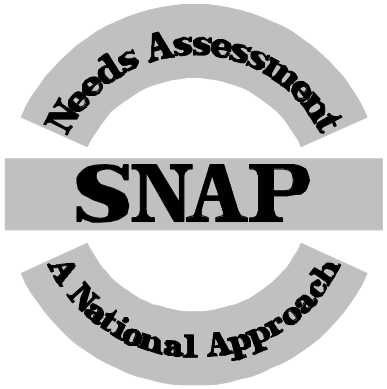
Scottish Needs Assessment Programme



Mental Health in the Workplace

SCOTTISH FORUM FOR PUBLIC HEALTH MEDICINE

Scottish Needs Assessment Programme

Priority Services Network

Mental Health in the Workplace

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EXECUTIVE SUMMARY

Aim and Objectives of Report

The aim of this report is to help all organisations throughout the NHS in Scotland to investigate and effectively tackle stress and the promotion of mental health in the workplace. In turn it is hoped that Health Boards will encourage and assist other major employers in their areas to do likewise. The report has the following detailed objectives:

- to outline the size and impact of mental health problems/stress in the workplace
- to describe current responses to the problem, review the evidence on effectiveness and cost effectiveness of responses and identify examples of good practice
- to outline approaches that can be taken to assess local needs and develop action plans
- to provide advice on implementing and evaluating local action plans

This report focuses upon mental health promotion and the prevention of mental illness in a workplace setting only (primary prevention). However, the approach taken to the treatment, support and rehabilitation of those with mental health problems or mental illnesses (secondary and tertiary prevention) does not differentiate between those instances where the workplace is thought to have contributed to causing the problem and those where it is not.

Mental Health, Stress and the Workplace

There is no concensus on the definitions of mental health, mental illness and stress, and therefore this chapter begins by discussing terminology and outlining the working definitions used throughout this report.

The prevalence of mental health problems in the general population is very high, and even higher levels have been documented in workplace settings. This is particularly the case within the NHS. Furthermore, a survey of 112 UK companies showed that 65% believed stress was the most important health issue within their workplace.

The financial cost to industry has been conservatively estimated at £5.3 billion per annum, equivalent to the loss of 9 000 to 10 000 full time staff for the NHS. However, the impact of stress (via absenteeism, high staff turnover, poorer interpersonal relations and so on) on performance at work and the quality of the service, and in terms of the health and well-being of staff and their families, may be even more significant.

The causes and influences on work-related stress are many and complex, involving intra and inter-personal issues, and group and organisational processes. More tangible issues such as exposure to violence, job insecurity and long and unsocial working hours seem to be important, as do less tangible ones such as poor communication, no feedback on performance and a non-supportive organisational culture.

The Effectiveness of Responses

There is a dearth of well designed evaluative studies addressing mental health problems in workplace settings. The evidence suggests that stress management training, designed to increase skills in handling stress, delivers benefits to staff, but these may not be maintained in the long term. There seems to be stronger evidence for the effectiveness of employee assistance programmes (EAPs), particularly those that are more broadly based. Nevertheless, the 'narrower' EAPs that provide only counselling services have also been shown to improve self-reported psychological health and absenteeism.

Intuitively, controlling the sources of pressure in the work environment would appear to be the most effective way of addressing stress at work. In fact the evidence available supports this intuition even though the sources of pressure modified were limited.

However, there is a strong consensus that comprehensive programmes of action providing a range of interventions (encompassing stress management training, EAPs and the control of the sources of pressure) are the most effective. There is also some evidence to support this view.

A matrix has been developed to help identify such comprehensive programmes of action, and covers the promotion of mental health and the prevention, treatment and rehabilitation of mental illness at organisational, group and individual levels.

Current Responses to Stress and Mental Health Problems in the Workplace

A minority of organisations appear to be taking action in relation to stress in their workplace. Those that are concentrate on individual workers by providing stress management training and/or counselling support for those experiencing problems. There are far fewer examples of interventions at the organisational level tackling the sources of pressure or of comprehensive programmes of action, with the notable exception of the Scandinavian countries.

Assessing Local Needs

A local assessment of needs is essential to describe the size and impact of stress, to identify the sources of pressure so that appropriate actions can be developed, and to engender ownership and commitment to change.

A wide variety of approaches can be used in assessing needs. For example, attention could focus on individual staff perceptions and experiences or on the organisation by auditing its policies and procedures; quantitative data can be collected using questionnaires or qualitative data using focus groups and one-to-one interviews; and questionnaires can collect individual (subjective) views and perceptions, or, if comparisons with elsewhere are felt to be important, a standard questionnaire and one which attempts to measure mental health more objectively may be favoured. There is no 'correct' way, and therefore this report describes, compares and contrasts the potential approaches so that decisions can be made locally on the most appropriate approach. Nevertheless, a number of principles are recommended which it is felt should underpin all approaches to assessing needs.

Developing and Implementing Action Plans

There is very little helpful guidance in the literature on developing and implementing action plans, yet these are critical stages if a successful outcome is to be achieved. Six key steps in developing action plans are suggested in this report as follows:

- Participation of all key stakeholders is crucial and helps to engender ownership and commitment to implementation
- Focusing upon the major sources of pressure/hazards identified
- Considering any 'hot spots' identified (departments, wards, professional groups and so on)
- Considering the benefits of an organisational audit (if not already conducted)
- Taking full account of the evidence on effectiveness from the literature
- Using a framework which outlines the full range of actions that could be taken

Similarly a number of key areas are put forward for the implementation stage:

- Support and participation of senior management, unions and staff
- Realistic expectations
- Good two-way communication
- Strategy to overcome known or expected barriers
- Effective implementation group to steer and monitor
- Clarity in responsibilities and timescales in relation to all individual actions
- Agreement on a mechanism for audit and evaluation

Evaluation

Evaluation should be an integral part of the whole process and is essential to check that actions are having the desired effect and to modify them in order to maximise their impact. A framework for evaluation, with examples, is presented and discussed. This begins with clarity about the specific objectives of the actions agreed, and then outlines several evaluation levels, relating to structure, process and outcome.

RECOMMENDATIONS

This report, and the recommendations which follow, are aimed at all organisations in the NHS in Scotland, including both commissioners and providers. However, the fourth recommendation is clearly addressed to commissioners, who may also wish to encourage providers to carefully consider all the other recommendations to maximise positive outcomes for their staff, their service quality and for patients.

1. All organisations in the NHS in Scotland should address stress and the promotion of mental health in the workplace, not only because of the considerable effect on staff, the impact on the quality of the service and the potential legal implications, but also because the NHS should be seen to be an exemplar employer.

2. A local assessment of needs is essential prior to developing an action plan and should outline the local 'hazards'/sources of pressure and appropriate responses to them.

3. Responses to this problem should be broadly based and address the sources of pressure. Evidence on the effectiveness of the more usual stress management training and counselling services alone is not strong.

4. Through the contracting process Health Boards should ensure that provider units address stress and the promotion of mental health in the workplace adequately. They should also encourage and support employers outside the NHS in their area to take action in relation to this important topic, particularly healthy alliance partners.

5. The active participation of, and support from senior managers, staff associations/trade unions and staff themselves is critical from the very beginning of the project, and strenuous efforts should be made to ensure this. This will increase the likelihood of successful implementation of action plans.

6. Careful planning of the implementation phase must take place and evaluation must be built in from the beginning to ensure that actions are being put in place as planned and that the intended outcomes are being delivered.

1 INTRODUCTION

1.1 This report covers one of the topics being addressed by the SNAP (Scottish Needs Assessment Programme) mental health programme of work. The purpose of the report is to assist Health Boards and Trusts in addressing mental health problems and stress in their workplaces. In turn it is also hoped that it will assist Health Boards in encouraging and supporting other major employers in their area to take appropriate action. The report has the following detailed objectives:

- to outline the size and impact of mental health problems/stress in the workplace
- to describe current responses to the problem, review the evidence on effectiveness and cost effectiveness of responses, and identify examples of good practice
- to outline approaches that can be taken to assess local needs and develop action plans
- to provide advice on implementing and evaluating local action plans

1.2 The report draws on the substantial literature that exists on this subject and the experience of two Health Boards in Scotland who have investigated and are attempting to tackle stress in the workplace, namely Borders and Lothian. For practical reasons the report has been written by a small team, who are from health promotion and public health backgrounds. However, this team wish to emphasise the crucial contributions made to this work from a number of other disciplines, and which are essential in any attempt to address this issue, particularly occupational health, health and safety, human resources, general management, and last but not least, clinical staff working in the mental health field.

1.3 Over the last few years there has been an increasing awareness of stress in the workplace. This is reflected in the number of articles within the health and general press, and in the number of editorials and research reports within academic journals. There is good evidence that the scale of the problem is considerable, and also that it is greater in health service employees than in the general population.

