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**A REPORT ON
REDUCING OCCUPATIONAL STRESS IN EMPLOYMENT (ROSE)
OF PROFESSIONAL SUPPORT WORKERS
IN INTELLECTUAL DISABILITIES AND MENTAL HEALTH VOCATIONAL
TRAINING AND REHABILITATION IN EUROPE
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AUTHORS

Dr John Wells

(Waterford Institute of Technology, Ireland)

Dr Margaret Denny

(Waterford Institute of Technology, Ireland)

Ms Jennifer Cunningham

(Waterford Institute of Technology, Ireland)

Professor Trudie Chalder

(Dept of Psychological Medicine King's College London)

Ms Mary Mary Ridge

(Dept of Psychological Medicine King's College London)

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Executive Summary

- The well-being of experienced support personnel working within the vocational and rehabilitation sector is a significant factor affecting successful implementation of socially integrative health and social policy objectives for people with mental health and intellectual disability needs.
- In this study 19% of those workers sampled across five countries in the European Union showed symptoms of job strain and occupational with the potential to negatively impact upon their health.
- The sector in the countries sampled does not have mechanisms in place to deal with or manage occupational stress effectively.
- Organisations need to consider how they organise their working environment and structure working relationships to promote a sense of individual control over work and facilitating workers to feel involved and supported in their work.
- There is wide variation across Europe in relation to funding structures, qualifications of staff and career progression in this sector.
- There is a lack of a shared conceptual definition of the role of the support worker in this sector in terms of purpose and functions
- There are wide variations in the range of staff employed, qualification requirements and abilities to cope with occupational stress.
- There is no national or European data collected in this sector upon which to base effective interventions to deal with occupational stress amongst the workforce in this sector and therefore there is a need for the European Union to develop a data base that profiles this sector to address these information deficits
- There is a need to develop effective transnational occupational stress management policy that supports staff working in this sector

Paper I- Europe and optimising mental health in the workplace – A comparative exploration of contextual stressors in the rehabilitation sector in five European countries

Short title: Europe, occupational stress and vocational centres

Authors:

John Wells, PhD, MSc, BA (Hons), PGDip, RPN, RNT, Head of Department of Nursing,
Waterford Institute of Technology

Margaret Denny, PhD, MPhil, BSc (Hons), PGDip, RPN, RNT, Lecturer, Department of
Nursing, Waterford Institute of Technology

Jennifer Cunningham, MSc, BSc (Hons), RPN, Research Assistant, Department of Nursing,
Waterford Institute of Technology

Work carried out at the Department of Nursing, Waterford Institute of Technology, Ireland

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

Europe and optimising mental health in the workplace – A comparative exploration of contextual stressors in the rehabilitation sector in five European countries

ABSTRACT

Background

Dealing with occupational 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 develop an 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 interventions to combat occupational stress amongst 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.

Declaration of Interest

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Introduction

It is reported that up to 28% of employees across the European Union experience work related stress (Health & Consumer Protection Directorate-General, 2005). The European Union's social and employment policy prioritised the need to combat stress in the work place, with the adoption in 2004 of a European Framework Agreement (*ibid.*). Occupational stress in the health care sector is recognised as a significant problem (Boorman, 2009) and working in the field of mental health and intellectual disabilities is seen as particularly challenging in terms work related stress (Jenkins and Elliott, 2004). Most studies in this area focus on clinical settings and few judge the experience of work related stress with reference to the policy context across the European Union. A particularly under-researched sector in this regard is the community vocational support sector for people with mental health and intellectual disability problems. This sector is likely to play an increasingly important role in the delivery of services with regards European policy on mental health and social integration. This paper reports on the results of a scoping exercise conducted in five European countries (Ireland, UK, Italy, Austria and Romania) order to explore the degree

contextual issues in this sector might contribute to the experience of stress amongst the work force.

Defining occupational stress in a European context

European Commission guidance on work-related stress states that it 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 place 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) states that work place stress can be caused by factors such as work content, work organisation, work environment and poor communication in the workplace. Organisational indicators of work related stress include high absenteeism or staff turnover, frequent interpersonal conflicts or complaints by workers. At the individual level, workplace stress can result in various emotional, cognitive, behavioural and physiological reactions (Sarafino, 2005).

The European Agency for Safety and Health at Work (Cox *et al.*, 2000) identified both physical and psychosocial hazards in the workplace as being linked to stress. Physical hazards include factors such as noise and poor physical work environments, whilst psychosocial hazards are the job characteristics, work environments and organisations as these relate to either the work context or the work content (Cox *et al.*, 2000), and include the interactions between the organizational culture and an individual’s role in the organisation; their career development opportunities; their decision latitude/control in their day to day work; interpersonal relationships at work; the home-work interface; the nature of the work environment and quality and availability of work equipment to do the job; task design; workload/work pace and work schedule. For example, a literature review conducted by Michie and Williams (2002) 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 policy and legislative context

The European Commission emphasises the importance of social inclusion of people with mental health problems, through occupational and vocational support (European Commission, 2005), and addressing workplace stress (Health & Consumer Protection Directorate-General, 2005). The European Pact for Mental Health and Well-Being (WHO Europe, 2008) states that employers implement mental health and well-being work place policies with risk assessment and prevention programmes for stressful situations that can cause adverse effects on the mental health of workers. The European Parliament (2008) also issued a draft report on mental health in which it called on employers to promote the emotional and mental wellbeing of their workers and called on the European Commission to disseminate positive models by publishing workplace stress management programmes on the internet.

