ISSN 1743-16737 (online)

Occupational Health Psychologist

Incorporating the Newsletter of the Academy

A publication of the European Academy of Occupational Health Psychology

Europe's leading body for individuals and institutions with an active involvement in research, professional practice and education in occupational health psychology

Volume 3, Issue 2 July 2006

At a glance

Editorial

Welcome to the summer issue of the *Occupational Health Psychologist* (OHPist). We bring you this issue just as we make the final preparations for the 7th EA-OHP conference in Dublin (see page 3 for conference information). The Scientific Committee received more than 230 submissions for the conference, and it promises to be the largest EA-OHP event to date. Dublin is a very beautiful and friendly city, and this is an event not to be missed!

In this issue of the OHPist, we provide the usual mix of interesting contributions from OHP researchers and practitioners, along with the latest news from the Academy. In the first article, Brad Gilbreath discusses the important links between supervisor behaviour and employee well-being, and maps out a number of avenues for future research in this area. Following this, Tom Cox reports on the continuing close relationship between the EA-OHP and the journal *Work and Stress*, including information on a free journal subscription offer for members of the Academy.

We are also delighted to present two interesting papers from OHP practitioners working within the UK's National Health Service (NHS). In the first of these articles, John Kincey describes some of the key issues involved in establishing an OHP

service within a healthcare organisation. Additionally, Anna Pullen and Leslie Morrison discuss the importance of clinical supervision for healthcare workers, and provide some useful tips on the implementation and evaluation of the clinical supervision process.

Our warm thanks go to all of these authors for taking the time out of their busy schedules to contribute to the OHPist. I hope that their efforts will encourage more of our readers to submit short articles for publication (publication guidelines can be found on the final page of this issue).

I would also like to draw your attention to the information on page 17 concerning a new Occupational Health Psychology email discussion list. I very much hope that you will take the time to sign up to this list, and make use of it to stay in touch with your OHP colleagues across the globe.

The OHPist editorial team will occupy a stand at the Dublin conference, and will be gently encouraging delegates to use this publication to communicate their work. Please feel free to visit our conference stand to say hello and discuss your ideas for future issues.

In the meantime, I wish you all a very pleasant summer and I look forward to seeing you in Dublin.

Best wishes,

Paul Flaxman
(On behalf of the OHPist editorial team)

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European Academy of Occupational Health Psychology

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Academy Publications

The Occupational Health Psychologist
Published three times per annum
ISSN 1743-16737 (Online)
Back copies can be download at www.ea-ohp.org

Work & Stress
The Journal of the EA-OHP. Published quarterly in association with Taylor & Francis
ISSN 0267-8373

Annual Conference Proceedings
ISSN 1473-0200
Comprises the proceedings of the EA-OHP annual conference. Previous editions may be ordered at a cost of £25 per copy or £125 for the entire back catalogue. The catalogue consists of Lund (1999), Nottingham (2000), Barcelona (2001), Vienna (2002), Berlin (2003) and Oporto (2004).
Copies may be ordered from Jonathan Houdmont at jonathan.houdmont@nottingham.ac.uk

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Europe's leading body for individuals and institutions with an active involvement in the research, professional practice and education in occupational health psychology

Four Academy members attending a recent Executive Committee meeting (from left to right: Frank Bond, Paul Flaxman, Jonathan Houdmont, and Phil Dewe)

Could you be an Officer of the EA-OHP?

By the time of the Dublin conference in November 2006 the Academy will have been formally incorporated as a Registered Charity under English law. Charitable Status requires a restructuring of the Academy's organisational and decision making structures. A number of new Offices of the Executive Committee have been created and vacancies exist for some existing Offices.

Am I eligible for Office?

- All Full Members of the EA-OHP are eligible for nomination.

What is required of Office holders?

- Attendance at biannual meetings of the Executive Committee. Each meeting is for a full two days. All travel, accommodation and subsistence expenses are provided by the Academy.
- Preparation and presentation of an activity report to the Executive Committee at each meeting.
- Commitment to undertake the roles and responsibility of Office.

Benefits of Office

- Contribute to the management and development of OHP at the European and wider level.
- Network with like-minded individuals and institutions.

How will elections be conducted?

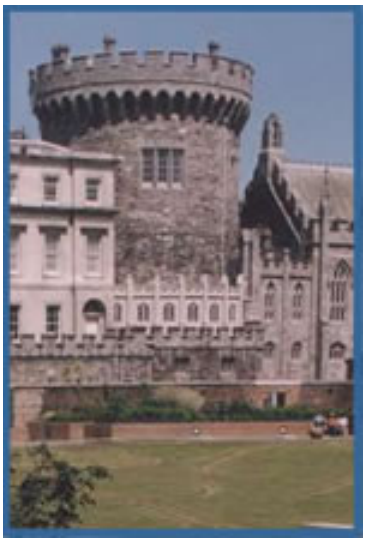
- Nomination details will be sent to all Full Members following the Dublin conference in November 2006.
- All members will be invited to vote for their preferred candidates via a confidential voting facility on the Academy website in January 2007.
- An announcement on the outcome of voting will be made at the end of January 2007 and new Office holders will be inducted with immediate effect.