1.4 In the last few years the NHS has been subject to major reorganisation. The introduction of market economics and the separation of the purchaser and provider roles has brought about a new management culture and employment practices alien to many NHS employees. Redundancies, changed job descriptions, increased workloads, market testing of services, the growth of short term contracts, and the shift to performance related pay are all now recognised as potential causes of stress in the NHS workplace. One of the biggest causes of stress identified very recently in the literature is job insecurity (Ferrie, 1995). In a labour intensive workplace like the NHS the threat of redundancy will remain as long as each year organisations are expected to continue to make “efficiency savings”.

1.5 It is in this context that managers will have to address mental health promotion. A response which is simply designed to help employees cope with the effects of stress by providing stress management courses and counselling

services will not be enough. To win the support of staff managers will have to take a preventative approach which will also tackle the causes of stress in the workplace.

1.6 The workplace is an important setting for preventing illness and promoting health because of the ability to control environmental hazards and the potential to influence a 'captive' population. There is a history of effective legislation and action in this setting in relation to physical health, and more recently a growing awareness and willingness to act in relation to mental health from key organisations like the Health and Safety Executive. This report therefore addresses the important area of mental health promotion and the prevention of mental illness in the workplace setting. However, it also seeks to address how those with mental health problems or mental illnesses (see next chapter for a discussion on definitions) can be helped and supported within the workplace setting, whether or not the workplace is thought to have contributed to causing the problem/illness.

1.7 Some recent central initiatives in the NHS are encouraging a greater awareness of the crucial contribution of staff ('Framework for Action' in Scotland), and therefore the importance of mental health problems amongst staff and the need for action (Health of the Nation 'Health at Work in the NHS' initiative in England). This is encouraging, particularly since the NHS should be an exemplary employer with regard to protecting and promoting staff health, and certainly if it is to have credibility with the public and with other employers. It is hoped that this report will provide further assistance to the NHS in Scotland in addressing this important topic.

2 MENTAL HEALTH, STRESS AND THE WORKPLACE

Terminology

2.1 A degree of confusion surrounds the term ‘mental health’, not least because it is frequently used in place of the term ‘mental illness’ on the grounds that this is less stigmatising. When the term is used to signify health rather than illness, it is often taken to mean only the absence of mental illness. Increasingly, however, it is recognised that to be mentally healthy means more than not having a mental illness. The use of the term in this report reflects this more positive meaning. In keeping with the World Health Organisation’s definition (WHO, 1946), mental health is viewed as an integral part of overall health, or well-being, alongside and intertwined with physical and social health. In this context, the term encompasses not only the absence of mental illness but also positive aspects such as a satisfactory quality of life, high morale and good self-esteem.

2.2 The use of the term 'stress' derives from a 'psychological' model which views stress as the product of the dynamic interaction between individuals and their environment (Cox, 1993), and therefore should more properly be referred to as a psycho-social model. This model recognises the importance of intra-personal issues, the same environmental ‘stressors’ producing different responses in different individuals. Before the 'psychological' model two others were widely quoted : an 'engineering' model, where stress was seen as a harmful characteristic of the environment; and a 'physiological' model, within which stress was regarded as a physical response to a threatening or harmful environment. There is a growing consensus that the psycho-social model provides a more adequate definition than these earlier models.

2.3 Of course, an increase in 'pressure' or environmental stressors can be a stimulus and lead to improvements in performance, and is by no means always detrimental. However, as external pressure increases eventually a point will be reached when further increases result in a fall in performance. Beyond this point detrimental effects on physical, mental and/or social health can occur. When the term 'stress' is used in this report it refers to the area beyond this point, the area where the interaction between the individual and their environment begins to have negative effects. Some refer to this as 'distress', and the sources of pressure as ‘hazards’, like other workplace hazards of a more physical nature.

2.4 In considering mental health in the workplace, this report focuses upon stress because this concept is consistent with the holistic understanding of health outlined above. Stress can affect every aspect of our well-being - mental, social and physical. Manifestation can therefore include, for example, anxiety and depression (mental), poor relationships, irritability and overuse of tobacco, alcohol and drugs (social), and headaches, indigestion and high blood pressure (physical). In addition, where mental health is concerned, stress can both lead to mental illness and be detrimental to positive health, for example by lowering morale and quality of life.

Prevalence of mental health problems and stress in the workplace

2.5 A national survey of psychiatric morbidity undertaken by the Office of Population Censuses and Surveys (Meltzer et al., 1994) found that one in seven people in the wider community had a mental health problem in the week prior to the survey. The most common problem was mixed anxiety and depression, followed by generalised anxiety disorder.

2.6 Not surprisingly, the prevalence of mental **health problems** in occupational settings has also been found to be high, with depression and anxiety being the most common problems as in the wider community (Royal College of Psychiatrists, 1993).

2.7 It is increasingly recognised that stress at work is a major cause of mental health problems**.** A recent survey is reported as showing that a third of respondents said work was the biggest source of stress in their lives and 50% of office workers said their levels of stress were increasing (Griffiths, 1995).

2.8 There is also clear evidence that levels of mental health problems in the NHS are higher than elsewhere. For example, one seminal study found that 50% of junior doctors (pre-registration house officers) achieved General Health Questionnaire (GHQ) scores suggesting that they would be likely to be regarded as a ''case'' on psychiatric assessment, and that 28% were clinically depressed (Firth-Cozens, 1987). Furthermore, in a later study by the same author even higher levels of depression (47%) were identified amongst a group of female house officers (Firth-Cozens, 1990). Caplan (1994) assessed levels of stress, anxiety and depression amongst consultants, general practitioners and NHS managers and, as for junior doctors, found that nearly half reached the psychiatric 'case' threshold score on the GHQ, compared to a level of 27% in the general population. Responses also suggested high levels of depression (using a different instrument to Firth-Cozens) and suicidal thinking, for example 27% and 14% respectively amongst general practitioners.

2.9 Furthermore, a survey of 200 companies in 1989 found that work stress was perceived as one of the top three causes of absenteeism, and in another that 65% of 112 'top' companies in the UK believed stress was the major factor in ill health for their organisations (Banham, 1992). The predominance of stress as the most important health issue in the workplace has been confirmed by a recent survey of health service staff in Lothian (Jones, 1994).

The impact of poor mental health

2.10 The impact of poor mental health on workplaces is enormous. Workplaces can be directly and indirectly affected by employees suffering mental health problems through absenteeism, staff turnover, poor work performance (affecting quantity and quality), interpersonal relations and an increased risk of accidents.

Organisational impact of mental health problems

Absenteeism
High staff turnover
Poor work performance
Increased risk of accidents
Poor interpersonal relations
Poor management/staff relations

2.11 In a widely reported study of civil servants, Stansfield et al. (1995) found that psychiatric disorder was the third most common cause of long spells of sickness absence (7 days or more) amongst women and the fourth most common cause amongst men. For both men and women, it was the second most common cause of very long spells of absence (21 days or more). In the UK National Health Service, it has been estimated that 2.1 million working days are lost each year through mental disorders (Jenkins and Cooney, eds., 1992).

2.12 Although financial costs are difficult to quantify exactly, the CBI has estimated that absence from work for stress and mental disorders cost British industry £5.3 billion in 1987/88 (Banham, 1992). This figure is probably an underestimate, since self certificated illness is excluded from absence figures and mental health problems may not be recorded as the cause of absence because of stigma. In addition, indirect costs such as those incurred due to poor work performance are not included.

2.13 The impact and cost of mental **health problems** to individuals, and their families, in terms of their health and social well-being, as well as finances, is even more difficult to quantify, but is also likely to be great.

The sources of work-related stress

2.14 As has been seen, the psychosocial model proposes that stress is the product of a dynamic interaction between the individual and their environment. Although research into the causes of work-related stress has traditionally focused either on individual factors or on hazards in the work environment, evidence is growing in support of the importance of the interaction between the two. Where individual factors are concerned, for example, a main focus of research has been on employees who exhibit 'Type A behaviour', characterised by:

- a strong commitment to and high involvement in the job;
- a constant awareness of time pressures and deadlines;
- a strong sense of competitiveness and a marked tendency to be aggressive.

However, current thinking is that Type A behaviour is unlikely to be simply a feature of an individual personality. Increasingly the importance of learning

this type of behaviour, which is often valued, encouraged and maintained by particular organisational cultures, is being recognised (Cox, 1993).

2.15 Similarly, employees' perceptions can influence the levels of stress produced in response to 'hazards' at work. For example, inequalities in conditions of service are associated with stress, but the process of comparison by which we assess our conditions in relation to those of colleagues also plays a part (Landy, 1992). Job insecurity is also a clear source of stress, but the threat may have more or less effect depending on employees' expectations and the value they place on stability (Robertson and Cooper, 1983; Sleeper, 1975). The personality of individual members of staff is therefore very important in influencing whether stress is experienced in response to a given hazard, and if so the degree of stress.

