"Helping the Helpers:

What factors contribute to health and wellness

for

Front line staff within a

Public sector social services

Work environment?"

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 Abstract

The purpose of this study was to understand the wellness needs of front line public sector welfare staff within the Canadian neo-liberal welfare state, framed in a public management reform context. Although research has begun in a variety of public sector social service settings, there has been little scrutiny given to those working on the fault-lines of society (Sawchuk, 2013).

The research design focused on both quantitative and qualitative tools for understanding the welfare employee experience. Quantitatively, the Perceived Wellness Survey (Adams, Bezner, and Steinhardt, 1997) and the COPE scale (Carver, Scheier, and Weintraub, 1989) were used respectively to generate data on staff wellness perceptions, and coping preferences. Qualitatively, a longitudinal journaling tool was used that allowed staff to record their work behaviors over 40 workdays. Specifically, they were able to record problems experienced, how they responded to them, and what resources were found to be useful. They were also able to rate each day as to level of satisfaction.

The results of the study identified the potential impacts of public management reform on welfare state employees, and the critical role played by coping strategies. It also brought into question the relevancy of the holistic paradigm for the welfare work environment within British Columbia. The findings revealed a wellness duality in that the problems staff identified, the responses to those problems, and the resources utilized all had a common foundation. Social/relational factors were found to be both part of the problem and part of the solution when considering employee wellness, with age and gender influencing participant responses.

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List of abbreviations

CSW	Client Service Worker
DS	District Supervisor
EAW	Employment and Assistance Worker
FMW	Family Maintenance Worker
HRDC	Human Resources Development Canada
HWSAPP	Health and Wellness Study (Computer) Application
IO	Investigative Officer
NPG	New Public Governance
NPM	New Public Management
NWS	Neo-Weberian State
PWS	Perceived Wellness Survey
PWD	Persons with Disabilities
SDSI	(Ministry of) Social Development and Social Innovation
WWC	Workplace Wellness Continuum
WWJ	Workplace Wellness Journal
COPE	Coping Orientation to Problems Experienced Scale

PFC — **Problem Focussed Coping Cluster (of the COPE Scale)**

ACO	Active Coping (Subscale of PFC)
ISS	Instrumental Social Support
PLN	Planning
SCA	Suppression of Competing Activities
RES	Restraint

EFC — **Emotion Focussed Coping Cluster (of the COPE Scale)**

ESS	Emotional Social Support (Subscale of EFC)
PRG	Positive Re-interpretation and Growth
ACC	Acceptance
HUM	Humour
RCO	Religious Coping

MFC — **Maladaptive Focussed Coping Cluster (of the COPE Scale)**

FVE	Focus on and Venting of Emotions (Subscale of MFC)
BDE	Behavioral Disengagement
MDE	Mental Disengagement
SUB	Substance Use
DEN	Denial

Chapter 1: Thesis Overview

1.1 Introduction

Front line welfare workers are charged with helping those on the margins of society. Working in the welfare state (Esping-Andersen, 1990), in the context of continuing public management reform (Politt and Bouckaert, 2011), staff provide income assistance and related services, mitigating homelessness, lack of food, mental, emotional and physical illness, legal issues and addictions. Academically and practically, it is important to understand the experience and wellness needs of those who labour on what Sawchuk (2013) deemed the "fault lines" of society.

First, Winston Churchill once observed that a nation's greatest asset was healthy citizens (Churchill, 1952). This commitment covers all citizens, including the most marginalized. The delivery of income assistance, euphemistically described as "welfare", is one example of a nations concern. The men and women on the front lines delivering those services are the face of the state, and their wellness should be a priority.

Second, wellness and service delivery are linked. For example, Wallace, Lemaire, and Ghali (2009) demonstrated that health-care service delivery is sub-optimal when a physician's wellness is impaired. Doctors who were unwell fell victim to fatigue, depression, and ultimately burnout, whereas physician wellness was integrally linked to positive health care delivery. This linkage was also found with child protection social workers, given that their work was subject to stress and burnout (Travis, Lizano, and Barak, 2015). Social workers need to maintain their wellness to ensure quality service delivery. The current study maintains that wellness is also a concern within the public management welfare work environment (Cox, Leather, and Cox, 1990), and staff need to maintain their wellness or service delivery will suffer.

Third, there is a growing focus on the wellness of public sector social service staff, as evidenced with research on social workers (Astvik and Melin, 2013; Graham et

al. 2014 ; Shier and Graham, 2011; Shier and Graham, 2013). Although change is now underway, Shier and Graham (2011) demonstrated that social work historically had a focus on recognizing and building client strengths and capacity, with meager attention given to identifying factors that enhance employee wellness. Astvik and Melin (2013) highlighted that staff work/life balance was difficult to maintain amid the on-going reconfiguring of human services, increases in workload, and the actual or perceived lack of resources. Karasek's (1979) demand-control theory asserts that maintaining wellness involves examining work demands, and the resources available to meet them. Karasek and Theorell (1992) expanded the theory to include not only work demands and control but also the important role played by social support. Recommendations for the work environment should acknowledge the negative impact of extensive work demands, and the positive impacts of workload control and social support from colleagues and supervisors (Fila et al. 2014). For social workers, there are many stressors within the work environment including: high caseloads, challenging supervisory and client relations, emotional exhaustion, and personal disengagement (Travis et al. 2015). Research has begun on social work staff coping strategies and what resources are utilized to mitigate problems within the work environment (Astvik and Melin, 2013; Ben-Zur, 2009; Smith and Shields, 2013). To date, however, there has been scant attention paid to the experience of welfare workers.

Welfare employees are faced with making financial, moral and ethical decisions that influence clients, community, and society. Dur and Zoutenbier (2014) demonstrated that the "helping" hand side of government remains a major budgetary commitment, with many thousands of employees involved in providing services for those in need. In a survey with over 30,000 staff across 50 countries, it was determined that public sector employees have greater altruistic leanings than those in the private sector, are more likely to see their work as a mission, and are more likely to be motivated to help others.   Sawchuk (2013) asserted that this work environment creates unique tensions. Public management reforms mean that those who administer benefits to the poor are themselves administered, with

Sawchuk (2013) using the term "discipline" in reference to both clients and staff. Welfare staff are often depicted in a straw-man fashion, as either mindless or heartless robotic cyphers or as scapegoats for the state's perceived Machiavellian assaults on the poor and dispossessed (Sawchuk, 2013). As someone who has been involved within the Canadian welfare work environment for over 34 years, I agree with his premise that the

> "…occupation is more complex and more contradictory than even most of its practitioners themselves care to admit…" (Sawchuk, 2013).

In summary, understanding the wellness needs of the "helpers" is both academically and pragmatically important. First, it is a moral priority of the welfare state. Second, it is integrally linked to the public management reform vision of successful service delivery. Finally, research has already been initiated in understanding the wellness needs of social workers.   It's time to address the wellness needs of welfare services front line staff, with a view to beginning a dialogue on what "helps the helpers". In that regard, this study addresses the following research questions:

1. How do public sector welfare staff perceive their wellness?

2. How is the job satisfaction of public sector welfare staff?

3. What are the coping style preferences for public sector welfare staff?

4. What are the primary coping behaviours of welfare services staff?

This research will bring a deeper understanding of the problems staff face within the welfare work environment, workers' responses and resources, and the factors that enhance employee wellness. The following sections detail the progression of the research, as these questions are examined.

1.2 Overview of Chapter 2

Chapter 2 examines the welfare state concept within the context of public management reform. Pollitt and Bouckaert, (2011) see public management reform as focussing on specific changes to processes, procedures and infrastructure designed to improve public services. This can mean assisting the public sector to function more efficiently, being more "citizen-centered", or achieving a government vision. This chapter will discuss the changes in public management and detail emerging reform models, including NPM (New Public Management), NWS (Neo-Weberian State) and NPG (New Public Governance). Each of these models impacts the welfare state and those that work within it. Although the welfare state is considered an integral part of nationhood for western democracies (Leibfried and Zürn, 2005), is there a positive alignment between public management reform and the welfare state? Understanding the welfare state work experience first requires an understanding of the public management reform forces shaping it.

When defining the modern welfare state, the work of Esping-Andersen (1990) has served to set the framework over the past several decades. His three primary welfare state models will be detailed, as well as a discussion on how these purist models are changing, largely due to overarching public management reform factors. Finally, a macro and micro look at the Canadian welfare state will be detailed, again within the context of public management reform. The guiding principles present at the national level and how these cascade to the provinces will be outlined. The service delivery structure in the Ministry of Social Development and Social Innovation, British Columbia will be discussed, including client rights and responsibilities, worker roles, and the types of stressors faced by workers.

1.3 Overview of Chapter 3

Chapter 3 presents a literature review of wellness, and begins with a continued discussion of public management reform and the linkage with employee wellness. Specifically, each public management reform model contains systemic factors that promote or mitigate stress in the work environment, and therefore support or undermine wellness. The Health and Safety Executive (HSE) Management Standard for Work Related Stress will be used as a guiding framework for this discussion (Edwards et al. 2008).

This chapter will also present a review of wellness, defining the concept and history, providing an overview of explanatory theories, and how wellness moved from a disease model to a prevention model. The concept of a gradient of wellness will be discussed and although the holistic paradigm is the prevailing view, this study argues for an alternative approach to understanding wellness in the public management reform welfare environment. Coping skills are highlighted as a central theme, with social/relational coping at the interpersonal and intrapersonal levels prominently aligned to employee wellness (Drury et al. 2014). In addition, understanding wellness includes exploring the duality of this concept, meaning it is possible to enjoy one's work, report high levels of job satisfaction, yet find that work to be a source of unwellness (Dale and Burrell, 2014).

1.4 Overview of Chapter 4

Chapter 4 examines the philosophical and methodological foundation for the study. Philosophically, this study incorporates both positivist and constructivist approaches. The work of Comte and Martineau (1855) and Weber (1978) will be referenced as respective apologists, and the advantages and disadvantages of combining methodologies from these two perspectives will be explored, with particular focus on the current study.

Methodologically, the research setting, staff selection process, and the quantitative and qualitative tools will be detailed, as well as an explanation regarding why these approaches are appropriate for this study. The 2 quantitative tools used are the Perceived Wellness Survey (PWS) for wellness perceptions, and the Coping Orientation to Problems Experienced Scale (COPE) for coping preferences. Qualitatively, staff will use the Workplace Wellness Journal (WWJ) for 40 days, to record their daily work problems and coping responses. In addition, the author's construct, the Workplace Wellness Continuum (WWC) will be presented. Data from the PWS, COPE and the Workplace Wellness Journal (WWJ) will be captured within a health and wellness computer application (HWSAPP) specifically designed for the study. The role of the internal researcher will be also be examined during Chapter 4, with a focus on the author's position within the organisation, and a discussion of potential ethical issues and their resolution.

1.5 Overview of Chapter 5

Chapter 5 presents the research findings and analysis flowing from the PWS, COPE, and the Workplace Wellness journaling conducted over 40 workdays, detailing problems and responses. Staff were also able to rate their daily levels of job satisfaction. The amount of data accumulated was immense, with over 2000 journal pages, plus extensive survey data on staff wellness perceptions and coping preferences. The data was sectioned primarily by age and gender, and themes were aligned with the foundation research questions:

1. How do public sector welfare staff perceive their wellness?
2. How is the job satisfaction of public sector welfare staff?
3. What are the coping style preferences for public sector welfare staff?
4. What are the primary coping behaviours of welfare services staff?

1.5 Overview of Chapter 6

Chapter 6 details the implications of the research findings, with a focus on the public management reform welfare state context. The intent of this study was to understand welfare worker wellness perceptions, job satisfaction, coping preferences, and coping behaviors, with a view to identifying wellness links. The study found that the problems identified, the responses to those problems, and the resources accessed all had a social/relational foundation. As outlined early in the study, the holistic view of wellness was the dominant paradigm, in which a myriad of wellness components were given equal priority. Study participants, however, identified social/relational factors as their primary wellness choices. Flowing from this, conclusions and recommendations are detailed, with limitations and future research directions outlined.

Chapter 2: Public Management Reform and the Welfare State

2.1 Introduction

What is public management reform and how does it align with the welfare state, with a particular focus on the Canadian experience? In order to understand welfare worker wellness, it's important to understand their work environment, in terms of the public management reform context. This chapter will discuss the major public management reform models propagated over the last 30 years, as well as the welfare state, considered a crucial hinge pin when defining nationhood for western democracies (Leibfried and Zürn, 2005). In a study of how public sector regimes have developed and changed it was demonstrated that there were competing models of both public management and welfare state regimes, and there was increased blurring of boundaries (Gottschall et al., 2015), which has consequences for staff wellness .

Leibfried and Zürn (2005) delineates welfare as one of the four defining pillars of the modern nation-state, the other three being state resources, law and democratic legitimacy. Welfare encompasses the state's responsibility for the health and well-being of its citizens. The acronym used is TRUDI (i.e.: **T**erritorial resources; **RU**le of Law; **D**emocratic State; **I**ntervention (welfare) State), with public management interlinking all aspects. Kelman (2005) highlights that there is general agreement that assistance for the disadvantaged is important, but there's a performance gap between the welfare state vision and the fiscal realities of delivering services to disadvantaged citizens. Put simply, there is a need to reform.

2.2 Public Management Reform

Pollitt and Bouckaert (2011) highlight that public management reform is defined as the improvement of public sector services, with welfare being one of the most complex and troubling. The issue of how to control public sector expenditure lead to a heated debate that public administration should resemble private sector business (O'Connor, 1979). This movement became known as New Public Management.

2.3 New Public Management (NPM)

NPM was designed to improve government efficiency and effectiveness, by applying business management methods to the public sector, including: performance goals, performance linked salaries, target outcomes, and competitive contracting out of services (Osborne and Gaebler, 1992). It was supposed to provide a more horizontal, entrepreneurial flavor to government, but the experience for staff is mixed (Pollitt and Bouckaert, 2011). Ferlie and Geraghty (2005) maintained that NPM sometimes cultivated a quality service orientation, but often had a more formal, rigid structure. The rigid NPM stream fostered a low trust atmosphere, and included controlling staff through carrot/stick performance measurement. Accountability rested primarily with contracted agencies, with a strong focus on market-based processes (Veggeland, 2007), which promotes a perception that public sector roles are being usurped. New public management was sometimes perceived as a primarily "anglo" model that didn't fit with certain national cultures, as Bach and Jann (2010) asserted was the case in Germany.

Although NPM was advanced strongly across the majority of the English-speaking world, there was significant pushback surrounding the model, with questions raised about effectiveness. Pollitt and Bouckaert (2011) maintained that the evaluation was only based on rhetoric and the number of decisions made to implement, instead of examining whether NPM was actually embedded within the organisation, and whether there was hard evidence of positive outcomes. Given the ease and economy of conducting research on talk/decision versus the extensive costs of research on practice/results, they maintained that the claims of NPM have been exaggerated.

Given the challenges of 21st Century society, Castells (2011) and Kopenjan and Klijn (2004) assert that governments cannot function as lone entities any longer. Networks are taking the place of traditional governmental hierarchies, starting a shift from "government" to "governance", with the term governance serving as an umbrella term for cross-government public sector initiatives. In the same way that

New Public Management referenced a transition from traditional public administration, New Public Governance (NPG) references a transition from stand-a-lone government to cross-government (McGuire and Agranoff, 2011).

2.4 New Public Governance (NPG)

Governance is an inclusive term, and requires involvement from a range of stakeholders. NPG is a coordinating framework that serves to network government within a matrix of other supporting players, including private and public corporations, associations, and societies (Klijn, 2008). It moves away from the hierarchy to the horizontal, with a shift toward participatory relationships between government and citizens. Decision making authority is delegated to governance member groups, responsible for specific goals across various jurisdictions (Bellamy and Palumbo, 2010). While NPM has a focus on the competitive business environment, NPG adopts a voluntary participatory collaboration to develop both policy and programs that meet citizen needs. This overarching umbrella can arguably subsume the relatively recent development of "Digital-Era Governance" (DEG), with its key principles being of integration, simplification, and digitization (Dunleavy et al. 2006). Instead of a formal network of coordinated services, there is an electronic integration of services. This computer based integration means processes become more simplified, and the digitized menu of services often results in a move to substantially more virtual service delivery.

Pollitt and Bouckaert (2011) assert that NPG has positive and negative impacts on government mandarins and employees. On the plus side, politicians are in a position to broker agreements between multiple parties, in order to ensure goals are achieved. On the negative side, politicians face various pressures that may result in agreements that are watered down, and not necessarily in the best public interest. For civil servants, the advantages include the opportunity to become partners in expanding, innovative networks that create new synergistic outcomes. On the negative side, it may be more difficult to monitor accountability.

While NPM and NPG respectively place government in either an arms-length private sector contractual service position or a participatory partnership approach, NWS places government as the central service provider.

2.5 Neo-Weberian State (NWS)

Drechsler and Kattel (2009) highlight that while NWS aims for efficiency and effectiveness, the state remains the key driver, with some ancillary use of business methods. The aim is to professionalize services, while retaining public sector culture, rules, and regulations. NWS is not against modernization, and it seeks to use updated methods and processes appropriate to the 21st century; however, the role of the public sector is never shunted to the side or diminished (Lynn, 2008). The government's legal framework is the guiding matrix. Rochet (2008) asserts that this is essential as any economy that seeks to be on the cutting edge of innovation needs a stable, highly trained, committed civil service with a long-range vision, and an ability and tolerance to learn from mistakes, which runs counter to the risk aversion of NPM, that relies on performance-based remuneration. Akerlof and Kranton (2005) asserted that an understanding of identity has a stronger linkage to building an esprit de corps, as monetary rewards can result in employees being tempted to undermine peers. NWS stresses the professionalism of the public service and promotes an organisational bond, with employees seeing themselves as a valued "insiders" who don't require extensive remuneration to produce quality work.

It is maintained by NWS advocates that a stable government bureaucracy is required for any management model to function successful, including NPM (Pollitt and Bouckaert, 2011). This structure helps maintain economic continuity, accountability and predictability. New business methods can be aligned with these traditional foundation pieces, and this combination provides an adaptive and responsive foundation for effectively meeting citizen needs, at the local, regional and national levels (Lynn, 2008). Administratively, government at all levels remains the gatekeeper of citizen rights, including security, privacy, equality as well as legal channels to citizen scrutiny of government decisions. Government has a

focus on citizen-centred quality service, and this is achieved through the professionalism of the public sector culture. There is a focus on results orientation, not procedural outputs, but always carried within the framework of government, by knowledgeable and experienced public sector staff (Rochet, 2008).

Pollitt and Bouckaert (2011) asserted that NWS had impacts on governmental structure and the front line staff experience. For example, traditional hierarchical structures were maintained, and this provided a framework to develop and maintain an esprit de corps among senior staff that supported ethical, quality decisions. On the negative side, however, these same traditional structures sometimes meant that decision-making took longer, and decisions were sometimes delayed in implementation.

While NPM maintains a focus on competitive business practices, and NPG looks to voluntary, participatory networks of collaboration, NWS has a focus on the professional, experienced (but innovative) public sector hierarchy.   All the above models contain three reform stages.

2.6 Public Management Reform Stages
NPM, NWS and NPG move through 3 stages: starting point, trajectory and end point, with each trajectory containing essential reform sub-paths, including: financial, personnel and organisational reform (Pollitt and Bouckaert, 2011).

Financial reform involves dealing with the twin pressures of keeping expenditures under control and enhancing efficiency/effectiveness. Personnel reform focuses on the terms, conditions, qualifications, and overall role of the civil servant within 21st century government. In Canada the majority of senior staff have long tenure, and although there are some NPM measures in place (e.g., performance related salary), there is still a strong NWS theme, demonstrating the blurring of boundaries between models (Pollitt and Op de Beeck, 2010).

Organisational reform references issues of specialization, coordination, centralization and scale (Pollitt and Bouckaert, 2011). Over the past 30 years,

most governments have moved toward specialization of services.   Coordination is about how to maintain connectivity across government levels and streams of service.   NWS coordination is generally hierarchical, with a top down authority focus, while NPM allows the markets to drive supply and demand. NPG looks to participatory networks to serve the coordination function. Centralization references the issue of what government functions should be handled centrally, and which should be decentralized.   Finally, scale addresses the size of public sector institutions. NPM, for example, maintains that organisations should be as flexible and decentralized as possible, with a specifically targeted function, all of which would infer a relatively small footprint.

Public management reform measurement is becoming more comprehensive and focussed, with an orientation both internal and external. In Canada, there is an openness to NPM, but this is more rhetoric than substance, and the NWS paradigm is strongly supported, in that there has been a relatively traditional public service bureaucracy in place over the past 30 years (Pollitt and Bouckaert, 2011).

2.7 Public Management Reform Themes

Over the past several decades, New Public Management (NPM) has been a major theme, but no country has had a purist NPM model. Public management approaches are not necessarily tied to any one model. Some methods enhance the competitive atmosphere within government. These may include performance-linked salaries, freedom of information legislation, contracting out for services, and business-like accounting structures.   All of these are strongly represented within NPM processes, but partial elements can also be seen within the NPG and NWS models (Pollitt and Bouckaert, 2011). In addition, Dunleavy et al. (2006) highlight the move toward e-government, which is strongly aligned with NPG, but is now a part of the majority of public sector reform initiatives. NWS features significant levels of control at senior public sector management levels, but aspects of this can also be found with NPG and NPM.

The point is that while there is a coherent policy/process linkage with models, there is also a certain level of policy/process linkage across models. In addition, there are policies and processes that only fit with one model, and trying to make them fit with another brings a sense of dis-alignment. For example, within a suite of NPM policies, the suggestion of introducing professionalization and lifetime tenure for senior managers would be out of sync, and would be more in alignment with an NWS protocol (Connelly, 2013).

Overall, it appears that public management reform is still more a faith-based exercise than a scientific endeavor. Hofstede and Hofstede (2001) might argue that this was due in part to the influence of national culture. They researched norms and values across 50 countries, and found 5 elements that may have a bearing on public sector reform. These included: power distance, uncertainty avoidance, individual/collective focus, gender focus, and long term versus short-term orientation.

Hofstede and Hofstede (2001) defined power distance as the cultural norms around equality. High power distance means a high tolerance of societal inequality. For example, this would tend to polarize citizen debates around the "deserving vs. undeserving" poor (Van Oorschot, 2006), and thus impact public management reform initiatives with welfare services.

Uncertainty avoidance referenced the degree that citizens felt pressured or threatened by the unknown. High levels of this trait would promote a cynical view of government, which would cast suspicion on government expenditures to marginalized citizens.

Individual/collective focus addressed the societal norms and values around self-reliance. Countries with a high regard for self-reliance (e.g., U.S.A.) would arguably be less likely to support government support initiatives like welfare.

Gender focus references how distinct masculine and feminine roles are within

society (Rosario et al., 1988). In those countries with very distinct roles, men are deemed to be assertive and task-focussed, while women are assumed to be more maternal, modest and caring. Arguably, the composition of the workforce, including the public sector, may contain a higher proportion of men within senior management ranks, if distinct gender roles are a societal value.

Finally, long-term versus short-term orientation is defined by Hofstede and Hofstede (2001) as a societal orientation toward reward. Long term orientation promotes traits that support long term rewards, thus perseverance and dealing with threats is valued. Short-term orientation values respect and meeting immediate social responsibilities and obligations, including the societal norm of "saving face". For example, Canada and the U.S. have a cultural short-term orientation, whereas Finland has a more long-term orientation.

The key point that Hofstede and Hofstede (2001) highlight is that national culture is the unseen hand that exerts pressure not only on how public management reform is framed, but also how issues are perceived and priorities established, which would either mitigate or promote public pressure on welfare initiatives.

In addition, as discussed earlier, evaluation methods used are often superficial, and there is still very little independent cost/benefit analysis used with of any of the models. Having said that, Kelman (2005) asserts there is some hard evidence available if one examines specific organisations, but it is difficult to provide widespread generalizations, and public management reform will continue to be more descriptive than analytical. Moving now to a discussion of the welfare state, it will be seen that models here are also becoming hybridized and boundaries increasingly blurred.

2.8 The Welfare State

Esping-Andersen's (1990) definition of a welfare state contains several key assumptions. First, there is an assumption that the state will take a significant level of responsibility and a commitment of care for its citizens. Second, the state institutionalizes this commitment (Titmuss, 1958), with a reasonable level of funding (Therborn, 1984). Third, Marshall (1950) maintained that social rights needed to be enshrined within the national fabric, linked to citizenship, not performance. Citizens shouldn't have to wholly rely on the job market for support, a process Marx and Engels (1848) termed the commodification of labour. Although Esping-Andersen (1990) maintained that there were three primary welfare state models: Conservative, Socialist, and Liberal, these idealized models are becoming increasingly hybridized (Yih-Jiunn and Yeun-wen, 2007).

2.9 The Conservative Welfare State

In Esping-Andersen's (1990) Conservative model, government takes a patriarchal stance, and strives to preserve class structure and hierarchy, discipline the market, and align social rights with status and class. Commodification is a minor issue, and both the church and family are aligned. For example, traditional roles for women are encouraged (Barnett and Baruch, 1987). Honouring the traditional family also means that state support is withheld in cases where the family is able to meet the needs of its members (Esping-Andersen, 1990).   Although Germany is cited as an example of the Conservative model, Augustin-Dittman (2010) highlights some of the changes that impact this view. For example, the initiation of full day schooling has moved the model away from traditional conservative values, and presents a hybridization of Esping-Andersen's conservative ideal.

2.10 The Socialist Welfare State

Disciplining the market is not part of the Socialist model, as the market contaminates enhanced equality and social rights, and promotes class schisms. The Socialist model, as demonstrated in Sweden, emphasizes universal benefits to all (Esping-Andersen, 1990). Conversely, this freedom from market domination co-

exists with powerful de-familiarization forces, including extensive public supported childcare, which promotes increased female attachment to the market (Humpage, 2010). Maintaining such a system is costly, and results in a hybridization of the model. For example, although citizens have the option of financial support from the state, there is an obligation to work built into the system, and citizens work longer before receiving pension income.

2.11 The Liberal Welfare State

With the Liberal model the labour market is the engine for achieving equality, equity and justice (Esping-Andersen, 1990). Benefits are means tested, and only made available to those with very low or no income. In addition, there is a stigma to applying for welfare and the rates of income assistance are at a level where it is unlikely that the individual would choose welfare over work (Eichner and Weinreich, 2015).

Welfare models described within public management reform research align closely with Esping Anderson's (1990) models, and include the Scandinavian model, the Continental European model, and the American model (Pollitt and Bouckaert, 2011). The Scandinavian model places emphasis on universal provision of social services, and is close to Anderson's Socialist model. The Continental European model is less generous than the Scandinavian model, but still provides a wide range of citizen centered services, and aligns with Esping-Anderson's (1990) Conservative model. The American model aligns closely with the Liberal model in that there is a strong focus on market involvement, with benefits being needs tested, significant levels of eligibility criteria and subsequent inequity in income distribution.

There are several challenging systemic issues for employees within the welfare state environment: client categorisation, client caregiving, and client choice (Esping-Anderson, 1990), as well as worker decision-making (Lipsky, 2010).

2.12 Client categorisation

All welfare state models claim to increase equality and equity for each citizen, however the relationship between the welfare state and the market is not mutually exclusive. State interventions allow the individual more flexibility and independence from market forces, while the market impacts the welfare states' ability to decommodify citizens' labour (Esping-Anderson, 1990). In addition, social rights conferred by the welfare state have an unexpected impact. The welfare state creates a new stratification that runs contrary to the intent of public good theory, the philosophical foundation of the welfare state. Public good theory is rooted in the idea that people have a genuine concern for the welfare of others (Culyer and Posnett, 1985). Out of this concern, people will provide funds toward the support of others. Some individuals renege on this commitment, however, and there is thus a role to be played by the state in restoring the balance. Instead of an informal personal support framework, a formalized bureaucracy is created, with front line staff serving as gatekeepers, charged with the unenviable task of categorizing applicants (DePanfilis and Zlotnik, 2008).

Being a welfare recipient comes with a stigma (Eichner and Weinreich, 2015), with those considered employable suffering the highest stigma, while those with severe disabilities less so. Across models, stigma and stratification is lowest in the Socialist model, moderate in the Conservative model, and highest in the Liberal model (Esping-Anderson, 1990). For example, front line staff within a Liberal welfare state experience significant tension between determining a client's financial benefits, while striving to divert the client toward the job market as a primary source of support (Clarke and Newman, 1997). Lipsky (2010) maintains that welfare workers are street level bureaucrats, who are called upon to act in both the public interest and the client interest. Part of working in the client interest involves an aspect of caregiving, which has implications for staff.

2.13 Client caregiving

The welfare state has gender implications that need to be articulated more forcefully (Humpage, 2010). Although Wolfe (1989) asserted that the welfare state's responsibility was the simple distribution of funds, and that caregiving should remain the domain of the family, the role of caregiver is thrust upon female staff. Women are overrepresented in front line human service positions (Humpage, 2010), and this places them in what Land and Rose (1985) term a compulsory altruism position, which has historically been undervalued. Female staff are thus caught in a care role that can be quite stressful (Land and Rose, 1985).   In addition to the pressures of categorisation and caregiving, client choice is a third systemic element.

2.14 Client Choice

Greve (2009) asserted that citizens in the welfare state are not content to be passive receivers and want more choice in their range of options, and this can impact both clients and service providers.   Within the welfare state, there are both rights and responsibilities. If, because of lack of understanding or poor decision-making, the citizen fails to comply with requirements, their choices become increasingly narrow, and in some cases they may become ineligible for any benefits. This is an example where increased choice might eventually result in a significantly fewer actual options (Schwartz, 2004).

Thomson and Mossialos (2006) assert that evidence is lacking about choice being linked to enhanced quality of service. Greve (2009) maintained that a key factor around choice involved accuracy and trust. Although providing clients with accurate information about choices is important, clients also need to have a level of trust in the service provider, and this creates tension for staff, given they are fiscally accountable. Staff are recognized both for decisions that result in delivering quality service, and for diverting clients from receiving those services.

