MENTAL HEALTH PROMOTION IN THE HEALTH CARE SECTOR

1. Introduction

The health care sector is one of the main sectors in the European workforce, employing around 10% of workers in the European Union. The main group of health care workers is employed in hospitals. Other health care workers are employed in workplaces such as medical practices, nursing homes and other health care domains such as blood banks or medical laboratories (European Agency for Safety and Health at Work (EU-OSHA), 2007a). This sector has a significant gender disbalance: nearly 80% of the employees are female (European Foundation for the Improvement of Living and Working Conditions, 2008).

According to the International Labour Organisation (ILO, 2005) psychosocial problems may result in illness, injury, stigmatization, isolation, and even death. They can also have a considerable impact on the employer – such as reduced productivity and lowered morale. Staff in the health care sector is particularly subjected to such mental health risks (World Health Organisation (WHO), 2004). Therefore, it is important and very useful to invest in mental health promotion in this sector.

According to the WHO (2009), mental health can be conceptualized as 'a state of well-being in which the individual:
- realizes his or her own abilities;
- can cope with the normal stresses of life;
- can work productively and fruitfully;
- is able to make a contribution to his or her community.'

In this positive sense, mental health is the foundation for well-being and effective functioning for an individual and for a community. This core concept of mental health is consistent with its wide and varied interpretation across cultures.

This article is targeted at the employers and it outlines in detail the mental health issues in the health care sector, and provides practical information on mental health promotion interventions.

2. Psychosocial risk factors of mental health and mental health outcomes

2.1. Psychosocial risk factors

Psychosocial risks are linked to the way work is designed, organised and managed, as well as to the economic and social context of work, and result in an increased level of stress and can lead to serious deterioration of mental and physical health (EU-OSHA, 2007b).

Different stress models have been developed in order to give an explanation to the relationship

between risk factors and employee's health. One of the best-known models is the demand-control-support model (Karasek, 1979; Karasek & Theorell, 1990; Johnson & Hall, 1988). This model defines three main psychosocial stressors that influence an employee's well-being:

- psychological demands;
- control or decision latitude;
- and social support.

According to this model, negative stress reactions (such as fatigue, anxiety, depression and physical illness) occur when psychological demands are high and job control in decision-making is low. Social support can function as a buffer.

Many work-related psychosocial risk factors exist (McNeely, 2005; Cox & Griffiths, 1996; Jettinghoff & Houtman, 2009), including:

- shift work;
- too tight or inappropriate work schedule;
- low job control;
- high job demands;
- high workload;
- tight deadlines;
- insufficient information;
- poor organisational justice;
- poor teamwork;
- poor interpersonal relationships;
- lack of social support;
- work in isolation;
- downsizing;
- insufficient resources.

Work-related psychosocial risk factors which are typical for the health care sector (McNeely, 2005; Cox & Griffiths, 1996; Jettinghoff & Houtman, 2009) include:

- high expectations combined with insufficient time, skills and social support;
- confrontation with pain;
- dealing with dying people;
- emergencies;
- exposure to traumatic events;
- complaints and litigation.

Also violence and harassment are psychosocial hazards in the health care sector. Violent behaviour can come from patients, visitors or colleagues (EU-OSHA, 2007a).The health and social sector has the highest reported exposure to violence at work in the EU-27 (15.2%). Incidence of bullying and harassment within this sector is higher-than-average. In occupations where physical risks are high (e.g. manufacturing or construction), violence and harassment does not occur often. In contrast, in the health and social sector (where physical risks are rather low), the experience of actual physical violence or the threat of physical violence is eight times higher than for example the manufacturing sector (Parent-Thirion et al., 2007). According to the Danish project 'Violence as a form of expression' (Pedersen, 2007) up to 32% of social educators in residential care units and nursing staff in hospitals are exposed to violence. In 2001-2002 in the United Kingdom, the National Health Services (NHS) reported 95.501 cases of violence and aggression against the NHS staff, and nurses were the most often victim of these acts (National Audit Office, 2003). In recent staff surveys of NHS including an acute trust staff and ambulance trust staff, respectively 29% and 50% reported to have been a victim of violence and aggression within the last 12 months.

Health care workers also have a high risk for substance abuse. Due to specific risk factors such as exposure to high workload, dealing with terminally ill and dying patients, inadequate preparation for the demands of the job, burn-out and insufficient knowledge of alcohol and drug hazards, medical staff is especially at risk for substance abuse. In an article of Trinkoff and Storr (1998) is reported that 2% to 3% of all nurses are addicted to drugs and that 40,000 nurses in the United States suffer from alcoholism. Cicala (2003) indicates that also physicians have a high risk for substance abuse. At least 8% to 12% of physicians develop a substance abuse problem during their career. Specific risk factors for physicians are high stress and long working hours, self-treatment, and the accessibility of medicines. The impact of substance abuse is severe. In addition to causing negative effect on a worker's own health, being 'under influence' of drugs or alcohol can cause medical malpractice and can lead to lawsuits.