2.16 Turning to the environment, a wide variety of potential sources of stress has been documented. A helpful classification of these sources was given in a Health Education Authority study of stress (Jee and Reason, 1989), as follows:

The physical environment

- Hazards: noise, temperature, bad lighting and so on
- Smoking
- Buildings: overcrowded, badly maintained; poor workplace layout, inadequate staff facilities
- Inadequate or poorly sited equipment; overexposure to VDUs.

The job itself

- The design of the job
- Disruptive shifts and rotas
- Work overload: unsustainable demands on quantity, quality, responsibility or diversity of work; fluctuating workload
- Work 'underload': work which makes insufficient demands on the capacity and capability of the individual, who becomes 'soporific' or 'torpid'
- Role conflict: conflicting demands of multiple roles within or outside the organisation
- Role ambiguity: lack of clarity or mixed messages about what individuals are required to do.

The organisation

- A corporate culture which presents individuals with dilemmas they cannot resolve (e.g. to be a workaholic, but also bring up a family)
- Authoritarian or *laissez-faire* management styles
- Staff having insufficient control over their own job
- Staff having no say in shaping organisational policy and decisions
- Poor systems of vertical and horizontal communication
- Hostile, suspicious or oppressive relationships, between colleagues, superiors and subordinates, management and staff side
- Discriminatory relationships and practices
- Lack of recognition, through feedback on performance, opportunities for development, pay, service conditions

- Organisational change and anticipation of change, job losses, relocation, poorly managed change processes.

3 THE EFFECTIVENESS OF RESPONSES

Evidence on Efficacy and Effectiveness

3.1 Three main types of response to workplace stress are identified in the literature: stress management training, employee assistance programmes and stressor reduction, also termed hazard control. Well designed evaluations of the three approaches are rare, even if one accepts the methodological problems involved in carrying out randomised controlled trials in this area and therefore the appropriateness of other approaches, often of a more qualitative nature.. As an example of the methodological difficulties consider participation in stress management training and employee assistance programmes. This is usually voluntary, and as such makes randomised allocation to control and treatment groups problematic. Evidence for the effectiveness of the three approaches is therefore limited. Nevertheless, some conclusions can be drawn from the literature.

3.2 Stress management training involves the provision of training in behavioural and/or cognitive skills such as relaxation, assertiveness and cognitive restructuring. Regardless of specific content, the aim is to enable employees to respond more adaptively to pressure.

3.3 Evaluations of this approach have produced mixed findings. On the basis of a review of 15 studies, Murphy (1984) concluded that benefits can result, for example reduced levels of tension and anxiety, sleep disturbance and somatic complaints. However, where follow up tests were carried out, usually between three and nine months after training, these benefits had not all been maintained. In another study where benefits *were* maintained after four months, Ganster et al. (1982) were unable to fully replicate their findings with the original control group. On the basis of his comprehensive review of this literature, Cox (1993) concludes that ‘the jury is still out on stress management training’.

3.4 Employee assistance programmes (EAPs) vary from counselling services for those who are currently experiencing problems, to broader based services also providing health promotion, training in coping skills and other types of support to employees, for example during 'relocation' and when approaching retirement.

3.5 Evaluations of EAPs are less common than for stress management training. This, and the breadth of variation in the content of programmes, makes it difficult to assess their overall effectiveness. However, the evidence which is available is more encouraging for EAPs which are broadly conceived to include health promotion than for stress management training (Cox, 1993). There is also some evidence that services at the narrower, counselling end of the spectrum can deliver benefits. A widely cited study of employee counselling provided by the Post Office found improvements in self-reported psychological health and absenteeism, although not in job satisfaction or organisational commitment (Cooper et al. 1992). Staff support groups, with either outside experts or with peers, are also popular and widely advocated. However, there appears to be little evidence on their effectiveness (Owen, 1992).

3.6 Stressor reduction, or hazard control, involves identifying and modifying sources of stress in the workplace itself. This approach therefore differs from the others in that interventions are targeted at the organisation rather than at employees.

3.7 Although they are currently receiving greater attention, in part as a result of legal action by employees (Cooper and Cartwright, 1994), programmes designed to address the sources of pressure within organisations are still relatively uncommon and evaluations are correspondingly rare. Those studies which have been carried out have focused on increasing employees' control over aspects of their work (Wall and Clegg, 1981; Pierce and Newstrom, 1983) and on increasing their participation in decision making (Jackson, 1983). All three studies report beneficial effects. On the basis of this evidence, Cox (1993) suggests that 'stressor reduction' is the most promising approach to workplace stress. However, he notes the need for further evaluation before firm conclusions can be drawn. A further caveat concerns the need to consider the fact that the organisational change involved may increase stress for some employees while reducing it for others (Wall and Clegg, 1981). In such situations it is important to assess the net effects of change.

3.8 The literature summarised so far might suggest that a choice has to be made between the three approaches described. However, some writers have emphasised the benefits of a comprehensive approach to workplace stress (DeFrank and Cooper, 1987; Rees and Cooper, 1990; Cox et al., 1992; Fingret, 1993). In line with this position, the 'Workplace Task Force Report' (1993) concludes that the most effective programmes are those that are comprehensive, have a high level of management and employee participation, are directly relevant to the expressed needs of the workforce, and offer a range of interventions.

3.9 One example of a more comprehensive programme is described by Murphy and Hurrell (1987), who used stress management training to raise awareness of stress issues prior to a stressor reduction programme. Jones et al. (1988) also combined these two approaches in an intervention aimed at reducing malpractice claims within hospitals. The disadvantage of these more comprehensive approaches is that evaluating the relative benefits of the different interventions involved is problematic.

Evidence on Cost-Effectiveness

3.10 Not surprisingly, since basic evaluations of approaches to workplace stress are scarce, cost-benefit studies are extremely rare. Where stress management training is concerned, a cost benefit analysis cited by Schwartz (1980) suggested that for every dollar spent on stress management, $5.5 of benefit were realised as a result of a decrease in symptoms and increased productivity. In view of the equivocal findings regarding the longer term benefits of stress management training, this assessment is clearly open to question. Similarly, although some studies suggest that EAPs result in financial savings (Feldman, 1991), one reported as claiming a saving of over $4 for every dollar spent (Intindola, in Cox, 1993), others have questioned the basis of such claims (Berridge and Cooper, 1993). No cost-benefit studies of stressor reduction approaches appear to have been undertaken.

A Framework for Action

3.11 Given that there are many factors which can cause, contribute to or influence stress, and the apparent consensus that a comprehensive and systematic approach is required (see above), a conceptual framework to help understand this complex subject and the wide range of potential actions is essential.

3.12 The matrix which appears below is an attempt to map out the areas where action can be taken within organisations (Mushet and Mordue, 1994) (there are, of course, others external to organisations, for example NHS central policy and legislative action). The two axes in the matrix relate to levels within the organisation on the one hand, and the aims of the action on the other (see chapter 2 for a definition of mental health; prevention, treatment and rehabilitation relate to mental illness):

MENTAL HEALTH IN THE WORKPLACE

ACTION FRAMEWORK

	Mental Health Promotion	**Prevention**	**Treatment**	**Rehabilitation**
Organisational				
Group				
Individual				

3.13 This matrix has been developed from earlier attempts to classify potential actions (see Newman and Beehr 1979, Cox et al. 1990, and DeFrank and Cooper 1987). The three levels can be viewed as either the target of a proposed action, for example training for individual members of staff, or the agent which carries an action out, for example the provision of an EAP by an organisation. 'Groups' can be defined in various ways, for example a management team, a particular profession or all the staff on a ward. This third level is important because it allows attention to be focused on staff who, for example, have particular problems in terms of the extent and/or the sources of pressure, and those who may have difficulties in accessing support and help.

3.14 The first action area on the vertical axis is related to actions which seek to promote positive mental health as defined in the previous chapter. Actions in the second area, prevention, would include attempts to control pressure and hazards in the work environment and training to increase individuals' coping skills; treatment is to do with the effective management of those who have developed stress related problems; whilst rehabilitation is concerned with supporting individuals to recover and manage any residual difficulties.

3.15 The framework is an aid to identifying actions across a wide range of areas. The boundaries between cells in the framework are not 'water-tight', some actions being able to be fitted in more than one cell. However, rigorous classification is far less important than ensuring all appropriate actions are identified.

3.16 Appendix 1 provides the 'Action Framework' with examples of actions in each cell of the matrix, the three levels being the agent rather than the target. There is a wide range of potential actions within each cell, those in the Appendix are not necessarily exemplars, and actions developed should be appropriate to each organisation and their unique sources of pressure and culture.