2.15 Worker Decisions

Lipsky (2010) asserts that public sector welfare workers are the face of the welfare state. Staff use discretion in allowing access to the cornucopia of welfare state resources and these on-going interactions influence both workers and citizens. People applying for welfare are non-voluntary clients, and they have to tell their story as part of the eligibility process, often resulting in reactions to perceived injustice (Lipsky, 2010). Employees need to be able to cope with these reactions to their decisions.

In order to maximize client adherence to welfare policy, there are two suggested ways to equip staff (Lipsky, 2010). One is to continually professionalize the workforce, and maximize discretionary ability at the front lines while the other moves to minimize worker discretion and instead establish a complex decision matrix-type structure, which would direct workers in their decisions (i.e., If "A" occurs, then do "B"). If a case is ambiguous, the worker would consult their supervisor for direction.

In summary, welfare workers deal with challenging and complex issues around client categorisation, client care giving, client choice (Esping-Andersen, 1990), and decision-making (Lipsky, 2010). In addition to the above, there is the growing acknowledgement that the purist models of Conservative, Socialist and Liberal are increasingly hybridized, with overlap between the three types. The next section details the hybridized Canadian public management reform welfare context.

2.16 The Canadian Welfare State

Canada's population is ethnically diverse, with over 6 million citizens whose primary language is neither French nor English (Pollitt and Bouckaert, 2011). The central government delegates significant authority to the provinces, and federal/provincial cooperation on welfare issues has been the norm.

Tomblin (2009) highlighted that Canada has a variant blend of NPM rhetoric, NPG vision, while maintaining a NWS reality. Although talking the talk around NPM

policy restraints on the welfare state, the changes were not implemented due to a variety of factors. First, Canadians have a strong NWS slant toward institutions and traditions. Public health and welfare programs are sacrosanct, and there has historically been a significant backlash against changes in these areas.   Second, when reform is needed, citizens are more likely to favour existing government institutions handling those changes, rather than the private sector. Thus, NPM values, objectives and agendas tend to be watered down. The focus was not on the market as a driving force, but on existing government institutions. Having said that, however, there were more tangible elements of NPG than NPM in that there has been an increasing emphasis on building partnerships and networks between existing public sector federal and provincial institutions, as well as private sector stakeholders (Tomblin, 2009).

Within the welfare state, each reform model places the issue of motivating and engaging staff in a different priority. For NPM, the focus is on making government lean and productive, which usually involves some type of staff reduction in order to meet efficiency goals. With NPG, engaging staff is one factor among many, given that multiple stakeholders are always involved, and it is important to maintain positive stakeholder relationships. Canada has a hybridized liberal welfare state model, within an overarching NWS management reform umbrella. There is an overt focus on motivating and engaging staff in order to maintain a high level of professionalism so that efficiency and effectiveness goals can be realized.

Historically, the Constitution Act of 1867 provided the legislative authority (Moull, 1983), and this was subsequently defined through three separate acts (Federal-Provincial-Territorial Directors of Income Support 2010). The Canada Assistance Act (CAP) of 1966 clarified that the federal government would share social services costs with the provinces (Cragg, 1967).

2.17 The Institutionalization of Welfare

Brodkin (2007) maintained that the institutionalization of welfare flows from legislative and bureaucratic reference points. The legislative branch is charged with policymaking, the bureaucracy is charged with implementation, and there are difficulties at both levels. In terms of policy determination, there is often an oversimplification of problems and an overly optimistic view of proposed solutions (Arnold, 1992; Lowi, 1979). Overall, policy goals become increasingly blurred, creating challenges for the welfare state goal implementation (Brodkin, 2008). With high expectations, resources that are often politically under restraint, and goals that are increasingly ambiguous and sometimes contradictory, the bureaucracy, as represented by front line workers, essentially becomes the policymakers (Lipsky, 2010).

Within Canada, those with citizenship status are eligible for assistance and are required to complete several steps (HRDC - Human Resource Development Canada, 2010). These include: completing the application and means tests (with necessary documentation), records of employment, pay stubs, proof of name and age, and information related to any disability. Clients become categorized into a new class structure that, particularly within NPM is market dependent (Esping-Andersen 1990), and failure to look for employment will result in sanctions. Client control and compliance becomes an important role for front line workers.

Lipsky (2010) detailed four tools of control used by front line workers. First, they may limit or deny benefits as a form of sanction. Second, they may re-cast the worker/client relationship in that clients are sometimes given the freedom to look for work on their own, instead of being referred to an agency. Educating clients is the third method of control and involves orienting clients as to their responsibilities. The fourth area of control involves the psychological and emotional relationship with clients. The worker selectively shares with some clients how to work the system more effectively. This is not to say that the worker is overriding regulations. Instead, there may be benefits available that the client is not aware of, and the

worker selectively shares these with some clients and in return, the client complies with the worker's directions.

Van Oorschot (2006) demonstrated that welfare states place clients on a gradient of least to most deserving that reflects the varied policy, cultural, economic and political contexts. In Europe, for example, those who were unemployed or immigrants were considered least deserving, while those who were elderly or disabled were most deserving (Van Oorschot, 2006). Within the Canadian welfare state, there are several client categories. If deemed employable, there is a great deal of rigor applied to ensure that the individual is seeking work, and can provide proof of such activity (HRDC, 2010). In regard to single parent families, the client is required to obtain maintenance payments from the absent spouse, or to subjugate their rights to government.

Obtaining disability status in Canada involves first an application process for assistance, then a formal application for disability status, with documentation required from a licensed physician. Persons with this status receive higher basic assistance rates, additional health allowances, and higher exemption levels on assets and income (HRDC, 2010). If the condition is not deemed permanent, the applicant has to submit ongoing documentation, and he/she is described as a person with barriers to employment, which may include alcohol or drug addiction. This class status means they will temporarily receive a higher basic level of assistance, with some asset and income exemptions (HRDC, 2010).

As described, the federal Canadian guidelines align with the principles of the liberal welfare state, in that there is a modest universal, means-based welfare structure. These structures and guidelines are mirrored in the provinces' programs.

2.18 Welfare Services in British Columbia

Welfare services within the Province of British Columbia have evolved over the last 90 years (Prov. of B.C., 2011). From 1921 to the present, the name of the Ministry has often reflected the central role of the labour market. Names have included: Department of Rehabilitation and Social Improvement, Ministry of Social Services, Ministry of Housing and Social Development, Ministry of Employment and Income Assistance, Ministry of Human Resources, Ministry of Social Development, and currently the Ministry of Social Development and Social Innovation.

2.19 Social Development and Social Innovation: Environmental Context

The Ministry's Annual Service Plan (2014 – 2017) outlines the provincial environmental context. B.C.'s economy remains resource based, there is always the risk of reduced demand for exports. In addition, even when GDP increases, the labour market often lags behind. Further, changing demographics have resulted in a higher average age, increased First Nations and immigrant populations, and an increase in the number of disabled citizens needing assistance from the ministry (Prov. of B.C., 2014). For example, in 1995 the number of persons with disabilities (PWD) was 27,000. By April of 2014, that number was over 103,000 and continuing to rise (Prov. of B.C. 2014).

In summary, the projections suggest that in the future more British Columbians may be in need of support from the Ministry. The next section details the service delivery framework present within the province.

2.20 Social Development and Social Innovation: Service Delivery Framework

As stated previously, the Ministry mandate is the delivery of income assistance, with the caveat that the market is the primary source of support. Eligibility for income assistance includes the following requirements: unemployed, or if employed is earning a very low wage; unable to work due to medical issues; lack of shelter, food, or medical attention.

If found eligible, the actual amount received will depend on the individual's asset and income level, and the size of the family unit. In exceptional cases where the person may not qualify for regular income assistance, it may be possible to obtain what is termed "hardship assistance".

Access to income assistance is available through a variety of avenues. Traditionally citizens went to a local district office, however there is a strong move toward encouraging citizens to apply via the internet, using a self service assessment and application process (www.iaselfserve.gov.bc.ca), or calling a toll free number (1-866-866-0800) (Prov. of B.C., 2014). Prior to the eligibility interview, the individual is expected to be looking for work, and provide proof of this. Only those 65 and over, in crisis (e.g., no food/shelter) or fleeing from abuse, are exempted from this requirement (Prov. of B.C., 2014).   As discussed previously, however, defining what constitutes a crisis, or what constitutes fleeing from abuse has a subjective element, and is subject to worker discretion (Lipsky, 2010).

 Those eligible for income assistance sign an employment plan, and access to various work support programs is provided.   Recipients may also be eligible for other types of assistance including: disability assistance, security deposits, crisis grants, natal support, moving assistance, camp fees, funds to obtain proper identification, additional funds at Christmas, assistance with medical transportation costs, funds for children's school start up, and dietary allowances. Single parents are also able to access the services of a Family Maintenance Worker, who assists them in obtaining support from absent spouses.

2.21 Social Development and Social Innovation: Rights and Responsibilities
Client rights reveal elements of the equality and equity that Esping-Andersen (1990) outlined within the Liberal welfare state model, albeit hybridized. For example, rights include (Prov. of B.C., 2011): the right to apply for income assistance, to have their information kept confidential, to be informed about decisions, the right of appeal, and freedom from discrimination. In addition,

citizens have the right to receive all services in a respectful and courteous manner, and to have any issues dealt with rapidly and effectively. That being said, however, staff are still subject to the tension involved with both being fiscal gatekeepers and caregivers, and these pressures impact decisions.

Client responsibilities again demonstrate the hybridization of the Liberal model, as well as the categorisation and commodification that Esping-Andersen (1990) described. However, like the Conservative model, the province will meet their support and shelter needs if the person is unable to access other resources. Adequate identification and social insurance numbers are required for all family members, however if the documentation is unavailable, the EAW can provide funds to assist the individual in obtaining these credentials. As outlined to this point, there are numerous staff roles involved in the overall delivery of income assistance services.

2.22 Staff Roles

Front line staff include Employment and Assistance Workers (EAWs), Client Service Workers (CSWs), Family Maintenance Workers (FMWs), Investigative Officers (IOs) and Supervisors (Prov. of B.C., 2011).

CSWs and EAWs are the first contacts for those applying for income assistance. CSWs are able to deal with a wide range of general enquiries from citizens. In addition, they deal with complex administrative duties, including the set-up and printing of cheques for clients, once eligibility has been determined. CSWs work in a close supportive capacity with EAWs.

EAWs are charged with assessing eligibility for income assistance and assisting each person in moving toward employment. Those recruited for this role need excellent interpersonal and multi-tasking skills, as well as the ability to assist clients with a wide variety of physical, mental and emotional issues. In addition, the EAW is responsible for the administration of all supplementary allowances, services, and employment resource referrals. If the citizen is not eligible for income assistance,

the EAW needs to complete the denial decision, and ensure that the person is aware of their right to appeal.

As part of an overall prevention and loss management strategy, Investigative Officers (IOs) are involved with assessing cases of misrepresentation and potential fraud. This includes interviewing clients, identifying criminal activity, preparing for court, and negotiating repayments. Family Maintenance workers (FMWs) assist clients with children in obtaining financial support from absent spouses and partners, thus helping to obtain a level of regular financial support.

Supervisors are responsible for leading service delivery teams in both physical and virtual settings. They direct work duties, assist in the planning and implementation of various social service initiatives, manage budgets, monitor staff performance and development, ensure staff health and safety on the worksite, develop protocols with other service delivery partners, and participate in long range planning at the regional and cross regional levels.

Given the many agitated, anxious, depressed, and often angry clients, welfare staff face a range of workplace stressors.

2.23 Workplace Stressors

Most public sector wellness research has examined military, emergency, fire or police personnel (Basinska, Wiciak, and Dåderman, 2014; Cicognani et al. 2009; Day and Livingstone, 2001; Evans et al. 1993; Pienaar and Rothmann, 2003). One research area that aligns with welfare workers' experience is front line social workers and nurses (Bennett, Evans and Tattersall, 1993; Boverhof, 2006; Collins, 2008; Udod and Care, 2012; Ashker, Penprase and Salman, 2012). Boverhof's (2006) study outlined the stressful impacts of child protection work and most of these concerns are found in front line welfare work as well. Stressors include: working with vulnerable clients, tensions between societal expectations and client

service, political environment changes, and burnout due to staff shortages.

Benavides and David (2010) determined that there was a lack of research in public sector settings. Although the focus was not specifically on the welfare service work environment, the findings identified a number of general public sector trends in wellness programming. For example, there were both disease-model components (e.g., enhanced medical coverage; employee assistance programs) and prevention components. Employee assistance programs (EAP) have been found to be useful in assisting staff with problems, but there is still a perception that EAPs are about fixing staff instead of being a genuine concern from the employer (Johnson and O'Neill, 1989).

Wellness programs, in contrast, are about prevention, and their popularity has risen dramatically in all levels of government, largely due to increased health care costs (Parks and Steelman, 2008). Powell (1999) asserted that the following components were found to have a strong connection to a high return on organisational investment: effective wellness communication, opportunities for wellness assessments, and individual/group supports. Jewell (2005) identified the following trends in the content of public sector wellness programs: smoking prevention and quitting programs, fitness equipment on site, nutrition supports, and overall general health assessments. This is in line with Benavides and David's (2010) contention that wellness programs are taking a more holistic approach and include not only physical health, but social, emotional, psychological, mental, spiritual and environmental components as well, leading to the promotion of a culture of workplace health and wellness. Rather than taking a holistic view, however, there are other studies that indicate that it is possible, even preferable, to focus on particular wellness components within the overall continuum (Farrel and Geist-Martin, 2005; Siu, Cooper and Phillips, 2014), and this approach may be particularly useful within the welfare services work environment.

When looking specifically at the Ministry of Social Development and Social Innovation, many of the above stressors are present. For example, Ministry staff are tasked with working with clients in severe duress. Lack of food and shelter are common concerns, and issues of domestic violence, crime, addiction, and mental health problems are widespread (Prov. of B.C., 2011). There are a multitude of conflicting messages that need to be delivered to each applicant. One deals with equality and equity while the other deals with communicating the client's class strata, the requirements (e.g., employment plan) and the penalties for non-compliance. For those disabled clients, their class strata is higher than those deemed ETW (i.e., expected to work), and they have access to various additional benefits. Similar to the Socialist model, PWD clients have total freedom from the market.

For employees working with clients through the above processes, it can be an emotional rollercoaster. Front line workers want to assist those in crisis, and to promote social change (Graham et al. 2014; Haynes, 1998). There is a tension, however, between employee ideals and public management reform welfare state expectations, and leads to increased stress (Savaya, Gardner and Stange, 2011). Lipsky (2010) asserts that front line public sector staff are cooperative and accepting of the demands placed on them by the governmental hierarchy; however, they labour under a number of systemic pressures. These include: chronic lack of resources, increasing demands for service, ambiguous and sometimes contradictory goals, difficulty in measuring progress toward performance goals, and dealing with non-voluntary clients.

If not able to maintain their own health and wellness, front line staff face potential burnout. Because of the pressures noted above, the continuous exposure to clients in crisis, and the very real potential of violence within this work environment (Kim and Stoner, 2008; Macdonald and Sirotich, 2005), establishing and maintaining wellness for front line staff is critical.

In summary, this chapter began with the assumption that understanding employee wellness perceptions, job satisfaction, coping preferences and coping behaviors starts with understanding their work environment, in terms of the public management reform welfare state context. Each reform model shows a measure of alignment with the goals and vision of the welfare state. NPM demonstrates minimal alignment, with NPG and NWS showing greater alignment. The Canadian experience represents a hybridized Liberal welfare state within a hybridized NWS public management reform setting. The next chapter begins a review of the wellness concept, with a specific exploration of how reform models either undermine or enhance front line staff wellness.

Chapter 3: Literature Review

3.1 Introduction

The intent of this thesis is to understand how welfare staff wellness perceptions, their daily job satisfaction, coping preferences, and coping behaviors. Examining the major themes flowing from these questions will assist in more fully understanding employee wellness. With the exception of social workers (Astvik and Melin, 2013; Bennett, Evans, and Tattersall, 1993; Boverhof, 2006; Collins, 2008; Graham et al. 2014; Shier and Graham, 2011; Shier and Graham, 2013), these questions are not dealt with within the existing literature. This study will contribute to addressing this gap.

Given the focus on public sector welfare services, it is useful to begin the literature review of wellness with a further discussion of the public management reform models introduced in the last chapter. Each welfare state is framed within the larger umbrella of a public sector management reform infrastructure, and this influences employee perceptions, attitudes, values and behaviors. There are factors within each reform model that mitigate or promote workplace stress, thus impacting staff wellness. NPM, NPG, and NWS will be examined in terms of these linkages, with the HSE Management Standards for Work Related Stress used as a framework for understanding the issues found within the work environment (Edwards et al. 2008).

Following this, the history of the wellness concept will be outlined, including the progression from disease eradication to prevention, leading to a holistic perspective. Wellness will be defined, and the three major wellness phases delineated. An overview of major wellness theories will be provided, including the work of Dunn (1959), one of the early holistic advocates. Although the holistic paradigm represents the current consensus for understanding wellness, alternative explanations will be discussed. In addition, it is important to realize that wellness is a duality, and there are factors in the organisational environment that are linked to unwellness as well as wellness (Dale and Burrell, 2014).

3.2 HSE Management Standards for Work Related Stress

Within the work environment there are various issues/problems that promote stress. As discussed previously, the welfare state contains systemic factors that impact staff wellness, and include categorisation, choice, caregiving and decision-making. Additional workplace stress factors include: Demands, Control, Support, Relationships, Role and Change (Kerr, McHugh and McCrory, 2009). If these attributes are effectively managed, there is an inferred link to positive health and well-being. A major tool for accomplishing this is the Health and Safety Executive's (HSE) Management Standards indicator tool (Edwards et al. 2008), and all three management models (NPM, NPG, NWS) have systemic attributes that either mitigate or exacerbate these 6 key domains.

Demands covers all aspects of worksite pressure, including working environment conditions and level of work. The HSE standard states that the organisation should have resources in place to mitigate employee issues, so that all staff can cope with work pressures. Specifically, the organisation should design the work environment in such a manner that work demands are rational, staff are working within their capacity, with skills being matched effectively to work assignments.

Control references how much input an employee has into their work responsibilities. Staff should have some measure of control over how they perform their duties, and the organisation should have policies, procedures and systems in place to garner feedback from staff and respond effectively. Specific suggestions include allowing staff some ability to prioritize the pace of their job assignments, facilitate staff skill building, as well as opportunities to stretch themselves professionally.

Support references both general support and encouragement from colleagues and supervisors as well as organisational resource support. Specifically, the organisation needs to have protocols, and resources in place to meet employee needs, for everything from health and safety to necessary work tools. Staff should know what is available, as well as how and when it can be accessed.

Relationships includes organizational resources designed to promote positive working relationships, as well as resolving conflict. This specifically covers protocols for helping staff and supervisors deal with potential violent situations (e.g., bullying). Systems should be in place that will help staff and managers report and resolve inappropriate behaviors, as well as promote fair and equitable treatment for all employees.

Role references the importance for all employees of understanding their position in the organisation and their designated work duties. Specifically, this includes the boundaries of their position, and all the responsibilities and requirements placed upon them. In addition, avenues should be available to staff to report issues they have regarding their work responsibilities.

Change covers all the procedures and protocols around organizational change management, including resources for staff to understand and embrace change initiatives. For example, there should be change communication planning, timetables, employee liaison systems and supports for staff for the impacts of changes.

In conclusion, the above standards represent an organizational foundation that will promote health and wellness and arguably higher performance levels (Edwards et al. 2008). The next section details the three public management reform models and their level of alignment with the HSE management standards.

3.3 New Public Management and HSE Alignment

Connelly (2013) highlighted several reasons why NPM gained transcendence over traditional public administration. These included mounting fiscal expenditures that the traditional bureaucratic apparatus appeared incapable of restraining, growing citizen choice and the expectation for a more conservative approach to the public sector (Flynn, 2002). Given that government has a virtual monopoly on certain services, employees may become more "self-serving" than customer focussed (Farnham and Horton, 1996).   Brodkin (2007) highlighted that welfare services in

particular had this tendency, and thus there was a need for reform.

New Public Management offered the promise of moving the public sector toward a business-like framework, reducing inefficiencies, increasing accountability, creativity and innovative problem solving (MacCarthaigh, 2012). MacCarthaigh and Boyle (2011) suggested that NPM's move toward market-based approaches might improve employee performance, with managers having more latitude in dealing with staff, thus enhancing staff engagement and organizational productivity (Grey and Jenkins, 2003). Hood (1995) highlighted that conservative political pressure in the U.S. and Britain sought to restraint government largesse, as the costs for maintaining the welfare state appeared unaffordable. NPM offered politically attractive cost cutting rhetoric, while promising better service.

As stated previously, however, the reality is more faith than fact in terms of whether NPM lived up to its promise (Pollitt and Bouckaert, 2011). Newman (2008) stressed that accountability is embedded within relationships between managers and workers, workers and clients, staff and stakeholders, and government and the public. NPM has lost sight of this principle and uses performance targets as the primary accountability index. Ferris and Graddy (1998) emphasize that government services like bridge repair, park fee collection, and road maintenance, are concrete targets and measuring success is simple, whereas evaluating performance targets for welfare, child support, or mental health services are more challenging. Given NPM's endorsement of contracting out services, the profit motive means that contractors may ration their services in an effort to maximum profits at the expense of client needs (Clarke, 2008). Private and public sectors are not interchangeable, and the core raison d'etre for the public sector is to provide services to citizens, thus NPM's business focus may not be relevant (Pollitt and Bouckaert, 2011). For example, in terms of efficiencies, setting limits on welfare expenditure may be logical, but given that clients are in a dependent, non-voluntary circumstance, this is problematic. Hoggett (2000) asserted that the issue of dependency was part of the human condition, and it was the role of government to support citizens during these periods. When facing crisis issues that overwhelm

their capacity, citizens arguably turn to welfare as part of their struggle for survival (Honneth, 1995). Staff are charged with providing a safety net for their dependent clients (Debord, 1967). Under NPM, workers are directed to consider their clients as informed consumers, who are able to rationally evaluate their choices, and then respond accordingly. There are often cases, however, where clients' decisions are not rational, and they are not able to make informed choices (Gibson, 1995). This places an obligation on staff to make choices on behalf of disadvantaged clients (Lipsky, 2010), which places undue demands on them according to the HSE scale.

Ferlie and Geraghty (2005) assert that NPM can be present in either a rigid or flexible format. The rigid NPM format promotes a low trust atmosphere and may result in increased workload pressures. As Osborne and Gaebler (1992) highlight, there is a concentrated focus on contracting out public sector work, which erodes control, and raises the potential for internal conflict between staff and supervisors. The constriction of role assignments, and carrot/stick performance management approaches can result in more formal and constrained working relationships (Pollitt and Bouckaert, 2011), as well as problems obtaining employee engagement when organizational changes are required.

The flexible NPM format promotes more creativity for both staff and supervisors. Demands are more reasonable, with some measure of control over work pace, and more consideration afforded to staff input during times of change (Ferlie and Geraghty, 2005). The flexible/softer NPM stream highlights a "quality service" orientation, that functions within a high trust atmosphere, fostering a culture of innovation, allowing both managers and staff more freedom and flexibility in their working relationships, resulting in more mutual support and less potential for conflict. This form of NPM, however, appears to have more in common with the New Public Governance (NPG) model, with its participatory slant. Most of the examples in the literature present the rigid form of NPM that aligns with the vision of arbitrarily changing the public sector into a mirror of the private sector. For

example, a recent Canadian study by McDonough and Polzer (2012) highlighted the plight of public sector employees facing an NPM restructuring. The term "hysteresis" was used to describe the rupture staff experienced between their public service vision and the NPM vision. Extreme levels of stress were particularly common with those involved in delivering welfare services. Staff felt severe pressure, with heightened work demands and limited work control, which lead to feelings of work role disconnect. Large numbers of staff experienced an on-going lack of support, and a deterioration in relationships with supervisors and managers, which further disengaged them. There was an overall cultural misalignment with staff, and this is not uncommon when NPM is applied within the public sector. Bourdieu (1998) highlighted that NPM values do not align with the traditional public sector principles of "serving the public good" (Culyer and Posnett, 1985). There is instead an assumption, mentioned previously, that the market can best serve client needs, with workers playing only a facilitation role between the market and the client. Workers, however, entered public service with a goal of serving disadvantaged clients, and both male and female staff reacted to the NPM initiatives. McDonough and Polzer (2012) highlighted that male staff disengaged emotionally, while female staff increased their level of work commitment, in an effort to both fulfill NPM values, while still striving to hold their own values of compassionate connection with their clients. This "workaholic" pace tended to result in a state of unwellness, with a number of female staff becoming ill. Other studies have found similar results when NPM-type management values of "public good" disconnect with staff values around "public good" (Bone, 2002; Nowak and Bickley, 2005; Zipin and Brennan, 2003). This is again evidence that there are differences between the public and private sector, and the wholesale application of NPM's private sector methods has to be scrutinized closely (Connelly, 2013), as there are consequences for staff wellness. Looking now to New Public Governance (NPG), there is a more pronounced alignment with the HSE's management standards.

3.4 New Public Governance and HSE Alignment

New public governance (NPG) takes an inter-organsational, network approach to public sector issues (Castells, 2011). For example, NPG's focus on networking requires mutual relationship and support linkages, which aligns well with HSE factors. Rather than the market-based structure of NPM, NPG focuses on a participatory alignment, which potentially bodes well for workplace demands, and issues of workload control (Klijn, 2008). The delegation of decision-making (Bellamy and Palumbo, 2010) is another aspect that aligns with the HSE management standards. The move toward digital-era governance (DEG), which arguably is an extension of the principles of NPG, has potential positive but also negative impacts on employee wellness, when examined with the HSE management standards lens. This electronic integration of services can potentially afford staff more time for quality interactions with citizens, by positively impacting workload demands, giving staff more flexibility and control over the pace of their work, creating a collegial supportive work environment. This move toward what Dunleavy et al. (2006) describes as virtual service delivery can also have a negative aspect. There is the potential that staff will essentially "serve" the system, resulting in scripted rote responses to service requests, long hours spent on phones or in front of computer screens, with limited social connection. In terms of the HSE, this could mean less control, less support, more potential for conflict and increased work demands, given the ability of the computer system to monitor how many service requests staff are able to deal with each hour. In this circumstance, accountability is achieved, but at the cost of staff morale and wellness.

Overall, however, the alignment between NPG and the HSE standards is arguably better than NPM. Christensen and Laegreid (2007) highlight that the NPG-type models has a stronger focus on building trust with staff, employee development, collaborative decision-making and participatory, values-based management. This has the potential to translate into more manageable work demands, more control over work pace, enhanced onsite social support, positive relationship building, and more defined role boundaries (De Jonge et al. 2008). In addition, employees

facing organizational change within the NPG model may face fewer challenges as staff have more opportunities for input.

Moving now to a discussion of NWS and the HSE management standards, there are again potential advantages and disadvantages for employee wellness.

3.5 Neo-Weberian State (NWS) and HSE Alignment

NWS is marked by both similarities and differences when compared with NPM and NPG. In the same way that welfare state typology boundaries (Esping-Andersen, 1990) have become blurred, the lines between NPM, NPG and NWS are blurring. Collins and Cradden (2007) assert that the key features of NWS include the centrality of government, with public sector positions being full time permanent vocations, obtained through a merit process, and having clear roles and responsibilities. There is a vertical chain of command, with clear spans of control for supervisors, managers, and line staff.   Work procedures/protocols are clearly delineated into SOPs (standard operating procedures). As with NPG and NPM, the importance of seeking efficiencies and effectiveness is extremely important, but the cultural milieu is different.   Rather than a business focus like NPM, or a network focus like NPG, NWS maintains a core public sector focus (Pollitt and Bouckaert, 2011)

NWS cultivates a level of professionalism, and Rochet (2008) highlights that this can build an esprit de corps among staff. The alignment with a civil servant "identity" (Akerlof and Kranton, 2005) links positively with HSE management standards, with staff seeing their role as an important link in the service delivery chain. Within welfare services, there is a cultural alignment between organizational and staff values on what constitutes positive client service (McDonough and Polzer, 2012). In terms of the HSE management standards, this constitutes a measure of support for staff, and the enhancement of positive relationships between supervisors and frontline workers. NWS values accountability, predictability and continuity, allowing for the potential to forecast work demands for

staff, and some measure of employee input into the pace of their work (Pollitt and Bouckaert, 2011). It should be noted, however, that NWS, like NPM and NPG all contain the service delivery tension between meeting fiscal goals, while maintaining compassionate, high quality client service. The difference with NWS is that the organizational values are tilted toward the side of client service, instead of the market.

In conclusion, there is a gradient of alignment between the HSE Management standards with all three public management reform models. NPM arguably has the lowest level of alignment due to several foundation concerns. First, NPM has a focus on quantitative measurement, and welfare policy and practice is considerably more qualitative than quantitative (Rose, 1976). Second, NPM maintains a focus on market forces as a means to meet client needs, and Dominelli (1996) highlights that this approach has only a superficial concern for marginalized citizens. Finally, there is a disconnect between NPM values and staff values (Kirkpatrick and Ackroyd, 2003) that has the potential for significant resistance to the implementation of public policy. The welfare state within an NPM public management framework contains real wellness challenges for staff.

Moving from the public management reform foundation, it is also important to understand the basic tenets of the wellness movement, and this is detailed in the following sections.