2.2. Health outcomes

All of these psychosocial risk factors have a great influence on employees' physical and mental health. The specific health problems caused by these risk factors may include:
- stress: reportedly 22% of the working population is affected by work-related stress (Parent-Thirion et al., 2007); this makes work-related stress one of the most common work-related health problems; health, social services and education are the sectors most at risk: up to 29.4% suffer from this problem;
- burnout: a study of the International Hospital Outcomes Research Consortium 1998-1999 revealed that 36.2% of the English employees in the health care sector suffer from major burnout (EU-OSHA, 2007a);
- anxiety: 11.4% of health care workers suffer from anxiety (Parent-Thirion et al., 2007);
- irritability: 15.2% of health care workers suffer from irritability (Parent-Thirion et al., 2007);
- depression: in a survey of the Northwestern National Life of Minneapolis (1991) 32% of the interviewed health care workers reported feelings of depression.

3. Mental health promotion in the health care sector

3.1. Mental health promotion

According to Pollett (2007), mental health promotion is 'the process of enhancing protective factors that contribute to good mental health'. Many scientific studies have proven that skills and attributes related to positive mental health lead to positive outcomes, such as better physical health and quality of life, economical well-being and personal dignity (European Mental Health Implementation Project, 2006).

Workplace is an appropriate setting where mental health of the workers can be effectively protected and promoted. The European Pact for Mental Health and Well-being, (EU High Level Conference, 2008) lists mental health in the workplace as one of the priority areas. It recommends implementation of the mental health and well-being programmes with risk assessment and prevention programmes for situations that can cause adverse effects on the mental health of workers (stress, abusive behaviour such as violence or harassment at work, alcohol, drugs) and early intervention schemes at workplaces.

3.2.   Effectiveness of mental health promotion initiatives

Some organisations have already understood the importance of mental health promotion, nevertheless there are many workplaces where such measures still have not been put in place. Thus, members of the hierarchy in health care are often very critical about mental health promotion programmes. This is because they mainly focus on cures, in order to attain immediate results, rather than focusing on long-term preventive solutions (Munn-Giddings, Hart & Ramon, 2005). Next to key professionals in the hierarchy, various other stakeholders need evidence of the effectiveness of mental health promotion: policy makers need it to justify spendings, practitioners need it for the planning and implementing of programmes, and employees affected need to know whether the interventions will help them or not (Barry & McQueen, 2005).

Detailed studies on evaluation of stress interventions are scarce, both the evaluation of the cost-benefits as well as the evaluation of effectiveness of individual stress reduction measures (Burke & Richardsen, 2000). Due to research design it is not always possible to determine which outcomes are the actual results of an intervention (Cox, Griffith & Rial-Gonzalez, 2000). Although scientific research on cost-effectiveness is not easy, many organisations and policy makers have tried to determine the costs and benefits of stress interventions at work. The Sainsbury Center for Mental Health (SCMH, 2007) in Britain gives an overview of the costs related to mental health at the workplace, and estimates the cost-effectiveness of stress interventions (based on examples from organisations in Britain).

The annual business cost of mental health at work for Britain is divided as follows:
- sickness absence: £8.4 billion (c €9.7 billion);
- reduced productivity: £5.1 billion (c €5.9 billion);
- staff turnover: £2.4 billion (c €2.8 billion).

Based on examples from the workforce an estimation of the cost-effectiveness of mental health programmes is possible. British Telecom reported a reduction of 30% of sickness absence that was due to mental health problems (SCMH, 2007) after implementation of a mental health strategy. Hilton (2005) reports on the results of an Australian mental health programme. This programme was aimed at early diagnosis and intervention of workers that showed depressive symptoms. The idea was that employers would play a role in identifying people with mental health symptoms, and that they would provide these employees with an employer-funded care. The financial benefits were visible through a higher productivity of the employees. The annual financial benefits were five times higher than the annual investment in the programme. Wang et al. (2007) describe a similar programme from the USA where the annual financial benefits per employee were $1800 (C €1268), in contrast to an annual cost per employee of only $100 (C €70.5) to $400 (C €281.8).

3.3.   Interventions in the health care sector

As work plays an important role in people's life, the workplace is a good setting for mental health promotion interventions (Pollett, 2007). These interventions need to focus on areas to be improved, both on individual level and on organisational level. It is important to build a working culture in which mental health issues are not taboo.

