy to deal with

absence from work and two managers reported that they had employee assistance programmes and conflict resolution policies.

In Ireland, four managers reported that their organisations had a policy on workplace stress, and all five said they had a policy to deal with absence from work, and an anti-bullying policy. Four managers reported that their organisations had an employee assistance programme and four reported that they had a conflict resolution policy in place.

In Italy, three managers indicated that they had policies that dealt with workplace stress, absence from work and employee assistance programmes. Only one manager reported that they had policies on an anti-bullying policy and conflict resolution. Again, only one manager reported that their centre had a stress risk assessment policy that incorporated workplace stress.

In the UK, four centres have a policy on workplace stress, five had a policy to deal with absence from work, five had an anti-bullying policy, four had an employee assistance programme and four centres had a policy on conflict resolution. Notably, managers from Romania stated that there were no policies in place in any of the above areas.

Staff profile and career pathways

In terms of the numbers working in the sector, as with the case of numbers using such services, there was no national data available in any of the five countries. Data in this regard are held at the level of individual organisations. For example, in Ireland, the National Federation of Voluntary Bodies (NFVB) employ approximately 15,650 staff. Data from the National Association of Professional Educators (ANEP) and the Ministry of Health in Italy indicate that there are 25,000 educators working in the sector, 70,000 working in the social sector and 1,300,000 working in what is described as the sanitary health field. No data was available from the UK, Austria or Romania.

Qualifications and training

Each country was asked to report on the staff profile of those working in the sector and qualifications and training required. In the UK, in education services, e.g. special schools (which may run occupational workshops), a post-graduate teaching qualification was reported as necessary; however, in the wider sector there are no uniform requirements. In NHS-run services, it was reported that staff would typically have a nursing qualification (Mental Health or Learning Disability). In services registered with the Commission for Social Care Inspection, a National Vocational Qualification at level 2 in Health and Social Care is required. In occupational day services and other services 'giving occupation', the framework is loosely based on the adult or school education services. As such, typically but not necessarily, staff would have a diploma in adult education, sometimes specifically related to a particular client group such as people with learning disabilities.

In Italy it was reported that high levels of qualifications were the norm in the sector, though again based on role. Doctors/psychologists working in centres require a college degree. In the case of nurses particular specialist diplomas are requested. Others in the rehabilitation team (e.g. special educators, physiotherapists, speech therapists, neuro-psycho-motility therapists, technicians, educational therapists, occupational therapists) require either a degree or a special diploma.

In Austria, disability support workers are required to complete a minimum basic training of 2 years, which can lead to a diploma qualification. Occupational therapists are required to complete a Bachelor of Science in Health Studies in a college of further education. In the case of a nurse, a 3-year diploma is necessary. Social workers also require a 3-year diploma.

In the past, Romania did not have a structured educational framework for personnel working in this sector. However, in the last decade, specific training for occupational therapy has been developed. However, the number of qualified professionals within the sector remains very small. Front line staff are not required to hold any specific qualifications and it is at the discretion of the employer to ask for any proof of formal training before employment. As a result there remain a large number of people without specific or high levels of qualification or training working in the sector.

Managers at a local level were asked to comment on the qualification requirements of the staff they employ. Most managers indicated that newly recruited staff were required to be specifically trained for their work in their respective centre. In Austria, Ireland, Italy and the UK, managers indicated that staff received specific training in mental health/intellectual disabilities. In Romania all managers indicated that their staff did not receive training in mental health/intellectual disabilities and were not required to be specifically trained in order to be employed.

In terms of staff in service training, the managers were asked to indicate whether there was a formal co-ordination of staff development and education in their centre. Most indicated that staff development and education was not controlled by themselves, but dealt with by their central administration. This was reported by five managers in Ireland, one manager in Romania, three managers in Italy, and by four managers in the UK. In Austria ($n = 1$), Italy ($n = 2$) and the UK ($n = 1$) four managers reported that staff development was managed from within their particular centres. However, in Romania, two managers reported that there was no oversight of staff development in either of their centres by themselves or their central administration.

Career pathways

Respondents reported that there was no nationally recognised career path for this sector in their respective countries. Recognised professionals working in the sector, for example nursing, have their own specialised career path, but even with regard to these professions, there was no clearly defined avenue of progression. This national perspective was also confirmed by local managers.

Discussion

Perceptions around limited or uncertain resources, the impact of these on structures of organisations and the actual impact on day-to-day work are known to impact on the experience of work related stress (Edwards and Burnard, 2003; Lenthall et al., 2009). In most countries that we report on in this paper, resourcing appears to have a strong contingent, and therefore unpredictable base – with perhaps the exception of the UK. As a result there is a degree of uncertainty built into the system with regards to level of resource from year to year which is likely to contribute to work-related stress. This may explain variation in both level of service provision and nature of demand in terms of numbers clients served between countries, with services in the poorest country in terms of resource security – Romania – often having to deal with significantly larger case loads than other countries, such as Austria and the UK which receive a significant element of government funding.

Severity of problems and large numbers of case load are known to have a significant impact on work-related stress, particularly in the field of mental health compared to other areas of health and social care work (Fagin et al., 1996; Jenkins and Elliot, 2004; Zarghami & Schnellert 2004), even though recent research indicates that at a personal level staff derive satisfaction from

working with individuals (Harvey et al., 2009). A further consequence of the contingent nature of funding is personal perceptions of employment insecurity and a lack of a sense of belonging as a result. Both of these are known to increase work-related stress significantly (Margallo-Lana et al., 2001; Mandy & Tinley, 2004; Zeytinoglu et al., 2009).

Career pathways in the sector do not appear to have a clear progression, with little in the way of systematic approaches to staff development and support. In the context of the evidence for the protective nature of training and career paths helping employees deal with work-related stress this is significant (Golubic et al., 2009; Pitts, 2007).

Finally, bearing in mind the exhortations of European policy and the requirements of national legislation it is clear that at a local organisational level the presence of policies and procedures that address work-related stress vary considerably. The results would seem to indicate that the English speaking countries, Ireland and the UK, have a greater consciousness of work related stress – measured by policies and systems reported in place – than the non-English speaking countries. However, it is notable that no country at a local level appears to have a fully comprehensive set of policies and procedures that address the issue.

This variation may be due lack of awareness on the part of these organisations not only of their legal responsibilities but also of the issue of work-related stress itself or the possibility that most of the literature on the issue appears to be in English.

Conclusion

These findings suggest a wide variation across the five reported partner countries in terms of funding structures, qualifications of staff and career progression which can all increase work related-stress. Whilst recent research indicates that uniform policy approaches to dealing work place hazards such as work-related stress can be significantly affected by culturally derived interpretations and responses (Madan et al., 2008) this should not invalidate a European approach to such issues in a context of workforce mobility within the European Union. Indeed, our findings seem to indicate that there are shared structural issues with reference to work-related stress in the vocational and rehabilitative sector that need to be addressed within the context of European policy on employee well being. Perhaps, most striking is the gaps in national profile data for each country on even the most basic indices to allow measurement and comparisons to be made with regards the success of policies and the sharing of successful practices. As a result, developing effective transnational work-related stress management policy that addresses deficits and promotes an environment of worker well being in this sector is greatly impaired.

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