3.6 Foundations of Wellness

In the 21st Century, the leading health issues in the workplace include cancer, heart and stroke, diabetes, depression, and muscular skeletal concerns (Goetzel et al. 2004). These have behavioural components, including: obesity, substance abuse, and physical inactivity (National Center for Health Statistics, 2012). Employee quality of life and the ability to maintain employment is significantly influenced, and organisationally the costs for lost time are enormous. In Great Britain, labour force surveys indicate that 27 million work days were lost in 2011/2012 due to

employment related illness or injury (HSE, 2014). In Canada, trends from 2001 to 2011 indicate a steady increase in days lost due to illness or injury. In 2001, there was an average of 8.5 days lost. By 2011, that figure had risen to 9.3 days lost on average, with a cost to the economy of $16.6 Billion (Dabboussy and Uppal, 2012). The business case for health prevention and wellness promotion is increasing dramatically, with the Centers for Disease Control (CDC, 2013) highlighting a range of benefits at both the individual and organisational levels. For staff, these include: improved general health, increased ability to cope with problematic issues at work, enhanced work satisfaction, and improved overall well-being. Organisationally, the benefits include: decrease in days lost due to illness/injury, improved staff retention and productivity, and enhanced staff morale flowing from the establishment of a culture of health and wellness (CDC, 2013). Thus, improving overall health means a focus on health prevention, medical treatment (as required) and wellness promotion. Defining wellness, however, is a challenge.

3.7 Defining Wellness

Historically the first reference to the term wellness was in a 1654 diary of Lord Archibald J. Wariston, in which he expressed his thanks for his daughter's "wealnesse" (Johnston, 1911). He was expressing relief that his daughter was free of illness. Wellness was the absence of illness. Panacea, the daughter of the Greek god of healing, Aesculapias, held that treating illness was the way to wellness. Hygeia, his other daughter, advocated the teaching of positive ways of illness prevention as the way to wellness. Although her preventative stance is the perspective most closely aligned with our current view of wellness, it was Panacea's viewpoint that held sway to the middle of the 20th Century, as evidenced in the University of California Los Angeles (UCLA) phases of general health model.

3.8 Three Phases of Wellness

UCLA's Life Course Health Development model (Halfon, 2005) described the time up to 1950 as the foundation phase to understanding wellness. In line with the views of Lord Wariston, wellness was considered the absence of disease.

Physicians maintained that the body was composed of specific, isolated physical systems, and specific diseases targeted these systems (McSherry and Draper, 1998). The primary goal of medicine was to reduce death, and that was best achieved by targeting specific diseases such as tuberculosis, typhoid, polio, diphtheria and smallpox. Vaccines, antibiotics, improved sanitation, and quarantine measures were the major tools developed, and these were very successful (Seaward, 1997; 2002; Thornton, 2010). This focus on treatment meant that resources could be specifically allocated toward eradicating various diseases. The limitations however were that other aspects of wellness were neglected. Defining wellness as the absence of disease means the person is labeled as a patient who needs treatment (Halfon, 2005). There is a lack of focus on the interplay between the medical practitioner and the individual, and the responsibility of the individual for their own wellness. People are seen as victims, patients, subjects for scrutiny and treatment. The second phase of the model addressed this issue.

UCLA's Life Course model's second phase described the period from 1950 to 1990 as a period of shift to more holistic approaches (Halfon, 2005). There was now a focus on both the absence of disease and freeing the person from disabling and dysfunctional conditions. Quality of life became important. With life expectancy increasing, there was a deeper consideration given to multiple risk factors, including behavioural and lifestyle components. One of the leaders promulgating this paradigm shift was H.L. Dunn (1959). His "High Level Wellness" (Dunn, 1959) laid the foundation. He felt that the focus should be on maintaining fitness levels throughout life, with higher levels of wellness aligning with higher levels of overall health. Alternatively, lower levels of wellness would make the individual more susceptible to illness. This more comprehensive view of wellness built upon the early work of the World Health Organisation (WHO) and its description of positive health as *"complete physical, mental, and social well-being, and not just the absence of illness"* (WHO, 1948). Dunn's diagrammatic representation of his high level wellness concept featured interlocking circles representing the body, mind

and spirit, the interconnectedness between them, and the need for balance between them. Only through maximizing a balance between mind, body and spirit could the individual achieve optimal wellness. In summary, Dunn (1959) presented foundation principles that have garnered wide support and include the following assumptions. First, wellness is not a fixed state but a gradient, a continuum from lowest wellness (i.e., death) to highest wellness. This bears a striking resemblance to Maslow's (1943) self-actualization concept. Second, it is possible to move from a lower order of wellness to a higher order of wellness along the continuum. Third, the individual is responsible for understanding where they are in the wellness continuum, and taking action to move forward, realizing that they also require supports to achieve this movement.

A multi-component wellness continuum is an integral aspect of the third phase of the model (Halfon, 2005), and many researchers ascribe to this multi-component framework. Lafferty (1979) emphasized a combination of 5 components as part of his Credo of Wellness. These included: social, intellectual, physical, spiritual and psychological/emotional. Egbert (1980) believed that the wellness continuum consisted of spiritual components (i.e., meaning/purpose in life), social (positive relationships), psychological/emotional (maintaining a positive, hopeful perspective) and the ability to cope with daily stressors. Coping abilities are enshrined within the WHO (1986) Ottawa Charter, which emphasizes that optimal wellness should include not only mental, physical, and social health and well-being, but also the ability to set goals and attain them, and to cope with stressful events. This focus on the ability to cope with stressful events is at the heart of wellness, and this study's research questions are therefore focussed not only on wellness perceptions and job satisfaction, but also on understanding both coping preferences and behaviors. The following studies demonstrate the centrality of coping skills within the wellness literature.

Bouchard, Shephard, and Stephens (1994) emphasized that positive wellness should include a strong ability to cope with stressors. Although Witmer and

Sweeney's (1992) wellness configuration included a range of dimensions (i.e., spiritual, social, psychological, and emotional), coping had a pivotal role in self-regulating problematic events. In their wheel of wellness, Myers, Sweeney and Witmer (2000) put spirituality at the centre. In this case, the term spirituality speaks of an ability to oversee all aspects of the wheel, to cope and coordinate both interpersonal and intrapersonal thoughts, attitudes, perceptions, and behaviours. There were 12 spokes around this spiritual core: creativity, problem solving, control over events, self-worth, personal beliefs, emotional control, mental stimulation, humour, physical fitness, management of stress, self-care, and gender/cultural alignment. Hettler (1980) of the National Wellness Institute formulated a 6-tiered configuration for conceptualizing wellness. The tiers were: physical, mental, social, emotional, spiritual and occupational. It also highlighted coping skills, which assisted the individual in making positive life/work choices.

By this point, it is clear that although wellness is a socially constructed concept, there is strong support for the holistic framework (Clark, 1996; Jonas, 2005; Lafferty, 1979; Myers, Sweeney and Witmer, 2005; Sackney, Noonan and Miller, 2000).   However, Thomas Kuhn (1970) contends that scientific advances do not proceed in a linear manner, building knowledge incrementally until certain truths emerge. Instead, certain concepts that Kuhn coined paradigms demonstrate new shifts in thinking. The new paradigm attracts a certain number of vocal adherents who champion it in part due to its novel direction, and the fact that it presents a sufficient volume of new issues to explore. As the number of adherents increases, a tipping point occurs and the new paradigm becomes the accepted norm (Kuhn, 1970). It is suggested that the holistic view of wellness is one such example.

When looking at the three phases as outlined by Halfon (2005), there appears to be a balanced and progressive understanding of wellness.   Moving from the disease eradication focus in phase one, through the disease and prevention focus in phase two, and ultimately to a strong holistic prevention focus in phase three, it appears that there is a stronger focus on individual health and well-being. Is this

the case, however?

3.9 The Duality of Wellness

Wellness is more than the absence of illness. Halfon's (2005) phase one highlighted the attack on medical scourges that plagued society. There was a certain purity to the goal of disease eradication, and as previously discussed, it was very successful (Seaward, 1997; 2002; Thornton, 2010). By phase 3, things were not as clear. The major health issues were linked to lifestyle choices, and the focus was on the individual's capacity to cope with the increasing demands of the work environment (Ganster and Fusilier, 1989), and to self-actualize (Maslow, 1943) across multiple wellness components. The responsibility for these efforts, however, was increasingly laid at the door of the individual. CIPD (2007) admitted that in the past, employee wellness was generally the responsibility of the employer as part of their overall moral responsibility. In the 21st Century, however, the CIPD (2007) views well-being as "...ultimately an individual's responsibility…", which minimizes the role played by the organisation, and raises the spectre of unwellness within the corporate culture (Dale and Burrell 2014).

The momentum of the holistic wellness paradigm hides the duality of wellness, namely unwellness (Priolcar, 2014). Dale and Burrell (2014) contend that employees involved with wellness programming are potentially positioning themselves in the path of unwellness. First, staying well is increasingly seen as part of the individual's commitment to the company. This could be perceived as a slippery moral slope, where those who have wellness challenges (e.g., obesity, smoking) are not considered as deserving as those who remain fit (Dale and Burrell, 2014). Although not yet in evidence, it is reasonable to assume that organisations will begin to penalize those found to be unwell, in the same way that statistics are being generated showing how those who are fit are more productive (CIPD, 2007).

Second, there is an attempt to merge corporate values into wellness behaviors. For example, the CIPD (2007) defines wellness as including employee willingness

to contribute to the further growth of the company. This puts additional pressures on staff, when they realize that it isn't enough to be healthy in body, mind and spirit. They must also have a concern and commitment to the corporate body, mind and spirit. Third, it is suggestive that the sum total isn't about wellness within a health context anymore, it's about wellness within an economic context. Thus, the promotion of well-being as related to health is only valuable as it pertains to the economic health of the company. Lemke (2011) uses the term bio-economy to describe circumstances in which the health and well-being of employees is deemed secondary compared to a monetary evaluation. Hypothetically, if the data revealed that there was a limited economic benefit to worker wellness, support for this resource might be extinguished (Dale and Burrell, 2014). The organisational context for wellness is highlighted by glowing positive endorsements, which blur the reality that the work environment can have a negative impact on employee health and wellness. This takes a very literal form in a number of countries where the lack of basic health and safety standards results in potentially catastrophic disasters, as occurred in Bhopal (Murphy et al. 2014). Even in those countries with a solid health and safety infrastructure, the organisational work environment can be problematic. Dale and Burrel (2014), cite several systemic unwellness factors within the work environment. These include embedded unwellness, invited unwellness and interactional unwellness.

Embedded unwellness means that the work environment contains toxicity in various forms that impact the worker. The classic toxic environment of Bhopal is one example (Murphy et al. 2014), but in Europe and North America, many workers labored for years in work settings with embedded asbestos, which caused extensive health damage (Singer, 1986). When the problem was identified, there was a strong entrepreneurial response which lead to additional problems. In Britain, many small businesses were created with a mandate to clear out asbestos from toxic sites. Unfortunately, there was little or no regulation, and the individuals carrying out this work often fell victim to catastrophic illness (Singer, 1986). Another aspect of embedded unwellness is repetitive strain, which is often an

integral aspect of work within modern offices (Dale and Burrell, 2014). In the U.S., this type of muscular skeletal injury has been growing over the past several decades (Cutlip, R., Baker, B., Hollander, M., and Ensey, J., 2009), and it results in a significant level of lost work claims. The key point is that every work environment contains elements that have the potential for unwellness.

Invited unwellness describes those situations where employees reach out and invite factors into their work life that are not beneficial in the long term. In many cases, the employee may be reporting positive perceptions of their own health and wellness. Workaholism is the classic example of this, where individuals pursue their careers with such unrelenting vigour that there is damage to their health. McDonough and Polzer (2012) highlight that this has been a presenting issue when NPM reform pressures are brought to bear within the social sector. Given the increasing move toward defining wellness as a willingness to contribute to the organisational bottom line (CIPD, 2007), it is not surprising that workaholism is a prevalent part of today's work environment. Given the perks afforded to those working 60-80 hours/week, many staff feel they are accomplishing their life/work goals, and they report high levels of job satisfaction even while their health suffers (Dale and Burrell, 2014).

Interactional unwellness references Marx and Engels (1848) and the concept of commodification. The assertion is that the selling or commodifying of one's skills in the marketplace is essentially a re-modification of the body to the occupation. Within the 21st century workforce, the organisation appears to promote and recognize each person's unique contribution. However, Dale and Burrell (2014) would maintain that organisations are just more sophisticated in how they "fit" the person to the job. It may not resemble a motor vehicle assembly plant anymore, however each employee's employability is closely scrutinized. Providing gyms, fitness centres, nutritional counselors, wellness experts, etc., may be linked to the bottom line. Employees who are healthy use less sick leave and are more productive. Even change management programs are promoted as helping staff to become more emotionally and psychologically healthy. Coincidentally, they also

serve to make staff more willing to agree with the latest organizational initiative, again aligning an employee's willingness to work as an integral part of wellness (Dale and Burrell, 2014).

In summary, holistic wellness and unwellness are two sides of the same coin. An examination of the wellness continuum components reveals elements of this duality. Determining coping preferences and behaviors is a central research direction in this study, and there is a continued link to coping found within each of the wellness components.

3.10 Components of the Wellness Continuum
3.10.1 Physical Component

Although physical wellness is sometimes thought to be interchangeable with physical fitness(Bell and Blanke, 1989; Dolan et al. 2014; Lechner and de Vries, 1997), this foundation element of wellness is more than just fitness. It's about cultivating behavioural choices and attitudes that are linked to health (Iwasaki, Zuzanek and Mannell, 2001). For example, Ryff and Singer (2006) targeted negative behaviours (e.g., smoking, alcohol abuse, sedentary lifestyle) as well as positive behaviours in their research (e.g., exercise, nutrition). Other physical health indicators identified by researchers included cholesterol levels and blood pressure (Anspaugh, Hamrick, and Rosato, 2004; Durlak, 2000). Cooper (1975; 1977) focussed on positive behaviours (e.g., exercise) and the relationship to heart health and longevity. The results lent impetus to the fitness movement and strong links were found between an active lifestyle and positive wellness (Baun, Bemacki and Tsai, 1986). It also includes taking responsibility for evaluating how one is coping with internal and external stress, and responding in a proactive manner to identify and deal with possible illness (Hettler, 1980; Leafgren, 1990; Renger et al. 2000).   Indeed, physical wellness coping includes knowing one's medical history, injuries, diseases or disabilities (Crose et al. 1992). Those with positive coping skills had higher wellness levels (Helliwell, 2005). Ryan and Deci (2001) found that even those with diagnosed illnesses, if they have a positive coping strategy, will

experience a higher level of well-being than those who are physically healthy, but have maladaptive coping strategies. Physical wellness aligns with the first phase of Halfon's (2005) life course model, and most organisations promote physical health as an important factor influencing wellness, keeping in mind that organisational motives require a certain level of scrutiny (Dale and Burrell, 2014). For welfare workers, for example, the work environment is very sedentary, with continual repetitive movements with computers, thus presenting an element of embedded unwellness.

3.10.2 Social/Relational Component

The ability to successfully seek out, manage and maintain social relationships is an integral part of social wellness (Crose et al. 1992; Eisenberger, Fasolo and Davis-LaMastro,1990; Hettler, 1980; Renger et al. 2000). This is a very constructive coping strategy (Carver, Scheier and Weintraub, 1989), and the ability to maintain intimacy (Anspaugh, Hamrick and Rosato, 2004) and resolve conflict is an important aspect of social wellness. As mentioned previously, those drawn to work in the social sector strive to engage others, and to help them cope with life and work issues. The nature of the work involves connecting with clients, with the intent to understand and ultimately assist them with traumatic issues. The danger, however, is that this may be a form of invited unwellness, in that staff overextend themselves in client service, which the organisation sees as a positive behavior, even though it may lead to burnout (Dale and Burrell, 2014). In order to maintain balance, workers benefit from social/relational coping, and this is a key factor in maintaining positive wellness (Wang, Wu and Liu, 2003).

3.10.3 Emotional Component

Adams, Bezner, and Steinhardt (1997) and Leafgren (1990) and describe emotional wellness as a positive awareness and control of one's feelings. It includes the ability to maintain positive relationships and positive coping strategies (Pienaar and Rothmann, 2008; Gunthert, Cohen and Armeli, 2002). Coping with emotions is a fluid process (Hettler, 1980) designed to sustain the individual in their

views of self, others, and the community (Park, Armeli and Tennen, 2004). Renger et al. (2000) used the term self-control as a reference to coping mechanisms and maintained that it was essential in maintaining an emotional balance and the ability to experience an optimistic perspective and work satisfaction, all of which are subsumed under the definition of emotional wellness. For welfare workers, maintaining emotional support while working with clients in crisis is very important, and emotional social support (ESS) coping strategy aligns with this (Carver, Scheier and Weintraub 1989).

3.10.4 Psychological Component

Psychological wellness is linked to the actualization of the self, thus fulfilling basic psychological needs. These needs include: competence, connectedness to others, and sense of autonomy and control (Ryan and Deci, 2001). Coping strategies are linked with these areas. Positive coping enhances feelings of control, competence, and connectedness with others, which is an aspect of psychological maturity (Ryff and Singer, 2006) and psychological maturity enhances the capacity to both empathize and engage with others. DeNeve and Cooper (1998) link psychological wellness to extroversion, and the ability to deal with life/work experiences. Hales (2005) asserts that the individual's ability to cope with adversity and setbacks (e.g. illness) is a powerful aspect of psychological wellness. For welfare workers, this speaks of resilience, the ability to deal with the cumulative stress that is an integral aspect of the work. Again, there is a fine line between resilience and burnout, and if the organisation places the values of willingness to work and contribute above promoting employee health for its own sake, staff may well push themselves further than is beneficial to either themselves or their clients. Interactional unwellness infers that workers strive to commodify their skills in a way that benefits their clients and the organisation, even to the point of illness (Dale and Burrell, 2014).

3.10.5 Spiritual Component

Spiritual wellness does not necessarily align with established religion (Adams, Bezner, and Steinhardt, 1997); rather it involves finding meaning and purpose in life and work experiences (Hettler, 1980; Renger et al. 2000). It also includes being able to accept life problems which is a key aspect of positive coping strategies. Ingersoll (1994) defined spiritual wellness along a number of dimensions, including: meaning, interconnections with both others and a higher power, ability to cope with life as mystery and uncertainty, ability to forgive, hope, learn and both live in the present, and look to the future. This aligns with a positive coping strategy called religious coping (Carver, Scheier and Weintraub, 1989). For welfare workers, religious coping speaks of finding meaning and purpose at work. Those in the helping professions strongly value the ability to assist those on the margins of life (Graham et al. 2014). The dark side of religious coping, however, speaks of seeing one's work as a religious calling, and deifying the corporate structure. Gabriel (2012) uses the term religion of the bottom line, and contends that the employee who looks to the corporate structure for meaning and purpose comes away dissatisfied. Similar to the novel Animal Farm (Orwell, 1946), each employee is asked for more and more, until they have nothing left to give at which point they are deemed expendable (Gabriel, 2012).

3.10.6 Intellectual/Mental component

Intellectual/mental wellness includes a commitment to learning, a willingness to share knowledge, and a desire for mentally stimulating activities (Adams, Bezner, and Steinhardt,1997; Hettler, 1980). Having a sense of humour is part of it (Hales, 2005) as is enhancing cultural knowledge and sensitivity (Crose et al. 1992; Renger et al. 2000). Durlak (2000) included the areas of "learning to learn" under this category, as well as the development of enhanced cognitive flexibility, which is integral to cognitive coping skills, the ability to discern maladaptive thinking patterns and to change direction. Active coping (Carver, Scheier and Weintraub, 1989) is an example of intellectual problem solving within the welfare work environment, and involves complex decision-making and navigating sophisticated

computer applications. The unwellness aspect of intellectual coping involves what Pelzer (2005) terms the hostility triad. Given that active (intellectual) coping involves being able to discern maladaptive thinking patterns, there are times when the emotions of disgust, anger and contempt cloud the horizon, and result in poor decision making and problem solving, and at worst sabotage intellectual coping integrity (Pelzer, 2005).

3.10.7 Environmental Component

Environmental wellness incorporates the idea of work/life balance and a sense of individual stewardship to the community/environment (Reese et al. 2014; Renger et al. 2000). This sense of stewardship includes safety at the individual and community level (Anspaugh, Hamrick and Rosato, 2004). Helliwell (2005) focussed on the interplay between income, employment, governmental infrastructure, and family/social environment. In British Columbia, there is a health and safety infrastructure in place, ensuring legislative compliance (Prov. of B.C., 2011), given that environmental safety is a serious concern and an integral part of wellness in the workplace. In spite of this progress, some research reflects aspects of unwellness. For example, IOD (2006) tried to compartmentalize safety and wellness, and declared that the modern work environment was so safe that there were very few accidents anymore. Organisations were encouraged to put their focus on wellness programs instead, thus raising the potential for degradation in safety standards.

3.10.8 Occupational Component

Occupational wellness is present when employee skills and values are in accord, resulting in higher job satisfaction ratings (Anspaugh, Hamrick and Rosato, 2004; Hettler, 1980). This aligns with the positive coping strategy of positive re-framing and growth (Carver, Scheier and Weintraub, 1989), and it suggests that welfare workers are drawn to this occupational setting because they feel there is a sense of alignment between their personal skills, beliefs, attitudes and values, and the work to be undertaken (Holland, 1997). As discussed previously, however, this

raises the potential that the worker may look to the corporation for overall work/life purpose and meaning, which is an aspect of unwellness.

3.11 Wellness Component Summary

In summary, the holistic paradigm has been strongly represented within the wellness movement (Brown, Applegate and Yildiz, 2014). Happell (2014) acknowledges that there are numerous resources provided to enhance staff wellness in various domains, but raises the question whether these efforts represent only a superficial solution? Are organisations operating from pure motives out of a concern for employee health and wellness, or is there a dark side to the wellness movement (Rhoades and Eisenberger, 2002; Rudman and Steinhardt, 1988)? Certainly there is evidence to suggest that organisations highlight the positive side of wellness, while glossing over questionable organisational motives (CIPD, 2007; Pelzer, 2005; Dale and Burrell, 2014; IOD, 2006; Gabriel, 2012).

The holistic wellness model is a utopian vision. For example, in order to obtain Dunn's (1959) optimal levels, it is critical to maximize ratings across all wellness components. Although this is an admirable ideal, it is the author's contention that certain components may have a stronger impact on wellness within the welfare work environment (Kossek, Ozeki and Kosier, 2001). Aside from the necessity to obtain and maintain good general physical health, it is suggested that social, emotional and psychological wellness components should be given more weight (Wang, Wu and Liu, 2003). These components focus respectively with relationship building, management of one's feelings, and psychological maturity, all of which may enhance welfare workers wellness. The one other component that bears consideration is the intellectual/mental. This component includes the cultivation of a commitment to learning and problem solving, especially within a collaborative atmosphere. For welfare workers, determining eligibility for benefits requires that staff learn a very sophisticated array of rules, regulations and policy, as well as becoming knowledgeable with a complex software system (i.e., Integrated Case

Management – ICM), that serves as a case management platform. In addition, clients often have a complex range of disabilities and psychosocial disorders, and each worker has to learn how to interact with each person effectively, within a very brief period, which makes decision making challenging.

In addition to a review of the individual wellness components, there are several wellness models that incorporate some or all of the above components. The following section provides an overview of three of these and discusses the potential relevance for welfare workers.

3.12 Organisational wellness models

3.12.1 Workplace Health Promotion (WHP)

Workplace health promotion (Harris, 1994; Mclean, Feather and Butler-Jones, 2005; Schott, 1999) serves as a bridge between the traditional medical model and the holistic perspective. It builds on the physical wellness component, with health coaches helping staff understand their health risk factors (e.g., diabetes, heart disease, cancer), facilitating a change in behaviour. One to one and group assessment techniques are part of this approach. Most public sector welfare services organisations within Canada have acknowledged the importance of physical wellness, and there is a significant body of literature supporting the importance of maintaining and enhancing employee health (Astvik and Melin, 2013; Graham et al. 2014; Henke et al. 2011; Shier and Graham, 2011; Shier and Graham, 2013). There is the shadow of questionable organisational motives, however, and Thygeson (2010) highlights that although enlightened employers show a deep concern for the well-being of their staff, there is always the economic question. Although it may be beneficial to employee health, is it beneficial to the corporate bottom line? Employee health is seen as an asset that is essential to the profitability of the organisation, although even that term is used with the qualifier that "...employees are often…" the most valuable asset (Thygeson, 2010). The objectifying of employees from individuals to things casts a pall over the corporate

claim that the well-being of each and every employee is a priority, and resources are tailored to meet those needs.

3.12.2 Healthy Organisation (HO)

The Healthy Organisation model (Lowe, 2010) has five guiding principles, and four foundation pillars. The five principles include: staff performance scrutiny (i.e., at the individual and organisational levels); comprehensiveness – more than just health and engagement issues; holistic (i.e., long term focus on links to performance and wellness) and sustainability. The four pillars are: positive work culture, establishment of a vibrant workplace, inspired staff, and collaborative leadership. Lowe (2010) believes that organisations need to be consistently examined with a health lens. He maintains that there is a value chain, with links between staff wellness and long term performance at both the individual and organisational levels. This model aligns with the majority of wellness components, particularly the social, psychological and emotional sectors. It stresses the critical importance of a positive relational foundation and sees this as a key feature for creating and sustaining inspired employees. Supportive connections between co-workers, and between staff and management help to build engagement and a nurturing culture for successful customer/client interactions.   As will be discussed later, however, negative social interaction can create unwellness within the work environment (Beehr, Bowling and Bennett, 2010).

3.12.3 Psychologically Healthy Workplace (PHW)

The psychologically healthy workplace is represented by the acronym "PATH", standing for Practices for the Achievement of Total Health (Grawitch et al. 2006). PATH is a holistic model with a framework that links organisational goals and staff wellness in a symbiotic relationship. The model has a focus on five categories: work-life balance, employee growth and development, health and safety, recognition, and employee involvement in decision-making. The authors of this model assert that organisations can develop comprehensive systems based on the PATH model and will find growth in both staff wellness and organisational

improvement. In the variety of case studies cited, it is clear that PATH is not designed as a "cookie-cutter" approach. Indeed, there isn't one specific method to achieve employee health and wellness. The above categories serve as guideposts and the mix between the five can vary from one organisation to the next. The PATH model has an alignment with the current study in that the majority of the categories have a social/relational component. For example, work/life balance includes positive relationships with family as well as work mates. Employee growth assumes positive relations with one's supervisor, and recognition involves meaningful acknowledgement of work achievement. Even given this, however, there is again the unsettling assumption that organisational goals and employee wellness can co-exist within a symbiotic relationship. As has been discussed, it is possible that corporate economic goals may take precedence over employee health and wellness.

Workplace Health Promotion (WHP), Healthy Organisation (HO), and Psychologically Healthy Workplace (PHW) are all models that fit the holistic paradigm of wellness (Foster et al. 2011). Within Canadian social services jurisdictions, there is a realization of the need for health and wellness policies. Within British Columbia, an overarching policy statement has been established that emphasizes this direction (Province of British Columbia, 2011, p.10), and acknowledges the integral role of coping skills, which will be explored in the following sections:

"Healthy Workplace Policy Statement

The Ministry has adopted this healthy workplace policy to support employee health and wellness:

- *We recognize a key element to a healthy workplace is enabling and supporting healthy lifestyles, behaviours and coping skills for managing life in healthy ways.*
- *We support a work environment that makes the healthy choices the easy choices.*

- *We recognize that employees must feel empowered and be supported by their supervisors to be physically active, eat a healthy diet, manage stress in healthy ways, and be smoke-free in the work place.*
- *Through the Wellness Committees, we will provide information, education, and skill building programs and services to assist employees in practicing healthy lifestyles and fostering work/life balance.*
- *We will collaborate with service providers in the workplace and health care professionals in developing and implementing healthy public policy in the workplace"*

3.13 Coping and Relationships: Integral roles in Wellness

For purposes of this study, coping is defined with the inclusion of three levels (Carver, Scheier and Weintraub, 1989; Lazarus and Folkman,1984). First, coping involves the perception that there is some stressful or challenging issue present. Second, there is the formulation of a potential response to the issue. Third, the response is implemented. Coping is the behavioural response to a perceived issue or threat, and this is not a linear process. For example, if one perceives there is a very positive resource readily available, it tends to diminish the level of threat. Conversely, if one responds and the effect is less than successful, it leads to a re-appraisal of the issue as more threatening than originally perceived (Carver, Scheier and Weintraub, 1989; Lazarus and Folkman, 1984).

To this point, it is clear that wellness is not just the absence of disease (Halfon, 2005). Wellness is fluid and fluctuates on a continuum, with coping being an integral factor across all wellness components. In physical wellness, coping involves knowing and taking responsibility for one's health (Ryan and Deci, 2001) Social, emotional and psychological wellness includes the coping skills of seeking help from others, emotional management, and increased connectedness with colleagues (Crose et al. 1992; Meléndez et al. 2012). Spiritual coping includes the ability to deal with uncertainty in the present and future, while intellectual/mental coping involves cognitive flexibility. Coping skills within the occupational wellness

component bears a strong resemblance to the coping skill of positive reframing and growth (Carver, Scheier and Weintraub, 1989). In short, coping is the common thread and can serve to both enhance wellness and mitigate unwellness.

Thus, as an alternative to the holistic model, it is suggested that the focus should be on coping skills, framed within an interpersonal/intrapersonal social/relational context. Lowe, Shannon and Schellenberg (2003) demonstrated that employees with positive wellness had strong interpersonal and intrapersonal alignment. How the worker sees themselves, their attitudes and perspectives is the intrapersonal perspective, while interpersonal alignment includes the relationships between worker and client, between workers, and between workers, managers and community stakeholders (Matud, 2004).

3.13.1 Interpersonal Perspectives

Deery, Iverson and Walsh (2010) found that a key element to both building and maintaining a wellness culture rested on the relationships between co-workers, and between co-workers and supervisors. In a study focusing on call centre service delivery, positive interpersonal worker relationships had what Deery, Iverson and Walsh (2010) termed a humanizing impact on the workplace, in that it created a more collegial, supportive atmosphere.

Call centre work can be very stressful, and positive interpersonal relationships help immensely (Zapf, 2002). Specifically they diffuse the daily stressors flowing from client-worker interactions, leading to the development of worksite norms that offer front line staff some defence against overwork. In fact, Korczynski (2003) showed that the intensity of the call centre environment results in an enhanced awareness among staff of their need to support one another. That support was framed in what Korcynski (2003) termed "Communities of Coping".