In order to reduce psychosocial risk factors and promote mental health in the health care sector, different types of interventions exist.

3.3.1. Organisational level interventions

At this level the employer introduces measures to reduce stressors in the work environment. These interventions are meant to eliminate the causes of stress at work (EU-OSHA , 2002).

Interventions at organisational level are aimed at changing the structure of the organisation and/or at changing physical and environmental factors. These interventions try to reduce negative elements in the work organisation. The intervention in the demand-control-support model focuses on organisational redesign with the aim of increasing the control that the worker has on their work and their abilities (Luceño & Martín, 2008). Stressors can be monitored through a psychosocial risk analysis. The analysis will show which elements in the organisation (at task, team or organisational level) are critical and need improvement.

Organisational level interventions include:
- psychological demands: to improve quantity of work, to optimise intellectual requirements, to reduce time pressure;
- control or decision latitude: to improve the use and development of skills, to enhance control over work, to increase participation in decisions;
- social support: to improve social support among colleagues, and between colleagues and superiors;
- work-life balance: to introduce flexible working hours, to provide childcare services at work, to allow study leave and career breaks, to enable employees to plan and implement rotas based on work rota autonomy.

Examples of organisational level interventions in the health care sector include (EU-OSHA, 2002):
- improved staffing levels during peak hours; this enables a reduction in workloads, improvements in organising shifts, and absence and contingency cover;
- specifying functions and responsibilities; for example, in nursing auxiliaries, for dispensing assistance with medication, and assistance and backup for providing treatment;
- establishing a communication protocol for those situations that, in the opinion of the workers, could pose risks to their health and safety;
- introducing a degree of discretion in carrying out some tasks, under the guidelines set by the corresponding department, to certain groups of workers to improve autonomy and decision-making;
- promoting worker participation through meetings, enabling them to contribute suggestions, ideas and opinions.

3.3.2. Individual – organisational interface level interventions

These interventions try to increase the worker's ability to tackle stress. The employer should invest in interventions to increase the coping capacity of his employees, for example via training.

Examples of such interventions include (EU-OSHA, 2002; Pollett, 2007; Marine et al., 2009):
- improving relationships between colleagues and managers at work;
- establishing support groups;
- improving person-environment fit;
- clarifying role issues;
- increasing participation and autonomy;
- training to enhance employees' self-esteem and self-worth, sense of belonging;
- a Mindfulness-based stress reduction program: this programme consists of a training to improve communication skills, learn how to deal with stress reactions, self-compassion;

- training to improve practical skills to reduce stress, and to improve relation and functioning with patients;
- staff training in coping with situations experienced such as death, pain and the terminally ill.

3.3.3. Individual level interventions

Individual level interventions often are focused at reducing stress among those employees who already have symptoms. They aim to increase the individual's ability to tackle stress through, for example, relaxation techniques (EU-OSHA, 2002). These interventions make sure that an individual is more able to cope with the stress symptoms. By supporting these people properly, the damaging consequences of stress are minimised. Some examples are:
- therapeutic massage;
- learning coping strategies;
- cognitive-behavioural training;
- training in stress management;
- counselling.

3.4. *Tackling violence and harassment in the health care*

As discussed earlier, next to stress, also violence and harassment are common problems in the health care sector that lead to negative health outcomes. In order to tackle violence and aggression in the health care sector, the same intervention levels can be followed as for the prevention of stress.

On an <u>organisational level</u> the following interventions can be taken (ILO, 2002; NAO, 2003; United States Department of Labor, 2004):
- developing a human-centred workplace culture and issuing a clear policy statement in which is clearly stated that violence or aggression against health care staff is not tolerated; all parties involved should be aware of the policy: patients, employees and managers;
- management commitment to prevent violence and aggression;
- clear information and communication;
- conduct risk assessments on violence, aggression and harassment at work;
- environmental control: securing safety by using effective technology and procedures (e.g. alarm systems, create distance between client/patient and staff by using a deeper counter, etc.);
- information on necessary precautions, on increased risks with certain patients, etc.

On an <u>individual-organisational level</u> the following steps can be taken (ILO, 2002; NAO, 2003; United States Department of Labor, 2004):
- reporting of all incidents of violence and aggression;
- pre-incident training of staff on how to recognize actual or possible threats in the workplace; training of staff on how to react in violent situations.

Finally, some <u>individual level</u> interventions exist (ILO, 2002; NAO, 2003; United States Department of Labor, 2004; Arnetz & Arnetz, 2000):
- assistance and support;
- counselling;
- grievance procedures;

- debriefing;
- rehabilitation for staff who were victim of a violence incident.