The European Framework Directive 89/391 on the introduction of measures to encourage improvements in the health and safety of workers at work covers work-related stress and its causes as well as other risks to health and safety. Under this Directive employers have a duty to ensure the safety and health of workers in every aspect related to the work. The Directive emphasizes the importance of employers adopting a risk avoidance strategy by dealing with workplace risks at source and adapting the work environment to the individual. Therefore employers are legally required to take measures to reduce or counteract work-related stress. The

overall policy emphasis at a European Union level is on the promotion of high productivity through optimal quality of life as this relates to occupational and public health (Levi, 2002).

It should be emphasised however, that many of these requirements and the policy emphasis overall is left to individual member states to implement, encourage and monitor. Thus no EU country appears to have specific regulations on psychosocial risk factors and/or work-related stress. However, the legislative frameworks of all EU countries consider work organisations to be a source of health and safety risks. 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, Safety and Welfare at Work etc Act 1974; in Ireland-Safety, Health and Welfare at Work Act, 2005; in Italy-Safety at Work Charter, 2000; in Austria-Health and Safety at Work Act, 1995; and in Romania-health and safety law under the Romanian Labour Code, 2005.

Work related stress in mental health settings

Jenkins and Elliott (2004) found that although many of the stressors experienced by mental health professionals are similar to other health care specialities, a number of demands relate specifically to the mental health settings. These include the intense nature of interaction between the client and mental health professional (Cronin-Stubbs & Brophy, 1985), dealing with difficult and challenging behaviour on a regular basis (Sullivan, 1993), and service changes in the mental health organisations (Fagin *et al.*, 1996).

Edwards and Burnard (2003) found that the most frequently reported sources of stress amongst mental health nurses were administrative, organisational and resource concerns. However, in addition to these organisational factors, they found that interpersonal and intrapersonal factors were also important, such as client-related issues, heavy workload, interpersonal conflict, professional self-doubt, home/work conflict and poor supervision. Findings from a systematic review on occupational stress in psychiatrists (Fothergill *et al.*, 2004) indicate that psychiatrists also experience significant levels of stress. Specific stressors included overwork, management and resource issues, personal stresses, lack of time, organisational changes, lack of administrative support and low pay.

As the above studies indicated the focus of work related stress research in the mental health sector has tended to focus on clinical staff. Some studies have looked at the phenomena in community mental health settings, where high levels of ‘emotional exhaustion’ have been found to be a significant component of ‘burnout’ (Carson *et al.*, 1995; Prosser *et al.*, 1996; Marine *et al.* 2007) and a significant reason for experienced staff turnover in social care related work (Cherniss 1997). For example, an unpublished Irish survey found staff turnover in the National FAS Supported Employment Programme was 47%, with *burnout* a significant factor (National Co-ordinators Forum 2005, unpublished). However, published research on the experience of stress in rehabilitative settings, particularly comparative European studies in this sector are notable for their absence.

Data Collection

The aim of this ‘scoping’ exercise was to provide an organisational profile of the vocational support and rehabilitation sector for people with mental health and intellectual disabilities as this

related to occupational stress in five European countries (Austria, Ireland, Italy, Romania and UK)..

A baseline information gathering sheet was designed to gather information on the national profile of occupational and rehabilitation centres for mental health and/or intellectual disability service users, looking at such questions as funding sources and staff training. These questionnaires were sent to senior managers of five representative national organisations in each of the target countries. In addition the managers of 25 vocational and rehabilitation centres at a local level (five from each country) were asked to comment on these issues, via a short face to face interview and questionnaire, specific to their centre.

Service provision

Level of case load and numbers of clients being served are known to be a significant service consideration in terms of impact on individual occupational stress (Zarghami & Schnellert 2004). 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 was 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 (it should be noted that the Irish government has completed such a survey nearly 18 months ago but at the time of writing has not published its results). Thus data could only be provided as this related to the specific organisations approached.

This in itself however revealed some interesting variations. Thus in Italy there were an average of 20 service users at centres whilst in Romania 380; both 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.

In each country, a range of training and occupational activities are offered with most services offered in community settings some are still attached to hospitals or to larger residential care homes. Thus, in Austria residential and day services are offered, providing training and occupational activities include day structure, assisted living, mobile care, diverse training and workshops. In contrast, in Romania training and occupational 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 centres where clients were based. In Austria and Romania most clients are located in community home settings. In the UK, Ireland and Italy most clients occupy day places centres and live at home.