Further information

- To discuss nominations informally ahead of the election process please contact the Academy's Executive Officer, Jonathan Houdmont at jonathan.houdmont@nottingham.ac.uk.

7th Conference of the EA-OHP
Dublin, Ireland, 8-10 November 2006

UPDATE...



An unprecedented number of delegates have registered for the forthcoming Academy conference. Delegates from more than 30 countries are registered and this number is expected to rise as the conference approaches. Some indication of the tone that the conference might develop can be taken from the fact that the Guinness Brewery tour was the first event to sell out within days of the online registration facility going live!

Accommodation

Delegates are advised to book their accommodation as soon as possible. There is an international rugby match taking place in Dublin on Saturday 11 November and as a result many hotels are beginning to book up. See http://www.ea-ohp.org/Conferences/index.asp for a list of recommended hotels.

Timetable

The provisional timetable is now available on the conference pages of the Academy website. The full presentation schedule will be published on the website once all presenters have confirmed their intention to attend. If you are presenting and have not confirmed as much, please do so as soon as possible.

Registration deadline

The deadline for delegate registrations is 1 October 2006. Please be aware that early bookings are advised to guarantee a place. Spaces at the social events are strictly limited and are liable to sell-out well before October.

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Promoting Well-being through Healthy Supervision: Current Knowledge and Future Directions

Brad Gilbreath

Brad Gilbreath is an Associate Professor in Indiana University-Purdue University Fort Wayne's Division of Organizational Leadership & Supervision. He earned a Ph.D. in management from New Mexico State University. Before that Brad worked in human resource management in the manufacturing and nuclear industries (Ford, Elcor, Westinghouse). His previous education includes an M.S. in Industrial Relations (Purdue) and a B.B.A. and M.B.A. (Baylor University). Brad's primary areas of interest are supervisor behaviour, work and health, person-environment fit, and performance-based pay. One of his current research projects is a study on how supervisor behaviour affects well-being, presenteeism, and job neglect. Another is an investigation of behaviours that cause employees to view their managers as credible. He is also investigating determinants and consequences of student-university fit. Brad enjoys collaborating on research, and would like to work with others to measure and improve supervisor behaviour.

It was quite a shock to walk in and see my supervisor lying on a stretcher. The best boss I'd ever had was leaving our worksite in an ambulance. Was he having a heart attack? Would he be alright? Would we ever see him again?

Fortunately my boss recovered from what was diagnosed as tachycardia. I later learned that the tachycardia had come on after a shocking episode of mistreatment by his unscrupulous manager. That and other incidents sensitised me to the profound influence supervisors can have on their employees. Years earlier, I too had experienced supervisor-induced strain, though not as dramatic as my boss's. While working for my first and worst supervisor, I spent many a Sunday dreading returning to work on Monday. And, in another organization, I worked in close quarters with a Type-A boss. During the workday my chest would inexplicably tighten while working within what I dubbed my boss's "stress aura." Later, as a doctoral student, I was puzzled when I noticed there was nothing in management and supervision textbooks on the effects I'd witnessed. I made it my mission to address that gap, and I've been working on that off and on for about ten years now.

What Have We Learned About The Health Effects Of Supervisor Behaviour?

From the earliest empirical results in the late 1970's to the present, studies have been consistent in finding that supervisor behaviour is associated with employee well-being. Employees working for supervisors who are considerate and supportive are more likely to have good psychological health. Employees working for less considerate, less supportive, or abusive supervisors are likely to suffer from psychological and physical strain. However, it's important to note that a broad range of supervisor behaviours is associated with employee well-being. Mundane supervisor behaviours such as organising work and providing resources are also important. Even whether supervisors admit it when they make a mistake is associated with employee stress!

Supervisors affect employees' job stress and health in at least two ways. First, they can be a source of stress for employees. Supervisors who micromanage, communicate poorly, who are disorganised, or who show no discernable interest in their employees as human beings add to the amount of workplace stress employees must attempt to deal with. Second, supervisors can be stress moderators, helping employees cope with stressful work events or making events more stressful. An empathic supervisor who is a good listener can help an employee wind down after a stressful encounter with a customer. Conversely, the supervisor could increase the employee's stress level by chiding the employee for not handling the situation better.

Supervisors' influence on employee well-being is amplified by their position power. They determine who gets which work projects, who gets training, and who gets pay raises. They also—through their discussions with upper-management—affect perceptions of employees' promotability and value to the organization. That is why—for many employees—the supervisor is the most important work factor affecting their well-being.

What We Need to Know

So this much is clear: supervisors are a potentially significant influence on worker well-being. But what else do we need to know? I've identified seven questions that should be answered to gain a better understanding of supervisor behaviour and its health effects.

What Categories of Supervisor Behaviour Affect Employee Well-Being?