3.5.   Good practices

Comprehensive mental health promotion interventions exist, though often organisations do not pay equal attention to all three intervention levels (Cox et al., 2000; Kompier et al., 1998). Organisations more focus on individual-organisational interface and individual interventions. As a consequence interventions aimed to reduce stressors in the workplace preventively are often forgotten.

In order to implement a good mental health promotion policy, any organisation needs to approach this topic from a holistic point of view by implementing actions on all three levels. As the causes of stress are multifactorial (e.g. a combination of staffing issues, work loads, work organisation issues and physical working conditions) all of these causes need to be tackled together for an intervention to be effective (EU-OSHA, 2002). In this process it is very important that employers and employees work together (Keleher & Armstrong, 2005).

Two practical examples of interventions on an organisational level are given below. The focus is put on examples of preventive measures, since they address the roots of the problem. Examples of organisational-individual and individual level interventions can be seen above in the respective paragraphs.

In box 1 a good practice example is given to demonstrate how organisations in the health care sector can tackle psychosocial risks, related health consequences and how an organisation can meet the need for participation in decision-making process. In box 2 a good practice example is given on how to tackle violence directed towards the health care staff.

Box 1. The Caregiver Support Programme (Jané-Llopis et al., 2005)

Context
The Caregiver Support Programme is designed to increase participation and social support in work-related decision-making for caregiver teams in (mental) health care facilities. This programme increases effectively the ability of teams of caregivers to mobilise socially supportive team behaviour and problem-solving techniques.

Programme
- six training sessions (4 to 5 hours);
- participants: 10 home managers and 10 direct care staff;
- focus:
    - to better understand and strengthen existing networks within the organisations that might be able to help and support;
    - to increase worker participation;
    - to develop and lead training activities;
    - to learn techniques to maintain these new skills over time.

Evaluation of the programme
- the programme increased supportive feedback on the job;
- the programme strengthened participants' belief and perception that they are able to cope with disagreements and overload at work;
- the programme enhanced the team climate, mental health and job satisfaction.

Box 2. The management of violence against staff in the health care sector (EU-OSHA, 2002)

Problem
In Ireland 12 incidents of violence or abusive behaviour towards staff in the Mid-Western regional hospitals were reported in 2000. This number increased to 64 by 2001. Staff reported feelings of stress, frustration, fear and vulnerability.

Solution
Together with the hospitals' health and safety executive the Risk Management Department decided to develop a structure to systematically address violence in the workplace. This structure contained different steps:
- development of a new incident reporting policy and encouragement of an open reporting policy;
- development of a comprehensive framework and programme for the management of violence and aggression;
- treatment of aggression and violence in the same way as all other occupational hazards; risks of aggression and violence must be identified, evaluated, and control measures must be implemented and evaluated; in order to meet these demands a formal method of risk assessment was developed;
- a specific training to the staff enable them to cope with and intervene in aggressive and violent situations (because of behaviourally disturbed clients); this training was aimed at teaching the staff to eliminate risk of injury to either the staff or clients.

Practical examples
A multidisciplinary team in the Emergency Department conducted a major risk assessment together with health and safety consultants. After the identification of several high-level risks, following actions were taken:
- 'Non–Violent Crisis Intervention' training programme;
- increased security presence;
- information in the department relating to policy towards abusers;
- provision of personal and panic alarm systems;
- a closer working relationship with the Gardai (police); a liaison officer was appointed to work closely with hospital staff;
- three successful prosecutions of offenders through the courts;
- attention to ergonomics of the department from the point of view of prevention and safe work practice.

4.   Further information

Websites:

European Agency for Safety and Health at Work:
http://osha.europa.eu/en/topics/stress
http://osha.europa.eu/en/topics/whp
http://osha.europa.eu/en/sub/sme/products/stress_at_work/index.htm

European Foundation for the Improvement of Living and Working Conditions:
http://www.eurofound.europa.eu/areas/index.htm

European Commission:
http://ec.europa.eu/health/ph_determinants/life_style/mental/index_en.htm

European Network for Workplace Health Promotion:
http://www.enwhp.org/index.php?id=4

ProMenPol:
http://www.mentalhealthpromotion.net/

World Health Organisation (WHO):
http://www.who.int/topics/mental_health/en/

International Labour Organisation (ILO):
http://www.ilo.org/public/english/dialogue/sector/sectors/health.htm

Health and Safety Executive (HSE, UK):
http://www.hse.gov.uk/healthservices/stress.htm

National Institute for Research and Security (INRS, France):
http://www.inrs.fr/dossiers/stress.html

Projects:

European Network for Workplace Health Promotion (ENWHP): Project Move II 'Mental health at the workplace':
http://www.enwhp.org/index.php?id=606

European Mental Health Implementation Project:
http://mentalhealth.epha.org/index.html

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