Bearing in mind, European directives and legislative requirements to have in place a range of policies, procedures and programmes to address issues that impact on work place stress (see above) local managers were asked to comment on the degree to which the centre which they managed had policies in place that specifically dealt with this issue as per European Union requirements. In Austria managers reported that there were no local policies on workplace stress, stress risk assessments or anti-bullying. Only 1 manager reported that there was a policy to deal with absence from work and 2 managers reported that they had employee assistance programmes and conflict resolution policies.

In Ireland 4 managers reported that their organisations had a policy on workplace stress, and all 5 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. However, only one manager

In Italy, 3 managers indicated that they had a policy on workplace stress, policies to deal with absence from work and employee assistance programmes. Only 1 manager reported that they had an anti-bullying policy and a conflict resolution policy in place. Again, only one manager reported that their centre had a stress risk assessment policy that incorporated workplace stress place.

In the UK 4 centres has a policy on workplace stress, 5 had a policy to deal with absence from work, 5 had an anti-bullying policy, 4 had an employee assistance programme, and 4 centres had a policy on conflict resolution. Notably, managers from Romania stated there were no policies in place any of these areas.

Staff profile and training

The nature and level of educational qualifications are known to impact on the ability of individual health care workers to cope with occupational stress (Golubic *et al.*, 2009; Pitts, 2007) Respondents were asked to provide information on the numbers of people working in the sectors and educational qualifications and training required. In each country type of training for staff depends on the type of professional role being undertaken within a rehabilitation, vocational or occupational training centre. In the UK, in education services, e.g. special schools (which may for example run occupational workshops), a post-graduate teaching qualification is necessary, otherwise, there are no mandatory requirements. In NHS-run services, staff would typically have a nursing qualification (Mental Health or Learning Disability Nursing). In services that are 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 doctors/psychologists working in centres require a college degree. In the case of nurses particular specialist diplomas are requested. Other professionals of 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 yrs, 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 the support 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. It is at the discretion of the employer to ask for any proof of formal training before employment.

Literature indicates that within the health and social care sector, a sense of belonging to a large organisation appears to give employees a sense of community, and assist in their ability to deal with occupational stressors (Margallo-Lana *et al.*, 2001). 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 partner countries. Data in this regard is held at the level of individual organizations. 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 indicates 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.

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. However in Romania one manager indicated that newly recruited staff were not required to be specifically trained in order to be employed.

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

In terms of staff development, the manager 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 parent bodies. This was reported by 5 managers in Ireland, 1 manager in Romania, 3 managers in Italy, and by 4 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, 2 managers reported that there was no oversight of staff development in either of their centres.

Career pathways

Good career pathways and occupational status are noted as significant in terms of dealing with occupational stress (Mandy and Tinley, 2004). Respondents reported that there was no nationally recognised career path for this sector in their respective countries. Recognised professions

working in the sector, for example nursing, have their own specialized career path, but even with regard to these professions, there was no clearly defined avenue of progression.

Sources of funding

Perceptions around limitations on resources and the actual impact on day to day work of funding shortages are known to impact on the experience of occupational stress (Lenthall *et al.*, 2009). Respondents were therefore asked to profile their respective countries in terms of principal sources of funds as a means of gauging the degree of security of funding arrangements for the sector in each country. All respondents reported that there were no figures available for the overall national level of funding for the sector. Each reported that 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, centres are based on a fee for service model with service users' families paying towards costs. These fees are also supplemented with funding from the local regional authorities.

Austrian services are funded through a mixed funding model. Extramural mental health services, other than psychiatrists in private practices, are publicly funded but available only from a large variety of private and charitable providers. Private health insurance provides approximately 42% of income, government funding, accounts for approximately 27% of resources and self financing by service users and their families, accounts for 30%.

Ireland has a complex model, in which services are primarily funded from 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 through charitable donations 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 program, 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).

Discussion

The results indicate that whilst there is a broadly a similar range of services is provided in each of the five countries, there is a wide variation in both level of provision and nature of demand in terms of numbers clients served between countries, with services in the poorest country – Romania – often having to deal with significantly larger case loads than other countries services. Significantly, however, from a perspective of drawing both national and European policy on employee welfare in this sector there is no national and European data collected at any level in this sector upon which can be based effective interventions to combat occupational stress that may be peculiar to the sector.

With the exception of Romania, all countries reported that some sort of relevant formal training and qualification was required. However, career pathways in the sector appear to be management orientated with no clear progression and poor educational and staff development support. Again in the context of the literature on the protective nature of training and career paths in helping employees deal with psychosocial stress related to the work place this is significant.

Finally, with perhaps the exception of the United Kingdom, funding sources are significantly dependent on private giving, either through charitable donation or fee for service. This inevitably

engenders an element of uncertainty in terms of future development and job security in the sector. In the case of Romania, which is heavily dependent on external sources of funding, principally from the European Union, the lack of security is likely to be more pronounced. Such perceptions of employment insecurity are known to significantly increase occupational stress (Zeytinoglu *et al.*2009).

As illustrated by the contributions of frontline managers, there is a failure of compliance with European and national legislation as well as adoption of good practice in relation to employee welfare at a local level. Our limited snapshot survey seems to indicate that lack of compliance with legislative requirements to have policies and programmes in place to assist employees suffering from occupational stress 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 place stress itself.