Although a variety of supervisor behaviours have been linked to employee stress, we don't have a good understanding of the underlying performance dimensions. What are the categories of supervisor behaviour that affect employee well-being? This is important because categories will provide more clarity than long lists of disparate behaviours. It will be easier, for example, to train supervisors about important types of behaviour they should attend to rather than to say something like "Here are 63 employee-stress-related behaviours you should be mindful of." Fortunately several teams of researchers are currently working to identify relevant performance dimensions, and findings are forthcoming.

How Are Health-Related Behaviours Related to Overall Performance?

Once we have an understanding of the categories of supervisor behaviour that reduce stress and promote well-being, we need to establish how they are related to supervisors' job performance. That need was highlighted during a discussion I had with a rather testy human resource manager. We'd been discussing her organization's efforts to promote employee health. After 20 minutes of hearing about the organization's health initiatives, I mentioned that supervisor consideration is also important for employee well-being. Apparently I touched a nerve I didn't know was there, because it was as if an iron curtain dropped between us. The HR manager said something to the effect that "we don't have time to be nice to employees; we've got production schedules to meet." Although I attempted to raise the curtain a bit by assuring the manager that getting tasks done was certainly essential (coincident with treating employees decently), I never was able to re-establish any rapport or productive dialogue.

That incident suggests it would be worthwhile to study how well-being-related supervisor behaviour relates to supervisors' overall job performance. For example, it would be helpful to establish that supervisors who manage in a way that has positive effects on employee well-being are also more likely to be viewed as effective by *their* managers. At the very least it could be helpful to show that supervisors who are "nice" to employees aren't less effective—from an upper-management perspective—than their more hard-driving peers.

What Are the Bottom-Line Effects of Healthy Supervision?

Unfortunately some organisations won't do much to humanize work until they're convinced that to do so will be of benefit. For that type of organization, arguing that bad supervisors take a toll on employees' quality of life isn't enough; we need to show how poor supervision affects profits. This is true of all occupational-health interventions; being able to show positive financial impact will give us greater ability to persuade organizational decision makers to invest in employee-health initiatives. However, most of us have read admonishments that we need to show the bottom-line impact of what we do, so I'm wary about repeating that truism. And I feel some ambivalence because I know the kind of damage bad supervisors can do, and I don't see why that has to be translated into dollars, pounds, or euros. Yet I would appreciate having persuasive statistics to use when needed (e.g., "employees working for poor supervisors are absent 22% more often, ill 11% more, and have 13% more accidents"). A few studies have provided those types of statistics, but more data would be helpful.

To What Degree Does Supervisor Behaviour Affect Physical Health?

It would be helpful to know more about the effects of supervisor behaviour on physical health. A clever study by Wager, Fieldman, and Hussey found that nurses' blood pressure tended to go up when they were around a supervisor they didn't like, and went down when they were in the

presence of a supervisor they liked and considered fair. Findings like that are salient and bring more attention to supervisors' effects.

What Other Outcomes Are Affected by Supervisor Behaviour?

It would be interesting to know how supervisor behaviour relates to some not-yet-explored outcomes. For example, nurturing supervisors who build employees' job self-efficacy and organization-based self-esteem may also increase employees' global self-esteem and cause long-term changes in employees' self-concept, goals, and behaviour.

Other variables await attention. One outcome that seems worth investigating is presenteeism. Employees who have a good supervisor experience less stress, allowing them to focus more on doing their job and less on "managing stress." Organizations presumably are interested in maximizing the percentage of employees' cognitive energy devoted to work, so results showing that positive supervisor behaviour reduces presenteeism should be of interest.

Can Supervisor Behaviour Be Changed?

We are on the verge of being able to describe what healthy supervision is, but we also need to know how amenable supervisor behaviour is to shaping and improvement. Will we be able to change supervisor behaviour to make it more conducive to employee well-being? It seems likely to be difficult to change ingrained supervisory patterns, so it's essential to know the types of interventions that will improve supervisors' behaviour and increase employee well-being.

There are some grounds for guarded optimism. Gill and colleagues, for example, achieved some success in altering Type-A behaviour patterns through a well-planned and comprehensive intervention. Similar programs could be designed to change supervisor behaviour. However, because few organizations are likely to implement such a rigorous behaviour-change regimen, it would be good to determine how to select people who will supervise in a healthy manner. To what degree can we forecast how candidates for a supervisory position will behave once they're in the position? This, too, needs research attention.

What Are the Antecedents of Healthy Supervisor Behaviour?

Supervisors don't operate in a vacuum. They are influenced by their organization's culture, rewards, and stressors. It's not difficult to understand how otherwise humane supervisors could become less patient, empathic, and participative when they are experiencing a great deal of stress. So we need to know more about the antecedents and moderators of healthy supervisor behaviour. What organizational variables should be addressed to bring about the type of supervision we'd like to see? Although this could entail some intimidating research designs, supervisors themselves should be able to shed quite a bit of light on what organizational factors most influence their behaviour.

"Let me know if I'm micromanaging you."