4 CURRENT RESPONSES TO STRESS AND MENTAL HEALTH PROBLEMS IN THE WORKPLACE

4.1 A survey undertaken by the Health Education Authority in England showed that there were stress management activities in only 8% of workplaces (Workplace Task Force Report 1993). It also showed that organisations with smaller numbers of employees were far less likely to be tackling stress, a finding confirmed by a recent literature review on workplace health promotion generally from the Health Education Board for Scotland (Crosswaite and Jones).

4.2 When action has been taken, in the UK and North America, it has tended to focus upon individuals by training employees to increase their skills in handling stress, or on the provision of support to those who are experiencing problems or are recovering from them (Murphy 1988, Ivancevich et al. 1990, Cox 1993). Cox suggests that this emphasis on individual rather than organisational action may have arisen because of the prominence given to 'management' views, which he says focus upon personality, lifestyle and family pressures as being important in the genesis of stress, as opposed to worker views which emphasise more the work itself and the work environment.

4.3 By contrast the Scandinavian countries have focused more upon changing the work environment, including psychosocial factors and job design (Workplace Task Force Report, 1993). Such organisational approaches are only just appearing in the UK. A very recent example is a report commissioned by the Health Education Authority which outlines an approach to auditing stress within organisations and agreeing appropriate responses (OPUS, 1995). The approach advocated is now being piloted within a small number of NHS organisations.

5 ASSESSING LOCAL NEEDS

Why assess local needs?

5.1 Given that the literature summarised in chapters 2 and 3 provide an insight into the potential causes and appropriate responses to stress in the workplace, the first issue to address is why is local assessment necessary at all? There are several reasons summarised in the box below.

Why assess local needs ?

To assess the size, nature and pattern of stress and its effects locally

To identify the perceived causes of stress and the risks associated with them

To involve people to ensure responses are appropriate to the local culture and to facilitate implementation

5.2 Not surprisingly, organisations (as well as individuals) differ in the extent to which stress is perceived as, and actually is, a problem for them. Both the size and nature of stress and its effects can differ, as reflected, for example, in individuals' job satisfaction and their mental health, and at the organisational level in terms of absenteeism, retirement because of ill-health etc. Similarly the pattern of stress and its sequelae can differ, with particular groups of staff experiencing more or less of a problem than elsewhere. Certainly perceptions of whether there is a local problem, and if so the extent of it, can vary considerably, so that a local study can be essential to convince some of the need for action.

5.3 One of the criticisms of occupational stress practice in the UK voiced by Cox (1993) is that "there has been a tendency to treat the application of stress management strategies as a self-contained action and to divorce that application from any preceding process of problem diagnosis". Certainly if organisational change and hazard control are being contemplated as Murphy (1992) points out (see chapter 3), a detailed audit of stressors within each organisation is required. It is important to appreciate that one cannot assume that sources of pressure or hazards documented in the literature apply locally. In fact the literature emphasises the differences between organisations not only in terms of hazards, but also in terms of the organisational culture and its interaction with the individual staff members. Moreover, the relative importance of individual hazards or the risk associated with them cannot be known unless assessed at the local level. Cox advocates the use of a ‘control’ cycle to assess stress and design appropriate responses (see box). This is particularly apt since control cycles are widely used in the health and safety field and therefore serve to emphasise that stress at work should be viewed as a hazard, and should be effectively controlled like any other.

Control cycle

1. Acceptance that employees are experiencing stress at work
2. Analysis of the potentially stressful situations, and identification of the hazards and harm that they might cause, and possible mechanisms by which the hazard, stress and harm are related
3. Assessment of the risk to health associated with those hazards
4. Design of reasonable and practicable control strategies
5. Planned implementation of those control strategies
6. Monitoring and evaluation with feedback and reappraisal of the earlier steps.

5.4 Last but not least, it is important to build upon local perceptions of causes and risks and identify actions which are appropriate to the local circumstances and culture. In the process this can help generate ownership of the action plan and commitment to its implementation.

Approaches to Assessing Needs Locally

5.5 A variety of approaches to assessing local needs is reported in the literature and known to the authors. There is no 'best' way, and therefore this section seeks to describe, and to compare and contrast these approaches, so that the reader can decide on the most appropriate approach locally. There are, however, a number of key principles which it is recommended should underpin all approaches and these appear in the box below:

Approaches to assessing needs - key principles

- Assessments of need must include the identification of local sources of pressure so that appropriate preventative strategies can be designed.
- Key stakeholders should be involved from the beginning, particularly senior managers, staff associations/trade unions, occupational health, human resources, mental health professionals and health promotion staff.
- Evaluation should be considered at the very beginning so that appropriate baseline data can be collected.

5.6 The approaches reviewed differ in a number of important ways; in the overall focus of the investigation, in the underlying theoretical or philosophical approach taken, and, connected to this the methods employed, and in the dimensions or parameters assessed. Taking the focus of the investigation first, one approach recommended, in effect, an organisational audit, examined policies, procedures and facilities of importance to health and mental health (Fingret 1992). Most other approaches seek to gather information, perceptions and opinions from individual members or groups of staff, and by aggregating the results describe what seems to be happening at the organisational level (for example Rees and Cooper, 1990). These two approaches provide different types of information, which are, of course, potentially complementary. Perhaps the logical approach therefore is to assess the size, nature and pattern of stress within an organisation by accessing staff experiences and views, and then to conduct an audit of organisational structures and processes to help the development of action plans.

5.7 The theoretical or philosophical perspective adopted is of major importance in influencing the whole approach to the problem, indeed, in even defining whether there is a problem and if so what it is. A wish to apply principles such as staff participation, self determination and empowerment lead to an approach which is open, and constrains responses and contributions as little as possible. Such an approach would start by asking staff if they have a health problem which could be related to the workplace, and if so what it is, what they think is causing it and what should be done about it. An analogy to open or closed questions in questionnaires is useful. Closed questions provide a number of pre-determined responses, and force the respondent to accept a categorisation imposed by the researcher, limiting the respondent's freedom and the types of information the researcher will receive. By contrast the open question allows greater freedom in the response and potentially the collection of a richer set of information.

5.8 Differences in the underlying philosophy are evident in the approaches taken by Borders and Lothian Health Boards who have both recently undertaken studies to examine mental health and stress in the workplace. In Lothian focus groups were used to consult staff about the effects of work on their health, both positive and negative, and then to explore the issues around the points raised to help construct a questionnaire. In the Borders by contrast an interim assumption was made that there was likely to be a significant problem with mental health in the workplace or stress on the basis of studies elsewhere, including in the NHS. A questionnaire developed elsewhere was then used to test this assumption and quantify the degree of stress reported by staff. The questionnaire used had been tested in terms of validity and reliability, and because it had been used on other organisations, 'normative' data to compare the experience in the Borders were available. Neither approach is necessarily better, but clearly they offer different advantages and disadvantages. Appendix II gives greater detail of these two case studies.

5.9 The theoretical perspective adopted can have important methodological implications, for example in the choice of questionnaire type discussed above, and also lead to different approaches to the development of action plans and to their implementation. A variety of other methodological issues need to be considered, for example whether to involve in the investigation a sample of staff from the whole of an organisation or whether to sample complete

management units. The former approach produces results which are potentially representative of the whole organisation and therefore enable action to be developed for all. However, such an approach can potentially miss or give confusing messages about some issues, for example management styles and approaches which differ across the organisation (unless large samples are taken). Another important issue is whether individuals' subjective perceptions of their mental health are assessed (as for example in Cooper's Occupational Stress Indicator (OSI)) or whether an attempt is made to measure this more objectively to facilitate comparisons (using for example the General Health Questionnaire (GHQ)).

5.10 Quantitative and qualitative approaches to data collection can be used, or both. In the Lothian case study a qualitative approach was used first and the information collected was used to design a questionnaire for quantification. In the Borders interviews and groups were conducted after a questionnaire to explore in greater detail issues that had emerged. A similar approach is advocated in a recent report addressing stress from the organisational perspective (OPUS, 1995). This report is seeking to identify the sources of stress at the organisational level, the underlying reasons why these problems exist and the group or organisational dynamics which maintain them. Qualitative approaches are essential for in depth exploration of such issues, and therefore ‘Listening’ groups and workshops are recommended.

5.11 Whatever theoretical perspective is taken, there are some useful pointers in the literature to the broad areas that should be investigated. In his control cycle Cox (1993) suggests that the stressful situations and the psycho-social hazards associated with them, the risk to health from these hazards and the harm that results, should be examined. He does not make suggestions or recommendations, however, about appropriate methods and instruments. Cooper et al. (1988) identify four important dimensions or parameters: personality, coping strategies, sources of 'pressure' and the effects of that pressure and the resulting stress. The latter are conceptualised in terms of job satisfaction, mental health and physical health. Cooper's effects appear to equate to Cox's harm, sources of pressure to stressful situations and psychosocial hazards, and the relative importance or contribution of particular sources of pressure to the risk to health. Personality and coping strategies are attempts to examine the mechanisms by which the hazards, stress experience and harm are related, which in reality must involve complex and dynamic intra-personal, inter-personal, group and organisational issues.