Conclusion

These findings suggest a wide variation across the five reported partner countries in terms of funding structures, qualifications of staff and career progression. This in part is a consequence of the lack of a shared conceptual definition of the role of this sector in terms of purpose and functions, inevitability leading to wide variations in the range of staff employed, qualification requirements and abilities to cope with occupational stress. However, most striking is the lack of centralized profile data in each country on even the most basic indices. There is no European initiative to these deficits in the sector. This is significant bearing in mind that there is now a European policy emphasis on developing integrative models of service delivery in these areas. In effect policy at a European and national level on many indices in this area is 'flying blind'. As a

result developing effective transnational occupational stress management policy that supports staff working in this sector and measuring its success is greatly impaired.

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Paper 11- Psychosocial job strain amongst mental health and intellectual disability servicesupport workers in five European countries and implications for workforce development policy

Authors:

Margaret Denny, PhD, MPhil, BSc (Hons), PGDip, RPN, RBT, RNT, Lecturer, Department of Nursing, Waterford Institute of Technology

Professor John Wells, PhD, MSc, BA (Hons), PGDip, RPN, RNT, Head of Department of Nursing, Waterford Institute of Technology

Jennifer Cunningham, MSc, BSc (Hons), RPN, Research Assistant, Department of Nursing, Waterford Institute of Technology

Work carried out at the Department of Nursing, Waterford Institute of Technology, Ireland

Correspondence to: Margaret Denny, PhD, MPhil, BSc (Hons), PGDip, RPN, RBT, RNT, Lecturer, Department of Nursing, Waterford Institute of Technology, Waterford Institute of Technology

Tel: 00-353-51-302816

E-mail: mdenny@wit.ie

Abstract

The European Union's social and employment policy emphasizes that member states should develop workforce development policies that combat work related stress (Directorate General for Health and Consumers, 2008). Within the European Union there is little comparative data on the psychosocial job strain characteristics and experiences of staff working in the vocational rehabilitative sector in mental health and intellectual disabilities. This paper reports the findings of a small-scale exploratory study on psychosocial job strain amongst support workers in five European countries. Data was gathered through administration of the Job Content Questionnaire (JCQ) and a series of focus groups. Findings from the JCQ showed that just under 19% of the sample were showing symptoms of job strain, whilst results from the focus groups indicated that the key stressors for workers were balancing work demands with time available to carry out tasks, poor communication within organizations and feeling unsupported in one's work

Keywords: psychosocial stress, support workers, Europe

Introduction

The European Pact for Mental Health and Well-being (Directorate General for Health and Consumers, 2008) emphasizes the need for governments, employers, trade unions and experts to exchange policies, practices and evidence from research on mental well-being in the workplace. The Green Paper on the future of the European Workforce for Health (Commission of the European Communities, 2008) emphasizes psychosocial elements in employee welfare as an important factor for a sustainable workforce if health services are to be effective and maintained.

Studies on stress and burnout in the workplace have considered individual and contextual work related factors separately rather than incorporating the two (job-person fit) in relation to the assessment of the psychological demands placed on workers and their capacity for autonomy in a busy and demanding working environment (Fernet, 2004 Maslach *et al.*, 2001).

One demanding area, given the increased policy emphasises on the social integration of people with significant psychological problems, is the rehabilitation of people with intellectual disabilities and mental health problems (Directorate General for Health and Consumers, 2008). Whilst there is little or no published research on the consequences of staff burnout within support and rehabilitation settings for this client group, an unpublished survey in Ireland found staff turnover in the National FAS Supported Employment Programme was 47%, with burnout a significant factor for leaving employment (National Co-ordinators Forum 2005 unpublished). Based on the European policy emphasis on workplace well-being and the lack of data on its impact in this specific sector, this paper reports on the findings of an exploratory small-scale study of stress in the workplace in five European countries.

Methods

The objectives of this study were:

- To compare psychosocial stress across countries occupational.
- To ascertain if any of the participants in the five countries presented with a combination of high job demands and low job control that signifies higher stress job situations.
- To investigate if the main sub scales of the JCQ: decision latitude (DL), psychological job demands (PJD) were associated with the prevalence of job strain

risk behaviours, that is, smoking, high blood pressure, sleep problems that are associated with coronary heart disease.

A multi-method research approach was adopted. An available sample from five rehabilitation centres in five European countries – United Kingdom, Ireland, Italy, Romania and Austria – were accessed using a questionnaire and focus groups. Specific parameters of interest to this project were centre managers (n=30) and centre support workers (n=30).

The Job Content Questionnaire

The Job Content Questionnaire (JCQ) is a standardized 49 item instrument with a scoring system that enables both within and across population comparative analysis of occupational psychosocial stress. It is available in several languages (Karasek, 1979, 1998). For this study the languages used were English, German, Romanian and Italian.