Conclusion

Let me conclude with a couple of observations. First, I've noticed that researchers focusing on other independent variables but who also include a measure of supervisor behaviour in their research often seem surprised when supervisor behaviour ends up having strong associations with their well-being-related independent variables, often stronger than their focal variables. From my vantage point, I would be surprised if supervisor behaviour *didn't* have

significant effects on well-being. Second, I've found that there's quite a bit of interest in the effects of supervisor behaviour. Although U.S.-based leadership researchers I talk with about the topic typically react with what amounts to a big yawn of disinterest, I've been gratified by the response from practitioners everywhere and from researchers outside the U.S. Although there's still plenty of work to be done, it shouldn't be too difficult to justify the need for more work aimed at improving supervisor behaviour. I hope some of you will join me in this work.

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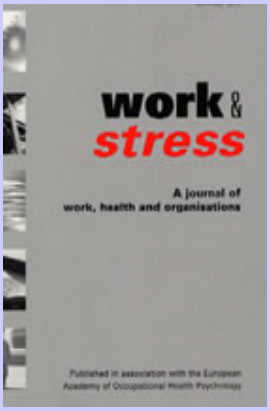
The author thanks Dr. Erin Frew, Dr. Nadia Wager, and Paul Flaxman for their assistance with the article.

Work & Stress

Tom Cox, Managing Editor
Work & Stress, Nottingham, UK



The relationship between the scientific quarterly Work & Stress and the European Academy is an important one for both parties. As one strengthens, so does the other. As the long-standing Managing Editor of the journal and, at the same time, the President of the European Academy, it is gratifying to be able to report on the current successes of this relationship.

Impact factor

The journal is 20 years old this year and is the longest established journal in occupational health psychology. The editorial in volume 20 number 1 for 2006 celebrates this anniversary and makes some suggestions as to the future of scientific publishing and the possible positioning of the journal in this new world. It notes that over the last few years the journal has strengthened in terms of the impact rating system developed by the Institute for Scientific Information (ISI). In 2001, its impact factor was 1.585 and the journal was among the strongest in applied psychology. Sadly, it then fell back the following year, but in their recent Editorial Cox and Tisserand (2006) noted the recovery, with the journal reaching 0.935 last year. Since the publication of that editorial, I am pleased to report that the journal has continued in its ascent and has now achieved 1.209 for 2005 (announced June 2006). It has once again passed the critical threshold for most national research assessment exercises, of 1.000. Undoubtedly, this will result in an increased number of excellent submissions and increased competition for publication. I would like, on behalf of both the journal and the European Academy, to thank all those who have contributed to this welcome success – to those involved in delivering the journal to a high standard of quality and to those whose papers we have published.

Best paper award for 2004

In this, its 20th year, the journal will award a prize for the best paper published in a particular year. The rules governing this award have been published in the journal (Cox and Tisserand, 2006). They are, to a large extent, based on the original comments of the referees on the paper, together with the number of 'hits' and 'downloads 'that it has received, as recorded by our publisher Taylor & Francis from its website. Given the nature of these data, there is naturally a time lag in judging the published papers. The award for 2004 will be presented formally at the Dublin Conference of the European Academy in November 2006. The prize has been awarded to the report of a one-year longitudinal study on work-to-family conflict and its relationship with satisfaction and well-being by Ulla Kinnunen, Sabine Guerts and Saija Mauno. Our congratulations to the authors. This prize will be awarded in addition to the André Büssing Award for the best paper presented at the conference by a younger researcher (aged under 35 at the time of submission).

Editorial Board

Each year the journal restructures its supporting team of Editorial Board members to introduce new blood and ideas and to rest those who struggle to maintain their contribution against ever increasing demands from elsewhere. For now, the journal will have a team of five Associate Editors: Frank Bond, Bonnie Long, Kathryn Mearns, Arie Shirom and Philip Dewe. We appreciate the excellent service that they are giving. In addition, we are very pleased to announce that Toon Taris, who has up to now been the sixth Associate Editor, has agreed to be Deputy Editor to work closely alongside myself and Mary Tisserand to support the strategic as well as the operational management of the project. This is a new appointment, which has been made to assist us in maintaining standards

while dealing with the increasing number of papers submitted to the journal. Dr Taris has already invested a considerable amount of time and effort "behind the scenes" in supporting the journal and will continue to work for it on a formal basis.

Dr Taris is a long-standing member of the European Academy, as are all three of the Europe-based Associate Editors.

Enhanced membership benefits

Finally, a new deal has been agreed with Taylor & Francis that will provide increased benefits for individual members of the European Academy and for the organisation itself through increased financial support. From January 2007 all members (existing and new) will receive an individual subscription to Work & Stress as part of the membership package. Members will then receive both print and online subscriptions. This agreement has been reached without the need to increase member subscription fees. The terms reflect the commitment of Taylor & Francis both to the journal and to the Academy as leading forces in OHP.

Our thanks must go to Scott McIntyre, the Academy's Registrar, for managing the negotiations with Taylor & Francis and bringing them to a successful conclusion.

