A holistic approach to stress and wellbeing at work

Part 4: reducing stress and sick leave

STRESS, anxiety and depression are important occupational health issues, and are major causes of sickness absence, loss of productivity and long-term worklessness. The cost of these to the individual, the organisation and society is considerable and there is a need for prevention and management. In 2007, the Sainsbury Centre for Mental Health estimated that the total cost to UK employers of absenteeism, presenteeism and staff turnover was £25.9 billion1. In the UK, 40% of overall sickness absence is due to mental health problems—amounting to 70 million working days lost to psychiatric sickness absence per year1. Recent economic analyses suggest that mental health problems account for most sickness absence, in total cost £105 billion a year, of which only £10 billion are direct NHS costs2.

Stress management interventions in the workplace target either the individual or the organisation, and may act at primary, secondary or tertiary prevention levels. Interventions can also target both the individual and the organisation such as workplace policies that promote good work-life balance and peer-support groups. Most interventions to manage stress and mental ill health at work have targeted the individual, usually at a secondary or tertiary prevention level, using a clinical intervention such as cognitive behaviour therapy or treatment of depressive illness with medication.

A meta-analysis of individually targeted health promotion has shown that it is not especially effective, but exercise increases overall wellbeing and work ability and reduces sickness absence3. However, given that it is often the psychosocial environment that influences stress and mental health one can suggest that there should be primary preventive interventions targeted at changing the workplace at the organisational level. So far, evaluations of organisational-level interventions targeting the effects of workplace stressors on mental health are limited. The majority of studies in a meta-analysis of 48 studies of occupational stress interventions4 were aimed at the individual rather than the organisational level. Improved support was also associated with improved health in the majority of studies in which it was measured5. Furthermore, a review6 of workplace reorganisation studies, aimed at increasing skill discretion, team working and decision latitude, showed that team working interventions did improve the work environment, by increasing support.

A review7 of six studies found that training and organisational approaches which increased participation and decision making, increased support at work and improved communication led to reduced levels of sickness absence. The difference between 'healthy' and 'unhealthy' workplaces, in terms of the psychosocial as opposed to the physical environment, was attributed to the quality of leadership in the organisation and the competence and awareness of management throughout the organisation. Additionally, one meta-analytical review8 found that participation in organisational wellness programmes was associated with decreased absenteeism and increased job satisfaction.

Certain jobs have been shown to be associated with high levels of stress—for example teaching9; nursing10; and being a manager11. Social care is another profession that can lead to those working in this sector to report occupational stress, have high levels of sickness absence, presenteeism and ultimately a large number of people leaving the profession.

This article reports a study examining stress, mental health and sickness absence in the managers of a social care provider (Freways) based near Bristol. Following an initial audit, an occupational support service was introduced and the efficacy of the service evaluated two years later.

CASE STUDY
In social care the management team are pivotal to the quality of the service as they are responsible for recruitment, induction, training and supervision of all the support staff within the organisation. Management absences lead to under achievement and adversely impact on staff morale and service provision. In 2007–08, sickness absence data were analysed and it was found that the 31 managers (58% female; average age 42 years) had an average absenteeism of 15 days. Over one-third of the sickness absence was due to stress or mental health problems.

A survey (based on the methodology of the Bristol
Stress and Health at Work study\(^{10}\) was also carried out to determine the scale of occupational stress and mental health problems. Almost one-third (31.6\%) of the sample reported that they were very/extremely stressed at work (18\% of the Bristol sample reported high levels of stress) and over half of this group had clinical levels of anxiety. As well as reporting high levels of stress, the managers reported frequent problems of memory, attention and action, which suggest that their job performance was impaired. Potential causes of stress were: working hours (over 50\% did shiftwork and 42\% were often on call), the working environment (26\% reported noise levels that disturbed their concentration), high job demands and inter-personal problems.

Following the survey, focus groups were held separately for the different levels of management (managers, assistant managers, and team leaders). The aim was to identify work-related stressors that could be prevented/managed by the support service.

The results showed very different profiles for the various managerial levels. The managers' stressors related to their workload and continued responsibility for services. In contrast, assistant managers reported that it was their dual role – support work and management – that led to stress. Team leaders aligned themselves more to support staff than management and their stress was due to ambiguity in their role.

On the basis of the information from the focus groups it was possible to define particular aspects of each management role with the overall aim of producing an organisational change that supported the different roles and enhanced teamwork. The next section describes the occupational support service.