5.12 Appendix III gives some further details of information that might be available locally in relation to some of the dimensions or parameters discussed above and instruments that are available and have been used elsewhere.

Approaches to assessing local needs - important issues to consider	
Theory/Philosophy	emphasis on open, non-constraining approach or on reliability and comparability will help inform the choice of methods
Focus of investigation	individual or organisational (or both)
	which dimensions to assess
Methods	routine or specially collected (or both)
	sample of whole organisation or complete management units
	qualitative or quantitative methods (or both and, if so, in which order)
	questionnaire which assesses subjective or objective outcomes (or both)

6 DEVELOPING AND IMPLEMENTING ACTION PLANS

Developing Action Plans

6.1 The box presents a few key points to consider when local investigations are complete and discussion turns to the action that is required.

Key Points for Developing Action Plans*

- Participation of all key stakeholders is crucial and helps to engender ownership and commitment to implementation[5,6]
- Focus upon the major sources of pressure/hazards identified[5]
- Consider any 'hot spots' identified (depts., wards, professional groups etc.)[5]
- Consider the benefits of an organisational audit (if not already conducted)[5]
- Feed into discussions evidence on effectiveness from the literature[3]
- Consider using a framework which outlines the full range of actions that could be taken[3]

* (Numbers in superscript refer to the chapters which discuss each issue)

6.2 Having identified a significant problem there may be a temptation to immediately 'treat' it and forget about prevention, the 'sticking plaster approach'. Assistance to those who are currently experiencing problems is important, but so too is stopping others getting into the same position. The main sources of pressure or hazards should therefore be carefully reviewed and strategies to control them developed.

6.3 Inevitably there will be staff groupings who report more of a problem than their colleagues, and these may need special attention. For example, because of the scale of their difficulties they may warrant early and concerted action, consideration should be given to whether they have particular types or unusual levels of pressure and to whether they have problems in accessing existing informal and formal mechanisms for getting help.

6.4 If not already conducted, consideration should be given to the merits of a more formal review of organisational structures and processes (policies, procedures etc.) to document current practice in relation to the main hazards and identify improvements. However, this may not be necessary, particularly if those involved in discussing the actions required have a good knowledge between them of such issues.

6.5 It is essential that literature evidence, and where this is not available 'expert' consensus views, are taken fully into account if action plans are to be effective and efficient. Certainly there is a strong consensus that a comprehensive

response is likely to be more effective, and therefore a framework which facilitates this to be developed is needed (see chapter 3).

6.6 Many of the actions required may involve substantial change and therefore will be potentially threatening to some members of staff and management. Furthermore, the fact that action has not been taken earlier may point to there being significant barriers to change at the individual, group or organisational levels. Participation can help to overcome such barriers, and therefore key individuals and groups should be involved, ideally at the very beginning when the subject is first raised, and certainly well before the action planning phase. The principles of staff participation, self determination and empowerment discussed in chapter 5 would certainly lead to the involvement of staff throughout the whole project. The case histories in Appendix II outline the interests represented and the individuals involved in addressing mental health in the workplace in the Borders and Lothian Health Boards.

Implementing Action Plans

6.7 If the intention is to go beyond a sticking plaster approach then the commitment of senior management is critical. Ivancevich et al. (1990) have argued that this can only be achieved if practical organisational issues are addressed by the proposed actions. Fortunately many interventions that have the potential to reduce stress are also no more than good management practice, for example well conducted performance appraisals of staff. Nevertheless, it is obvious that implementation of actions that address practical organisational issues per se is unlikely to be successful unless senior management themselves perceive these issues as needing to be changed.

6.8 Given the above, the question of how to gain senior management support is crucial. Data on the size and severity of the problem locally and its potential impact on the organisation and its performance may persuade some; the economic arguments may influence others, in terms of the hidden costs of stress and the reports of net savings when the problem is addressed; in the NHS concern about health should be more prevalent, and this is reflected in some central policy initiatives ('Framework for Action', Health of the Nation 'Health at Work in the NHS' etc.). As a major employer the NHS has a clear responsibility for the health of its employees (see NHS Circular: GEN(1995)4), and furthermore there is a requirement to act as an exemplar employer if the service is to have credibility with others. However, there is another strong argument for action to address stress, and that is the risk of legal action.

6.9 UK and EC legislation requires employers to take reasonable action to protect the health and safety of employees (see Health and Safety at Work etc. Act (1974)). In a recent landmark case which has set a precedent and is beginning to change attitudes to this issue, an employee successfully claimed substantial damages against his employer for failing to take reasonable steps to avoid exposing him to a workload which was not conducive to his mental well-being (Walker v Northumberland County Council, 1994). The employer appealed against the decision of the original Court but this decision was confirmed very recently by the Appeal Court, as was the award of substantial damages. This case has confirmed that employers have a duty to care for employees' mental as well as physical safety. In another recent case, this time in the NHS itself, a junior doctor pursued an action against a Health Authority because of long working hours and the impact on his mental health. Although this case did not come to trial because the Health Authority concerned (Bloomsbury) settled out of court, liability of the employer was established and will increase the likelihood of further actions and their chance of success. These cases also demonstrate the willingness of unions and employees to challenge working practices which can affect mental health.

6.10 In a similar way to the involvement of management, the support and active participation of trade unions and staff representatives, as well as staff themselves, is essential. This is certainly important at the implementation stage when their support and encouragement can be crucial, but should start at the very beginning of the enterprise and continue throughout (see previous chapter).

6.11 The box lists a number of factors which increase the likelihood of successful implementation of action plans.

Important Factors for Successful Implementation

- Support and participation of senior management, unions and staff
- Realistic expectations
- Good two-way communication
- Strategy to overcome known or expected barriers
- Effective implementation group to steer and monitor
- Clarity in responsibilities and timescales in relation to all individual actions
- An adequate budget for those actions needing additional funding
- Agreement on a mechanism for audit and evaluation

6.12 On the one hand expectations of what can be achieved and the timescale for change must be realistic, and on the other practices which are damaging to the organisation, to individual members of staff, and indirectly to their families, should not be continued any longer than absolutely necessary. The balance can be difficult to strike, and a long term view may be needed.

6.13 Uncertainty is a cause of stress and therefore good communication is essential. Attempts to address mental health in the workplace should not increase levels of stress amongst staff. This, of course, should start when the subject is first raised for examination, should continue through the stage of local investigations, and then into the action planning and implementation phases. Communication is particularly important to the general staff, to unions and staff representative organisations, and to management, and can take many forms - briefings, meetings, newsletters, workshops, reports and so on.

6.14 There can be significant barriers to any change, and perhaps more so in this area than many. Given this, careful thought is needed about what these are likely to be and how they can be addressed. Past experience of implementation in other areas, and local knowledge, can be useful pointers to potential barriers. These should be identified and strategies to address them developed. Good communication and the involvement of senior management have been mentioned. Others should be considered, for example the support of external facilitators who have organisational/group analytical (OPUS, 1995) or change management skills. There is far less in the literature about implementing actions than investigating stress, yet the outcome sought is not, to use a medical analogy, a perfect diagnosis, but a healthier organisation and workforce. Compliance with the 'treatment', is therefore a critical issue and warrants a similar level of attention and planning as the needs assessment phase.

6.15 Once a commitment to take action has been reached, then a group of appropriate seniority and skill-mix to steer and monitor implementation is needed. In addition, there must be clarity, for each individual action, as to who will be doing it and by when. This provides the steering group with criteria against which to monitor progress. However, successful implementation of all the actions agreed is not the end of the story, there must be an assessment of whether the actions are having their intended effect, an attempt to measure the outcomes. In the implementation phase therefore there should be agreement on appropriate mechanisms for audit and evaluation, with the results feeding back to influence action.

7 EVALUATION

7.1 Evaluation has been defined as: "A process that attempts to determine as systematically and objectively as possible the relevance, effectiveness, and impact of activities in the light of their objectives" (Last, 1988). Unless an evaluation is undertaken, it is impossible to know whether an intervention is having the desired effect, or any effect at all. The purpose of obtaining this information is:

- to develop and improve interventions to maximise their relevance, effectiveness and impact
- to discover which actions are more useful and which are less useful
- to demonstrate the benefits to employers in order to maintain commitment to action
- to encourage commitment to action amongst other employers.