Work & Stress Website:
http://www.tandf.co.uk/journals/titles/02678373.asp

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Establishing Occupational Health Psychology Input within a Healthcare Setting: Some questions to ask about content and process

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Author profile
John Kincey is a chartered clinical and health psychologist with a career-long interest in psychological contributions to physical healthcare systems, particularly the effects of clinician-patient communication on anxiety, stress, dissatisfaction and information transmission in surgical, mental, medical and primary care settings. His involvement in occupational health psychology focussed initially on the development processes for an NHS staff support service. John and his colleagues are currently examining psychological factors affecting recruitment/retention and the impact of occupational pressures on medical staff working in critical care.

Introduction

This paper seeks to make explicit a number of questions which might usefully be considered when seeking to establish occupational health psychology (OHP) input within the context of a healthcare organisation (such as the UK National Health Service (NHS)). The framework outlined relates, at a specific level, to the considerations and decisions over a period of years before and during the establishment of a service within one such organisation. It is hoped, however, that the issues identified will have some generality and value to other settings where attempts are being made to develop similar services.

The paper is written from the perspective of a chartered clinical and health psychologist who was, during the time of establishment of this service, employed within the organisation in question, as the Head of Psychological Services. The OHP service development to which this paper refers was undertaken prior to an organisational reconfiguration. By mutual agreement between the two emerging healthcare organisations, a professional arrangement has continued in place whereby the consultant clinical psychologist now working within the Staff Support Service of the acute organisation is managerially accountable to the medical head of Occupational Health, but receives professional support and supervision from the author who is now employed within a different organisation. The structure of this paper comprises the following series of specific questions in the hope that these might provide both a stimulus and a reference point for managers from psychological, occupational health, and board level perspectives.

Why is there a move to establish the OHP service at a given point in time?

Answering this question should help to clarify the priorities for an OHP service, and may also help to clarify the balance of different functions to be provided and the types of evaluative data which will be necessary to assess the effectiveness and efficiency of the service. In the UK National Health Service there is increasing pressure to develop such services in the context of various initiatives, such as Improving Working Lives, the recommendations of the UK Health and Safety Executive, and the implications of workforce planning. Concerns about the possibility of being legally challenged by staff for the non-provision of staff support services may act as a spur to introduce such a service. There may be previous anecdotal or local scientific evidence of high levels of staff (di) stress within the specific organisation, in addition to the well established evidence of significant levels of stress within healthcare organisations (e.g., Borrill et al 1998). There may also be evidence of increasing or at least more recognised errors hypothesized to be caused or influenced by psychological factors or problems. Finally, in the context of major problems of recruitment, retention, illness, retirement or low morale, organisations may wish to explore psychological perspectives to identify ways to reduce these. It is likely that more than one of these factors will have been influential within an organisation and there may be a cumulative effect, possibly triggered by a specific local concern or problem. Understanding the local influences which move the organisation from a 'pre-contemplation' stage to one of 'action' will be valuable in negotiating and developing relevant change (Prochaska and Velicer, 1997).

Where should the service be located, both organisationally and physically?

The first decision here is that of whether an OHP service is directly managed by the employing organisation or whether it is bought in from a similar organisation or via some other external

provider framework. The view may be expressed that buying in an external service is a simpler process than developing one internally. However, even if a more complicated process, the development of a service which is home-grown may lead to benefits because of more sophisticated and detailed local knowledge of the organisation by those working in this context. Subsequent involvement in organisational well-being policy development and implementation may also be more possible and effective if the service is internal.

There is a related question about the physical location of the OHP service, particularly those aspects of it for which there is a need for the best possible balance between accessibility and privacy. For example, it can be argued that off-site counselling or other clinical help will be taken up more readily by individual staff members than would be the case if the service was provided on-site. However, besides the question of travel and leave of absence time required for such an arrangement, there is the alternative hypothesis that where an organisation funds and provides an appropriate confidential on-site location for staff support it will be seen by staff as taking this issue seriously and this may, in turn, lead to greater uptake. At a specific level, the exact location of any staff counselling or psychological therapy services may need to be seen as physically and conceptually separate from occupational and mental health services particularly if there are concerns or even fears among staff about management awareness of their uptake of the service. There does not yet appear to be scientific evidence to definitely confirm any one or other of the above strategies as always the most appropriate. Local considerations, both practical and psychological, should presumably determine the eventual decision.

How can confidence in the OHP service from staff be maximised while convincing managers that the concept is a valid and helpful one?

The key issue here is how to seek and obtain "top table" support for the OHP service, up to and including senior board level, while also seeking and obtaining support from the varied staff groups within the organisation and from staff representatives within the organisation. Although less likely than it may have been some years ago, there is still a possibility that senior management could view the development of an OHP service as an unjustified distraction from the core function of the organisation. Alternatively, the staff side perspective could be one of suspicion of the development as an attempt by senior management to put inappropriate pressure on individual staff members to remain at, or return to, work, despite psychological health problems. Creating a steering group mechanism and structure which accesses the views of and involves managerial, staff side, professional and other occupational perspectives may help to minimise these misperceptions and suspicions. Within a healthcare setting (such as the UK NHS), important perspectives on this are likely to include occupational health, human resources, health promotion, chaplaincy and psychological services, among others. The exact membership of such a steering group and the exact line management for psychological input will need to be decided upon locally.