**OCCUPATIONAL SUPPORT SERVICE**

It is important to emphasise that the service had the complete support of senior management and an external steering group. There was also a project working group, which included the executive director and HR manager, which was concerned with issues such as the development of a stress policy, auditing of the managers’ role, recruitment and training. The service consisted of two main approaches, both of which were facilitated by the support manager.

**One-to-one support**

This service was available to all members of the management team. It was emphasised that this was a confidential service that provided an opportunity to discuss and reflect on work-related issues with someone who was external to the peer group and was not work/task focused. Use of the service was voluntary and the managers were encouraged to be proactive in determining the specific form that it took. No notes were taken and no records about the meetings were held at head office.

**Peer group support**

Separate peer-group meetings were arranged for managers and assistant managers. In the focus groups, isolation was cited as a cause of stress and the aim of the peer-group meetings was to discuss concerns openly and gain support from other group members. Again, the structure of the meetings was very informal although the aim was to continuously monitor the format and to adapt it to the needs of the group. Indeed, after the initial meetings it was suggested that more structure was needed to move from social affiliation to a problem-solving mode.

**EVALUATION**

**Use and satisfaction**

The first issue to be examined was whether the service was actually used. There was a high uptake, with 76\% of managers and assistant managers using the service. With regards satisfaction with the service, 95\% of participants stated that the service had reduced feelings of stress at work; all felt that they were more supported when dealing with workplace stress; and 88\% stated that the service had influenced the way they managed their team through stressful incidents. The major perceived benefits of the service were:

- an opportunity to discuss issues in confidence
- an opportunity to discuss issues with someone who understands the occupational aspects of the problem
- an opportunity to reflect on your working practices and the service provided.

**Changes in sickness absence and reported stress**

In the first year after the introduction of the occupational support service the average sickness absence for those who used the service fell from 15 days to nine days. In the second year of the service sickness absence continued to fall to an average of four days a year. With regards sickness absence due to stress and mental health problems, there was a reduction of nearly 50\% in the first year and a complete absence of this category in the second year. Long-term sickness (over 20 days a year) was also non-existent in the second year of the project.

Prior to the introduction of the occupational support service 21\% of the managers reported low levels of stress. After two years of the service this had increased to 37.5\%. Depression was also reduced in those using the service (mean score before the service: 4.95; mean after: 3.5).

**DISCUSSION**

The results from the present project suggest that occupational support is a cost-effective way of reducing sickness absence and stress at work. A crucial part of the service is buy-in by senior management and the
provision of practical help, such as use of the service during work time. Both of these features are often neglected by approaches aimed at improving wellbeing at work. Another important feature was placing the support service outside the formal management structure of the organisation. This does not mean, however, that support is best provided by external case managers. Indeed, the results obtained here with a support officer who knew the organisation and staff appear much greater than those found with a case manager from another organisation. Whether external case management can be effective will depend on the way it is introduced into the organisation and the skill of the support officer.

A major strength of the project has been the continuous evaluation of procedures. This has been based on objective measures (sickness absence), use of validated questionnaires and qualitative analyses of focus groups. The major question for the future is whether such an approach will work with other organisations and other support officers. Indeed, support groups can often make things worse (for example, patient support groups that focus on the negative effects of a disease) and use of the present approach with hostile groups may not be feasible.

It is widely agreed that ‘one size fits all’ approaches are less successful than those that match the approach to the individual and/or organisation. Future studies will determine whether the approach adopted here can be translated into forms that are suitable for other organisations. Similarly, it is important to determine whether it can be combined with other approaches (such as e-learning packages) aimed at improving wellbeing at work. Comparison with other approaches is also desirable as this will not only provide information on efficacy but also allow cost–benefit analyses. One also needs to examine this approach in scenarios that are less susceptible to a ‘Hawthorne effect’. The Hawthorne effect is a form of reactivity whereby workers improve or modify an aspect of their behavior simply in response to the fact that they are being involved in the intervention, not in response to any particular aspect of the service. Further use of the present approach, and comparison with other services delivered by other people, will be able to address this issue.

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Professor Andy Smith is director of the Centre for Occupational and Health Psychology at Cardiff University. Deborah Cowap continues to provide occupational support services.

CONCLUSIONS

- Stress, anxiety and depression are among the most prevalent of OH issues and have a large impact on sickness absence
- There is a need to integrate fundamental research on these topics with practice and policy, this series of articles aims at such an integration
- This fourth paper in the series examines the effects of an occupational support service on the sickness absence and stress of social care managers
- The results show that high stress levels were common in this group and that stress was a major cause of absenteeism
- The occupational support service reduced both sickness absence and stress
- Further studies are now required to determine whether this approach is beneficial in other contexts

Notes