Front line nursing staff face similar stressors to call centre staff, and social support takes the form of collaboration between nursing management and staff on risk

assessments and program implementation when dealing with workplace stressors (Jackson, 1983). Noblet (2003) conducted a stress audit within the Australian public sector. The top 6 workplace stressors were: workload time pressures, unreasonable deadlines, inequitable salaries, colleagues not performing at the same level, challenging client issues, and work/life balance issues. Workers reported that their level of work satisfaction and wellness increased when they had more control over their work, and when they experienced high levels of social support.

Sloan (2012) demonstrated that social support from colleagues had a mitigating effect for workers who had experienced mistreatment by clients, supervisors or co-workers. Selye (1975) highlighted that positive relationships between group members was critical to both organisational and individual health and wellness. Lewandowski (2003) looked at organisational factors that contributed to social worker burnout, and determined that relationships on the worksite were found to be a key to understanding and resolving worksite stressors. Stressors included: ambiguity and conflict around work roles, conflict over values, feelings of isolation, and dealing with volatile clients. In this regard, the relationship connection came in the form of guided dialogue sessions with staff. These sessions helped social workers come to a more comprehensive awareness of their place within the organisation, and assisted in resolving isolation and enhancing a sense of control. They were then able to effectively raise issues of concern about their work environment and share ideas around resolving them.

Siu, Cooper, and Phillips (2014) also focussed on interpersonal social support and highlighted this specific emphasis rather than an overall holistic direction. The study looked at methods to promote wellness among teachers and health care staff, and recommended three levels. Two of the three focussed on interpersonal social support, including initiatives to enhance personal coping, and treatment/support for personal health issues.

Viswesvaran, Sanchez and Fisher (1999), in a meta-study, determined that social support impacts both stressors and strains in the workplace. Stressors referred to a variety of conditions, including: work volume overload, lack of control, underemployment of skills, role conflict or confusion. Strain referenced the negative influence of the stressor, and included: increase in reported health issues, lowering of either life or work satisfaction, and feelings of burnout or withdrawal. Social support reduced strain in that there was less reporting of lowered job satisfaction, health issues, and feelings of burnout (Viswesvaran, Sanchez and Fisher, 1999). Social support also diminished the power of the stressors. It appeared that staff did not experience as much work overload, lack of control and role conflict, because of the presence of social support within the work setting (Farrell and Geist-Martin, 2005; Thoits, 1995; Plancherel, Bolognini and Halfon, 1998). This may allude to the fact that when a person perceives that they have the resources to deal with a stressful event, the event itself is perceived as less of a threat (Siedlecki et al. 2014).

Etzion (1984) determined that the potential for vocational burnout was correlated positively with stressful events, and that social support in both life and work settings helped mitigate this risk. Bowling, Beehr and Swader (2005) found that the quality of worksite relationships was linked to the giving and receiving of social support, with reciprocity being the key. Those who gave social support were more likely to receive social support, with the traits of extroversion and agreeableness being particularly linked to this.

In summary, the literature reflects a strong emphasis on the importance of interpersonal social support. Indeed, interpersonal social support from co-workers and supervisors in the form of feedback, advice, problem solving and emotional assistance is evident in other studies as well (Beehr, King and King, 1990; Black, 2008; Chappell and Badger, 1989; Leong, Furnham and Cooper, 1996; Shier and Graham, 2013).

When working with marginalized clients, the relationship between worker and client

is both a privilege and a challenge. In spite of the types of work pressures (i.e., workload volume, vulnerable clients, unrealistic expectations, political pressure, burnout, violence, deadlines, decision-making, work role conflict, isolation), one of the constants is the impact of interpersonal social/relational supports. The key however is that there needs to be a positive social connection (Wallace, 2013). In a study with university staff, Beehr, Bowling and Bennett (2010) determined that workers perceive some types of social exchanges as more harmful than helpful. These included exchanges where colleagues draw attention toward stressful incidents, instead of striving to mitigate them. In addition, when support is forced, the outcome is negative. Finally, if social support is offered in a demeaning, patronizing manner, the co-worker feels incompetent and belittled. In addition to interpersonal social support, positive intrapersonal support is important in building and maintaining subjective well-being (SWB).

3.13.2 Intrapersonal Perspectives

Shier and Graham (2011) was one of the first researchers to explore the subjective well being (SWB) of social workers. Subjective well-being was affected by staff perceptions of the work environment (i.e., physical setting and workplace culture), relationships within the work site, and aspects of their work (i.e., workload issues, work content).

On the worksite, Beal and Weiss (2012) maintained that an employee's level of wellness is linked to their perception of their own attitudes, affect and perceptions, which impact and are impacted by the work environment and other staff. One of the major hurdles to overcome is the fluid nature of moods.   For example, when people are asked how their day went, most will segment their daily experience into episodic clusters. They may say: *"I had breakfast, then drove downtown, had a meeting about the new construction project between 9 am and 10 am, had lunch with a friend I hadn't seen for years, finished the report about staffing costs, went for a short walk around 3 pm, etc…"* In this example, there are both general behavioural episodes (e.g., *"had breakfast, went for a walk, had lunch with a*

friend"), and what Beal and Weiss (2012) would describe as work performance episodes (e.g., *"…had a meeting about the new construction project, finished the report"*). A performance episode is defined as a cluster of behaviours, with a specific focus on a work goal (e.g., *"…conducted meeting regarding new regulations...").* Beal and Weiss (2012) determined that there was a strong tendency to cluster daily activities into these personally meaningful segments. This segmentation is extremely helpful in identifying activities related to workplace wellness with two factors identified, one fluid, and the other concrete. The fluid factor references attentional focus, meaning how they're attending to (i.e., coping with) the matter at hand, and includes attitude, affect, mood, and perception. The concrete factor references resources that each person brings to bear on the issue. These resources can include general subject knowledge or expertise, specific skills and cognitive potential. All of these resources differ from person to person, given their training and experience. A successful work performance episode is one in which the individual has close to a 100% focus on the work goal at hand, and is devoting all available resources to its resolution.

In order to both effectively attend to the issue at hand and apply all available resources as well, people must self-regulate, which is another aspect of coping. It involves staying on task, mitigating external factors (i.e., people, events, circumstances) and internal factors (i.e., attitudes, affect, moods, perceptions) that take one away from the work goal. This aligns very closely with problem focussed and emotion focussed coping (Carver, Scheier and Weintraub, 1989). Problem focussed coping means the individual is using all available resources (skills, knowledge, cognitive potential) to resolve the issue. Emotion focussed coping means one is keeping the internal environment (i.e., affect, attitude, mood, perceptions) stable, and free from distractions, allowing the resources unfettered focus on the work goal. Coping strength is enhanced if there is time allowed for rest and rejuvenation, and if the goal is specific and challenging with an intrinsic motivational interest for the person (Beal and Weiss, 2012).

Moving now to an examination of public sector welfare worker wellness, the combining of age and gender is an under-researched area (Wilks and Neto, 2013). Intersectionality is a useful research lens for understanding the interplay of factors within the current study.

3.14 Wellness and Intersectionality

Intersectionality asserts that perception and behaviour are influenced by a multitude of social parameters interacting within the context of power structures (Hankivsky, 2014). It seeks transformative, tailored responses to social problems. This study is intended to find ways to both understand and enhance employee wellness within the context of the welfare services work environment. Hankivsky (2014) highlighted the following principles: intersecting categories, macro/micro interactions, power, multiple truths, co-construction, and resilience.

First, there are numerous intersecting categories, which in this study are age, gender, work role, experience, and geography. Second, the effects of these interactions have an impact at both macro (i.e., institutional and policy) and micro (i.e., worker and client) levels. Third, power is present at multiple levels, with individuals experiencing both the leveraging of power and the impact of power. Fourth, there are multiple perceptions of truth and diversity, allowing room for marginalized voices (e.g. welfare clients) to be heard. Fifth, knowledge and social meaning is co-constructed (Hulko, 2009). Finally, resilience is an integral part of intersectionality, and Dhamoon and Hankivshy (2011) maintain there are no real victims or oppressors. People are simply responding in a manner that they perceive will assist them in their survival (Honneth, 1995). In summary, intersectionality offers a comprehensive method for understanding similarities and differences in human behaviour, as well as explaining social problems (Hancock, 2013). It should be noted, however, that this is more of a descriptive than analytical explanation of social problems. McCall (2005) uses the term anticategorical complexity because using numerous interacting categories to explain social problems is a double-edged sword. Intersectionality helps counter

the simplistic single factor approach, and acknowledges the complexity of social issues. Conversely, the focus on increased complexity decreases the ability of the researcher to provide definitive causal links and explanatory factors. That said intersectionality provides an insightful lens into how welfare staff experience their work environment, wellness perceptions, daily job satisfaction, coping preferences, and coping behaviours. The next section provides a short introduction to the Workplace Wellness Continuum, which will be discussed in more detail during the methodology chapter.

3.15 Workplace Wellness Continuum

In reaction to the passive view of health as the absence of disease, wellness became increasingly defined as the seeking of a golden mean: physical, mental, social, emotional, spiritual, psychological, occupational, and environmental balance (Adams, Bezner, and Steinhardt,1997; Hatfield and Hatfield, 1992; O'Donnell, 1989). Antonovsky, (1979) referred to this process as salutogenesis, a focussing on those factors that contributed to enhanced well-being. In this same context, Keyes (2002; 2005) and Keyes and Michalec (2010) maintained that health and illness are not mutually exclusive, but could be more effectively understood as gradients that intersected on a continuum. Within the work environment, the assumption is that there is an ever increasing rise in each of the aforementioned wellness components, each of which are crucial to optimal wellness, and thus each is given equal weight.

In this study, the author sees a different form of Workplace Wellness Continuum (WWC), with the following principles. First, not all wellness components are of equal importance within the work environment. Second, it isn't necessarily required that each wellness component grows incrementally stronger over time, or that there is some type of wellness self-actualization. Third, wellness as a concept is fluid, within an interpersonal and intrapersonal context. Fourth, wellness and unwellness are a duality, and there are factors, including the public management reform context, that push the pendulum in one or both of these directions. For

example, NPM is a public management reform model that contains several systemic factors that potentially contribute to increased workplace unwellness (Connelly, 2013).

The next chapter will explore the research methodology, including the study's philosophical foundation and examination of the quantitative and qualitative research tools. In addition, the author's internal researcher position will be detailed, as well as background on the study participants and ethical issues.

Chapter 4: Research Methodology

4.1 Introduction

What factors contribute to the wellness of front line welfare services staff? The research questions in this study are designed to provide the data to illuminate those factors:

1. How do public sector welfare staff perceive their wellness?

2. How is the job satisfaction of public sector welfare staff?

3. What are the coping style preferences for public sector welfare staff?

4. What are the primary coping behaviours of welfare services staff?

These questions will highlight themes about the welfare work environment and the employee wellness experience within the public management reform context. Although the holistic perspective has been a major theme used to understand wellness, the author argues that an alternative view is worthy of scrutiny. That perspective will be explored in more detail in chapters 5 and 6, and involves more attention being paid to a sub-set of wellness components, specifically social, emotional, psychological and to some degree intellectual/mental, and to do so within a theme of interpersonal and intrapersonal coping.

This chapter first outlines why a positivist and constructivist philosophical foundation is appropriate for this study. Following this, the study setting and staff selection process will be detailed. The benefits of the quantitative and qualitative tools will be outlined, as framed within the author's Workplace Wellness Continuum (WWC) construct. The role of the internal researcher is then examined, with a particular emphasis on the author's position. A computer application was specially designed for this study, and descriptions and screenshots will be provided to illuminate the progression of the research. Finally, ethical issues and their resolution will be detailed.

4.2 Philosophical Foundation

Philosophically, researching wellness involves certain assumptions about what encompasses social reality. This is the domain of ontology (Blaikie, 2009) and there appear two polarities: Is wellness an objective reality or is wellness socially constructed? Both perspectives are found within the history of wellness. Wellness as an objective reality was evidenced in Halfon's (2005) first phase of wellness, being anchored firmly in positivism, with a focus on the eradication of diseases. Halfon's (2005) second phase of wellness was a mix of disease eradication and the holistic paradigm. Wellness as a socially constructed paradigm flows from constructivism, and this is the central paradigm of Halfon's (2005) third phase, with its focus on individual and organisational attitudes, perceptions, values and behaviours. The next section details positivism and constructivism, both of which are useful in wellness research (Bryman, 2004).

4.2.1 Positivism

Positivists assume that natural laws dictate human behavior, and these laws can be discovered (Comte and Martineau, 1855). There is a focus on quantitative data, with personal values, feelings and opinions considered a contaminating influence. Distance is needed between the researcher and participants, and control of the research environment maximizes the probability of establishing cause and effect, and ultimately the ability to predict future behaviour. Onwuegbuzie (2002) highlighted that research conducted from a positivist perspective has a focus on verification, with reliability and validity being integral aspects (Bryman, 2004). In this study, two quantitative surveys will be used to respectively gather participant wellness perceptions and coping preferences.

4.2.2 Constructivism

Constructivists assert there are no natural laws governing human behaviour (Weber, 1978). Truth is socially constructed and subjective, with no golden key to understanding and predicting behaviour. As people make choices, hold values and develop relationships societal rules are constructed and these rules are the truths

explored during research. Weber (1978) maintained that cause and effect were pragmatic concepts. Instead of objective causality, he spoke of adequate causality, the reasonable probability that an event would occur. For constructivists, the participants' subjective experience explains social reality and makes sense of the world.

The qualitative approaches used in this study flow from a constructivist focus. Instead of testing a specific hypothesis, the intent is to use probing journal questions. When dealing with worksite issues, participants reflect on their attitudes and behaviours, leading to a deeper understanding of coping patterns. The constructivist perspective asserts that there are multiple realities (Weber, 1978), and this study strives to understand the wellness mosaic present within the public sector welfare work environment, embedded within the public management reform context. Given this orientation, reliability (i.e., repeatability) of the results is ambiguous. Other researchers may examine the same layers of information and arrive at differing, equally valid insights. It is not necessary that they agree with everything, but that they find the processes and outcomes reasonable, credible and potentially transferable.

Closely connected to the concept of reasonableness is meaning. Weber (1978) defines meaning in two ways, both of which will be used in this study. At the first level, meaning references the individual worker experience. The collective theme experience is the second level, and is conceptualized as ideal type. This constitutes meaningful, reasonable action by, for example a teacher, a police officer, etc. In this case, we are suggesting that certain actions represent meaningful, reasonable welfare worker behaviour, as framed within the Canadian hybridized Neo-Weberian State (NWS) welfare state.

In summary, both positivist and constructivist approaches are very appropriate for this setting, and the combining of both philosophical frameworks within public

sector research is very beneficial (De Vries, Bekkers and Tummers, 2015), as the following section will detail.

4.2.3 Relevance of Combining Positivist and Constructivist Approaches

Both positivist and constructivist approaches share commonalities that are relevant to the current study. First, both approaches acknowledge that validity and reliability are an important focus (Creswell, 1998). Secondly, McLoughlin (1991) and Dzurec and Abraham (1993) demonstrate that positivist research can include interpretative narratives that flow alongside the hard data collected and measured, while constructivist research can include statistical as well as qualitative analysis. For this study, the Perceived Wellness Survey (PWS) and the Coping Orientation to Problems Experienced scale (COPE) are quantitative positivist instruments that provide an objective baseline on wellness perceptions and coping preferences. Workplace Wellness Journal (WWJ) is a qualitative constructivist tool designed to shed light on both the individual and collective wellness experience. Data collected from the PWS and COPE scales will be aligned and interconnected with the subjective data collected from the longitudinal workplace wellness journaling.

Third, although positivism and constructivism have differing perspectives on causality and prediction, both agree that these are worthy areas of exploration. In this study, the quantitative scales and qualitative journaling do not necessarily predict future coping behaviour, but they do support causal adequacy (Weber, 1978). Newman and Benz (1998) maintain that positivist and constructivist perspectives are situated on a continuum, and are not simply fixed, polarized positions, therefore it is useful to include methodology linked to both perspectives.

Fourth, both constructivism and positivism seek to bring a greater depth of understanding to defining and operationalizing wellness for front line staff. Sechrest and Sidani (1995) highlight that the positivist focus on order and predictability and constructivist's focus on context and meaning are just different sides of the same coin.

Finally, operationally it is beneficial to combine constructivist and positivist methods. Roth and Mehta (2002), in their research on the shootings in Kentucky and Arkansas, demonstrated the usefulness of including both perspectives. The positivist strategies helped to objectively align the facts and data, while the constructivist methods assisted in bringing a deeper understanding of the cultural context of this tragic event. In the current study, the findings garnered from the quantitative scales, combined with the qualitative longitudinal journaling will illuminate both wellness and unwellness factors present within the public management reform welfare environment.   In spite of the above benefits, however, there are also disadvantages as the following section details.

As stated previously, positivism and constructivism are not really polarized and Howe (1988) asserts that the idea of the two being incompatible is not supportable. Brannen (2005) maintains that research should look for ways to combine differing philosophic positions. Bryman (2008) cites that corroboration is one advantageous outcome. Quantitative and qualitative outcomes may complement or build on each other and contribute to a better understanding of the bigger picture. However, in terms of disadvantages, there may be a lack of any corroboration, alignment, or complementarity. They may be polar opposites. For example, the quantitative results may reveal staff perceptions and preferences that are not aligned with behaviours.   In summary however, even polarities can provide insight into the way wellness is perceived and operationalized within the environment. In respect to the work environment, the following section outlines the setting for this study.

4.3 Study Setting

The welfare services setting for this study will be the Ministry of Social Development and Social Innovation (SDSI), British Columbia.   Employment and Assistance Workers (EAWs) and Client Service Workers (CSWs) are the primary front line staff and their duties include determining eligibility for clients for both financial and employment-related services. Other workers who have contact with

clients include Family Maintenance Workers (FMW), Investigative Officers (IO) and Supervisors. Family Maintenance Worker (FMW) will ensure that single parents are receiving support from absent partners, while Investigative Officers will become involved in cases involving fraud.

Supervisory staff includes Supervisors of Admin Services (SAS), Assistant Supervisors, and Supervisors. SASs supervise administrative staff, while Assistant Supervisors handle a variety of operational details. Supervisors are responsible for all district office service delivery functions and the supervision of EAWs, CSWs, SASs, and Assistant Supervisors.

Income assistance work is extremely detailed, with high client volumes. The work involved proceeds in a monthly cycle. Clients need to submit a request for further assistance by the fifth of each month, and disclose changes in their circumstances over the previous month, including whether they have obtained work or received any income. Workers process requests for assistance throughout the month, with increased pace and volume, culminating in cheque issue week, where the traffic into the offices plus phone calls reaches a climax.

Given the high client volume, the complex administrative processes, and the on-going in-office traffic and phone calls, the work environment is extremely frenetic. People applying for income assistance are often grappling with various complex issues, including: problems with violence, depression, mental or physical disabilities and addictions. With these on-going pressures, stress for staff tends to be cumulative (Pines and Kafry, 1978). In addition, there are sometimes specific violent incidents requiring critical incident stress debriefing (CISD). To manage health and safety incidents, a provincial Incident Reporting and Tracking (IRT) system was initiated. The IRT system is a computerized application and employees are encouraged to report any event that they feel impacts their health and safety.

4.4 Study Participants

Citizens sometimes see the helping professions as a necessary evil (Culyer and Posnett, 1985), and welfare staff have to cope with this societal view in order to maintain both their professionalism and their mental health.

As discussed in the introductory chapter, this study has a focus on the men and women, the helpers, within welfare services and addresses the following research questions:

1. How do public sector welfare staff perceive their wellness?

2. How is the job satisfaction of public sector welfare staff?

3. What are the coping style preferences for public sector welfare staff?

4. What are the primary coping behaviours of welfare services staff?

Study participants come from a range of classifications. The largest cohort will be Employment and Assistance Workers (EAWs), and Client Service Workers (CSWs), who make up the majority of all staff. The other classifications include family maintenance workers (FMW), investigative officers (IO) and Supervisors.

At the time of the study, there were five regions within the province. Region One includes Vancouver Island. Region Two includes the Greater Vancouver regional district, as well as some outlying geographic areas north of the city. Region Three encompasses communities along the 100 mile corridor of the Fraser Valley. Region Four is located approximately 250 miles from Vancouver. It includes the Okanagan Valley, the Kootenays, and the Cariboo/Chilcotin. Region Five is the largest of the regions, and covers approximately 50% of the geographic territory within British Columbia, and is larger than the combined area of Holland, Belgium, Switzerland and Germany combined. Although the geographic size is enormous, the staff population is small, and there are fewer employees in the north than in other regions.

In working with the study participants, the author was in the position of being an "insider" within the organisation. This has advantages and disadvantages, as the next section will outline.

4.5 Organisational Research – The Internal Perspective

Costley, Elliott and Gibbs (2010) highlighted that doing research within one's own organisation has both benefits and challenges. As a member of the regional management team, the author has extensive knowledge of the organisation's processes and policies. At this point, it would be useful to detail the author's position and delineate the specific advantages and challenges that flow from that background.

Starting with the Province of British Columbia public sector in 1982, my base position was that of a Rehabilitation Officer. Duties included developing and delivering training programs designed to assist clients with job seeking, training and placement. Following this I became a District Supervisor, responsible for the delivery of income assistance and employment services within a designated geographic area. After a number of years in this role, I became a Learning Manager, responsible for staff training for Region 4. Over the last 15 years, I've been the Manager of Organisational Health and Development (MOHD), responsible for staff training, leadership development, organisational initiatives related to the yearly business plan, and the areas of health, safety and wellness. These activities have brought me into extensive contact with line staff, supervisors and managers across all five regions within the Ministry of Social Development and Social Innovation (SDSI). I am thus positioned as an internal researcher, a role which Reed and Proctor (1995) maintain is very useful. The advantages include having knowledge of how things work, and having access to staff at all levels through the informal connections established through years of working together. My responsibilities have included developing and implementing a successful Safety and Wellness Program, which has served to establish credibility with staff. Working in a consultative capacity with offices throughout the region, I encourage

involvement in wellness activities, and work with the wellness representatives in each office. In line with Reed and Proctor's (1995) cited advantages, I've been able to conduct wellness education and training events, identify management practices to enhance wellness, and promote access for staff to wellness initiatives.

Although there are many advantages to being an internal researcher, there are also disadvantages. For example, when the study is relatively narrow, there may be a focus on only immediate practical applications. This can result in the research being quite insular (Bassey, 1999).   Although the study may lead to improvements in organisational practice, there may be only limited transferability to other settings. Setting the research within the larger context of the public management reform welfare state can mitigate this. Many countries have some form of welfare and there is limited research on how welfare staff perceive their own wellness or coping perceptions and behaviors. This study addresses that gap. Looking now at staff selection, the next section details how various challenges were resolved.

4.6 Staff Selection

Being an internal researcher, it is important to realize the potential power imbalance. If a supervisor preselected staff, a bias might be perceived, and those selected might feel some compulsion to participate while those not selected may feel some resentment. In order to ensure an inclusive process, a decision note was drafted for Executive. This briefing note outlined the various aspects of the study, with a view to obtaining the full support and approval of the Assistant Deputy and Deputy Minister (see Appendix, Figure 5).

Although there were names suggested by supervisors or managers, all staff were invited to participate. The management teams in all five regions sent out a global invitation (See Appendix, Figure 8). The selection process moved slowly through several stages, so that staff would not feel coerced or pressured into participating (Bryman, 2008). Those that indicated they wanted to hear more about the study were invited to a virtual online meeting (See Appendix, Figure 9).

From this point, information sessions were scheduled. Initially, there were 7 virtual sessions scheduled for staff in Regions Four and Five, with between 6 - 16 staff/session. Each session provided an overview of the background to the study, highlighting the voluntary nature of participation, the rights and obligations of participants, confidentiality and anonymity of participant data, time commitment, and benefits to those participating in the study (See Appendix, Figure 1). A web camera was used so that people could see the author, and each session was thirty minutes, with a question and answer period at the end of each session. Questions raised included processes around missed days, expectations about the results of the study and the application, and definitions of terms used.

Throughout each information session, informed consent was highlighted. Each participant had the option to exit from the study if they wished, and to have their data excluded from the study. Their data would be kept confidential at all times using a unique numeric identifier (See Appendix, Figure 2). During each information session, there was also a time set aside to share screen shots of the app, as it was being developed. As demos of the app became available, time was also spent sharing with staff how the app would work, in regard to both detailing generic foundation information, the Perceived Wellness Survey (PWS), the Coping Orientation to Problems Experienced (COPE) scale, and the Workplace Wellness Journal (See Appendix, Figure 3). Once the session was complete, everyone who was interested in voluntarily participating in the study was asked to send an email, indicating that "Yes, I want to participate in the research study". Following the information sessions conducted with Regions Four and Five, there were sessions held with staff in Regions One, Two and Three which followed the same process.

Pilot testing of the application was completed during late November and early December, 2012. Several staff reviewed the app, including the Executive Director of Regions Four/Five, a supervisor, two EAWs and the headquarters computer team. The feedback resulted in more plain language, user-friendly icons and processes, and increased help screens. In early December 2012, testing was

completed. There was some question around how frequently participants should submit their journal data. For example, if participants submit their journal entries daily, emerging themes can be identified, and support can be provided to those who may be struggling. The disadvantage is the labour intensive nature of data collection. If staff submit their data at the end of the 40 day period, there would have fewer files per person. However, in the event staff failed to fill out the journals, it wouldn't be known until the end of the study and thus too late to rectify.

By mid-December, 2012, the Health and Wellness Study Application (HWSAPP) was being put into the hands of the first cohort of staff.   It was decided that participants would send in their entries at the end of each day.   Each day the folder on the provincial computer drive was checked and the data imported to the administrative module. When the invitations went out, there was expected to be a certain level of staff dropping out at each stage.   The initial invitations were sent to approximately 1200 - 1500 staff. Of these, approximately 400 staff wanted to hear about the study, 300 signed up for an information session, with 200 attending sessions. From there, approximately 150 indicated they wanted to be part of the study, and signed up for a session designed to show them how to download the HWSAPP. Of the 150, approximately 130 staff came to these sessions, and the final number who expressed that they wanted to start the study was 120.

During December, approximately 10% of participants began the study. By early January, another 20% began. By Mid-January, another 20% had started, and a further 10% were involved by the end of January. Throughout February, an additional 20% began to join the study. Some had been away on vacation, and some had been ill, or had operational issues that precluded their involvement. Through March and early April, the remaining 20% of participants had joined the study. There were occasional participants (i.e., between three and five) that had to stop participation due to personal issues, but they did not wish their data to be excluded. Over this period, there were additional staff who came forward and wished to become part of the study. The total number who eventually became

involved was 76 (See Appendix, Figure 4).

4.7 Front Line Staff Demographics

There were 76 front line staff were involved in this study. Close to 40% of participants were less than 40 years of age, with 60% over 40. BC Stats (2010) highlights that the average public sector employee is at least 4 years older than the general British Columbia labour force, and the age gap is increasing. At the other end of the spectrum, at least 25% of the BC labour force is currently under 30, whereas the public sector only has 11% of staff under 30 (BC Stats, 2010). With this sample, slightly over 5% were under 30, and close to 30% were over 51 years of age. Participants mirrored the gender mix of the Ministry (i.e.: 70-80% female; 10-20% male). In this study, 12% were male, and 76% female (12% gender undeclared). Concerning level of experience, over 60% of participants had 10 or fewer years of experience with the Ministry. This reflects the fact that over the last 5 years, there have been increasing retirements, with new staff taking these positions.

The major role are Employment and Assistance workers (EAWs) and almost 63% of participants were in this category. Client Service Workers (CSW) constituted approximately 3% of the sample. Family Maintenance Workers (FMWs) make up approximately 5% of the study participants, and Investigative Officers constitute 12% of participants. Approximately 13% of participants were supervisors.

Educationally, over 37% of staff in the study had some post-secondary education, with over 25% having a 1 – 2 year diploma. Almost a third of all those in the study had an undergraduate degree. Over the last 5-10 years, there has been an increase in educational attainment among both existing staff, and new staff. In terms of work environment, most staff who work for the Ministry work in an urban work environment, and the cohort of participants is an accurate reflection of this demographic. In this study, 78% of participants worked in an urban work setting, with 22% in a rural setting.

Service Delivery is changing within the province.   Strategies for delivering services have increasingly highlighted phone contact over face to face (F2F) service. In the current study, 50% of those involved provided services via the phone, with 25% providing face to face services. The category "Other" (at 25%) includes first a large component of "Phone and F2F" (42%) and other Virtual work (12+%), with the remaining a mix of a variety of work projects.

Moving now to the research methodology, the guiding principles will be discussed, as well as the quantitative and qualitative tools used in this study.

4.8 Guiding Framework for Research

Action research, as conceived by Lewin (1946), takes the view of both understanding participant attitudes and actions, and assisting with their practice and development. Selener (1992) highlighted the importance of five foundational principles: open co-operation and participation; on-going interaction between researcher and participant; empowering participants; building knowledge at the local level, and enhancing the possibilities of positive change. This study, using an action research lens, provides a point in time wellness assessment through the use of the PWS and COPE surveys. The Workplace Wellness Journal (WWJ) will assist in bringing both understanding and empowerment, as staff reflect on what constitutes a problem, and how they respond. The next section provides specific details on the Workplace Wellness Continuum construct introduced in the last chapter, and the research tools utilized for this study.

4.9 Workplace Wellness Continuum: Perceived Wellness Survey

The Perceived Wellness Survey (Adams, Bezner, and Steinhardt,1997) was designed as a tool to understand individual wellness perceptions. It has been used in educational (Harari, Waehler and Rogers, 2005) and police force settings (Rothmann and Ekkerd, 2008), and has 6 dimensions: psychological, emotional, social, physical, intellectual and spiritual.