7.2 As the definition above implies the first step in evaluation is to be clear and explicit about the overall aims of the project and the specific objectives of the programme of action agreed. Linked to this is the need to be clear about the aim of the evaluation. Is it to add to the body of academic research and attempt to unequivocally describe the relationship between action and outcome, or is it more pragmatic and about assessing the likely impact of the actions to facilitate local decisions and enable further refinements to be made? In any event there are likely to be many areas that could be assessed or measured, and therefore there is a need to agree a realistic number of high priority areas to evaluate. Having done this, consideration can be given to appropriate methods (see later).

7.3 Evaluation can focus upon various aspects of an intervention and its effects. Four evaluation 'levels' are identified below with examples, for each one, of key questions which could be investigated:

Evaluation level	**Evaluation questions**
Structure	Are the policies, procedures, facilities and services that were planned in place? Were they in place according to the timescale agreed?
Process	Is the intervention reaching all the people it aims to reach? Is it being delivered to satisfactory quality standards? Is the intervention perceived to be appropriate by all concerned?
Short Term Outcome or Output	Are the end results of the intervention apparent (both the more and less tangible ones)? Are there any unforeseen effects?
Long Term Outcome	Is the intervention achieving its objectives?

To illustrate the use of these evaluation levels the box provides two interventions with potential areas to evaluate under each one.

Examples of the use of evaluation levels				
OBJECTIVE	**STRUCTURE**	**PROCESS**	**SHORT TERM OUTCOME**	**LONG TERM OUTCOME**
To improve performance, job satisfaction, career planning and mental health through effective and constructive feedback on performance at work.	Performance feedback policy and system in place (not performance related pay).	Training of relevant staff. Objectives agreed and review meetings occurring.	Feedback of performance seen as constructive by both parties. Career development plan.	Improved performance. Increase in job satisfaction and self-esteem. Improved mental health.
To provide short term, confidential counselling support for those experiencing mental health problems at work.	External counselling service available.	Staff informed of service and how to access it. Take up of service.	Staff perception that service was helpful.	Reduction in absenteeism. Improved time keeping. Improved quality of work. Improved mental health.

7.4 Assessing outcomes is sometimes seen as the only or most important aim of evaluation. However, it is of limited use to know that an objective was or was not achieved without also knowing what led to the intervention's success or failure. For example, consider feedback on individual performance via a formal appraisal system with one of the objectives being to improve job satisfaction. No improvement could be due to a lack of implementation, or inadequate implementation (e.g. no training, differing expectations between manager and subordinate), or to the fact that performance feedback does not increase job satisfaction. Therefore structure, process, and outcome should all be considered in relation to the key questions that the evaluation will focus upon.

7.5 Quantitative and qualitative methods are both valuable for evaluation research. Where outcome evaluation is concerned the randomised controlled trial (RCT) is usually regarded as the 'gold standard'**.** However, as mentioned previously carrying out an RCT in the workplace setting raises many practical difficulties. Nevertheless, other quantitative methods such as survey questionnaires, as well as check lists, can be useful for evaluating structure, process and outcome levels.

7.6 However, qualitative methods such as semi-structured interviews and focus group discussions may be more useful for ascertaining whether any

unforeseen effects have occurred. An alternative is to include some open questions in a survey questionnaire, for example 'Has introducing the performance appraisal system had any effects we haven't asked about in this questionnaire?'

7.7 For process evaluation, qualitative methods are more useful when it is important to explore the employee's own perceptions of the intervention. Whereas surveys and measurement scales are based on the researcher's perceptions of what is important, semi-structured interviews and focus group discussions allow employees to influence the topics to be explored.

7.8 The way in which an evaluation is carried out is crucial for its success. Laying the groundwork is the most important part of the process, especially making sure that everyone concerned understands what is being done and why. If this is not achieved, the quality of the feedback received will suffer. The steps outlined in the box are adapted from guidelines commissioned by a sub-group of The Health of the Nation Workplace Task Force.

Key points for evaluation

- Clarify the aims of the project and the objectives of the actions
- Decide on the key questions you will focus upon and the evaluation level(s) you will use
- Make sure the evaluation is part of the intervention from the beginning
- Involve everyone concerned in planning the evaluation
- For outcome evaluation, use more than one measure of change
- Allow a realistic amount of time for outcomes to occur before measuring
- Treat evaluation as an ongoing review and learning process

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Appendix 1

MENTAL HEALTH IN THE WORKPLACE

ACTION FRAMEWORK

	Mental Health Promotion	Prevention*	Treatment*	Rehabilitation*
ORGANISATIONAL	Constructive feedback on performance	Review/development of a training policy	Access to counselling support	Personnel policies providing flexibility on taking up employment again (e.g. in terms of responsibility and time)
GROUP	Team building activities	Training programme surrounding mental health issues	Peer support	Caring and sensitive support structures for individuals returning to work
INDIVIDUAL	Take holidays and lunch breaks	Participate in training e.g. assertiveness	Self referral to Occupational Health Service or counselling service	Develop awareness of stress-inducing situations and coping strategies

(* of/from mental illness)

Case Studies

A Introduction

B Borders Health Board

C Lothian Health Board

A Introduction

The two case studies presented here document two different approaches taken by two Scottish Health Boards/Trusts to assess the health needs of NHS employees.

This report has emphasised throughout a number of important principles which should inform any needs assessment exercise. There is, of course, no one perfect way to carry out a needs assessment that will be applicable to all workplaces. Employers and employees will have to work together to decide upon the most appropriate methods for their own organisations.

The differences in the approaches taken in the two case studies are compared and contrasted below.

	Lothian	**Borders**
Focus	Health in the workplace.	Mental Health in the Workplace.
Methods	Focus groups informing Questionnaire Survey.	Stage 1 - Quantitative, findings identified issues to be explored in Stage 2 - Qualitative, consisting of focus groups and one-to-one interviews.
Instruments	Focus group discussion schedule. Specifically designed self completion postal questionnaire.	Standard, tested questionnaire. Schedule for focus groups and interviews.
Sample (for survey)	10% NHS employees in Lothian Health Board and Trusts sampled from the Personnel Management Information Systems.	All employees of Borders Health Board and the Medical Directorate within Borders General Hospital NHS Trust (215 in total).
Timescale	10 months (research phase of 5 year strategy)	12 months (research phase, discussion and development of action plans).

B Borders Health Board - Mental Health in the Workplace

Introduction

In 1994 Borders Health Board supported a Mental Health in the Workplace initiative, which involved research into the experiences and views of staff. This paper is a report on the three stage process adopted in completing the project.

The terms of reference for the project were to develop for Borders Health Board a statement of principles, a policy and a strategy on mental health in the workplace, addressing the following:

- a full range of actions covering prevention, treatment and rehabilitation.
- participation of staff, for example to identify levels of stress, 'stressors' and potential interventions.
- action orientated towards individual and organisation action and change to improve mental health.
- evaluation and feedback.

Background

Framework for Action (1993) reminded Health Boards and Trusts of their responsibility and exemplar role in supporting and encouraging staff to improve their own health, and identified the development of health promoting policies in the workplace as a priority. To date in Borders Health Board the focus has primarily been on aspects of physical health such as smoking, alcohol and healthy eating. However, it was felt that other issues, in particular occupational stress, arising in the workplace, had to be addressed.

As Borders Health Board is committed to providing a healthy working environment for all its employees, a decision was taken to sponsor an initiative to address this issue of emotional and psychological well-being and stress in the workplace.

Assessing Needs

A multi-disciplinary steering group to plan this initiative was established. The Mental Health in the Workplace Group included representatives from Occupational Health, Health Promotion, Public Health, Unison, the Medical Directorate within the Acute Trust, a Clinical Psychologist, the General Manager and Chairman of Borders Health Board.

The group's remit was to:

- Draft a policy on mental health in the workplace for Borders Health Board
- Review the literature on mental health in the workplace.
- Commission a survey to outline the extent of stress locally and to enable appropriate actions to be designed.
- Encourage and support implementation of the identified interventions.
- Ensure dissemination of results.
- Monitor and evaluate the project.

Using the above objectives, this multi-professional group co-ordinated the project. To assist with the survey the Board commissioned an independent organisation.

Approach

The approach adopted, as detailed below, was designed to provide a sound theoretical basis from which to develop an appropriate framework to address Mental Health in the Workplace.

The project was scheduled into 4 stages:

Stage 1 - Project preparation
Stage 2 - Data collection, both quantitative and qualitative
Stage 3 - Data integration, analysis and project report
Stage 4 - Development of recommendations and interventions

Stage 1 Project Preparation

1.1 Sample Selection (August 1994)

This section outlines the various elements in the preparation process.

The two groups of staff who were involved in the research were:

- Health workers employed in the Medical Directorate at Borders General Hospital (now an NHS Trust), including clinical, nursing, paramedical, secretarial and ancillary staff.