It will be important that access arrangements for individual staff members to such a service are clearly defined, are recognised as needing to be confidential and, almost certainly as self-initiated rather than by others. Where the line management arrangements for OHP input may lie within occupational health or mental health services structures, staff will need to be reassured that any clinical contact they have with the service is "ring-fenced" in terms of confidentiality from other occupational health or mental health provision unless they wish for further referrals to be initiated. Without such reassurance it may be impossible to develop the perception that the service is both organisationally and psychologically "secure" for the potential service user. The perceived value and subsequent use of such a service almost certainly depends upon achieving this perception.

As with many new developments, initial funding for an OHP service may be on a fixed term basis, with permanency contingent upon positive evaluation. This raises obvious associated questions about recruitment potential, about minimum necessary duration to achieve meaningful positive change and how such decisions may impact upon perceptions among staff of the strength of commitment of the organisation to the service. Negotiating both reasoned and reasonable levels of input and duration of initial funding will be essential. This may necessitate prioritising different functions in the early stages of service provision in a way different from that which might be seen as ideal. Compromises may well need to be made in this context.

What range of functions will the service attempt to provide?

As identified in previous papers addressing this question, (Jennings 2002, Wren 2001), at least four main levels of work can be identified within such services. These relate partly to the models and attempts to develop primary, secondary and tertiary prevention and partly to the need to respond to central government initiatives in the health care setting (Williams et al 1999). In very brief summary, they comprise: a) Clinical/counselling help for individual staff; b) Awareness raising and training concerning stress and its management; c) Consultancy work with specific clinical or organisational units in the organisation; d) Involvement in Trust- wide policy development on relevant issues (e.g. bullying and harassment, stress and well-being, Improving Working Lives initiatives). It is not the purpose of this paper to detail the components of these areas. It is, however, probably useful to identify potential frustration in the early stages of developing occupational health psychological input. This may arise if individual clinical referrals, with high priority for response, "overload" the nascent service, reducing time available to develop other primary and secondary prevention work. Careful definition and agreement of the proportions of time available for each of the categories of activity is likely to be important. Subsequent feedback concerning the success of a service may need to focus on different functions undertaken within different sections of the organisation. The development of waiting list pressures for individual clinical work, in this setting as any other, may have a double-edged effect, both positive and negative, on service development.

How do the agreed functions predict and determine levels and skill mix of staffing?

Training and competencies from within occupational/organisational, clinical, counselling or health psychology are all likely to be desirable, if not all essential for appointments of individuals to work within such settings as discussed. In the UK, while a number of psychologists would have chartered status within two of the above areas, very few would have chartered status in all four. Decisions will need to be made about the combinations of knowledge, skills and training from within applied psychology which will be essential for a specific OHP practitioner post. Bearing in mind the likely service development role as well as initial service provision, posts with sufficiently senior grading will need to be established. No absolute advice exists about this issue as yet, although well established OHP services in the UK typically have consultant level psychologist posts in place.

The second major issue is the balance between posts which require professionally recognised chartered psychological status and posts from other disciplines, most notably counselling. A post filled by individuals with approved counselling qualifications, and experience in occupational and physical health settings, will almost certainly meet some of the service and job requirements. At the individual clinical level of work, therapeutic orientations will vary considerably between individuals, within or between professional disciplines. The balance of organisational development work with that at a more individual level will partly determine the staffing skill mix. Clarity of functions, issues around team dynamics and professional boundaries will obviously be important ongoing considerations for services which have a mixture of staffing backgrounds. Norms for staffing in relation to the employee population being served have not been defined with reference to the full range of functions involved. Some norms exist with respect to individual counselling and clinical work but these as yet currently relate more to counsellors than applied psychologists.

Is it sensible for an established service to offer its skills to other organisations within or outside the organisation, or is it better for the focus to be entirely on the host organisation?

This question is relevant even at the point of inception of an OHP service. In particular, there may be a temptation for a new service to attempt to raise income to maintain or grow itself by offering services to other organisations. While this may seem a viable and successful strategy, it does need to be considered carefully. The amount of time needed to develop internal patterns of working, the need for flexibility of time usage for quick response and the need to inculcate a perception of priority for local help all suggest that initial energy might most appropriately be focused inwards. External contracts will have activity and response time components and could easily draw away internal effort to meet these, particularly if staff turnover, illness or internal organisational changes have

negative effects on the initial service. Over time and with anticipated gradual increase in service staffing levels and expertise, external work might be anticipated to become more feasible.

What criteria should be used in evaluating the service?