The theoretical interpretation of the JCQ reflects a sociological focus since it presumes the existence of socially objective environments that systematically affect an individual's well-being and behaviour (Karasek, 1979, 1985). In addition, the JCQ adopts a psychological focus as it proposes that there is a behaviour basis for emotion-driven work related psychological distress and psychosomatic illness development (Karasek *et al.*, 1998). Based on this conceptualisation Karasek and Theorell (1990) developed a job demand control model (JD-C). Job control is conceptualized as the control over work process, or the ability to make decisions and the chance to exercise a degree of control over the work to be accomplished (Fernet *et al.*, 2004). The purpose of using the JCQ was to measure JD-C is to *job strain* in the workplace as an indicator of future physical and psychological illness amongst a given workforce

The negative ill health outcomes of job strain relate to the physiological manifestations of stress, such as a risk factor for coronary heart disease (CHD) (Akiomi *et al.*, 2009; Landsbergis, *et al.*, 2005; Leroux *et al.*, 2006; Steenland, 2000; Cheng, *et al.*, 2000), insomnia (Nomura *et al.*, 2009; Kalimo *et al.*, 2000; Cahill, & Landsbergis, 1996; Murata *et al.*, 2007; Leroux *et al.*, 2006) and risk of developing cancer (Elovainio *et al.*, 2004; Achat *et al.*, 2000).

Focus Groups

Two focus groups were facilitated by two of the research team in each country. One focus group in each consisted of managers of centres and the other of support workers. Discussions were

audio recorded and then transcribed into NVivo 8. The focus groups explored the views of managers and support workers everyday stressors within their workplace and how these impacted on their work and what they felt might help them to manage workplace stress. As such this data supplemented data gathered through the JCQ.

Data analysis

All JCQ scores were imported into an industry standard software package – *Statistical Package for the Social Sciences* (SPSS- version 15) and statistically analysed through both descriptive and inferential statistical methods.

Qualitative data was analysed using NVivo 8. Data was coded under free nodes. The free nodes consisted of the general consensus of the participants on their understanding of stress; awareness of stress; their views on stressors within their respective organisation; organisational structures and processes; relationships at work; management techniques and their views on the utility and design of an online de-stressor programme.

Results

The JCQ was distributed to managers (n=30) and support workers (n=30) and a response rate of 90% was achieved. Altogether, fifty four questionnaires were completed by both managers and support workers from the five partner countries.

Table 1 presents the demographic details of participants from the five participating countries.

Country	Response	Gender		Ethnicity		Marital Status			
	F (n)	F (%)	M (%)	W (%)	O (%)	S (%)	M (%)	D/S (%)	W (%)
Austria	9	6	3	8	1	3	4	1	0
Ireland	12	10	2	12	0	5	6	1	0
Romania	14	13	1	14	0	1	12	1	0
Italy	7	5	2	7	0	2	3	2	0
UK	12	9	3	10	0	1	8	2	1
Total	54	43	11	51	1	12	33	7	1

Key: F=female; M=male; W=white; O=other; S=single M=married; D/S=divorced/separated; W=widowed

Table 1: Gender, ethnicity and marital status by Country

As can be seen from Table 1 the greatest response rate was from Romania (n=14). Italy had the lowest response rate (n=7). In relation to gender the greatest response was from females (n=43) compared to men (n=11). With regard to race, respondents were predominantly white with one in the 'other' category. The greatest number of respondents were married (n=33) followed by eleven (n=12) who were single.

Table 2 provides summary statistics on the mean age of all participants.

Country	Mean (SD)
Austria	48.0 (9.2)
Ireland	34.7 (7.7)
Romania	39.9 (7.1)
Italy	51.0 (9.4)
UK	46.3 (11.2)

Table 2: Age and Country

The distribution of scores for age shows that participants in Italy (mean =51.0) were slightly older than the other participant groups with the youngest participants coming from Ireland (mean= 34.7; SD 7.7).

Table 3, 4, 5, 6, and 7 evidences the demographic distribution of the recommended scales scores for ‘Decision Latitude’, ‘Psychological Job Demands’, ‘Social Support’, ‘Job Insecurity’ and ‘Physical Psychosomatic Strain’.

Decision Latitude				
	Support Workers		Managers	
Country	n (%)	Mean (SD)	n (%)	Mean (SD)
Austria	4	57.7 (7.1)	5	60.4 (4.9)
Ireland	6	54.6 (5.7)	6	57.5 (4.9)
Romania	8	52.5 (4.2)	6	57.2 (7.5)
Italy	3	60.1 (6.1)	4	61.3 (6.0)
UK	4	58.0 (9.0)	8	56.1 (6.9)
Total	25		29	

Table 3: Decision Latitude cross-tabulated by country and job type

Scores for decision latitude (skill discretion and decision authority) were greater for managers than support workers in each country other than the UK.

The results of psychological job demands, cross-tabulated by country and job type, which is the psychological stressors involved in accomplishing the work load, stressors related to unexpected tasks, and stressors related to job related personal conflict, are presented in Table 4.