- Managerial, administrative, secretarial, medical and nursing staff of the Purchasing Organisation of Borders Health Board.

These areas were chosen to take part in the pilot study, to ensure provision of both a clinical and management orientated organisation and because they had expressed a particular interest in this issue.

1.2 Briefings (September 1994)

All members of the two organisations within the pilot were invited to attend briefing meetings organised and delivered by members of the Mental Health in the Workplace Group. Ten of these meetings were held to explain the purpose of the survey; the approach to be taken and to alleviate any concerns, particularly with regard to confidentiality which was assured for both the questionnaire response and the personal 'stress profile' feedback (see later). In addition, each project participant received a detailed briefing paper, with appropriate contact numbers.

Stage 2 Data Collection (October 1994)

2.1 Quantitative Data

Key factors in conducting the research element to the project was the need to ensure that the data obtained was of high quality and provided an accurate and valid measure of the mental health status within the sample groups. The Occupational Stress Indicator (OSI), a questionnaire based tool was developed by Cooper, Sloan and Williams and was used as the main instrument to establish the level and nature of occupational stress. The OSI is a validated instrument and was deemed to be the most appropriate method of collecting the required information.

The questionnaire itself had been designed to provide an integrated approach to stress management and to gather information on groups of individuals. It is divided into six sections:

- Job satisfaction: how staff feel about their job.

- Physical and mental health: how staff assess their current state of health.
- Type of personality: the way staff behave generally.
- Locus of control: how staff interpret life events.
- Sources of pressure: what are the sources of pressure in their job.
- Coping strategies: how staff cope with the stress they experience.

In addition to the OSI, respondents completed twelve additional items, set by the project team, designed to establish sources of pressure specific to Borders Health Board. Members of the steering group distributed the OSI questionnaires to 215 employees within the Medical Directorate and Purchasing Organisation.

To encourage respondents to complete the questionnaire, staff were allowed to complete it in worktime, with relief cover being provided where necessary. In addition, all participants were offered, if they provided their name, feedback on the results of their questionnaire. This personal profile identified, on a scoring system, results from each of the six sections. Several members of the steering group had received training in interpreting these 'scores', and this one-to-one service was freely available. In addition, provision had been made for participants wishing to access an external counselling service to do so.

2.2 Qualitative Data (November 1994)

In order to complement the quantitative data collection process, a total of three focus groups, involving 23 staff in total, and eight individual interviews were held, covering a variety of staff within each sample group. The purpose of the interviews and the group sessions was to explore the main issues identified from the OSI.

The in-depth, structured interviews considered how the organisation's culture and structure exacerbated or ameliorated occupational stress. They also identified the coping strategies used by individuals to deal with stress and how they are supported or undermined by the organisational processes.

Stage 3 Data Integration, Analysis and Findings

3.1 Data Integration and Analysis

The data from the questionnaires were analysed at an individual level, producing as stated above, a personal profile for each individual employee, and the results grouped together for analysis of mental well-being across the sample group. The quantitative data was then integrated with the qualitative information arising out of the focus group session and individual interviews.

Through analysis of this data, the key issues relating to sources of stress for each of the two sample groups and, where appropriate, for specific disciplines within those groups, were identified. 215 questionnaires were distributed, 197 were returned giving a response rate of 90%.

3.2 Project Report

A comprehensive report was produced detailing methodology, the key findings, the consultants interpretation of the findings, and recommendations for possible individual, group and organisational interventions. Specifically it focused on the general mental well-being of the sample group, providing information on sources of stress, effects of stress and the coping strategies used.

The report also included external comparisons with the general population and with other health workers, and internal comparisons showing the differences in the mental well-being according to profession, department and so on. These comparisons helped to identify potential problem areas within each of the sample groups, and gave direction to appropriate interventions.

Stage 4 Development of Recommendations and Interventions

Following completion of the survey and dissemination of the results, a 'workshop' for managers was held to discuss the findings and the action needed to address them. Representatives from both the Purchasing Organisation, Medical Directorate and the hospital management team attended.

One of the actions agreed at this workshop was to involve staff in the further discussions necessary to arrive at a more comprehensive list of interventions. In order to achieve this three discussion groups were held, involving 10 staff in each, representing the range of professions and disciplines within the two organisations. Participants selected for these groups were asked to read the survey draft report prior to the meeting and when doing so to consider the findings from two perspectives:

- The major problems/issues raised.
- Potential actions to address each problem/issue.

To assist with the process of implementing identified interventions an 'action framework' was presented. This 'matrix' (see Appendix 1) diagram was introduced to help participants focus resolutions from two perspectives:

- At three distinct levels - organisational, group and individual.
- Across a full range of interventions from mental health promotion to rehabilitation.

Subsequent reports were compiled for each of the two organisations identifying specific issues causing concern - for example, feeling undervalued, poor communication and the actions necessary to alleviate them. These were then taken back to the respective management team meetings where an appropriate action plan was developed.

Recommendations

Contained within the reports mentioned above to respective management teams was a series of specific key areas which were identified by members of the project's steering group as requiring immediate attention.

In addition the following were recommended:

- Early action be taken within a few key areas to demonstrate commitment to addressing the concerns raised.
- Feedback to staff on all actions that are agreed takes place, with an indication of timescale.
- Clear responsibility for implementation of actions is agreed, with timescales.
- The commitment to evaluate the impact of actions taken to address stress in the workplace is confirmed.

Conclusions

After completion of the project, negotiations are under way to encourage implementation of the interventions, for example:

- The development of workplace strategies for both the Trust and the Purchasing Organisation.

- The development and implementation of some of the interventions identified, including a staff mental health policy.

- Evaluation of the interventions, within the two organisations, suggested timescale is 6 months and 1 year.

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C Lothian Health Board - Lothian NHS Healthy Workplace Strategy

Introduction

The purpose of this paper is to present an example of how needs assessment can be undertaken in a workplace setting, in this instance the NHS. The focus is on the process and methods rather than the results. In this study the needs assessment covered all aspects of health and well-being and not just mental health, although this emerged as a major concern for NHS employees who felt their mental health and well-being was undermined by the stress they experienced at work. The results of the research are available in three reports, the focus group discussions, the survey and a summary which can be obtained from the Health Promotion Department, Lothian Health.

Background

At the end of 1991 Lothian Health Board adopted a healthy workplace strategy that aimed to protect and promote the health and well-being of NHS employees in Lothian. Board members not only recognised that as employers they had a duty to provide their employees with a safe and healthy working environment, but that a work force which feels valued and cared for and has its own health needs met is more likely to provide an efficient high quality service to patients.

The strategy was produced by a sub group of the Joint Working Party on Health Promotion. The group with representatives from Lothian Health Board, Local Authorities and the Voluntary Sector had been convened to consider a key settings approach for health promotion in the workplace. The approach which they recommended is based on a recognition that work can be both a cause of physical and mental ill-health, for example when workers are exposed to hazardous chemicals or have heavy workloads, but also that work can be a positive, satisfying and rewarding experience which can be a source of health and well-being.

The strategy, therefore, does not advocate the use of the workplace simply as a setting for initiatives to encourage individuals to adopt healthy lifestyles, but aims to prevent the occurrence of ill health in the workplace and to develop a positive health promoting working environment. It is an ambitious approach which extends what might be described as a traditional occupational health emphasis on safety and the control of hazards in the workplace, to include the development of health promotion policies in the workplace and to provide employees with opportunities for health education. It also aims to encourage the development of good management practice and organisational policies which can contribute towards developing a health promoting working environment.

The strategy emphasised the need for policy development to promote health at work to take into account the needs of employees and that a needs assessment study should form the basis for development. It was felt that the strategy was more likely to be successful if staff were actively involved at all stages of its development rather than imposing policies determined by managers and occupational health professionals whose needs and priorities might well be different to those of staff. The strategy also called for a review of existing policies and activities which would acknowledge the valuable work that is already taking place to promote staff health and highlight areas of good practice on which to build as well as exposing gaps in provision where new initiatives are needed.

In 1993 two health promotion officers were employed by Lothian Health Board on a job share basis to facilitate the development of the strategy. Soon after a steering group was established with representatives from staff associations and trade unions, management, occupational health, health and safety, public health and health promotion. One of the first tasks of the facilitators, seen as crucial to any success, was to secure senior level management commitment to the strategy and support the needs assessment research. Meetings were also held with other key players and groups to raise their awareness about the strategy and the concepts and principles underpinning it.

In 1994 the reorganisation of the health service led to the introduction of the purchaser/provider split and the formation of the six Lothian Trusts. Despite this fragmentation of the health service which could have been damaging to joint working, the six Trusts and the College of Health Studies continued to work with Lothian Health the purchasing authority, to support the development of the strategy by sharing skills, knowledge and examples of good practice. The steering group provides a good example of collaborative joint working across the NHS and a multidisciplinary team working approach which values and respects the different perspectives and expertise of the various professional groups represented on the group. Staff participation was also seen as extremely important and although it is regrettable that employees and their representatives were not involved in the initial drafting of the strategy, they do have representation on the steering group and are expected to play a full part in developing the strategy by being active in both defining the problems and in determining solutions.