Given that most new OHP service developments will require evaluation for continuation of funding, data on both output and outcome are likely to be required. The range of potential functions, as outlined above, make it almost certain that a range of outcome measures will be necessary. The balance of different functions will determine the choice of measures. Subjective data from service users, either at individual clinical level or in terms of feedback from units on which organisational consultation takes place, will be relevant. Whichever clinical outcome measures are used will need to be valid, acceptable and practicable in a setting in which post-therapy or follow-up requests for such data are quite likely to meet non-adherence difficulties, as they do in other clinical contexts. For service-wide comparisons measures will obviously need to be generalisable but will probably lack the specificity needed for some individual clinical assessments. The limitations of these data, in the eyes of the clinicians providing this service, of the staff receiving it and of the managers reviewing it, will need to be acknowledged from the outset.

Objective data on levels and patterns of staff sickness or turnover, or on levels and patterns of complaints, errors or grievances within the organisation may be relevant. Access to these, particularly at fairly specific levels, such as within a particular unit or directorate, may be very useful. However, agreement will need to be obtained about the ways in which such data are released and used without their jeopardising confidentiality for the individual staff member or team. It will be important to discuss and agree, again at the outset of the OHP service, which subsets of data cannot be presented in detail as feedback for fear of unintentionally identifying individuals inappropriately.

A range of measures of organisational morale, climate and job satisfaction could be used either for organisation-wide or unit specific surveys. In agreeing evaluation methodologies it may be relevant to use measures consistent with those used in other similar healthcare organisations in order to assess trends and changes over time. However, in the UK, the multiple and rapid organisational changes within the National Health Service place strong limits upon the interpretation of the effects of the service. Randomised control trial evaluations may not be acceptable and even if so, may not be feasible. Trends and changes in levels of stress, morale or other occupational health variables may not in a simple way be attributable to the impact of the new service and commentary on this phenomenon will be necessary as part of the evaluation feedback.

Conclusion

The above questions are not all unique to the establishment and development of occupational health psychological services and addressing them will not in all situations produce clear-cut answers. Doing so, however, should help to avoid some of the potential pitfalls in this process and, hopefully, will facilitate dialogue within an organisation which is considering establishing an OHP service. Focusing the service on the high priorities of the organisation, ensuring that it is established in a way which makes it acceptable to all stakeholders, maximising effectiveness by identifying the appropriate skill mix and agreeing relevant but workable evaluation criteria are all likely to be necessary conditions if a service is to flourish!

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Experience of Facilitating Group Clinical Supervision Within a Healthcare Setting

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Introduction

This paper considers the role of group clinical supervision within healthcare services and describes the experience of providing clinical supervision to staff groups in response to requests made to a consultancy service for healthcare staff within a National Health Service (NHS) organisation in Gloucestershire, England.

Clinical Supervision

As part of the ongoing modernisation of the UK NHS (DOH, 2000), initiatives such as Clinical Governance and Improving Working Lives promote Continuing Professional Development (CPD) activity and lifelong learning (DOH, 2001). In accordance with these requirements, clinical supervision is becoming an integral part of the working lives of healthcare professionals.

The term supervision however, has been associated with the more traditional model of managerial control such as monitoring, performance appraisals, working in accordance with organisational guidelines etc. Although clinical supervision does not take the place of service and people management, its emphasis is on more of a supervisee-led and supportive process with a view to providing a broader outlook and reflection on work-related activities. This conceptual shift is summarised in Bond and Holland's (1998) definition of clinical supervision as:
"regular, protected time out to reflect on practice, in which the supervisee can develop high-quality practice through the means of focused support and development".

It is generally acknowledged that for most effective supervision to take place, the roles of the manager and clinical supervisor need to be separate and distinct from one another. In practice, this means that managers should not provide clinical supervision to those to whom they have a direct managerial responsibility. Instead, many clinical teams find themselves looking for external facilitators to provide clinical supervision. Psychologists are often considered in such roles as they have the appropriate professional supervisory skills, experience to facilitate interpersonal support and enable consideration of the broader perspective of process as opposed to content (i.e., the underlying issues and themes as opposed to solely dealing with what has been spoken about). In this article, psychologists were approached through a staff support service for one geographical area (Gloucestershire).

The Staff Support Service

The UK NHS-funded service aims to promote the well being of health service staff in Gloucestershire through individual and group support, consultancy and organisational development. It is one of the largest services nationally, in terms of the number of staff who have access and is provided by a group of clinical psychologists, some of whom also have experience and qualifications in occupational psychology. Although the majority of staff support work is about supporting individual members, the service is increasingly being used by staff in managerial roles who request consultancy work for issues from planning for change to supporting staff under stress. One such request is for group clinical supervision and this article reflects

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on some of the realities of setting up and facilitating supervision.

Setting up group clinical supervision

Clinical supervision can be set up as a one-to-one meeting or group format comprising either a uni or multi-disciplinary team. The process of setting up supervision within these models is similar and this article focuses on group clinical supervision, using an example of a team of Specialist Nurses.