Psychological wellness involves having positive perceptions when dealing with life circumstances, which is part of building enhanced resilience and psychological maturity (Ryff and Singer, 2006). Emotional wellness means having a positive self-regard and positive self identify, which helps to regulate one's internal environment (Renger et al. 2000). Being a social support to others, and having a strong social support network are key aspects of social wellness, which aligns with Hettler's (1980) definition. Physical wellness includes both maintaining and continuing to anticipate future physical health, which speaks of taking responsibility for one's health, both in terms of illness as well as needed lifestyle changes (Hettler, 1980; Leafgren, 1990; Renger et al. 2000). Having access to mentally stimulating activities is an integral part of intellectual wellness (Hettler 1980), while spiritual wellness encompasses a belief that life has positive meaning and purpose (Renger et al. 2000).

The Perceived Wellness Survey (PWS) is based on the contention that there is a connection between the perception of one's wellness and actual health/wellness states (Adams, Bezner, and Steinhardt,1997). For example, Pelletier (1992) conducted a 10 year review of mind-body studies, with the study concluding that one's perceptions appear to have a causal link in relation to future health. In a study by Idler and Kasl (1991), a subjective query asking respondents to describe their overall health as excellent, very good, good, fair or poor appeared to serve as a reasonable predictor of general health. In fact, the study raised the possibility that some subjects appeared to alter their real health status to that of their perceptions. Those who perceived themselves as healthy, even though they had a diagnosed medical condition, showed improvement in their health status. Conversely, even without supporting medical evidence, if a person perceived their health to be poor, they experienced a deterioration of their health status.

Building on these studies, Adams et al. (1998) ascertained that those who perceived themselves enjoying positive levels of wellness were physically healthier, expected positive events to occur, were more connected socially with

family and friends, had a higher sense of meaning and purpose in their lives, were more satisfied and confident with who they were, and were more intellectually active. Drilling down into the various categories, Adams et al. (1998) contended that individuals who perceived themselves to be physically healthy made positive choices around exercise, were less likely to smoke, and had a healthy physical self-image. Those who perceived themselves to be spiritually healthy were found to have high ethical standards, be more committed to specific goals/purposes in their lives, and were more likely to both live according to a set of guiding principles and to see meaning/purpose in their world. Persons perceiving themselves as psychologically healthy were more resilient, optimistic and felt a higher sense of control over events in their life. Socially positive perceptions were linked to positive behaviours toward others, high levels of tolerance, gratitude, generosity, and a strong sense of worth and connection with family and friends.   Positive intellectual perceptions were aligned to higher levels of job satisfaction, connectedness with work, and cognitive effectiveness.   Finally, Adams et al. (1998) found that positive emotional perceptions were linked to high self-assurance/esteem, confidence in functioning constructively with or without the approval of others, and a clear sense of identity. These results are in line with the aforementioned studies indicating that one's subjective perceptions around health correlate strongly with one's actual health status (Idler and Kasl, 1991; Mossey and Shapiro, 1982; Pelletier, 1992). In the present study, the PWS is being utilized because it's a tool that can provide an accurate measure of how staff perceive their wellness.

This 36 item wellness instrument uses a Likert scale that offers choices from 1 (Very Strongly Disagree) to 6 (Very Strongly Agree) over the 6 domain sections of the survey. The Statistical Package for Social Sciences (SPSS) was used to process the data, and Adams, Bezner, and Steinhardt (1997) provided procedures for setting up the SPSS coding. These included the importance of recoding those variables that may have inadvertently reflected unwellness responses (e.g. PWS - Q 2 - *There have been times when I felt inferior to most of the people I knew).* Without recoding, the strongest wellness response (i.e. Very strongly disagree)

would only net a score

of "1".

Prior to examining the data, a code book was established, with values assigned to all categorical variables (See Appendix, Figure 6). Following this, the data was examined with a view to determining whether any values fell outside the variable range (e.g., Gender was coded: 0 = No Further Details (i.e. if the participant failed to enter information); 1 = Male; 2 = Female). Examining the data, it was determined that there were no other values, other than those prescribed according to the codebook established. The frequencies for all variables were checked and no errors were detected. This included all the scale items making up each subscale as well as the categorical variables (i.e., age, gender, etc.).

4.9.1 Perceived Wellness Survey: Cautions

Adams et al. (1998) cited the following cautions regarding the Perceived Wellness Survey (PWS). First, the initial selection of subjects to test the instrument was not done in a random manner. It would also have been useful to use control and treatment groups, which would have enhanced the transferability of the findings. In addition, Adams et al. (1998) admits that people who volunteer for studies are generally healthier than the general population, and the fact that these subjects were volunteers may have resulted in healthier people being selected.

For the current study, a cross Ministry invitation was extended, and volunteers self-selected to enter the study. The author did not arbitrarily select participants. A control group was not included in Adams et al. (1998) study, and this study also does not have a control group, which may bear on the transferability of results. Overall, however, PWS reliability and validity have been supported (Adams et al. 1998) and for purposes of this study, the instrument provides a reasonable base for understanding staff wellness perceptions. The next section will detail the SPSS foundation data for those study participants who completed the Perceived

Wellness Survey.

4.9.2 Perceived Wellness Survey: Total Wellness Scores

Figure 1: Perceived Wellness Survey Data

Total Wellness Scores

The optimum score possible on the Perceived Wellness Survey is: 28.80. Scores ranged from 5.06 to a high score of 22.96.   With a mean of 14.82, the majority perceived their wellness as just satisfactory.

Statistics		
TOTAL_WELLNESS_SCORE		
N	Valid	76
	Missing	0
Mean		14.8278
Std. Deviation		3.32783
Variance		11.074
Skewness		-.079
Std. Error of Skewness		.276
Kurtosis		.105
Std. Error of Kurtosis		.545
Minimum		5.06
Maximum		22.96

4.9.3 Perceived Wellness Survey: Normality of Distribution of Study Participants

Using the Kolmogorov-Smirnov tool on SPSS to assess the normality of the score distribution resulted in a significance value of: .200. Given that any value more than .05 indicates normality, this infers that the total wellness score distribution is normal.

Figure 2: Histogram of PWS Total Wellness
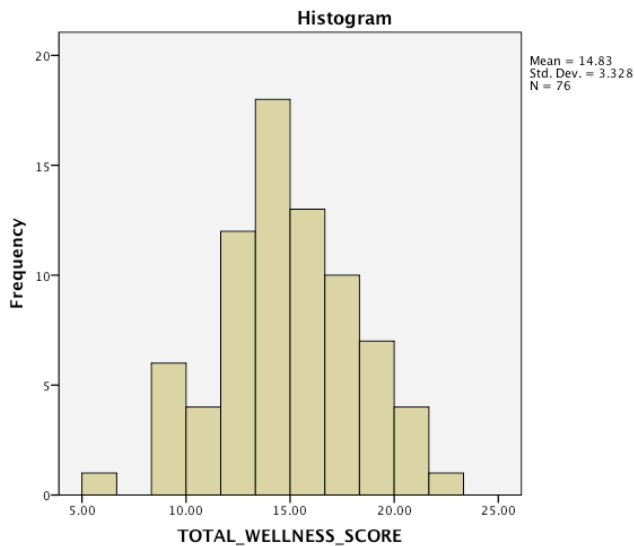
The histogram of the total wellness scores also indicates a normal distribution. (Figure 2)

A Normal Q-Q plot is very revealing. Individual scores are positioned against the value expected with a normal distribution. In this case, the scores fall along an essentially straight line, providing further evidence of a normal distribution (Figure 3)
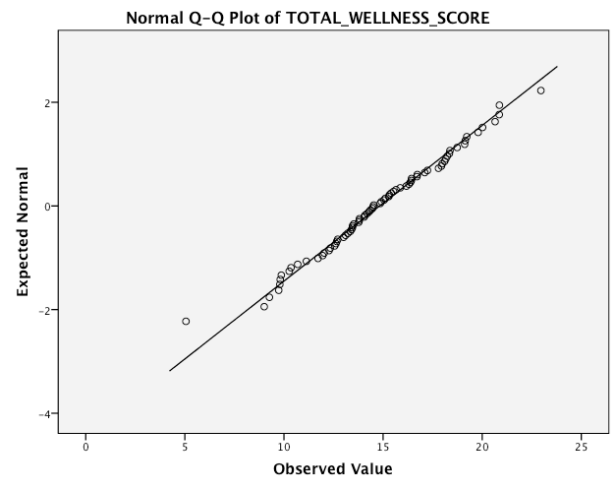
Figure 3: Normal Q-Q Plot of PWS Total Wellness

In regard to potential outliers, the boxplot of the distribution (see Figure 4), suggests that this is not an issue, as outliers would be represented by a range of circles outside the box. In this case, there is only 1 circle represented. Many social science scores are skewed either positively or negatively (Pallant, 2011).   Given the construct being measured, it is reasonable to assume that

Figure 4: Boxplot of PWS Total Wellness Scores

those who entered the study would represent individuals who see their wellness in a positive light.   At the outset, however, it appears that this is not the case as the distribution of scores is normal.

4.9.4 PWS: Validity and Reliability

Adams et al. (1998) confirmed the construct validity for the PWS, in that it does measure individual perceptions of wellness. In addition, both Harari, Waehler and Rogers (2005) and Roscoe (2009) confirmed that the PWS had strong internal consistency with reported Cronbach Alpha scores of .90+. This was confirmed with the current study, when reliability statistics were garnered using the Cronbach Alpha (see Figure 5). Satisfactory values are considered to be above .70, with values above .80 preferred. At .93, the Perceived Wellness Survey total wellness scores demonstrate strong reliability.

Figure 5: Total Wellness Scores - Reliability Statistics

Total Wellness - Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.931	.934	36

Adams, Bezner, and Steinhardt (1997) indicated that 4 of the 6 subscales had satisfactory Cronbach Alpha scores, so the conclusion was that both the total scale scores and subscales had satisfactory reliability. In the current study, the reliability scores were even stronger, with Cronbach Alpha scores above .70 on 5 of the 6 subscales (see Figure 6)

Figure 6: Subscale Reliability

Reliability Scores	Cronbach's Alpha		
Subscales	Cronbach's Alpha	C.A. Based on Standardized Items	N of Items
Psychological Wellness (Psywell) Subscale	.784	.791	6
Emotional Wellness (Emotwell)Subscale	.778	.792	6
Physical Wellness (Physwell) Subscale	.856	.860	6
Intellectual Wellness (Intwell) Subscale	.682	.684	6
Spiritual Wellness (Spirwell) Subscale	.853	.860	6
Social Wellness (Socwell) Subscale	.771	.782	6

These reliability findings provide support for further use of the subscales, at least concerning the 5 that came in at .7 or above. These include the following subscales: psychological, emotional, physical, spiritual and social. Arguably, even the intellectual subscale is potentially useable, given the score of .682

In summary, the PWS is a useful tool for understanding wellness perceptions. In addition to wellness perceptions, the intent is to also understand staff coping perceptions and the COPE scale is the quantitative tool utilized**.**

4.10 Workplace Wellness Continuum: COPE Scale

Coping is defined as a person's ability to handle organisational stressors, in the form of one time events, or on-going situations (Carver, Scheier and Weintraub, 1989); Lazarus and Folkman, 1984). An individual's overall wellness is directly related to their coping effectiveness, and coping is a central thread running through all wellness components. The COPE Scale (Coping Orientation to Problems Experienced) will be used to explore staff coping preferences when dealing with daily problems. Carver, Scheier and Weintraub (1989) outlined coping preferences

that were functional and others that were dysfunctional. These dysfunctional strategies were found to align with those identified by McCrae and Costa (1986), who labeled them as neurotic coping categories. Carver, Scheier and Weintraub (1989) developed the scale over several iterations. The diverse scales were tested with samples of undergraduate students, and the scales proved to have average to above average reliability and validity scores (Carver and Scheier, 1994). The 60 item instrument uses a Likert scale that offers choices from 1 (*"I usually don't do this at all"*) to 4 (*"I usually do this a lot"*). The Statistical Package for Social Sciences (SPSS) will be used to process the data, following detailed scoring instructions (Carver, Scheier and Weintraub, 1989), highlighting that there was no need to recode any of the variables. Scores were simply added together, and compiled into 15 subscales.

The author broke the categories delineated by Carver, Scheier and Weintraub (1989) into three coping clusters. These were: Problem Focussed Coping (PFC), Emotion Focussed Coping (EFC) and Maladaptive Focussed Coping (MFC).

4.10.1 Problem Focussed Coping (PFC)

Problem Focussed Coping (PFS) has an external, task orientation, and involves actively addressing the problem at hand. PFC includes the following 5 subscales: Active Coping (ACO), Planning (PLN), Suppression of Competing Activities (SCA), Restraint (RES), and Instrumental Social Support (ISS).

Active Coping (ACO) is about dealing directly with the problem or issue with a view to either removing it, taking an end run around it, or resolving it. Planning (PLN) is closely linked with Active Coping (ACO) and involves creatively thinking about the problem, including preparation and evaluation of potential solutions. Suppression of competing activities (SCA) consists of putting other work to one side, in order to focus on the presenting issue. Restraint Coping (RES) is both active and passive. It is a positive strategy of non-action. There are some situations when the most effective course is to wait until a more appropriate time, or avoid taking any action

at all. The final PFC subscale is Instrumental Social Support (ISS). It involves actively contacting others with a view to gathering further sources of information, counsel and direction.

4.10.2 Emotion Focussed Coping (EFC)

Emotion Focussed Coping (EFC) has an internal orientation. That is to say, gaining control over inner emotions, thoughts and attitudes when faced with problematic events is often an effective strategy. The 5 subscales of the EFC are: Emotional Social Support (ESS), Positive Reinterpretation and Growth (PRG), Acceptance (ACC), Humour (HUM), and Religious Coping (RCO).

Emotional Social Support (ESS) has a focus on garnering understanding, moral support and sympathy from others when dealing with a difficult issue. ESS can be very useful, but can sometimes overlap into venting (Billings and Moos, 1984). Positive Reinterpretation and Growth (PRG) involves re-framing the problem/issue into a more positive light. This is similar to Lazarus and Folkman's (1984) construct of re-appraisal, and is essentially a method of looking for growth opportunities that may be present (Matthieu and Ivanoff, 2006). Acceptance (ACC) has a focus on the reality of the problem event. This is particularly useful when dealing with extreme circumstances with no immediate resolution. Humour (HUM) involves re-framing the situation (as with PRG), but with a humorous slant. Looking for the absurd in a problematic circumstance can be useful in obtaining and maintaining emotional balance. Religious Coping (RCO) is the final subscale in the EFC cluster. It overlaps with other scales in that a person who turns to their faith for strength and comfort in problematic circumstances could be said to be reframing the situation (PRG), or gaining emotional strength as with ESS. In addition, praying for direction for actively dealing with the situation aligns with Active Coping (ACO) and McCrae and Costa (1986) indicate that this faith-based strategy is useful.

4.10.3 Maladaptive Focussed Coping (MFC)

In addition to these two positive coping clusters, Carver, Scheier and Weintraub (1989) described a third cluster, that contained strategies that arguably could be described as maladaptive in that the intention is to put literal or figurative distance between the person and the problem. Although there may be some short-term benefit to the following strategies, over the long term these approaches tend to be counter productive (Carver, Scheier and Weintraub, 1989). There are five subscales within the Maladaptive Focussed Coping (MFC) cluster: Focus on and venting of emotions (FVE), Behavioural Disengagement (BDE), Mental Disengagement (MDE), Substance Use (SUB), and Denial (DEN).

Focus on and Venting of Emotions (FVE) involves verbally sharing the negative aspects of a problematic circumstance. Although this may be useful when dealing with the death of a loved one, it is generally maladaptive over time in that it tends to focus on the negative, and can move the individual away from practical steps of problem resolution (Scheier and Carver, 1977). Behavioural Disengagement (BDE) has a focus on physically pulling away from involvement in problem resolution, to essentially give up on trying to resolve the problem. This leads to an attitude of helplessness and victim thinking. Mental Disengagement (MDE) constitutes the same attitude, albeit within the mind. It can involve such simplistic avenues as daydreaming to chronic mental disengagement strategies such as lengthy computer gaming or television viewing (Carver, Scheier and Weintraub, 1989). Substance Use (SUB) is another way of putting distance between the person and the problem, and includes drug or alcohol use. This can quickly move from use to abuse, leading the person to struggle with addiction issues in addition to their other problems. The final subscale is Denial (DEN), which again has some short-term benefit. Arguably, the denying of problems and circumstances can result in a lowering of emotional angst, especially in situations where the issue can be realistically ignored. In most situations, however, denial sets up the individual for more distress, especially when problems cannot be overlooked in the long term (Carver, Scheier and Weintraub, 1989).

Based on the evidence above, the author chose the COPE scale as an appropriate tool for understanding the coping preferences of welfare staff. It is suggested that welfare staff will prefer interpersonal and intrapersonal coping strategies. Specifically, the strategies of active coping (ACO), instrumental social support (ISS), acceptance (ACC), emotional social support (ESS), and positive re-interpretation and growth (PRG) are suggested approaches that welfare services staff may find most useful.

As Carver, Scheier and Weintraub, 1989) details, the COPE scale is a useful tool to ascertain coping strategies, but there are cautions.

4.10.4 Cope Scale: Cautions

Although the COPE scale was among the first to address both functional and dysfunctional modes of coping, there are far too many diverse ways of dealing with problematic events to be covered in one instrument (Carver, Scheier and Weintraub, 1989). COPE will be used as a baseline, with further in-depth information to be provided through longitudinal methods, to be described later in this chapter. The next section details a statistical overview of the COPE scale, including the normality of the distribution, reliability and validity.

4.10.5 COPE Scale: Normality of Distribution of Study Participants Coping Clusters

Problem Focussed Coping (PFC)

Using Komogorov-Smirnov, scores over .05 indicate normality, therefore the PFC cluster with a score of .200 is a normal distribution.

Figure 7: Tests of Normality

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Total: Problem Focussed Coping	.086	66	.200[*]	.985	66	.587

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

Figure 8: Histogram – Problem Focussed Coping
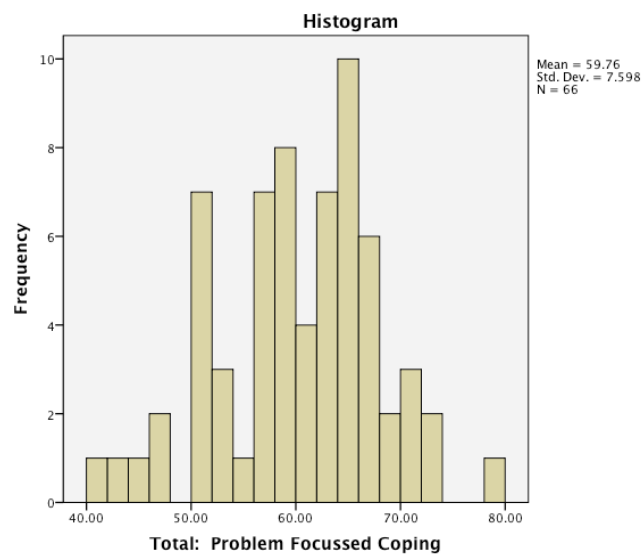
Emotional Focussed Coping (EFC

With the EFC cluster, the Kolmogorov-Smirnov score of .030, being less than .05, signifies lack of normality, and this is consistent with the histogram of score distribution, which indicates a skewing to the left.

Figure 9: EFC – Tests of Normality

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Total: Emotion Focussed Coping	.115	66	.030	.970	66	.117

a. Lilliefors Significance Correction

Figure 10: EFC Histogram
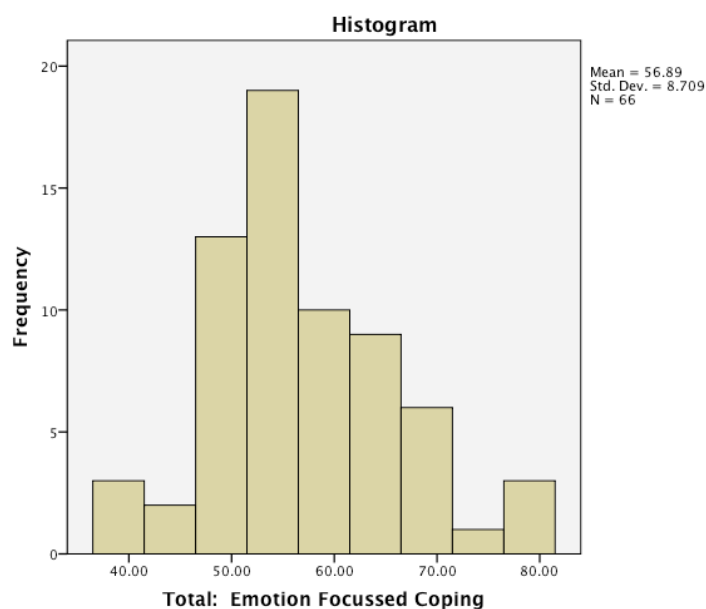
Maladaptive Focussed Coping

Like the EFC, the MFC cluster, at .039 is also indicative of a distribution that is not normal. The histogram, like the EFC, had a distribution that was skewed to the left.

Figure 11: MFC Tests of Normality

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	Df	Sig.
Total: Maladaptive Focussed Coping	.112	66	.039	.963	66	.047

a. Lilliefors Significance Correction

Figure 12: MFC Histogram

4.10.6 COPE: Validity and Reliability

The COPE scale has average to above average reliability and validity scores (Carver and Scheier, 1994). In the current study, the Cronbach Alpha scale was .836, well above the threshold of .700, thus indicating strong reliability.
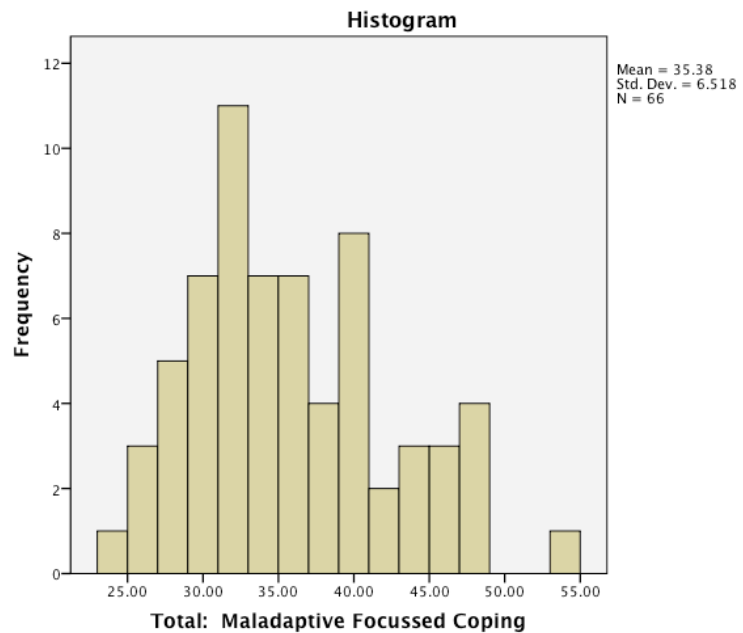
Figure 13: Reliability – COPE Scale

Reliability Statistics – COPE Scale		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.836	.828	60

Subscales Reliability:

The COPE subscales in this study showed some divergence in terms of reliability. The following scales indicate strong reliability: Positive Reinterpretation and Growth (PRG), Focus on and Venting of Emotions (FVE), Planning (PLN), Substance Use (SUB), Emotional Social Support (ESS), Humour (HUM), Religious Coping (RCO), and Instrumental Social Support (ISS). Those with moderate reliability include: Active Coping (ACO), Restraint (RES), Behavioural Disengagement (BDE), and Denial (DEN). Those with low reliability include: Mental Disengagement (MDE), Suppressing Competitive Activities (SCA), and Acceptance (ACC). (See Figure 14)

Figure 14: COPE Subscale Reliability

COPE Subscale Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
PRG .844	.856	4
MDE .394	.386	4
FVE .819	.820	4
PLN .846	.849	4
SCA .575	.573	4
ACC .368	.382	4
SUB .898	.918	4
ESS .816	.820	4
ACO .669	.688	4
RES .683	.685	4
BDE .691	.700	4
HUM .907	.906	4
RCO .969	.969	4
DEN .628	.696	4
ISS .716	.713	4

Reliability: Coping Clusters

If the subscales in the study were somewhat divergent in terms of reliability, this was not the case with the 3 primary coping clusters. From a strong score of .804 for the Maladaptive Focussed Coping (MFC) cluster, the remaining clusters were even stronger, with .814 for the Emotion Focussed Coping (EFC) cluster, and .833 for the Problem Focussed Coping (PFC) cluster.

Figure 15: COPE: Reliability of Coping Clusters

Coping Clusters: Reliability Statistics		
Cronbach's Alpha	Cronbach's Alpha Standardized Items	N of Items
MFC .804	.828	20
PFC .833	.842	20
eeeeeeee **EFC .814**	.818	20

In summary, both PWS and COPE are quantitative tools for understanding welfare worker wellness perceptions and coping preferences. In addition, however, longitudinal qualitative research tools add value as well.

4.11 Longitudinal Approach to Coping Research

Schuler (1985) asserted that coping should be framed as a process, and models developed should serve as guides for understanding, rather than definitive blueprints. In this study, a journaling tool will be used to assess coping responses. This will provide tangible information over time on an individual's repertoire of coping, if specific strategies are used at certain points in time, or whether groups of strategies are used together to resolve an issue (Pearlin and Schooler, 1978; Smith and Sulsky, 1995). Another benefit of a longitudinal approach is that changes in the choice of coping approaches can be determined. For example, evidence suggests that if direct, problem focussed approaches don't resolve a stressful event, the individual may begin to shift to strategies designed to alleviate symptoms, rather than solve the problem (Parkes, 1984). The use of a coping

journal is a useful method for detailing and more fully understanding the interaction between individual and contextual factors in the workplace. In this study, the journal tool is The Workplace Wellness Journal (WWJ).

4.12 Workplace Wellness Continuum: Workplace Wellness Journal (WWJ)

The use of a qualitative journal tool for understanding the work environment is becoming more widespread. Both organisational culture and workplace stress have become topics increasingly scrutinized using diary or journaling tools. Similar to the current study, Clarkson and Hodgkinson (2007) used journals as a way to gain insight into coping at work. Used over 5 consecutive days, the 15 workers involved found that using the journal tool allowed them to candidly reflect on their experience. The study shed light on coping approaches used. It was recommended that future studies should use the diary/journal approach with larger numbers, over a longer period.

Niessen, Sonnentag and Sach (2012) used a journal structure with social services staff, over a five day period. The intent was to understand thriving within the work environment. Thriving was defined as a state of vitality, and an enthusiasm and capacity for learning. Staff who experienced a sense of positive meaning in their work in the morning felt significantly higher levels of both vitality and learning by the conclusion of the day. Waddington (2013) used a journal research approach to understand and document emotional responses within the work environment. She found that the use of a journal was very useful for gathering information in real time, and capturing everyday subjective participant experiences.

Welfare staff in the current study have a significant period (i.e., forty days) during which to reflect on their daily work experience. They also have the ability to rate their daily work satisfaction. Employees are encouraged to spend a few minutes at the end of each day to record their subjective perspective on their work and thus the study will provide real time opportunities to capture insights. In addition, given the journal is a secure computer APP, participant confidentiality is heightened.

In terms of limitations, Waddington (2013) found that the quality of the journal responses was reliant on the participant's consistency in first recording their daily entries, their willingness to share their observations and experiences honestly, and to continue to do so over time. In this study, staff are being asked to conduct journaling continuously over 40 work days and this may mean inconsistency in the quality of the entries over time. One other aspect that Waddington (2013) found which is not likely to be a factor for this study is censoring. Realizing that names were attached to their entries, and that responses would be analyzed closely, Waddington (2013) found that some participants edited their responses. For this study, only numeric identifiers will be used, which will assist in ameliorating this issue.

Bolger, Davis and Rafaeli (2003) determined there were three types of research that fit well with a journal design, all of which are present in the current study: research dealing with aggregated data over time; research dealing with interpersonal issues and research dealing with intrapersonal issues. Sonnentag (2003) used a journal study to examine how public sector staff dealt with problems at work, and the degree to which they were able to recover. A journal tool was also used by Rook and Zijlstra (2006) in a study on flight attendants, confirmed that those who became engaged in physical (i.e., sports activities) found they had lowered levels of fatigue, which was often a common side effect of dealing with work related issues. Journals were also used in a study with health care workers (Sonnentag and Zijlstra, 2006). Those workers who reported that they became involved in a variety of non-work activities in the evening showed a higher ability to bounce back from the rigors of dealing with work related issues. Binnewies, Sonnentag and Mojza (2010) used a journal approach over a four week period to examine recovery issues. Workers' diaries revealed that on days when they felt they had dealt effectively with work issues, their engagement and initiative at work on the subsequent morning was significantly increased.

With the current study, a full 40 day period (approximately 2 months) will be used for journaling. Staff will use the Workplace Wellness Journal (WWJ) to track and understand how they handle problematic events in their work lives. With permission from their supervisor, they will be allowed to take 5-10 minutes each day to reflect on what happened during the day and how they responded. They can also rate each day on a scale from "1" (extremely difficult) to "5" (extremely positive). This type of reflective activity helps identify positive responses (i.e., areas of strength), as well as areas for improvement. The intent is to understand how staff actually deal with problems at work.

Journaling with the WWJ will provide participants with awareness about their own wellness capacity. It will also provide the organisation with information on building wellness, resilience and engagement capacity. The reflective questions explore the assumption that decisions are made in an atmosphere of interdependence (Allen, Carlson and Ham, 2007), with social/relational support being a particularly critical coping approach. Sulsky and Smith (2005) reports that those staff with supportive co-workers, supervisors and friends have considerably less depression when faced with stressful experiences in their work lives. In addition, in an interesting expansion on Karasek's (1979) demand-control model, in which stress increased where job demands were high and job control was low, Johnson (1989) demonstrated a strong link to social/relational support. Specifically, in cases where there were high demands and low job control, the most significant negative impact on wellness occurred where there was also perceived lack of social/relational support.   Arguably, the perception that social/relational support is accessible assists a worker in dealing more effectively with problems.