Psychological Job Demands				
	Support Workers		Managers	
Country	n	M (SD)	n	M (SD)
Austria	4	32.3 (3.9)	5	34.6 (2.9)
Ireland	6	30.3 ((3.3)	6	35.8 (6.1)
Romania	8	32.9 (6.2)	6	34.2 (2.2)
Italy	3	29.0 (3.6)	4	28.3 (1.8)
UK	4	31.8 (4.8)	8	34.4 (5.1)
Total	25		29	

Table 4: Psychological Job Demands cross-tabulated by county and job type

Mean scores for psychological job demands were greater for managers than for support workers. In Italy, psychological job demands scores were slightly higher for support workers (m=29.0, SD=3.6) than for managers (m=28.3, SD=1.8). The greatest score for psychological job demands was for managers in Ireland whilst the lowest score was for managers in Italy. Table 5 shows the variables ‘Social Support’ cross-tabulated by country and job type.

Social Support				
	Support Workers		Managers	
Country	n	M (SD)	n	M (SD)
Austria	4	20.0 (4.2)	5	32.0 (11.2)
Ireland	6	24.8 (2.6)	6	23.7 (4.2)
Romania	8	20.6 (4.0)	6	21.0 (3.6)
Italy	3	23.3 (2.0)	4	23.0 (1.0)
UK	4	25.3 (6.0)	8	28.6 (9.7)
Total	25		29	

Table 5: ‘Social Support’ cross-tabulated by country and job type

Social support scores were greater among managers in Austria and the lowest score was for support workers in Austria. Table 6 presents the results for ‘Job Insecurity’ cross-tabulated by country and job type.

Job Insecurity				
	Support Workers		Managers	
Country	n	M (SD)	n	M (SD)
Austria	4	6.8 (3.5)	5	4.6 (0.5)
Ireland	6	4.8 (1.0)	6	5.5 (0.8)
Romania	8	7.0 (2.1)	6	5.5 (1.7)
Italy	3	4.3 (0.6)	4	6.8 (4.1)
UK	4	4.3 (0.6)	8	4.9 (0.8)
Total	25		29	

Table 6: ‘Job Insecurity’ cross-tabulated by country and job type

Job insecurity was higher for managers than for support workers. Support workers in Romania scored highest on the job insecurity scale. The lowest score was by support workers in Italy and in the UK. Table 7 presents the results for ‘Physical Psychosomatic Strain’ by country and job type.

Physical Psychosomatic Strain				
	Support Workers		Managers	
Country	n	M (SD)	n	M (SD)
Austria	4	0.3 (0.3)	5	0.1 (0.0)
Ireland	6	0.1 (0.0)	6	0.3 (0.2)
Romania	8	0.2 (0.1)	6	0.3 (0.1)
Italy	3	0.2 (0.0)	4	0.2 (0.2)
UK	4	0.3 (0.1)	8	0.3 (0.1)
Total	25		29	

Table 7: ‘Physical Psychosomatic Strain’ by Country and job type

In relation to the scale physical psychosomatic strain, managers scored highest. The highest scores were by managers in Ireland, Romania and Italy and by support workers in Austria and the UK.

Table 8 presents a breakdown of results on workers exposed to both high *Psychological Demands (PD)* and low job *Decision latitude (DL)* (PD+, DL-) referred to as a high-strain group of workers.

Job Strain	Frequency	%
No job strain	44	(81.5)
High job strain	10	(18.5)
Total	54	(100.0)

Table 8: Job strain (High psychological job demands and low decision job latitude)

The findings indicate that 10 (18.5%) participants presented with high job strain. High job strain is defined as scoring above 32 (median score) in *Psychological Job Demands* and below 56.5 (median score) in *Decision Latitude*. Table 9 presents risk behaviours that have been associated with job strain.

Variable	Frequency	Percent %	Valid %
Smoker			
No	40	74.1	75.5
Yes	13	24.1	24.5
Missing	1	1.9	
Total	54	100.0	100.0
Blood Pressure			
Yes	2	3.7	3.7
Borderline	4	7.4	7.4
No	46	85.2	85.2
Don't Know	2	3.7	3.7
Total	54	100.0	100.0
Often Tired			

Often	11	20.4	20.4
Sometimes	29	53.7	53.7
Rarely	13	24.1	24.1
Never	1	1.9	1.9
Total	54	100.0	100.0
Trouble Getting to Sleep			
Often	4	7.4	7.4
Sometimes	17	31.5	31.5
Rarely	19	35.2	35.2
Never	14	25.9	25.9
Total	54	100.0	100.00
Trouble Staying Asleep			
Often	6	11.1	11.3
Sometimes	16	29.6	30.2
Rarely	11	20.4	20.8
Never	20	37.0	37.0
Missing	1	1.9	1.9
Total	53	100.0	100.0

Table 9: Risk behaviours associated with job strain

As can be observed from Table 9, approximately one-quarter (24.5%) of the participants stated that they smoke. Less than four per cent (3.7%) stated that they had high blood pressure problems. Seventy-four per cent reported that they are sometimes or often tired. Approximately 42% (41.5%) stated that they sometimes or often had trouble staying asleep. Table 10 presents the results of risk behaviours cross-tabulated with the high strain group.