Following an initial request for group clinical supervision, usually from a senior staff member, the psychologist arranges an initial interview with this person. The aim of which is to ascertain why clinical supervision is wanted and the context of the request - considering factors such as current team dynamics, cultural climate, service organisation and recent or impending changes. Other areas of enquiry would normally include the expectations of the person who has requested supervision as well as whether the concept of supervision has been proposed to staff and if so, how it was received.

As an example, a lead nurse specialist who wanted to foster team cohesiveness across split hospital sites made a request for clinical supervision to the service. The initial meeting enabled an exploration of the teams' history and structure, how the lead nurse perceived the differing cultures between the services, the advantages/disadvantages of the two ways of working as well as how she envisaged service development. The lead nurse specialist hoped that group clinical supervision would provide a safe, facilitated forum for the nurses to discuss issues relating to the service and working practices.

The initial meeting enables the psychologist to make a formulation of the request in order to prepare the most appropriate approach. Time can also be spent on how the supervision will be 'sold' to the team, whether membership is voluntary or not, and to emphasise that meetings will be recurring rather than a 'one off'. It is also helpful to make it explicit that all members of the group must be present for this meeting to promote commitment and collaboration.

Starting group clinical supervision

Having set the supervision up, the first meeting with the staff team is about 'setting the scene' and usually involves introductions and maybe an 'ice breaker', particularly if group members do not know each other well. For example, on meeting the nurse specialists, it was helpful to ask, in turn, their names, role and what they enjoyed about their work. The supervisor invited the nurses to share their expectations and hopes for the supervision before working with them to generate some ground-rules for the sessions.

Establishing ground-rules is vital in order to promote feelings of safety and trust within the group and often includes issues such as confidentiality, turn taking, and respect for other's opinions. The discussion can then be oriented towards agreeing on factors such as group membership (i.e. management participation), number of planned meetings, commitment to attendance, punctuality and booking in a review. Topics for supervision can also be generated to promote consensus and provide a structure for subsequent sessions. Areas may include improving communication, dealing with clinical cases, self-care/management or service interfacing with other organisations. The nurse specialists agreed that discussion of inter-disciplinary communications was a priority as well as ways to promote team consensus and cohesiveness.

Towards the end of the first session it is helpful to have an agenda for the next meeting to harness motivation and start momentum for the sessions. The nurse specialists agreed in their first session to take it in turns to bring a case for discussion and to have some time in each session to talk about any 'burning issue' they may have regarding the service.

As the clinical supervisor, it is important to keep a shared record of each session including details of who has attended, topics discussed, and issues for later sessions. This is particularly helpful for accountability and billing purposes. It is also important to keep a separate record of observations and reflections for the supervisor's own use. The records must respect the confidentiality of the supervisees as well as any third party discussed such as patients and other members of staff.

Role of clinical supervisor

The clinical supervisor needs to be mindful of concurrent roles such as managing not only the process of individual supervision, but also the overall development of the group as a whole. The supervisor also needs to be mindful of keeping time boundaries, monitoring the supervisees for signs of being overwhelmed, monitoring the meeting agenda and facilitating orderly questioning/discussion, protecting space for presentation of clinical material, as well as ensuring the ground rules are adhered to.

It is also important that the supervisor has access to supervision so as to ensure good practice and professional standards. Conducting supervision is inevitably a continuing learning process and supervisor supervision can provide a valuable reflective space. Peer group supervision is available to members of staff within the staff support service and is conducted by a psychotherapist. In addition to this, the service staff are able to obtain individual supervision from the head of the service.

Review and evaluation of group clinical supervision

The concept of a review session with the staff team will have been agreed in the initial group supervision session, e.g. in six sessions the fourth session might be used as a review. It is important to contract in the review the number subsequent sessions, as groups often do not have the luxury of never ending sessions. The review can be used to ascertain what the group feels is working well and what they would like to change such as staggering later meetings so they are spaced over a longer period.

During the last few sessions it is useful to set aside some time in order to begin considering the ending process. Discussion could include how the team can take forward suggestions and solutions to issues as well enabling group members to generate how they feel able to support each other.

Whether supervision finishes within a pre-agreed contract or due to unforeseen circumstances, it is important to obtain feedback via evaluation. The staff support service gives evaluation forms to each member of staff who participated in the supervision. Questions address issues including service satisfaction, individual feelings about the psychologist, outcomes such as better understanding and confidence in managing issues, what the individual found most helpful about the supervision and suggestions as to how the supervision could be improved. Feedback is anonymous and is used for service development.

Conclusion

Within the current healthcare climate in the UK, the benefits of clinical supervision are being increasingly acknowledged and occupational health psychologists are well equipped to facilitate supervision. Some advantages of supervision include the potential for the supervisor to tailor their approach to the needs of the supervisees as they arise and make more specific recommendations, rather than setting more generic training that staff may not subscribe to.

Other benefits include improved perceptions of team cohesiveness and communication, particularly when dealing with tricky situations as well as improved perceptions of well being at work. Supervision can also enable shared learning, the development and safeguarding of good practice and professional standards as well as offering support for staff – something which is often valued greatly.

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