As staff work through the PWS, COPE, and WWJ entries, they will be able to touchback with questions. In addition, at various times during the journal entries, the HWSAPP will provide a progress popup dialogue box indicating that the person is now 25%, 50%, etc. complete, and to keep up the good work!

As staff began the journaling, a baseline for analysis was established. This was accomplished through use of a test group.

4.13 Journal Test Group

Examination of the data began with a small cohort of supervisors. There were 8 supervisors who took part in the Workplace Wellness Journaling (N = 3 males; 5 females). These served as a test group for preliminary analysis. Mason (2007) asserts that cross-sectional indexing is perhaps the most commonly used approach for handling qualitative data. It involves developing a systematic approach for looking at the data, using consistent guiding categories. The test group participants found the guiding reflective questions and the rating scale useful for capturing their daily work experience (See Appendix, Figure 7- Sample Supervisor Journal Response).   With the lessons learned from the test group, all front line staff data was handled in the same manner. For purposes of this study, the three tools (PWS; COPE; WWJ) will be used within the author's Workplace Wellness Continuum (WWC) construct to serve as a lens for understanding front line welfare worker wellness.

4.14 Workplace wellness Continuum: Framework

As introduced above, the three intersecting domains that compose the WWC lens include: Perceived Wellness (PW), Perceived Coping (PC) and Actual (Coping) Behaviours (AB). Perceived Wellness (PW) refers to how the person perceives they are functioning across the wellness components (e.g., mental, social, emotional, physical, spiritual, psychological). Perceived Coping (PC) references the coping strategies the worker perceives they will use when dealing with problems or stressors. Actual (Coping) Behaviours (AB) references the actions that workers actually take when coping with problems. The interaction between these factors potentially links to staff wellness. The contention is that positive self-reporting in the three domains: Perceived Wellness (PW), Perceived Coping (PC) and Actual (Coping) Behaviours (AB) is aligned with positive wellness.
(See Figure 16: Workplace Wellness Continuum)

Figure 16: Workplace Wellness Continuum (WWC)

			Above Average Workplace Wellness				
	Perceived Wellness (PW)		Actual (Coping) Behaviours (AB) - PW: Positive perception of wellness - PC: Positive perception of coping - AB: Positive coping behaviours		Perceived Coping (PC)		
Satisfactory Workplace Wellness	Perceived Wellness (PW)		- PW: Satisfactory perception of wellness - PC: Satisfactory perception of coping - AB: Satisfactory Coping Behaviours		Perceived Coping (PC)		Satisfactory Workplace Wellness
	Perceived Wellness (PW)		- PW: Negative perception of wellness - PC: Negative perception of coping - AB: Negative Coping Behaviours		Perceived Coping (PC)		
			Actual (Coping) Behaviours (AB) Below Average Workplace Wellness				

Legend:

Above Average Workplace Wellness: Positive levels in the 3 domains:

    1. Perceived Wellness (PW): Positive perception of overall general wellness

    2. Perceived Coping (PC): Positive perception of coping within workplace

    3. Actual Behaviours (AB): Positive (coping) behaviours with problems

Satisfactory Workplace Wellness: Satisfactory Levels in the 3 domains:

    1. Perceived Wellness (PW): Satisfactory perception of overall general wellness

    2. Perceived Coping (PC): Satisfactory perception of coping within workplace

    3. Actual Behaviours (AB): Satisfactory (coping) behaviours with problems

Below Average Workplace Wellness: Below average in the 3 domains:

    1. Perceived Wellness (PW): Negative perception of overall general wellness

    2. Perceived Coping (PC): Negative perception of coping within workplace

    3. Actual Behaviours (AB): Negative (coping) behaviours with problems

Having discussed the tools used in the research, the next section outlines the health and wellness study computer research application (HWSAPP) that was designed to house these tools. It will detail how the APP is structured and how it functions for the PWS and COPE surveys, and the Workplace Wellness Journal.

4.15 Health and Wellness Study Computer Application (HWSAPP)

In order to facilitate the collection of data in a secure and confidential manner, a special Health and Wellness Study computer application (HWSAPP) was developed in conjunction with the Ministry of Social Development and Social Innovation's ICollaborate section of Information Management Branch (IMB).

4.15.1 Main Menu

Figure 17 - Main Menu - Health and Wellness APP (HWSAPP)

The APP is designed to be as intuitive as possible. Prior to using the APP, staff will have attended at least two information sessions, detailing the purpose of the study, and dealing with questions around confidentiality. When downloading the APP initially, a dialogue box comes up with the title "Informed Consent". The wording on the box indicates to the staff member that by clicking "I agree", they are agreeing to: 1.Participate in the study 2.Their questions/concerns have been satisfactorily answered. Once they click the "I agree" button, the APP generates a random numeric identifier that is found in the My Information Section (see Figure 18 below)

4.15.2 My Information

Figure 18 - My Information Section of the HWSAPP

The My Information section of the HWSAPP includes the unique numeric identifier. This number is attached to all the data that is sent forward to the researcher. In addition, this section includes the demographic data: gender, age, education, years of experience, work environment (urban/rural), region, work role, and major work duties. Work role includes several classifications: Employment and Assistance Worker (EAW), Client Service Worker (CSW), Investigative Officer (IO), Family Maintenance Worker (FMW), Supervisor, Manager/Director, and "other", in which the person can describe their work role. A sample of what this demographic data looks like is found in Figure 19 (below)

Figure 19 – Sample: My Information section – containing demographic data

Once completed, the demographic data (above) is attached, along with the unique numeric identifier, to the survey and journal data that is sent to the researcher.

Having completed the basic demographic information, the participant next moves to the My Survey section (Figure 20). This section includes electronic versions of the Perceived Wellness Survey (PWS) and the Coping Orientation to Problems Experienced (COPE) scale.

4.15.3 My Surveys

Figure 20 - My Surveys Section - PWS and COPE Scales

Participants need to complete all the survey questions before submission. The Submit button is grayed out until all questions are completed. At that time, it turns a bright blue, and the survey can be forwarded electronically to the researcher. (See Figures 21 and 22)

4.15.4 Perceived Wellness Survey

Figure 21 - Perceived Wellness Survey

Cope Scale

Figure 22 - COPE Scale

Although not mandatory, most participants proceed from the "My Information" section to the "My Surveys" section. Following this, they turn to the "My Journal" section.

4.15.5 My Journal

Figure 23 - My Journal Opening Page

In the example above, February 13th, 2013 was Day One of this staff member's journaling. In the box below the Main Menu icon, the APP displays the number of journal entries to be completed. In this case, since this is the first day, there are still a total of 40 journal entries to be done. To get started, the person would click on the green arrow, which would open the page for February 13th (See Figure 23)

Each journal page has the day, date and several reflective questions to guide the journaling. In addition, there is a General Comments section. In calculating the days for journaling, the APP does not include weekends and holidays.

There are times when staff will miss days in the Monday to Friday rotation for a variety of reasons (e.g., vacation, illness). There is, therefore, the ability to skip a day. When this occurs, the APP will generate another day at the end, to ensure that 40 work days are completed. As participants are journaling, there is the ability to provide not only a narrative of the day's issues, but to rate the day as well.

Figure 24 – Journal Page – with rating scale

In Figure 24, the drop down menu is visible. Each day can receive a rating from "1" (The day was very difficult) to "5" (The day was extremely positive).

Once the person has completed their narrative and daily rating, they can then submit the entry by clicking the submit entry button. Submitted entries cannot be changed. If a person wants to continue to work on their entry, they can pull back to the main menu. Figure 25 shows what the screen looks like for a day when the entry has been submitted, and one where the entry is still in progress.

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Figure 25 - My Journal – Submitted vs In progress

4.15.6 My Questions

When working with the HWSAPP, there are times when a participant may have a question or comment for the researcher.   On these occasions, the My Questions section can be used (See Figure 26)

Figure 26 - My Questions Sample

Once the person is finished framing their question, they can hit the submit question button, which submits the question to the researcher. The APP has a search function. When the APP is closed and then re-opened, the APP searches for any answers that the researcher may have remitted. If answers are found, they are posted on the participants APP, and will be viewed the next time the person opens the APP. Again, there are no personal identifiers with questions submitted, only the numeric identifiers.

4.15.7 Administrative Module

In addition to individual APPs for participants, there is an Admin Module for use by the researcher (see figure 27).

Figure 27 - Administrator Panel - Main Menu

The Journal and Surveys panels allow the researcher to import journal entries and survey data. The data can be sorted so that each unique numeric identifier's data is categorized together (See Figure 28)

Figure 28 - Admin Module - Sample Journal Entries

	User ID	Date	Entry	Overall Rating for the Day	
1	308488510	Jan 03 2013	I was feeling tired for most of the day as did not sleep	3 = The day was OK.	
2	308488510	Jan 04 2013	I left my cel phone in the cab I took to work this morning	4 = The day went well.	
3	308488510	Jan 07 2013	In one point of view, I didn't have enough work assigned	4 = The day went well.	

In terms of analysis, the Administrative Module allows the researcher to export the data to either a spreadsheet or a software program.   SPSS and NVivo were the respective software tools used to analyze the quantitative and qualitative data. SPSS stands for Statistical Package for Social Sciences, and is designed to assist with a variety of statistical functions. For purposes of this study, determining the normality of the sample distribution, as well as the reliability and validity of the PWS and COPE were three such areas. In addition, SPSS was used for the scoring and charting of both surveys, as well as the frequency graphing of the demographic data.

With the qualitative data, NVivo was used for dealing with the unstructured and semi-structured information. It assisted with tracking, organizing and querying functions.   Along with MS Word, NVivo was used to explore, describe and compare the data, in order to ascertain patterns and theoretical directions. The ability of the software to categorize the data into conceptual nodes was extremely useful. The one challenge was that the immense size of the data set caused the software to crash several times, on which occasions MS Word was used to assist with parts of the categorisation. This worked reasonably well, although it was considerably more time consuming than NVivo.

In summary, the health and wellness computer APP (HWSAPP) is an effective tool for study participants. Staff can download the APP to their own computers, and be assured that their data will be secure and confidential. They can send data and questions to the researcher using their unique numeric identifier. The researcher, using the Administrative Module, is able to both collate and sort data from journals, and surveys. In addition, it is possible to respond in a timely way to participant questions and concerns. As staff started to use the application, there were some emerging issues that needed to be resolved, and the next section details these issues.

4.15.8 Troubleshooting the Computer Application

Starting in late December, 2012, there were some recurring issues.   Some participants had difficulty downloading the APP to their computer. Although the researcher made an assumption about computer literacy, several staff struggled with basic concepts. For example, it was explained that participants needed to go the Ministry "L" drive and copy the source APP over to their own computer. In spite of these instructions, several participants started to use the source APP. This meant that anyone coming after them copied a corrupted APP to their computer, and upon opening the application, they would find existing data. There was no danger of any identifying information being revealed, but it was extremely frustrating for staff. In one instance, three individuals ended up with the same numeric identifier. In another instance, two individuals had the same numeric identifier. The demographic data (and the responses) were completely different in each case, and so it was clear what had occurred. This was corrected by altering the numeric identifier slightly to ensure that each case was separate. Given that the identifier follows through across the PWS, COPE and then onto the Workplace Wellness Journal (WWJ), steps were taken to ensure that the numeric identifiers were altered to reflect the changes made during the analysis.

The source APP was eventually moved to another folder, and the programmers wrote some additional code so that the source APP could not be used at that location. It could only be copied to another computer prior to use. Once this took place, the difficulties with data corruption ceased. Another issue arose once the APP was loaded on people's computers. Some participants submitted their daily entries with additional (empty) future dates enclosed. Although frustrating, it was either only a minor technical glitch with the APP, or the participant inadvertently included additional days by accident. In any event, the data still came through in tact.

Throughout the study, ethical procedures and processes were critical. The following section details these ethical considerations.

4.16 Ethical Considerations for the Internal Researcher

Ethically, the internal researcher needs to realize the importance of maintaining professional relationships with staff while realizing that there are tensions between the professional and academic roles (Costley, Elliott and Gibbs, 2010). The pressures of academic rigour on one side while maintaining organisational commitment, rapport and trust can be challenging. The traditional objective stance may be extremely difficult to maintain, and indeed, it may not be the best option from a constructivist perspective. Even before contemplating this study, the author had established and maintained a high level of trust with staff, and this mitigated the tension between maintaining academic standards and rapport with employees. This allowed the author to maintain freedom of access with participants, while maintaining confidentiality and anonymity when dealing with staff data.

During participant selection, the author's knowledge of and sensitivity to long held organizational values helped to defuse potential power issues during the research. The author was aware of the implications of having the research findings accepted or not accepted by the organisation, and the pressures that this might have both on the internal researcher and the organizational culture.

It is important to acknowledge accurately the strengths and weaknesses of the research strategy and not be swayed by feedback from those in the organisational hierarchy. Costley, Elliott and Gibbs (2010) assert that it is very challenging conducting research within one's own organisation, given the sometimes perceived absence of neutrality or objectivity. Again, the fact that the author had established a long standing positive relationship with staff at all levels helped to mitigate this perception. In addition, I have taken a leadership role in many organisational development projects over the last 30 years, and have been perceived as being objective and nonjudgmental.

There will be a number of general ethical issues that arise in every research setting (Bryman, 2004). These include: general access to resources and personnel, trust

and relationship, establishing a professional working environment, human rights, general issues around confidentiality, and data storage issues. The author proceeded systematically to address these issues. First, the literature resources came from a variety of sectors in order to obtain a balanced cross section of relevant sources. Access to staff for purposes of involvement in the study was conducted in an ethical manner (Munro, 2008). Prior to approaching staff, permission was obtained from all relevant authority levels, including immediate supervisors, managers, directors, and ministerial levels, as required. Staff needed dedicated time to complete the Perceived Wellness Survey (PWS), the Coping Orientation to Problems Experienced Scale (COPE), and to maintain their Workplace Wellness Journals (WWJ). Having obtaining management approvals, obtaining staff member approval was equally important. There may be a perception that the researcher is an agent of the employer. In order to alleviate these perceptions, on-going discussions with employees took place, to allay any concerns prior to asking for their involvement.

Building trust with participants means providing detailed information and explanations on the purpose of the research (Aoyagi and Portenga, 2010), therefore fact sheets outlining the purpose were included on permission documents, and questions were answered fully and completely prior to working with each participant. Anyone choosing not to participate was thanked for their consideration, and informed that their lack of participation did not in any way reflect negatively upon them, and their supervisor would not be informed about their choice. The researcher continually maintained a non-judgmental attitude when interacting with participants.

There was one disclaimer, and that involved harm to self or others. Information obtained from participants remained confidential and anonymous, unless the participant threatened harm to either themselves or others. Supervisors and managers were consulted regarding operational realities, and for advice and direction about how best to approach staff regarding this research. Being willing

and open to sharing the findings from the research is a critical factor toward building trust (Haverkamp, 2005).

Ethically, it is critical to realize that power issues are always present. In some cases, the background of the researcher may paint the picture of an expert, and may colour staff responses. Staff may perceive the researcher as a person of power (Haggerty, 2004). Following from this, they may feel that they cannot refuse to participate. The researcher was aware of this, and time was spent both with staff and supervisors, in order to assist staff in realizing that they can refuse to participate without repercussions.

The environment for the study is important. Participants should feel safe and comfortable. Given the use of a unique numeric identifier, each person was assured that they would be able to share candidly within the secure environment of the computer APP. Human rights, as well as gender and ethnicity issues need to be handled with care (Ponterotto, 2010). In this regard, the researcher ensured that all language and behavior was nonjudgmental and free from any type of discrimination. Confidentiality is always an important ethical concern (Pipes, Blevins and Kluck, 2008). If participants shared experiences of loss or pain, either in their journals or verbally, the researcher maintained a sensitive and empathetic attitude, and ensured both confidentiality and understanding. As mentioned previously, identifier codes were used, to ensure confidentiality and anonymity. During the information sessions, opportunities were provided for staff to self-disclose any areas of potential vulnerability (e.g., staff with literacy or learning difficulties may have problems handling surveys).

Data Storage is a consideration. Measures were taken to maintain adequate protective measures over confidential data, whether stored in paper form or electronically. For example, if the data server were located in the U.S. instead of Canada, the data may have been accessible under the Homeland Security regulations. Information, as required, was shared with respondents and all data

was stored in a secure location on the Ministry's provincial drive. Only the author and the APP designer had access to this folder.

In summary, this chapter has covered the salient factors around the research methodology. There was a discussion of the philosophical foundation and the appropriateness of combining positivist and constructivist methods. The benefits of the positivist quantitative tools PWS and COPE, and constructivist qualitative Workplace Wellness Journal were detailed, as well as the author's Workplace Wellness Continuum construct. The study setting, staff selection process and demographics were outlined, as well as the advantages and challenges of being an internal researcher.   Screenshots of the study's computer application were presented and the study's ethical issues and their resolution were delineated.

All the above methodology was designed to ensure that participants felt comfortable as they began providing responses to the research questions around wellness perceptions, daily job satisfaction, coping preferences and coping behaviors. Relations with participants was consistently professional, ethical and confidential (Bell and Bryman, 2007). Moving from this foundation, the next chapter presents the findings from the study.

Chapter 5: Research Findings and Discussion

5.1 Introduction

Participants completed surveys on their wellness perceptions and their coping preferences. They also completed a rating scale about their daily level of job satisfaction, and submitted two months of workplace journaling, identifying problems and coping responses. Given the vast amount of data, there was a focus on 4 major themes, sectioned by age and gender:

1. How do public sector welfare staff perceive their wellness?

2. How is the job satisfaction of public sector welfare staff?

3. What are the coping style preferences for public sector welfare staff?

4. What are the primary coping behaviours of welfare services staff?

This chapter will discuss the major findings. For example, across all age categories, there were gender differences in how men and women perceived their wellness, job satisfaction, coping preferences and coping behaviors. In addition, like the Roman God Janus, there was a duality between the problems identified and the staff responses to those problems. After detailing the findings, Chapter 6 will explore the implications for welfare worker wellness within the public management reform welfare state context.

Before examining the data, a short review of the demographics is useful, given the range of responses across age, gender and work role.

5.2 Review of Study Demographics

Figure 29 details the age of study participants.

Figure 29: Age of study participants		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Under 30	4	5.3	6.0	6.0
	30 to 40	22	28.9	32.8	38.8
	41 to 50	19	25.0	28.4	67.2
	51 to 60	19	25.0	28.4	95.5
	Over 60	3	3.9	4.5	100.0
	Total	67	88.2	100.0	
Missing	0 No Further Details	9	11.8		
Total		76	100.0		

Figure 30 details the gender demographics.

Figure 30: Gender of study participants		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	9	11.8	13.4	13.4
	Female	58	76.3	86.6	100.0
	Total	67	88.2	100.0	
Missing	0 No Further Details	9	11.8		
Total		76	100.0		

Figures 31 and 32 detail the work role demographics

Figure 31: Work Role

Work Title or Role

- EAW
- CSW
- IO
- FMW
- Supervisor/SAS
- Other

62.69%
4.48%
13.43%
4.48%
11.94%
2.99%
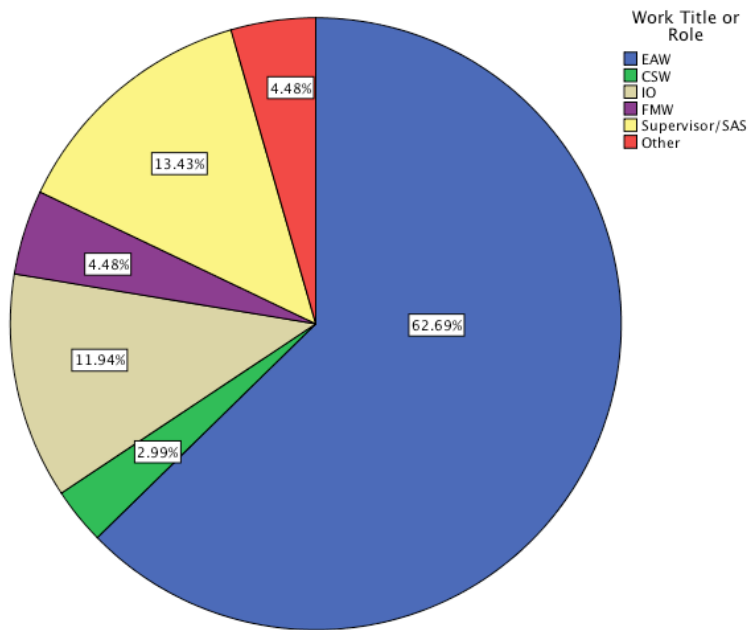
Figure 32 – Completion of the PWS, COPE and Workplace Wellness Journals.

Figure 32: Work Role - PWS, COPE and WWJ Completion

Work Title/Role		PWS Frequency	COPE Frequency	WWJ Frequency	
Valid	EAW	42	36	51	
	CSW	2	2	2	
	IO	8	6	8	
	FMW	3	1	2	
	Supervisor/SAS	9	9	8	
	Other	3	3	3	
	Total	67	57	74	
Missing	0 No Further Details	9	9	1	
Total		76	66	75	

Figure 33: Years of Experience

Years of Experience in the Ministry of Social Development and Social Innovation		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Under 1 year	5	6.6	7.5	7.5
	1-2 years	19	25.0	28.4	35.8
	3-5 years	11	14.5	16.4	52.2
	6-10 years	6	7.9	9.0	61.2
	11-15 years	9	11.8	13.4	74.6
	16-20 years	7	9.2	10.4	85.1
	21-25 years	8	10.5	11.9	97.0
	Over 25 years	2	2.6	3.0	100.0
	Total	67	88.2	100.0	
Missing	0 No Further Details	9	11.8		
Total		76	100.0		

In summary, the typical study participant is a female (EAW), between 30 to 60 years of age, with between 1 and 5 years of work experience. Moving now to the study findings, the next section details how welfare staff perceive their wellness.

5.3 How do public sector welfare staff perceive their wellness?

The following table (Figure 34) reveals staff wellness perceptions. The left side contains age cohorts.   The top contains gender, work role, type of service delivery and geographic location.   Perceived Wellness Scores (PWS) are clustered according to colour and symbol. Green, with the symbol "↑", represents total perceived wellness scores that are above average. Yellow, with the symbol "↔", represents scores that are average. Red, with the symbol "↓", represents scores that are below average.

Total Wellness Scores

PWS Green = Above Average wellness perception ↑ Yellow = Satisfactory wellness perception ↔ Red = Below Average perception ↓	Male	Female	Wk Role: Employment and Assistance Worker (EAW)	Wk Role: Client Service Worker (CSW)	Wk Role: Supervisor	Wk Role: Family Maint. Wkers (FMW)	Wk Role: Invest. Officer (IO)	Service Delivery Face to Face	SD: Phone	Urban Work Setting	Rural Work Setting
Age Overall	↔	↔	↔	↑	↔	↔	↔	↔	↔	↔	↔
Under 30	N/A	↔	↑	N/A	↓	N/A	N/A	↑	↑	↓	↑
30 – 40	↑	↑	↔	N/A	↔	↑	↑	↔	↑	↑	↔
41 – 50	↓	↑	↑	N/A	↔	↔	↓	↓	↑	↑	↔
51 – 60	↓	↔	↔	↑	↔	N/A	↓	↔	↔	↔	↓
Over 60	N/A	↔	↔	N/A	N/A	N/A		↓	↓	↔	N/A

Figure 34 - Total Wellness Scores for all research study participants

[Legend: Green = age cohorts where wellness perception was above average.   Yellow = average; Red = below average]

Adams, Bezner, and Steinhardt (1997) reported that there might be a positive bias with PWS scores, as those volunteering to take the survey are arguably committed to wellness. As revealed in Figure 34, however, the majority of participants rated their wellness as satisfactory, across both age and gender. In addition, with

increased age came a general decline in wellness perceptions.   It begs the question: Why are those who are arguably committed to wellness scoring at this level, and what does it say about Ministry staff?

First, satisfactory ratings are not unusual, as Olecko and Blacconiere (1990) found using the Health-Promoting Lifestyle Profile.   Second, average ratings may be a reflection of the level of pressure within the work environment. Given the intense working relationships with marginalized clients, Jones (2001) found social work, and by extension welfare services work, to be among the most pressure filled occupations. In addition, although promising service delivery improvements, public management reform impacts staff working within the welfare state environment (Sawchuk, 2013).   Third, those joining this study may be struggling with health or wellness, and they chose to participate in order to understand these issues.

Given the above, it suggests that if participants are wellness devotees, then the work environment is very challenging. If participants are struggling, however, a satisfactory perception is encouraging. The caveat is that there is a continuing gender difference throughout, and this is discussed in the next section.

Gender and age are two of the most basic means of demographic identification, and can be treated separately, or combined. In studies of well-being and job satisfaction, some studies indicate that women suffer from lower well-being and job satisfaction (Fotinatos-Ventouratos and Cooper, 2005; Stevenson and Wolfers, 2009), while others report that women have higher levels (Wilks and Neto, 2013). Some studies found that increased age aligned with enhanced well-being and job satisfaction (Mroczek and Kolarz, 1998), while other studies found mixed results, with those in the younger and older age spectrum experiencing higher well-being compared to workers in the middle years of their career (Warr 1992). Generally, there is a trend supporting the link between increased age, positive subjective well-being (Diener 1984; Ryff 1989), and positive job satisfaction (White and Spector 1987). In terms of age and gender, however, the trend is that women report lower

wellness levels as they age (Ng and Feldman, 2010; Pinquart and Sorensen, 2001).

In the current study, men had decreased wellness perceptions and job satisfaction with age, whereas women had satisfactory or above average levels. For example, males, 30-40, had above average wellness scores, but the scores in later age groups are below average.   Women's wellness scores are satisfactory for the under 30 cohort, and above average for the 30-40 and 41-50 cohorts, with the remaining age cohorts satisfactory.   Olecko and Blacconiere (1990) found similar gender results with women reporting higher wellness levels than men. Conversely, Crose et al. (1992) observed that women appeared to possess lower wellness levels than men. They further observed, however, that this might be because women were more likely to recognize their need for assistance with wellness, being more transparent regarding health symptoms (Fotinatos-Ventouratos and Cooper, 2005). Men ignored warning signs, and were construed to be functioning at higher levels (Crose et al. 1992). Women's recognition of their need for assistance suggests the importance of social/relational support. In this study, these higher ratings suggest that women are confident in their sense of self, their ability to cope, and levels of job satisfaction, and this was also found in the workplace wellness journal narratives. The next section delineates the wellness perceptions of those staff delivering services to clients face to face (F2F), phone or a combination of phone and face to face.

As seen in Figure 34, those specializing in providing services via the phone reported higher levels of wellness than those specializing in face to face services. This finding runs contrary to studies indicating that call centre work is fraught with pressures leading to burnout, with staff being closely monitored on performance goals (Choi, Cheong, and Feinberg, 2012; Kjellberg et al. 2010). Part of the stress of call centre work comes from the perceived or actual lack of social/relational support (Bakker, Demerouti and Schaufeli, 2003) and the negative behaviors of clients (Sliter et al. 2011). However, findings from the current study suggest that

verbal negativity in a call centre is not as stressful as face-to-face altercations in the local Ministry offices. In addition, Deery, Iverson and Walsh, (2010) maintained that the social/relational support available within a call centre environment positively influenced staff wellness, and this study supports that finding. Call centres within the Ministry have significant numbers of staff located in an open space environment, which allows for a great deal of interpersonal interaction. Conversely, offices providing face to face services have a variety of configurations. Some have a semi-open environment, while others have a front counter, with individual offices in the back part of the office. Overall, the environment is less conducive to staff interaction. Given that in both environments, the majority of staff are women (i.e., 85%+), and call centres offer more opportunity for social interactions (Lave and Wenger, 1991), it is not surprising that telephone workers report higher levels of wellness. The narratives from the daily journals also demonstrate that social/relational support is a central theme within this setting:

> *"I took the perspective that this was an opportunity - an opportunity to thank those that support the program and to shed a "human interest" light on the program. I focussed on my approach - being one of show and tell. Showing the stats metrics and the telling of the stories of 2 clients whose lives were positively impacted by the program" (Female EAW, ID: 69610843)*

When examining urban versus rural wellness perceptions, there were differences across age cohorts, as outlined in the next section.

Urban staff were marginally more positive in their wellness perceptions than rural staff, although both urban and rural staff over 60 reported below average wellness perceptions. Younger rural staff (age <30) had much higher wellness scores than their urban counterpart. Conversely, urban middle-aged staff had higher wellness scores than rural middle-aged staff. With age, rural wellness scores dropped significantly, while urban scores had only a gradual decline. Miller and Foster (2010) maintained that urban dwellers generally have lower levels of well being than their rural counterparts, due in part to less access to green space, and urban

crowding. Miller's study also reported that quality of life was perceived to be higher in rural areas (Miller and Foster, 2010).

It could be argued in this study, however, that urban staff have access to more resources than rural staff, and this could result in more positive interactions with clients. For example, when dealing with clients who have mental health or behavioural issues, it is often necessary to set them up on "TPA" [Third Party Administration], as they can be a potential health and safety risk to both themselves and others. In Ministry urban centres, there are more TPA resources, so this risk can be mitigated. In addition, urban centres have more employment, healthcare, and counseling resources for clients, as well as more staff generally, resulting in potentially more social support, which may translate into higher wellness perceptions.

The differences in wellness perceptions across age and gender were also found when looking at daily job satisfaction ratings, as the next section outlines.

5.4 How is the Job Satisfaction of public sector welfare staff?

Job satisfaction has been defined in a variety of ways, from positive mood states in relation to the work experience, to a more cognitively based definition (Zhu, 2012). Cognitively defined, job satisfaction is not contingent upon feelings but a positive evaluation of working conditions, the nature of the work, developmental opportunities, and the outcome of work efforts. In the current study, male responses reflected job satisfaction as a positive mood. Female responses reflected job satisfaction within the cognitive definition, in that problems were usually seen as developmental opportunities.