Smoker	No Job Strain		High Job Strain		Total	
	n	%	n	%	n	%
No	30	(69.8)	10	(100.0)	40	(75.5)
Yes	13	(30.2)	0		13	(24.5)
Total	43	(100.0)	10		53	(100.0)
High Blood pressure						
Yes	2	(4.5)	0		2	(3.7)
Borderline	4	(9.1)	0		4	(7.4)
No	36	(81.8)	10	(100.0)	46	(85.2)

Don't Know	2(4.5)	0	2 (3.7)
Total	44(100.0)	10 (100.0)	54 (100.0)
Often Tired			
Often	8(18.2)	3(30.0)	11 (20.4)
Sometimes	24(54.5)	5(50.0)	29(53.7)
Rarely	11(25.0)	2(20.0)	13(24.1)
Never	1(2.3)	0	1(1.9)
Total	44(100.0)	10(100.0)	54(100.0)
Trouble Getting to Sleep			
Often	3(6.8)	1(10.0)	4(7.4)
Sometimes	13(29.5)	4(40.0)	17(31.5)
Rarely	16(36.4)	3(30.0)	19(35.2)
Never	12(27.3)	2(20.)	14(25.9)
Total	44(100.0)	10(100.0)	54(100.0)
Trouble Staying Asleep			
Often	5(11.6)	1(10.0)	6(11.3)
Sometimes	13(30.2)	3(30.0)	16(30.2)
Rarely	9(20.9)	2(20.0)	11(20.8)
Never	16(37.2)	4(40.0)	20(37.7)
Total	43(100.0)	10(100.0)	53(100.0)

Table 10: Risk behaviours cross-tabulated with high strain group

Table 10 indicates that none of those in the high strain group smoke. All of those within the high strain group reported that they did not have high blood pressure. Eight of the 10 in this group stated that they are sometimes or often tired and four out of the 10 stated that they had trouble staying asleep.

The items corresponding to depression/life dissatisfaction are given in Table 11 together with the number and percent who reported a score of at most three for each item. This score indicates that the participants described their lives by the words outlined in Table 11.

Is your life	n	%	Cross-tabulated (High strain group) n
Boring	1	1.9	0
Enjoyable	47	87.0	6
Worthwhile	50	92.6	6
Friendly	48	88.8	5
Full	50	92.6	7
Hopeful	49	90.6	6
Rewarding	47	87.0	5
Brings out the best in you	46	85.2	3

Table 11: Depression/Life dissatisfaction items

Less than two per cent of participants described their life as boring. The majority of participants described their lives as worthwhile (92.6%), full (92.6%), hopeful (90.6%), friendly (88.8%) enjoyable (87%), rewarding (87%) and brings out the best in them (85.2%).

Of the 10 participants within the high strain group, boring was not selected by any of them to describe their lives. Seven described their lives as full. Enjoyable, worthwhile and hopeful were each identified by six participants. Friendly and rewarding were each selected by five participants. Three participants described their lives as bringing out the best in them.

Focus group Results

Client group as a source of stress

Several participants referred to the general nature of their work and the client group as a source of stress:

You're working in a stressful environment with service users with intellectual disabilities and mental health issues. (Ireland/Support Worker2)

The sound of yelling. (Romania/Support Worker1)

A number of support workers referred to the challenges that arise for them when dealing with clients' individual distress induced by unexpected change:

The clients are also getting stressed out, and when they get stressed out they show it...if somebody who is autistic plans are changed then their world is turned up side down and you have to deal with the consequences (Ireland/Support Worker4)

Work demand

Balancing the range of work demands and the availability of time to carry out tasks was also mentioned by many as a personal stressor. A support worker from Austria said:

You have to do five things at the same time. (Austria/Support Worker3)

Other participants felt their role was constantly expanding:

The role just expands continuously, it doesn't even stop there... it has evolved again. (Ireland/Support Worker3)

You are constantly being side-tracked...you are meant to be spending your time doing staff supervision and you end up doing other administrative tasks... your trying to be all things to everybody. (UK/Manager1)

Fear of crisis

Some participants spoke about anticipatory anxiety, in terms of the unpredictable nature of some of their work and the possibility of having to deal with crises:

Stress can be when I work with clients and I am very anxious because I am always afraid that it can happen, a crisis or whatever, so it is something still unexpected and that creates stress. (Italy/Support Worker2)

Poor communication

There was recognition from both managers and support workers that poor communication was a cause of stress within their workplace. Some support workers felt un-consulted about how centres were managed:

It would avoid a lot of stress if the decision-making level would communicate better with the worker, to see and to hear their views and to incorporate it into the decisions. (Austria/Support Worker1)

Feeling unsupported in one's work

Feeling unsupported from other workers and colleagues in one's work was frequently mentioned by support workers as a source of stress:

There was no one there to help me. (UK/Support Worker)

I feel that I get support from my immediate colleagues but with regards to the management system I don't think so because they are like you have to do a job and that's it. (Ireland/Support Worker4)

Interpersonal Conflict

Personal antagonisms between workers in centres were cited by a number of participants as a factor in work place stress:

I knew when I was going into this job the sort of stress you would get from the clients. You didn't know the kind of stress you would experience from the people that you are working with, that's what I found the hardest because it is not directly linked to your job. (Ireland/Manager4)