Developing the strategy

The concept of the health promoting working environment and the strategy's underlying principles of collaboration, multidisciplinary working and staff participation were all very important in shaping the research and the methods used. The research was not an academic exercise but intended to inform policy development across the NHS by providing managers with data about how employees perceived their health to be affected by their work. The chief target audience for the research was managers because it is they who have the main responsibility to protect the health, safety and welfare of employees and the power to ensure resources are made available and that action is taken towards becoming a health promoting employer.

In order to obtain as much detailed data as possible of staff perceptions the research was carried out in two stages using both qualitative and quantitative methods. Stage one of the research adopted an open ended qualitative approach which would allow staff to set the agenda. For this the facilitators would organise focus group discussions with the groups representing the different occupations within the health service. The data gathered from these groups would then be used to design a questionnaire to survey a larger randomly selected sample of the NHS work force in Lothian. In this way the questionnaire would cover the issues identified as important by staff rather than imposing our own concerns.

Focus groups

There were 11 focus groups organised according to broad occupational categories as it was felt that discussions amongst peers were likely to be more fruitful than mixed groups of staff with different backgrounds and experiences. The average group had five members with a total of 69 staff taking part in the discussions. It was not necessary to involve greater numbers or to take a random sample of staff as this stage of the research was exploratory to be complemented by a much larger scale survey. The College and two units were chosen from which to recruit volunteers. Displays about the strategy were set up and attended by the two facilitators so that staff had an opportunity to meet them and find out about the strategy and the proposed research before committing themselves to take part. A leaflet was also widely circulated and meetings were held with health and safety committees, junior medical committees, management and trade union groups to raise awareness and encourage staff to participate in the research.

The groups were led by the two facilitators for the strategy. There were three main questions for discussion:

1. What factors affect your health at work?

2. How is your health affected by work?

3. What measures are needed in your workplace to deal with the issues you have raised?

Although participants were asked to think of how their health was affected by working both positively and negatively the overwhelming majority reported only the negative aspects of work and only a few gave examples of how they felt work made a positive contribution to their health and well-being. What also emerged quite clearly in the discussions was a holistic view of health with participants defining health as physical, mental and social well-being. They described how work has an impact on all these aspects of health. Another interesting factor to emerge was that the different occupational groups all seemed to share the same concerns. For example, in all the groups there were problems to do with the physical environment and poor working conditions including overcrowding and lack of space, problems with lighting, heating and ventilation, dirty and dusty working conditions, risk of infection, and concerns about lifting and handling, and fears about personal safety. These concerns were seen to effect both physical and mental health.

However, the greatest concern of all the groups was with issues related to the psychosocial environment and the way in which work is organised. Considerable numbers felt that their health was threatened by the pressure they work under with increasing demands and fewer resources, long hours of work, difficulty in taking the breaks to which they are entitled and the effect that pressure at work has on their home and social life. Junior staff did not feel they were given enough support by their managers but managers felt equally overwhelmed by work and unable to give the level of support they would like to their junior colleagues.

It was also evident that employees felt their health was affected by the reorganisation of the NHS which they viewed as very stressful. Many staff complained about lack of consultation and poor communication about the changes. Some staff felt their own values in conflict with the new management culture and the market model of health care. They frequently used the word stress to describe how work affected their health. Symptoms of stress included headaches, tiredness, depression, anxiety, irritability, apathy, lack of self confidence, and difficulty in sleeping. They also felt that stress was a contributory factor in the development of digestive disorders, and skin conditions, and that it made them more vulnerable to infections as well as more serious illness such as heart disease.

Survey

It was felt that a large scale survey would be too time consuming for the two facilitators to administer and that the specialised skills of an experienced researcher were needed for this second stage of the research. An agency outside the NHS might also enable respondents to

feel more secure about the issue of confidentiality which was an important consideration given the lack of confidence in management that had surfaced in the focus groups. These were issues which could affect the response rate and it was important to ensure a good response rate to produce credible data on which to formulate policy. Funding for the research had already been allocated as part of the development costs for the strategy so was not a problem.

A research brief to design and administer a postal questionnaire to approximately 10% (2000) NHS employees in Lothian was put out for tender. Six research agencies applied for the contract which was finally awarded to Scottish Health Feedback who it was felt best fulfilled the criteria for the job. They had the relevant qualifications and skills to undertake the research, a good knowledge and previous experience of research in the NHS, they appeared also to have a good grasp of the subject of workplace health, and they demonstrated an ability and willingness to work with others.

A draft report on the focus groups was provided for the agency and discussions were held with facilitators and members of the steering group to decide upon a conceptual framework to structure the questionnaire. It was agreed that the questionnaire should aim to:

- determine the kinds of work related factors that employees believe effect their health;
- establish the relative importance of these factors, in terms of health, as employees perceive them;
- determine what kinds of ill health employees believe are caused or influenced by these factors;
- determine what changes at work employees believe would improve their health;
- determine how these perceptions and beliefs vary according to occupational group, gender, seniority and organisation.

It was a challenge to design a questionnaire that reflected the concerns of the many different groups of occupations represented in the health service, although this was made easier as it was clear from the focus groups that there were common themes emerging. This meant we did not have to design a separate questionnaire for each occupational group which would have been costly and complex to analyse. Respondents were all asked to respond to the same questions which meant they did not have to skip questions in a way that can become confusing and can produce inaccurate data. The questionnaire would have to be relevant to everyone and cover all the subjects raised in the groups without being too complicated or time consuming to complete. It was feared that a very long and detailed questionnaire might discourage staff from responding, on the other hand a questionnaire that was too short and did not cover the issues in a comprehensive way might not be taken seriously by staff.

There was also a concern that low morale in the organisation might lead to a cynical or apathetic response from some staff which would lower the response rate. After assessing all these considerations we finally produced a 25 page, very comprehensive and detailed questionnaire. It was felt that anything less than this would not cover all the issues raised by the focus groups and would not be seen as credible by staff. There was a risk that staff would not be willing to set aside the forty minutes we estimated it would take to complete. To make it more meaningful and easier to work through, the questionnaire was broken down into seven sections covering, for example, physical aspects of the job, effects of work on mental health and well-being and the changes staff would like introduced to promote health at work.

A final draft was approved by the steering group before a pilot. The pilot did not uncover any fundamental flaws in the design and only a few minor changes were necessary before the main survey.

Despite our earlier concerns the survey produced an excellent response rate of 73% and provides a real wealth of information which can be used to help determine health promoting policies based on the needs of staff. As the main aim of this paper has been to discuss the process of needs assessment we will not describe the results of the survey which are available in the research report. In fact the findings of the survey generally mirrored the concerns expressed by staff in the focus groups with stress at work again emerging as an important issue for many employees.

We are of course well aware that workplace stress has been identified as a major health and safety issue for many other industries in both the public and private sector and that in response the Health and Safety Executive have identified managing stress at work as one of their priorities for the coming period. The Lothian Healthy Workplace Strategy will also concentrate on reducing stress at work and improving the psychosocial working environment. To do this it is hoped to use the control cycle model developed by Professor Tom Cox at Nottingham University which advocates the use of risk assessment and risk management procedures to identify and deal with stressors in the work place. Discussions are underway with staff at Nottingham University to look at the possibility of setting up pilot studies.

Other discussions are being held with chief executives and senior managers, the members of the Joint Steering Group and with the local steering groups that have recently been set up in the Trusts to look at how we can disseminate the results of the research and how to develop the strategy in response to the research findings.

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Appendix 3

ASSESSING NEEDS - DIMENSIONS AND INSTRUMENTS

DIMENSION/PARAMETER		MEASURED BY*
Effects/Harm		
Health		
	General	Absence data (R) Ill-health retirement data (R)
	Mental	General Health Questionnaire Clinical Interview Schedule[2] OSI Mental Health Scale[3] Symptom Checklist 90 Depression Scale[4] Hospital Anxiety and Depression Scale[5]
	Physical	OSI Physical Health Scale[3]
Job satisfaction		Warr Job Satisfaction Scale[6] OSI Job Satisfaction Scale[3] Exit Interviews (R?)
Source of Pressure/Hazards		OSI Sources of Pressure section[3] 'Social stress and support' interview[7] 'Sources of stress' questionnaire[8]
Coping Strategies		OSI Coping Strategies section[3] (See 7 above)
Personality		Type 'A' behaviour[9] OSI Type A personality profile[3] Locus of Control[10]

* R = Routinely available data
Numbers in superscript refer to attached reference list

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