Staff used a Likert scale to rate each day from "1" [Very difficult], "2" [Challenging], "3" [Satisfactory], "4" [Went Well] to "5" [Very positive]. In addition, their narratives would sometimes describe the day as problem free, which also had a bearing on the issue of job satisfaction.

Men and women diverged in their daily ratings, and the percentage of problem-free days. With journal entries, a day that was problem free could mean two things. First, it meant that there were literally no problems or issues. This was the case with the majority of male entries, but only a limited number of female entries. Second, problem free meant that there were issues, but the employee felt both competent and confident, so didn't consider these issues problems. This second level was strongly represented in female journal entries. The following examples highlight some of the principles of intersectionality, specifically micro interactions (worker/client) and worker resilience. Women often used terms like "busy" or "a few new issues", and demonstrated resilience in dealing with what sometimes appeared to be non-rational client decision making. The second example below illustrates a case where the client was clearly upset about an unresolved request, but appeared reluctant to actually share the request. The female staff members rated both of these days as very positive:

"Today I was moved over to Face to Face to another office to help out. No problems today with clients just a few new issues from items I don't usually deal with on a day to day basis…"   (Female EAW; ID: 7647063122)

Busy day today but nothing to be described as a problem. MAaaaaybe one angry client who came in, vented, and left refusing to speak to a worker about his requests. He left the office yelling, "I hate people". (Female supervisor; ID: 91483099)

Figure 35: Daily job satisfaction ratings for Male/Female Supervisors
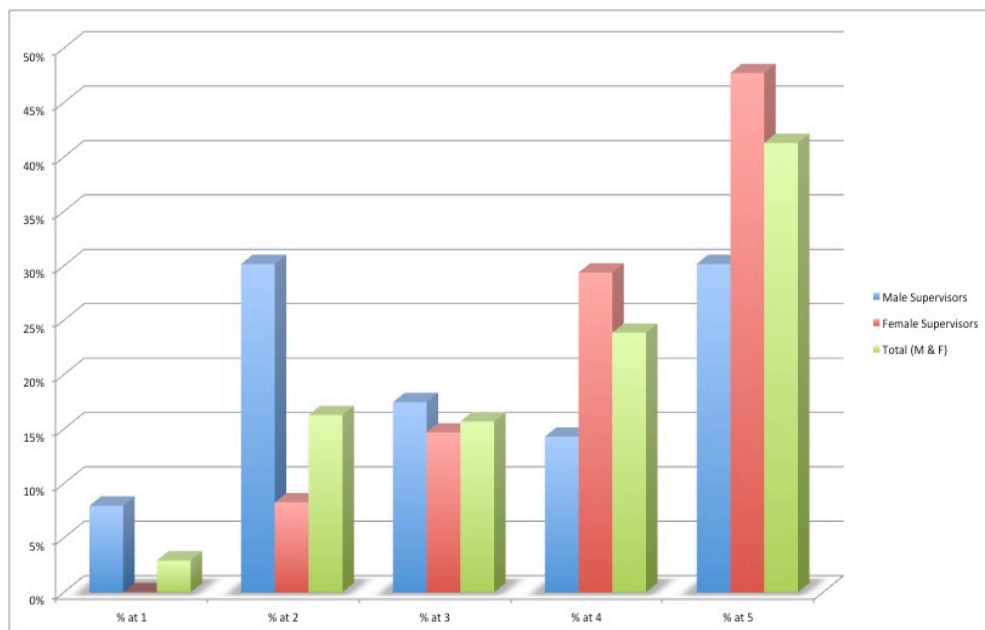
Female staff had higher daily ratings than males. For example, female supervisors rated 90% of their days between satisfactory and very positive, compared to 65% for male supervisors. Male supervisors rated 35+% of their days either very difficult or challenging, while less than 10% of female supervisors used these two categories.   Ratings by age show another clear distinction. Men under 50 expressed higher daily work satisfaction than those over 50, who rated almost 85% of their days as either challenging or very difficult. For men, advancing age seems related to lower levels of satisfaction, while women were less inclined toward these lower ratings.

Male Employment and Assistance workers (EAWs) reported 26% of days as problem free, whereas female EAWs reported up to 50% of their days as problem free. Rating their work experience more positively aligns with another primary finding, that of social/relational support. A study by Chappell (1989) revealed that although men tend to have a larger circle of social connections, women have more in-depth social connections, which assists them in dealing with stress. In a meta-study, Schwarzer and Leppin (1989) reported that social support and positive health were related. If female staff have more in-depth social connections, it suggests that they will have a more positive overall work experience (Sulsky and Smith, 2005; Duxbury et al. 1984). In the following staff journal narrative, this female EAW is combining the use of a job aid with supervisor consultation. The job aid is a decision-making matrix that helps the worker to prioritize service requests. It incorporates the type of client need, and the impact to the client if the need is not addressed within a certain period. In this example, the worker and supervisor are collaborating:

> *"I case consulted with the district supervisor; using the drafted matrix to explain the steps I had taken as a "reality check". My objective was to explain a somewhat complicated scenario in a straightforward manner."* (Female EAW, ID: 696103843);

In the example below, case consultation is seen as very helpful, even in cases where there is a power imbalance. In this case, the supervisor appears to be clandestinely monitoring worker and client exchanges:

> *"My supervisor overheard my discussion with client. Reviewed files with me and found out client is indeed difficult. Client called again. Supervisor talked to client to demand for docs…"* (Female EAW, ID: 5102683869).

With Client Service Workers, only female staff were represented in the sample, and 43% of daily entries were found in the "went well" category. The example below demonstrates that female staff often perceived their day not in terms of problems,

but in terms of opportunities to help clients in dealing with their issues by, for example, leveraging power on a client's behalf:

> "….At the end of the day you have a good feeling if you are able to help the client…" (Female CSW; ID: 3371854569)

Female staff also shared insights in their narratives that spoke of "self-efficacy", their ability to internalize their own power to problem solve and learn, as the following example demonstrates. In this case, a female Family Maintenance Worker (FMW) demonstrates a strong belief in her own ability to both learn and resolve a technical challenge:

> "...I worked on one part of the project alone that required Excel knowledge and experience which I don't have. It was a challenge but I managed to learn some great tips to using the program to complete the work. My day was very productive and I feel great and got a lot of work done..." (Female FMW, ID: 3458117852)

Overall, the results show high levels of job satisfaction for female staff, across all work roles, but not necessarily in a linear relationship with years of work experience, as the next section will outline.

Welfare staff work in a highly charged social/emotional work environment. Their ability to maintain a positive emotional perspective is directly linked to their ability to establish and maintain positive social support, and the results from this study indicate that women had a greater potential for this, due to their enhanced social networking ability. The positive daily ratings reported by women suggest a relationship between emotions and performance (Judge et al. 2001). With limited experience, or many years of experience, female journal narratives detailed regular examples where a day was given a very positive rating, and a very demanding problem was successfully resolved.

Male staff reported that increased years of experience brought lowered daily ratings. For male supervisors, for example, those with 25+ years of experience rated the majority of their days as either challenging or very difficult. The example below from a very experienced male supervisor records a day that was rated well below satisfactory, and the emotional tone suggests internal turmoil. This is a good example of the power pressures facing supervisors. There is pressure from above re: STIIP [Short Term Injury and Illness Program] reduction, concurrent with pressure from the team. The supervisor feels caught in the middle:

> *"…new STIIP reduction push - need to review STIIP and reasons monthly - staff not happy and personally don't see the point as the Region [Management] is fully aware of reasons for STIIP rising (lots of people off till LTD [Long Term Disability]….)"*(Male supervisor; ID: 4578492902).

For female supervisors, there was a general positive trend, although an increase in years of experience somewhat tempered the level of satisfaction. At the other end of the spectrum, those with less than one year had a very significant number of days rated as very positive, with a sometimes humorous slant:

> *"…BIG problem today... just kidding :)…"* (Female supervisor; ID: 91483099).

Surprisingly, those female supervisors with three to five years of experience had a high range of days rated as less than satisfactory. This could result from the fact that the honeymoon period was over in the new role, and the supervisor was settling into the long-term supervisory role. The following example shows a level of emotional and social turmoil, and references the interpersonal tensions sometimes present in offices. It also foreshadows the finding that social/relational factors emerged in the journals as both a problem as well as a resource:

> *"We continue to struggle with the proposed changes in service delivery, there is significant push back from 1 worker and that generates negative conversation with 2 other workers. The others who are ready for and accepting the changes aren't getting involved and now there is a division*

between them. Very negative atmosphere…." (Female supervisor; ID: 5185231660)

As stated previously, this study found that males tended to report lower levels of satisfaction with increased years of experience. There were exceptions, however. Male EAW daily ratings differed from male supervisors, in that increased years of experience did not result in lowered levels of satisfaction. Although those with only 1-2 years of experience had over 88% of daily ratings being either went well or very positive, this was replicated by those with 16 – 20 years of experience. These examples also demonstrate the importance of the giving and receiving of social/relational support:

> *"I feel that I don't have any 'problems' to report today. I had endless challenging work to complete. I requested the support of my team lead and colleagues to work through challenges, and also offered assistance when requested…" (Male EAW with 1-2 yrs. of experience, ID: 5815242794).*

> *"…it was unusually busy day, but the sense of accomplishment was very satisfactory..." (Male EAW with 16-20 yrs. exp., ID: 2790140794)*

Given the author's extensive experience within this work environment, there are several suggestive factors. Generally, the first 1 to 2 years in the Employment and Assistance Worker role is relatively positive for most new staff of either gender. The result for men in the 16 to 20 year category is harder to explain. Certainly for senior male EAWs who become trainers or SMEs [subject matter experts] in certain topics, their level of satisfaction increases. For female EAWs, this recognition is also present, plus there is usually an enhanced social networking for women that is not present with male staff (Chappell, 1989). This is demonstrated in the journal narratives as well, and reveals that males tend to deal with issues on their own, whereas women look to other colleagues for counsel and support:

> *"I am trying to make an effort to connect with people and smile at people throughout the day" (Female EAW, ID: 1503519304)*

"This was really based on my own experience. I've found that sometimes people need deadlines in order to follow through with tasks. Myself included." (Male EAW, ID: 447576628)

For female EAWs, increased years of experience continued to mean that levels of satisfaction were usually above average. For example, those with 16 – 20, and over 25 years of experience had close to 60% in the went well or very positive ratings. The following journal narrative strikes a very positive social/relationship tone, which was a central theme in the journals:

"Today was a fun day, not too busy, had time with clients to explore some options with them and chat a bit. Time to find out about people makes the job enjoyable, there are some very interesting stories…" (Female EAW with Over 25 yrs. exp., ID: 3701286893)

The exception to this trend among female staff was the Client Service Worker cohort. However, it is important to realize that there were only 2 CSWs participating in the study, so the results reflect one staff member with 1-2 years of experience, and one staff member who had over 25 years of experience.   The female CSW with only 1 - 2 years of experience showed close to 60% in the went well category, however the female CSW with over 25 years of experience reported over 85% of the days either challenging or very difficult.

For the work role cohorts of female Family Maintenance Workers and female Investigative Officers, job satisfaction generally increased with years of experience. For example, female FMWs with 3-5 years of experience had 67% of daily ratings in the very positive category, and those with 11 – 15 years of experience had similar positive ratings (i.e., 75% in went well/very positive). There were 5 age cohorts for female investigative officers. The trend here was similar to female EAWs in that ratings generally remained positive as experience increased. The exception was female IOs with 21-25 years of experience, where the majority of the ratings were only in the satisfactory level. These are very senior staff, and it

may suggest that they have plateaued out in their career, feeling underemployed and perhaps bored with their current station (Mael and Jex, 2015).

In summary, increased experience for men appeared to be connected to lower job satisfaction, with the exception of male EAWs.   For women, increased experience heightened job satisfaction, with the exception of female CSWs, and to some degree female IOs, who showed respectively a downturn in their expressed job satisfaction, or job satisfaction that was only average. When looking at job satisfaction by location, there was marginally more support for the urban versus rural work environment. These findings run somewhat contrary to the literature (Miller and Foster, 2010), however, as discussed previously urban welfare staff have access to more resources and options for their clients, which may result in higher levels of job satisfaction.

In the next section it will be shown that lowered wellness perceptions did not significantly influence coping preferences (Figure 36). The data flows from the COPE Scale as follows:

- Age cohorts are presented on the left column of the table:
    - Age Overall; Under 30; 30-40; 41-50; 51-60; Over 60
- Across the top the following categories are delineated:
    - Gender, Work Role [Employment and Assistance Worker, Client Service Worker, District Supervisor, Family Maintenance Worker, Investigative Officer], Type of Service Delivery [Face to Face, Phone] and Geographic Location [Urban, Rural]
- COPE Scores are clustered according to colour:
    - Green, "PFC" represents problem focussed coping strategies.
    - Yellow, "EFC" represents emotion focussed coping strategies.

5.5 What are the coping style preferences for public sector welfare staff?

Coping Preferences

COPE — Green = PFC First Choice; Yellow = EFC First Choice; Red = MFC First Choice	Male	Female	Work Role: EAW	Work Role: CSW	Work Role: DS	Work Role: FMW	Work Role: IO	Service Delivery: F2F	SD: Phone	Urban Work Setting	Rural Work Setting
Age Overall	PFC	PFC / EFC	PFC / EFC	PFC / EFC	PFC	PFC	PFC	PFC / EFC	PFC / EFC	PFC / EFC	PFC / EFC
Under 30	N/A	PFC	PFC / EFC	N/A	PFC	N/A	N/A	PFC / EFC	PFC	PFC	PFC
30 – 40	PFC	EFC	PFC / EFC	N/A	PFC / EFC	PFC	PFC / EFC	PFC / EFC	PFC / EFC	PFC / EFC	PFC / EFC
41 – 50	PFC	PFC / EFC	PFC	EFC	N/A	PFC	N/A	PFC	PFC / EFC	PFC	PFC
51 - 60	PFC	EFC	PFC	PFC / EFC	PFC	N/A	PFC / EFC	PFC / EFC	PFC / EFC	PFC / EFC	PFC / EFC
Over 60	N/A	PFC / EFC	PFC	EFC	N/A	N/A	PFC / EFC	PFC	PFC / EFC	PFC / EFC	N/A

Figure 36: Coping Preferences – Primary choices based on data from the COPE Scale

Legend: Coping preferences are delineated over age, gender, work role, service delivery function (i.e., f2f versus phone), and work location (i.e., urban versus rural).   Green represents problem-focussed coping (PFC), and is used on the graph when this was the reported first choice. Yellow represents emotion-focussed coping (EFC) and is used when this was the reported first choice. In cases where both green and yellow are represented together, this indicates that there was a roughly equal preference for PFC and EFC.   It should be noted that red was used for maladaptive focussed coping (MFC), but this cluster of coping was not found to be the reported first choice for coping under any of the designated categories.

Coping is at the heart of all wellness models. Positive wellness includes the ability to cope with stressors (Bouchard, Shephard and Stephens, 1994). Effective coping results in a self-regulation of problem solving approaches (Witmer and Sweeny, 1992), the coordination of attitudes, perceptions and behaviours (Myers, Sweeney and Witmer, 2000), and the ability to make positive life/work choices (Hettler, 1980). The coping clusters designed by Carver, Scheier and Weintraub,

1989) were used in this study and there is evidence that the problem focussed coping cluster (PFC) and the emotion focussed cluster (EFC) has alignment with positive well-being (Gunthert, Cohen and Armeli, 2002; Park, Armeli and Tennen, 2004). Ben-Zur (2009) highlighted that coping is a critical factor in understanding wellness, and that further research is needed into coping styles and their interactions and impacts. Problem focussed and emotion focussed coping was very evident in the current study, and this aligned with actual coping behaviour, as detailed in the fourth major section of this chapter.

The fact that there were surprisingly low scores on the perceived wellness survey did not translate into maladaptive coping choices. For example, male supervisors preferred on problem focussed coping, while female supervisors had strong preferences with both problem focussed and emotion focussed coping. The following example demonstrates the balance that female supervisors reported between problem focussed (PFC) and emotion focussed coping (EFC), and shows a resilience as well as social/relational support at the intra and interpersonal levels:

> *"Kept my cool... focussed on my priorities, kept a list of 'to do's', Stayed positive"* (Female supervisor, ID: 91483099). *"I was able to control my immediate reactions - I was calm and as supportive as I could be. Some clients left happy, some left grumpy - nothing I can do to fix everyone's problems or issues"* (Female supervisor; ID: 91483099**).   *"Clients are almost always receptive to kindness and help. Rarely do they leave irritated or lost..."* (Female supervisor; ID: 91483099).

Looking at the EAW cohort, there are similarities with supervisors. Male EAWs preferred problem focussed coping (PFC). Similar to female supervisors, female EAWs showed a bias toward emotion focussed as well as problem focussed coping. The following example details a female EAW using both problem focussed and emotion focussed coping. Social/relational support toward the client is an integral aspect of this exchange, and it helps mitigate the inherent power imbalance between client and worker. The worker also strives to resolve the

power issues at the worker to worker level:

> *"I tried to be very empathetic to this applicant, but stayed focussed on the application for income assistance. I contact the home office to let them know that he would be attending the office to sign his intake papers as I thought he may be a bit self conscious about his appearance as this happened only a month ago.   I emailed a response to my supervisor apologizing for not being able to cover for POC for my colleague who was wanting to go for a break. I explained my reasons nicely as being swamped with work and I told my boss that I have also apologized to my colleague who I declined to..."* (Female EAW, ID: 5830641678)

Like female supervisors and EAWS, female CSWs COPE survey scores have a strong bias toward both problem focussed and emotional focussed coping strategies. Somewhat surprisingly, the COPE survey indicated that maladaptive focussed strategies are also a strong second choice for female CSWs, although again with only 2 CSWs represented in the study, this may be an anomaly.

Female family maintenance workers perceived wellness scores were similar to both EAWs and supervisors in that again they were just satisfactory. Scores on the COPE scale showed a bias toward problem focussed coping strategies as a first choice, but also a strong tendency to use emotion focussed strategies, particularly social/relational support.

With the investigative officer (IO) cohort, there were only female staff represented, and although female IO wellness perceptions were just satisfactory, it didn't have a negative impact on coping scores. Female scores were very strong for both problem focussed and emotion focussed coping. Investigative officers spend a significant amount of time with clients accused of fraud, and both approaches would be helpful for maintaining interpersonal and intrapersonal balance.

As discussed to date, wellness perceptions did not have any significant linkage with maladaptive coping preferences. Looking at the very highest and lowest wellness perception scores, however, there was some variance, as the following section will detail.

Figures 37 and 38 details the three highest and the three lowest perceived wellness scores and the accompanying COPE scores.

Whether the wellness scores were high or low, the accompanying cope scores were quite strong in both the Problem Focussed Coping (PFC) and Emotion Focussed Coping (EFC) categories.

Figure 37: Three Highest Perceived Wellness Survey and COPE Scores
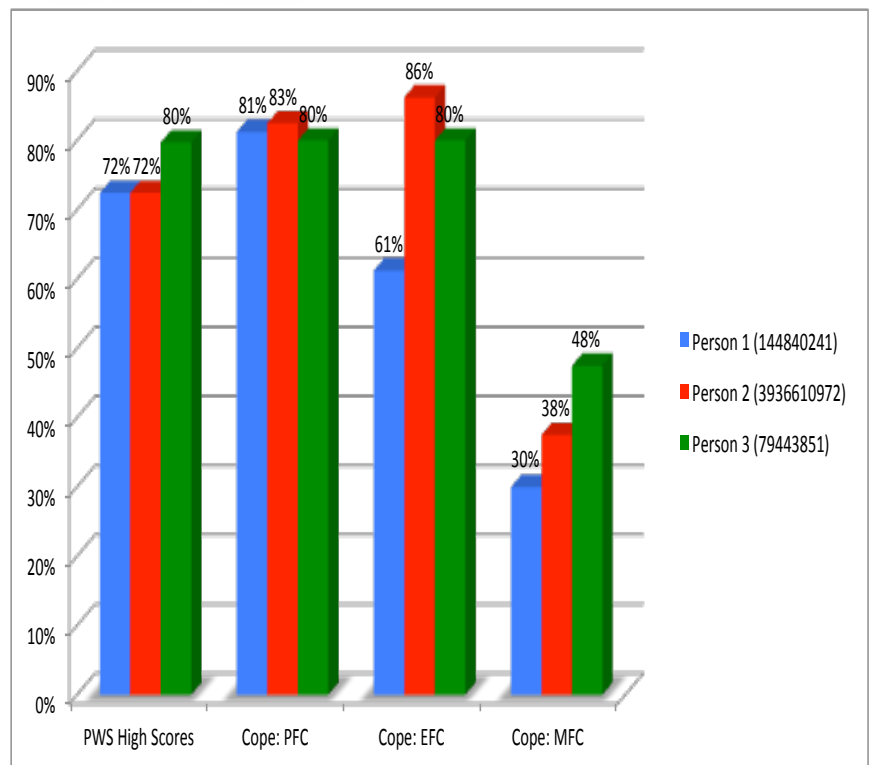
The one area where a divergence occurred was with the Maladaptive Focussed Coping (MFC) strategies. Those staff with the lowest perceived wellness survey scores had MFC scores that were somewhat elevated, suggesting negative wellness perceptions impacted their coping scores. This aligns with the findings from Loretto, Platt, and Popham (2010), who found that negative perceptions had an influence on behaviour. In
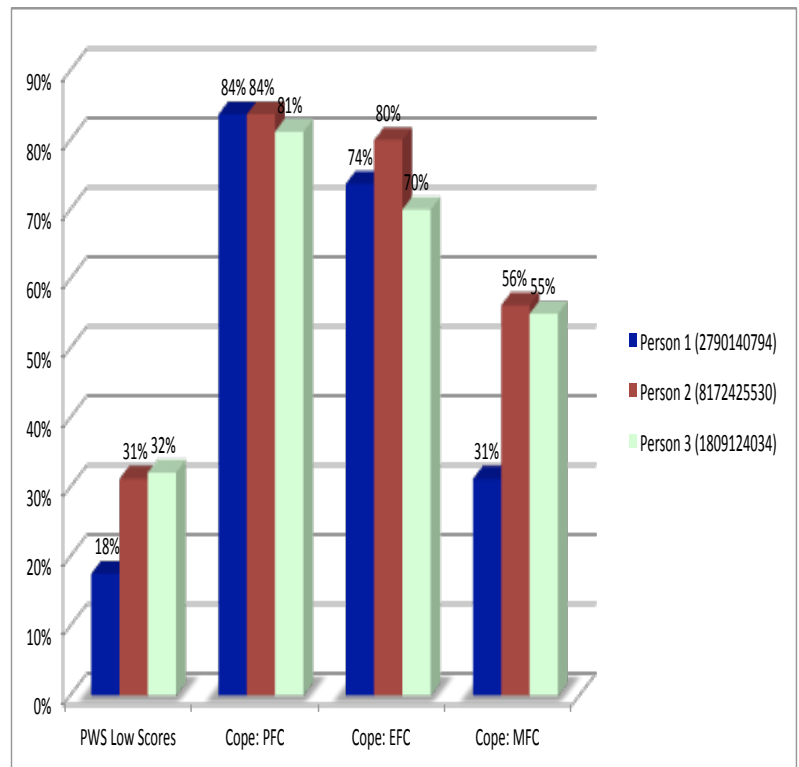
this study, staff perceiving that their wellness is below average appeared to have an elevated tendency for maladaptive coping choices. The following example is based on Person #2 on the above grid, and illustrates a maladaptive coping choice (i.e., denial). It also shows a lack of self-efficacy, and a negative constructed truth, in that the individual perceives that they are lacking power and immobilized:

> *"….frustration....tried to joke about things, but unable to action as I have no ability or authority to make things work properly……" MFC - Female EAW, ID: 8172425530).*

In summary, below average wellness perceptions generally did not influence coping preferences in a negative manner. The one exception was in cases where wellness perceptions were extremely low. When one's internal view is extremely negative, this may support the tendency to choose maladaptive coping strategies (Pelletier, 1992). That is to say, extremely low wellness perceptions may also be linked with lowered perceptions of control, leading to a heightened potential for maladaptive coping strategies. This in turn would lead to increasingly lowered wellness perceptions, which in turn results in an increased turn to maladaptive

coping, continuing a negative spiral (Idler and Kasl, 1991). This type of extreme negative spiral, however, was not present in this study, and although there was some gender divergence found in coping style, the next section details that there was not a major focus on maladaptive coping preferences.

In terms of gender, the literature has a slant toward problem focussed coping (PFC) as the primary coping strategy for both men and women in the helping professions. For example, Ashker, Penprase and Salman (2012), in a study on how nurses deal with stress, demonstrated that problem focussed coping, with an accent on planning, was the primary strategy. Further, Lambert and Lambert (2008) also found that nurses used problem-focussed strategies as the primary coping approach, followed by the seeking of social support. Given that nursing is still over 90% female (Landiver, 2013), this adds credence to the proposition that in social/health service-related occupations, both women and men utilize problem focussed coping strategies. Even within the problem focussed cluster, however, there is a strong element of social/relational support present.

Problem Focussed Coping strategies, with its 5 subscales [Active Coping-ACO; Planning-PLN; Suppression of Competing Activities-SCA; Restraint-RES; Instrumental Social Support-ISS] was the preferred coping strategy for men across all age spans represented. Women in many age cohorts also generally favored it.

Emotion Focussed Coping, with its 5 subscales [Acceptance-ACC; Emotional Social Support-ESS; Positive Re-Interpretation and Growth-PRG; Humour-HUM; Religious Coping-RCO] was the second choice for men, but for some women, it was a first choice (i.e., women 30-40 and 51-60). This would indicate a link to social/relational support, which is very prevalent in the workplace wellness journal entries.

Maladaptive Focussed Coping is composed of the following 5 subscales: Substance use (SUB), Behavioural Disengagement (BDE), Mental Disengagement (MDE), Focus on Venting Emotions (FVE), Denial (DEN). Both genders indicate a

lack of preference for this cluster. Having said that, however, it appears that the majority of women lean toward this occasionally, while male responses indicate that the MFC is a very infrequent choice.

The fact that women in this study showed a strong preference for both problem focussed (Ashker, Penprase and Salman, 2012), and emotion focussed coping is perhaps reflective of the type of work environment. Similar to nursing, both men and women in the welfare work environment are faced with an emotionally charged atmosphere. Welfare workers face the concurrent functions of engaging the individual, while completing a series of complex computerized administrative functions.   Emotional balance needs to be maintained while successfully resolving a variety of tasks. As will be seen in the workplace wellness daily journal narratives, women were more cognizant of this than men, and therefore cultivated a more comprehensive network of social support when dealing with either clients, colleagues or supervisors. Men had a preference toward relying on themselves, and this is evident when looking at the daily workplace wellness journals. Given that there was gender divergence, there is also variation in coping style by work role, albeit not as pronounced, as the next section will detail.

Staff across all work roles prefer the problem focussed coping cluster, followed by the emotion focussed cluster. The maladaptive focussed cluster is a distant third choice. Having said that, supervisors and family maintenance workers (FMWs) have a preference for problem focussed coping, while employment and assistance workers (EAWs), client service workers (CSWs) and investigative officers (IOs) have a balanced preference between the two clusters. Problem focussed coping has a strong social component (i.e., instrumental social support) that is represented in all clusters. For EAWs and CSWs, more of their time is spent on direct client interactions, so the social/emotional/psychological components are more pronounced. For example, most of their day is spent in listening to clients sharing their issues, and the worker needs to balance the administrative tasks with the need to fully engage each client, which requires a strong emotion focussed approach.

Investigative officers (IO) showed the highest utilization of maladaptive focussed Coping (MFC), with those IOs over 60 showing a definite leaning toward it. As mentioned previously, this may be an indicator that these seasoned staff are facing signs of burn-out. Spending perhaps several decades working with clients who are involved in fraud has its own form of cumulative stress, not unlike police officers (Basinska, Wiciak, and Dåderman, 2014). In fact, many of the investigative officers have had a background within either the RCMP [Royal Canadian Mounted Police] or local police forces. Supervisors showed the lowest utilization on maladaptive focussed coping. Given the key responsibility that supervisors have for supporting their team during challenging circumstances, this may be an indicator that supervisors are more cognizant of the dangers of turning to the MFC coping subscales. This may be further enhanced if welfare supervisors have a sense of "calling" within their role, as Ausbrooks (2011) found resilience was significantly higher for those child welfare supervisors who identified with a sense of vision in their work.

Udod and Care (2012) found that competing work pressures, combined with staff shortages resulted in a considerable level of stress for nursing supervisors, and these same pressures face welfare supervisors. Social/relational support from supervisors and peers was extremely useful in enhancing the ability of line supervisors to deal with issues. Moving now to a discussion of coping behaviours, the importance of social/relational support will continue to be evident, in terms of the problems identified, the response to problems, and the coping resources used.

5.6 What are the primary coping behaviours of welfare services staff?

Both problem and emotion focussed coping were strong coping preferences, and the workplace wellness journals revealed a pronounced alignment to social/relational support. The coping clusters (Carver, Scheier and Weintraub, 1989) include several approaches that have social/relational support embedded within them, either overtly or covertly.

These include the following problem focussed coping (PFC) approaches: active coping (ACO) and instrumental social support (ISS). Active coping means dealing directly with the problem or issue. Instrumental social support means actively contacting others for information, counsel and advice. Social/relational support is also an integral part of emotion focussed coping (EFC) approaches. These include: acceptance (ACC) and emotional social support (ESS). Acceptance means realizing that conditions likely will not change, and looking for ways to work with others within the circumstance. Emotional social support means seeking emotional counsel and empathy to deal with the social/relational/emotional pressures. Maladaptive focussed coping (MFC) approaches linked to social support include focusing on the venting of emotions (FVE), which involves expressing/venting of emotional frustrations as a way of relieving stress.