A manager in Romania described their role as refereeing between various factions

I am between my supervisor, my chief and my employees and I must manage the conflict between the chief and the employees and between me and the employees... It's a very difficult position. (Romania/Manager3)

Stress as 'weakness'

Some participants, notably managers, viewed 'stress as an indicator that they were unable to cope in their work and therefore unable to seek help:

The last thing people want to do is to put their hands up and say I'm stressed, I'm not coping... especially if you are in a management position you don't want to highlight what your weaknesses are or that you are failing in any way (UK/Manager2)

However, some support workers seemed more willing to admit to managers that they were stressed:

I spoke to management about reducing hours because of the stress I was experiencing (UK/Support Worker)

Specific stressors in Romania and Ireland

Although most stressors appear to be common across all five countries there were some differences of emphasis particularly between Ireland and Romania. In Romania lack of training and education was a dominant theme, with a desire amongst staff for more training and guidance.

I feel I need more training but this is not possible and I don't know why because I never get an answer (Romania/Manager3).

These managers also referred to lack of financial resources and their involvement in fundraising as greatly adding to their level of personal stress:

Sometimes I feel I am not able to do all these things...the fundraising...it's very difficult to think that in one or two months we may not have salaries. (Romania/Manager4)

Alternatively, in Ireland role creep was mentioned by a number of participants as a stressor:

*People are being put in roles that they have never been recruited for.
(Ireland/Manager3)*

Discussion

Findings from the JCQ showed that just under 20% of the sample showed symptoms of job strain, whilst results from the focus groups indicated that the key stressors for workers were lack the client group, work demands, fear of crisis, poor communication between staff, feeling unsupported, interpersonal conflict and stress as a weakness.

Scores for decision latitude (skill discretion and decision authority) psychological demands and social support in the JCQ were consistently positive for managers when compared to support workers in each country. This suggests that managers in centres who have high psychological demands and high control (latitude) do not appear to present with high job strain. This is consistent with the findings of other studies (Akiomi *et al.*, 2009; Leroux *et al.*, 2006). Social support was low for support workers

These results were also evidenced in the focus groups in that some support workers emphasised the need to feel supported in order to deal with day to day challenges of work. It has been found that high staff support at work increases staff retention (Brough & Frame, 2004; Houkes *et al.*, 2003). It has been suggested that staff feeling supported improves health outcomes because it acts as a stress buffer (Wang *et al.*, 2005 & Gruber, 2008).

The finding in the JCQ that ten participants presented with high job strain is consistent with the results of studies such as Akiomi *et al.*, (2009) and may be an important predictor of future physiological manifestations of job strain, such as cardio vascular disease, for these workers. The results do not support the findings of other studies that have suggested that insomnia increases with job stressors, including job demands/job strain (Nomura *et al.*, 2009).

This JCQ result is also consistent with the findings in the focus groups, as these relate to work demands and participants' dissatisfaction with levels of communication and involvement in decision making. The European Parliament (2008) in their draft report on Mental Health indicate that poor communication at work can contribute to the development of mental disorders or induce workers to take early retirement.

In terms of physiological manifestations of stress, the JCQ results indicate that risk behaviours in other research that is associated with job strain, that is, smoking and high blood pressure, were not substantiated by the 10 people in the high strain group. However, higher level symptoms were reported by this group in response to the following questions *often feeling tired, trouble getting to sleep and trouble staying asleep*. The latter symptoms are associated with health related risk behaviours and support the results of existing research that suggests that there is a connection between the physiological effects of stress and job strain (Nomura *et al.*, 2009; Murata *et al.*, 2007; Leroux *et al.*, 2006; Inoue *et al.*, 2009).

Limitations

The non random selection of participants meant an available sample had to be used and the sample (n=60), which impacted on the procedures needed to show statistically significant differences between countries. Measurement of job strain, using the JCQ, at only one point in time may have underestimated the effect of job strain in the identified centres and limits causal inferences. In addition, the subjective interpretation of questions by participants due to cultural or translation misunderstandings, may have impacted on the results. Eighty percent of the target group did not present with high job strain. This may have been due to the Likert scales distorting the results or other extraneous variables. However, it could be due to respondents avoiding extreme category responses or agreeing with responses as presented or trying not to portray themselves or their organisation in an unfavourable light (Hodge & Gillespie, 2003). However, the strength of this small scale assessment highlights the fact that the JCQ rightly identified

psychosocial stress in ten of the participants.

With regard to focus group results limitations relate to cross cultural understanding of stress. In addition there is the possibility that some participants gave views in principle rather than views in fact (Icheiser, 1949).

Conclusion

If European Commission policy on social integration of people with mental health problems is to be realised in member states, the well-being of experienced support personnel within the vocational and rehabilitation sector is a significant factor affecting successful implementation. The findings from this exploratory study indicate that in this particular sector a sense of control over one's work and feeling involved and supported are key variables that impact on a personal sense of occupational stress and that organisations need to consider this in how they organise their working environment and structure working relationships.

Declaration of Interest

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