The following table (Figure 39) presents an overview of the major findings flowing from the Workplace Wellness Journals (WWJ), which participants used to record their daily observations over 40 work days. The left hand column contains the following categories: Workplace Wellness Journal Daily Ratings [% of days rated Satisfactory, Went Well or Very Positive over 40 work days]; WWJ: % of days rated problem free; Problem Identification; Problem Response and Resources Used. Work Roles are placed in the top row.

Workplace Wellness Journal:

Figure 39: Workplace Wellness Journal

Categories/WorkRoles	Male DS	Female DS	Male EAW	Female EAW	Female CSW	Female FMW	Female IO
Workplace Wellness Journal (WWJ) Daily Ratings: ❖ % of days rated "Satisfactory, "Went Well" or "Very Positive" over 40 work days	65%	90%	50%	50%	43%	78%	50%
WWJ: ❖ % of Daily Entries that were rated "Problem Free"	18%	46%	26%	20%	51%	36%	4%
Problem Identification: (Top 4 categories) ❖ Staff shortage	1st						
❖ Workload Volume	2nd		3rd	3rd	1st	4th	3rd
❖ Issues with staff or colleagues	3rd	1st	1st	4th	4th	3rd	
❖ Issues with clients		2nd	2nd	1st	2nd	2nd	1st
❖ Policy/procedural issues		3rd					
❖ Personal issues				2nd	3rd	4th	2nd
❖ Issues with supervisors or mgrs.			3rd				
❖ Issues with technology	4th	4th	4th			1st	4th

Categories/WorkRoles	Male DS	Female DS	Male EAW	Female EAW	Female CSW	Female FMW	Female IO
Problem Response: ❖ Problem Focussed Coping (PFC)	**81%**	**85%**	**52%**	**52%**	**31%**	**73%**	**57%**
❖ Emotion Focussed Coping (EFC)	**4%**	**8%**	**32%**	**24%**	**46%**	**21%**	**30%**
❖ Maladaptive Focussed Coping (MFC)	**15%**	**5%**	**16%**	**24%**	**23%**	**6%**	**13%**
Top Resources Used: (ranked) ❖ None (i.e., Focus on Self)	1st (45%)	1st (18%)	2nd (24%)	2nd (26%)	2nd (17%)	2nd (19%)	2nd (24%)
❖ Colleagues/Team members	3rd (8%)	1st (18%)	1st (25%)	1st (31%)	1st (67%)	1st (48%)	1st (30%)
❖ People in Authority	2nd (37%)	2nd (17%)	4th (8%)	3rd (13%)	n/a	2nd (19%)	5th (7%)
❖ Combination of colleagues and people in authority	n/a	4th (7%)	5th (4%)	4th (8%)	2nd (17%)	4th (3%)	6th (4%)
❖ Job aids and SOPs (Standard Operating procedures)	4th (3%)	3rd (10%)	6th (1%)	5th (2%)	n/a	n/a	4th (9%)
❖ Technology	n/a	n/a	3rd (9%)	5th (2%)	n/a	3rd (6%)	3rd (10%)

Based on the above table, the following sections detail the problems identified, the responses to those problems, and the resources used. Social/relational factors are the common thread running through all categories.

5.7 Worksite problems identified were primarily social/relational

Staff reported that the primary problems identified had a social/relational link. Of the 7 top problems, 4 dealt with social/relational factors: issues with clients (#1), issues with staff/colleagues (#3), personal issues (#5) and issues with supervisors/ and managers (#7). This is the negative side of social support as a coping strategy. Relationships can be a stressor (Fotinatos-Ventouratos and Cooper, 2005), especially where what appears to be social support is in reality role overload (Thoits, 1995), with the employee feeling a sense of obligation, but lacks the resources. Further, Beehr, Bowling and Bennett (2010) found that when social/relational support is framed in a negative or coercive manner, the outcome is decidedly negative.

The social/relational trend emerged across all work roles. For example, male and female supervisors identified a large percentage of problems as relationally based. For men, this amounted to 40%, and for women 70%. The following example from a female supervisor outlines a negative exchange that demonstrates the intersectionality principle of multiple truths. The worker is trying to explain the office process, while the client has another perspective that they perceive as valid. The interaction cycles downward with the client ending the exchange frustrated and claiming that the worker is simply having a bad day. There was no co-construction of a solution or shared agreement. This type of exchange is a common problem, and creates significant stress for the worker as well as the client:

> *"Client in office to submit documents to intake worker. When asked if he had his SR# [Service Request], he said it is for Karen and she has it. Tried to explain process to client but he became belligerent stating Karen is expecting these. So then I went through his documents to check for missing info etc. - client had submitted an original document, a blank EFT [Electronic Funds Transfer] application as well as one issued by the bank, and another doc where his name was missing. When I asked him to copy the original doc, that I will take the bank issued EFT, he got upset at that.*

Then when I asked him to write his name on the other doc, he got upset because I gave him a pencil. When I tried to explain to reasons for these, he wouldn't listen. he took the pen i offered him and left the building. he also said to me, "just because you're having a bad day, you don't have to take it out on me." (Female supervisor; ID: 9700220926)

With both female EAWS and female supervisors, issues with clients were among the top three problems. Male EAWs had a similar focus, with the 3 top problem categories being: issues with staff, issues with clients and issues with supervisors. The example below demonstrates worker-to-worker conflict. This type of relational issue is often not easily resolved, and it was exacerbated by technology problems. The system referenced is ICM [Integrated Case Management], the software program that processes the thousands of case files in British Columbia. This narrative indicates the appearance of an on-going problem, showing how the lack of social/relational support can seriously impact client service:

"The major issue of the day revolved around a carryover from cheque issue Friday when I had a conversation with another worker in another office about documents that were not attached to a certain file. Despite my explanation that our system was taking hours to attach scanned documents to files and despite my offer to take a look around for the hard copies in case they did not attach, this worker got so pissed off he wrote about in the RUNNING HISTORY on the client's case, bringing a personal problem into a document that has no place for it." (Issues with staff - Male EAW, ID: 7649454488);

When examining client service workers, family maintenance workers, and investigative officers, social/relational issues were identified as the primary problem. For investigative officers, problems with clients were often linked to allegations of fraud, and the exchanges could therefore be very problematic. In the example below, the worker is clearly stressed by the prospect of dealing with this

type of problem, because there is always some uncertainty about how a client may respond to a denial of service. Intersectionality maintains that people make decisions in a manner that they perceive may help them to survive a crisis (Hankivsky, 2014). This may result in a response that appears to the worker to be "non-rational" in that it may involve verbally or even physically threatening or intimidating the worker:

> *"…I didn't want to contact a client to know I was denying his request. I remember seeing him in person and I dreaded the possible confrontational situation that would occur once I told him the bad news. I was anticipating the worst and didn't want to have to talk to him..." (Female IO, ID: 3413400808).*

In summary, social/relational issues were the key problem for welfare workers. These findings were mirrored in social worker studies, where stressors included personal issues (Siebert and Siebert, 2005), the tension between quality service relationships with clients versus fiscal responsibilities (Um and Harrison, 1998), and an organisational absence of social support (Lozinskaia, 2002).

The next section details the responses to worksite problems, and this reveals the duality.   Social/relational issues were the primary problem identified, and social/relational coping was the primary response utilized.

5.8 Responses to Worksite problems were primarily social/relational

Workplace Wellness Journal: Responses Across Classifications
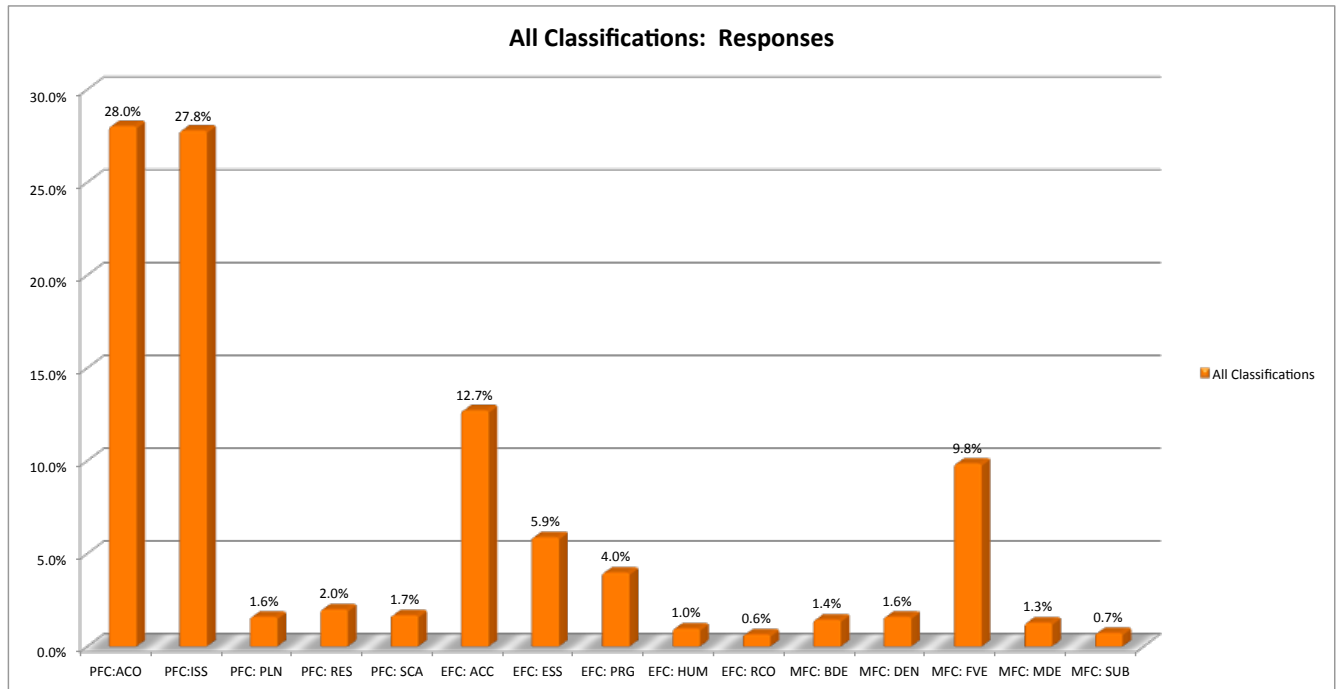
Figure 40: Coping Responses across All Classifications

Legend:

- PFC = Problem Focussed Coping; ACO = Active Coping; ISS = Instrumental Social Support; PLN = Planning; RES = Restraint;   SCA = Suppression of Competing Activities

- EFC = Emotion Focussed Coping; ACC = Acceptance; ESS = Emotional Social Support; PRG = Positive Re-Interpretation and Growth; Hum = Humour; RCO = Religious Coping;

- MFC = Maladaptive Focussed Coping; BDE = Behavioural Disengagement; DEN = Denial; FVE = Focus on Venting Emotions; MDE = Mental Disengagement; SUB = Substance Use

This section details the trends across all classifications, with a discussion around specific work role cohorts. Figure 40 shows that over 60% of responses fell within the problem focussed coping cluster (PFC), with approximately 25% falling into the emotion focussed coping (EFC) strategies, and approximately 15% into the maladaptive focussed (MFC) cluster. There is a pronounced social/relational support focus, often including intrapersonal self-talk that provides insight into the worker's assumptions and values:

> *"No real problems. There are often times where there are 'stressors', like an upset client that you know you won't be able to help, or a difficult client that demands to be paid the moment they drop off a piece of paper (or don't even*

submit a piece of paper...) but these are every day - all day dealings."
(Female Supervisor, ID: 91483099)

This aligns with recent studies (Graham et al., 2014) on the importance of social/relational support on worker wellness, and that positive relationships with colleagues was a predictive factor in determining job satisfaction. Social/relational support is extremely helpful in mitigating the impacts of stressful events in the workplace (Etzion, 1984; Viswesvaran, Sanchez and Fisher, 1999). Further, the reciprocity of social support results in stronger and more constructive relationships (Bowling, Beehr and Swader, 2005):

"No problems today- I had some wonderful encouragement from my
colleagues and a good meeting regarding upcoming ICM changes…"
(Female EAW, ID: 301567544)

Looking at the problem focussed cluster, the categories of active coping (ACO) and instrumental social support (ISS) account for the vast majority of responses. Welfare work is fast paced, and staff need to turn from one issue to another quickly and flexibly. It is not surprising therefore, that staff choose active coping (ACO) as a primary response. Active coping involves dealing directly with the problem with a view to resolving it immediately, if possible. Although this infers that the worker is taking action on their own, a typical active coping journal entry reveals a focus on both problem solving, and intrapersonal self-talk that is a form of social support for the employee. This example details an exchange with a client around a shelter allowance, and the fact that the client was renting accommodation that was over the basic monthly entitlement. It's a difficult balance maintaining a positive relationship while striving to understand the client's financial status. In the example below, the worker is using an active coping response, but there is also some intra personal social support in that the worker's self-talk is meant to provide (the worker) some solace and justification as she perceived her response as equitable. The worker-client power imbalance was strongly evident however. Worker phrases like *"…I gave the client the opportunity to…"* and *"…I asked questions about the*

client's plan ..." do not suggest a willingness to co-construct a solution, and the final comment *"....of course was only deflection"* is a withdrawal of the worker from the exchange. Both worker and client are struggling to make sense of the interaction, even as the exchange spirals downward:

> *"I gave the client the opportunity to discuss why he believed he was entitled to the allowance and I asked questions related to the client's "plan" as to how he would sustain his rental. My response to the client was a fair, reasonable explanation of the purpose of the allowance and why he was denied. The client continued to argue without reason and began asking questions of me and how I paid my rent which of course was only deflection." (Female EAW; ID: 7770834826)*

Instrumental social support (ISS) was tied with active coping as the other major coping strategy used across classifications. It involves actively contacting others to gather further sources of information and counsel to assist with problem resolution. ISS is a major interpersonal coping strategy, and typical responses highlight these connections. The following illustrates the importance of interpersonal social support. This example, unlike the one above, demonstrates a more balanced approach, moving away from the downward spiral, and acknowledging the ideas and counsel from others, which is at the heart of instrumental social support. In the second example, a solution was not found, but some progress was made, with a collegial working pattern being established:

> *"…Consulted with experienced worker on what she needs to provide regarding documentation to determine eligibility…"* (Female EAW, ID: 8167325389);

> *"...I had a coworker who is also a superuser [Integrated case management expert] like me, stay and help me. We worked until 6:30 and could not get the problem solved. I spoke to systems the morning of the 20th they said they fixed it but I am having the same issue…"* (Male EAW, ID: 7649454488)

The other coping strategies within the problem focussed coping (PFC) cluster were only marginally represented across all classifications (i.e., planning (PLN), suppression of competing activities (SCA) and restraint (RES). Working with clients within the front line welfare work environment is very action oriented, and both active coping and instrumental social support have an action orientation. In addition, the work is prioritized for each employee through the use of a service delivery priority matrix. A worker interacts with a client and sets up a service request based on an established process.

When looking at the approximately 25% of responses found under emotion focussed coping (EFC), the categories of acceptance (ACC) and emotional social support (ESS) are the two top choices, with some representation in the positive re-interpretation and growth (PRG) category. Typical journal responses across all classifications highlight that acceptance is a useful strategy when faced with systemic barriers and conditions that are not easily remedied. Often there are intrapersonal self-talk insights that provide background on the employee's decision to use acceptance as the strategy. The following example illustrates the tension felt by a worker who has some sources of potential social support (i.e., performance coach and supervisor), but only one is actually a resource. The power imbalance with the supervisor is clearly very stressful, but the worker's willingness to step back and use acceptance as a strategy was useful:

> *"…asked for assistance from my performance coach to see if there was something else i could do as I was not satisfied; in the end i decided better just to accept it as it is even though i wasn't satisfied because there is not enough time in the day to worry about supervisors who refuse to give straight answers or reasons for their decisions..."* (Female EAW; ID: 9856724003)

The other major emotion focussed strategy used was emotional social support (ESS), which involves seeking out others with a view to garnering empathy, sympathy, moral support and understanding when grappling with a problem.

Typical responses include interpersonal social support. The example below sees the worker seeking out both friends, co-workers and her husband, and being willing to co-construct solutions:

> *"…chatted with friends and coworkers at work, spoke to husband to help present a supportive front with her, so she can learn as well from experience..."* (Female EAW, ID: 5037773252).

The one other emotion focussed strategy that bears attention across all classifications is that of positive re-interpretation and growth (PRG). This strategy involves re-framing the problem and finding the silver lining in the circumstance. In many cases, the intrapersonal self-talk illuminates the continued importance of social supports, which in this example involved emotional social support as well as re-framing:

> *"…Just plugged my way through the work and told myself that tomorrow is another day. Busied myself on my breaks talking with co-workers about positive happy things going on...."* (Female EAW; ID: 5724159214)

The other emotion focussed sub-categories of humour (HUM) and religious coping (RCO) of EFC accounted for only approximately 2% of responses. Journal comments showed that both humour and religious coping are strategies that are sometimes piggybacked with other coping strategies. In the following example, the staff member appears to be combining emotional social support with religious coping:

> *"….We talked for a bit about that and I told her I would be praying for her…"*
> (Female EAW, ID: 3514640117).

In this example using humour, it is clear that the staff member is also actively coping with the problem. Similar to many occupations where there are extremely difficult situations to deal with, welfare workers sometimes use humour to lighten the atmosphere:

"I tried to make light of the changes and stated some suggestions that the intake team may be considering to assist with what the front line staff see as a problem for them..."   (Female EAW, ID: 5830641678)

Maladaptive focussed coping was also present across all classifications, and accounted for approximately 15% of journal responses. Of the various coping strategies represented under this cluster, the strategy of "focus on and venting of emotions (FVE) was the strongest, with almost 10% of journal responses. FVE is defined as verbalizing the negative aspects of circumstances. This can have short-term benefits (e.g., grieving), but it is considered maladaptive over the long-term, as it hampers problem resolution. For example, the focus on venting of emotions often included intrapersonal dialogue that referenced the lack of social, emotional or psychological support, and the presence of power issues, which caused significant on-going stress:

"…I was upset because the issue was brought up very publicly at the team huddle in the morning - feels rather like being trapped in a recurring emotional nightmare…". (Female EAW; ID: 2065575030)

Within the maladaptive focussed coping (MFC) cluster, the remaining categories of behavioural disengagement (BDE), denial (DEN), mental disengagement (MDE), and substance use (SUB) account for only 5% of responses in total.

The next section will detail responses by gender.   Social/relational support is a key factor impacting both social worker and welfare worker wellness, and is defined by Reid (2004) as relationship harmony. Reid found that there were gender differences in how relationship harmony was prioritized. For men, it was impacted more by self-esteem factors, particularly their own sense of self-satisfaction, which infers more of an autonomous perspective in life/work. Women put more focus on having positive relationships with others. Journal narratives by gender revealed this type of alignment (Reid, 2004), as the next section will outline.

5.9 Workplace Wellness Journal: Responses by Gender

Figure 41: Coping Responses by Gender

Legend:

- PFC = Problem Focussed Coping; ACO = Active Coping; ISS = Instrumental Social Support; PLN = Planning; RES = Restraint; sSCA = Suppression of Competing Activities

- EFC = Emotion Focussed Coping; ACC = Acceptance; ESS = Emotional Social Support; PRG = Positive Re-Interpretation and Growth; Hum = Humour; RCO = Religious Coping;

- MFC = Maladaptive Focussed Coping; BDE = Behavioural Disengagement; DEN = Denial; FVE = Focus on Venting Emotions; MDE = Mental Disengagement; SUB = Substance Use

Plancherel, Bolognini and Halfon (1998) found that young women were more prone to cultivating social support and venting their emotions than young men. For women, this seeking of relational support as a source of counsel and comfort is supported by other studies (Cohen, 1988; Steptoe, 1991). Meléndez et al. (2012), in a study of gender differences in coping strategies, found that female coping behaviors included significant focus on emotion focussed coping approaches, including significant levels of interpersonal social support and intrapersonal self talk (Meléndez et al. 2012).   The present study found that emotion focussed and problem focussed coping behaviors were well represented for both genders.

Journal entries by gender revealed that both men and women preferred problem focussed coping behavior, however male responses for emotion focussed coping were higher than female responses, due to the high rating males gave the acceptance (ACC) coping strategy and positive re-interpretation and growth (PRG). Women were higher on emotional social support (ESS) than men, and they used maladaptive focussed coping strategies approximately 15% of the time, while men used them only 6% of the time.

Within problem focussed coping (PFC) categories, active coping (ACO) and instrumental social support (ISS) were the 2 top categories for both genders. Women were almost equal in their choice of active coping and instrumental social support, with men showing a slight preference for instrumental social support. Male and female journal entries differed in that male narratives contained less background explanatory intrapersonal self-talk around the issue at hand. This gender difference is evident in the following two examples:

> *"I set about completing outstanding tasks and assisting other clients. I'm also completing some online training modules" (Active Coping - Male EAW; ID: 447576628);*
>
> *"I did my best to speak in Mandarin with the client. I explained that I am pretty rusty but he was ok and we understood each other. I went to see my supervisor to ask (if) my translation of the letter is acceptable to the ministry. I also asked another worker who is a Chinese and is in Chinese language training program to review my notes…" (Active coping and Instrumental Social Support – Female EAW; ID: 5102683869).*

When looking at the remaining problem focussed categories, there was some difference between male and female responses in the use of restraint (RES), planning (PLN) and suppression of competing activities (SCA). Although the percentages were low, men used restraint or planning more frequently:

> *"I completed a review of the application history and reviewed the legislation and policy in question."* *(Male EAW using planning as a strategy; ID: 447576628).*

Women were slightly more likely than men to use suppression of competing activities (SCA), which involves prioritizing issues and then resolving each problem in a step by step fashion. There was a tendency to piggyback suppression of competing activities with other coping strategies (e.g., active coping and instrumental social support). This again demonstrated the tendency for women to link in social/relational supports, even when using other strategies as a primary response:

> *"Tried to prioritize items. Responded to client first, responded to faxed request, consulted with Supervisor re: another issue, and asked that a colleague wait until tomorrow for a case consult question"* *(Female IO; ID: 9270112845).*

Male and female responses on the emotion focussed cluster were a little surprising. Although men and women chose acceptance (ACC), emotional social support (ESS) and positive reinterpretation and growth (PRG), men had a response rate on acceptance that was almost twice that of women, and positive re-interpretation and growth was their second choice. Women had a higher level of responses in the emotional social support category than men.

For the MFC cluster, female responses on Focus on Venting of Emotions (FVE) were higher than male responses. Male journal responses included only FVE, and behavioural disengagement (BDE). BDE involves physically pulling away from trying to resolve the problem, and can lead to a victim thinking attitude, as shown in this example:

> *"…I went silent. Rather than continue the argument, I turned away from my co-worker and left the room…."* *(Male EAW, ID: 447576628)*

Matud (2004) found that men have a stronger tendency to use problem focussed coping strategies (PFC), while women lean toward emotion focussed approaches (EFC). This was thought to be due to either socialization alignment or role alignment.

Socialization alignment means that coping style is due to traditional gender socialization (Barnett and Baruch, 1987). Traditional female socialization involves emotional expression and social support, while male socialization involves task focus and autonomy.   Role alignment means that coping is shaped by the work requirements (Rosario et al., 1988).

When examining the study results sectioned by gender, it suggests a link to role alignment theory. Given the demands on both male and female workers to exercise a level of emotional connection with both their clients and colleagues, it appears that male workers have increased their tendency to use emotion focussed strategies.

When looking at the supervisory work role, there is evidence to suggest the influence of both traditional socialization and role alignment theories. This is detailed in the next section.

5.10 Workplace Wellness Journal: Responses by Work Role: Supervisors
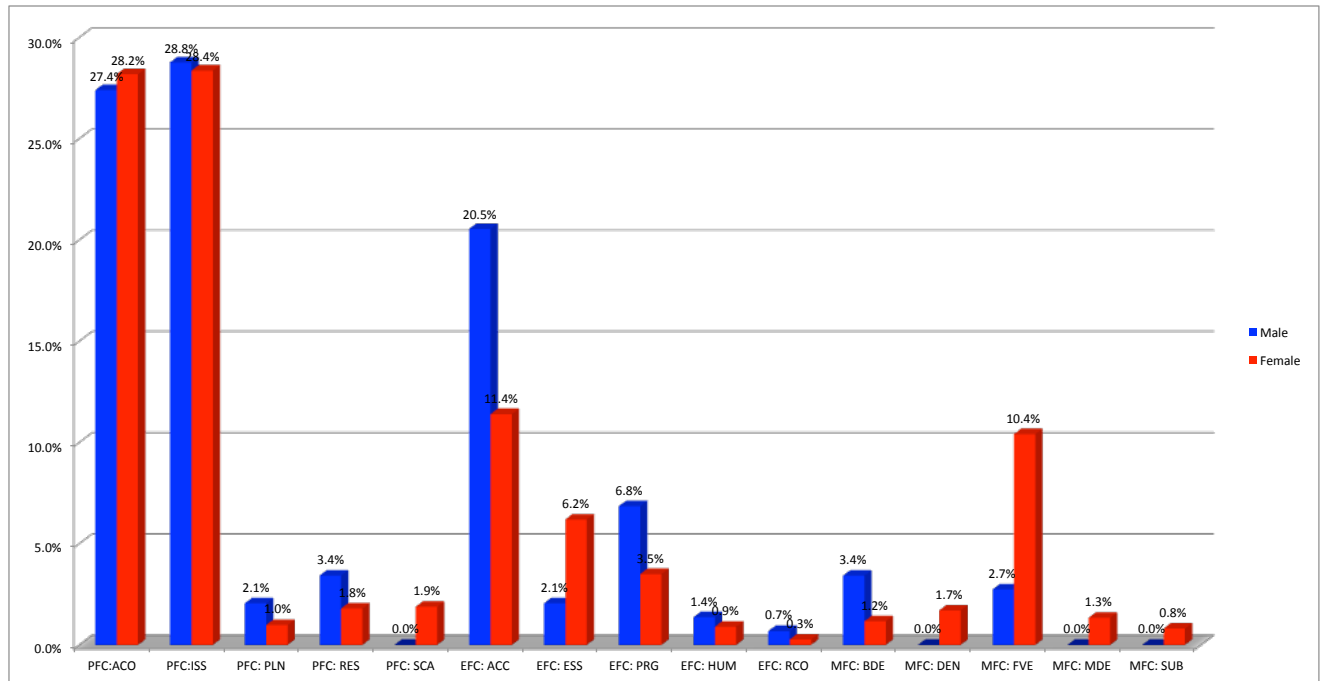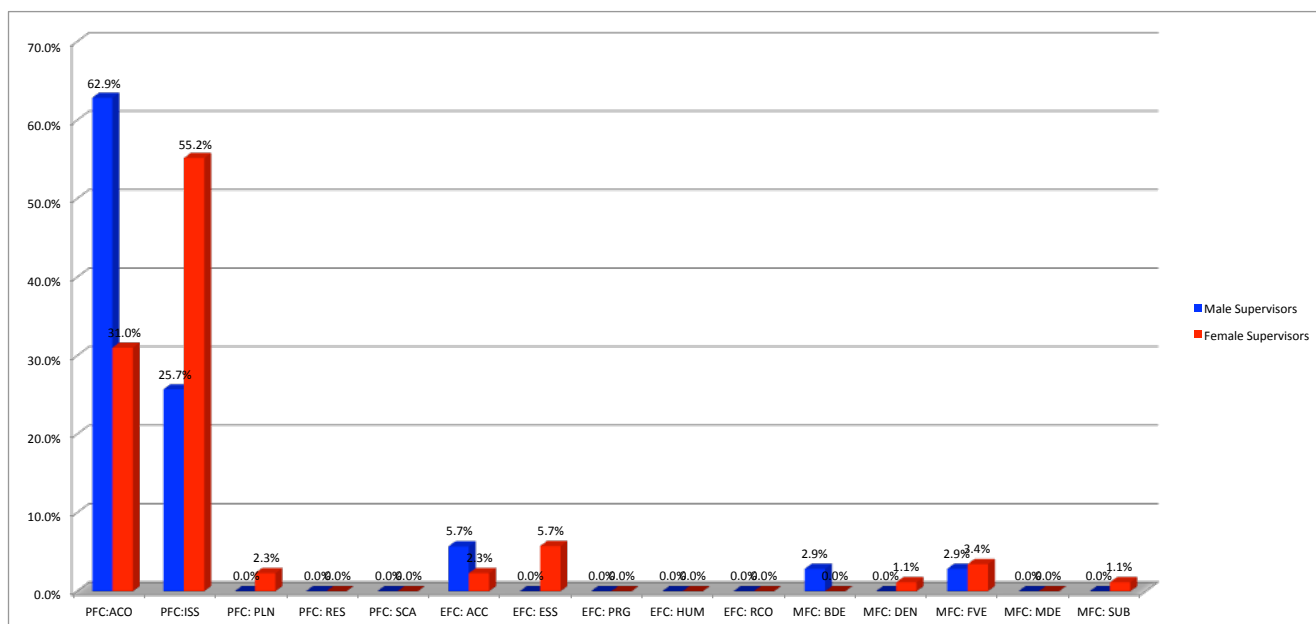

Figure 42: Coping Responses by Work Role: Supervisor

Legend:

- PFC = Problem Focussed Coping; ACO = Active Coping; ISS = Instrumental Social Support; PLN = Planning; RES = Restraint; SCA = Suppression of Competing Activities

- EFC = Emotion Focussed Coping; ACC = Acceptance; ESS = Emotional Social Support; PRG = Positive Re-Interpretation and Growth; Hum = Humour; RCO = Religious Coping;

- MFC = Maladaptive Focussed Coping; BDE = Behavioural Disengagement; DEN = Denial; FVE = Focus on Venting Emotions; MDE = Mental Disengagement; SUB = Substance Use

The gender gap in work role was clearest with supervisors. Because of the action orientation of the supervisor work role and the need to make quick decisions, it is not surprising that the problem focussed coping cluster was the overwhelming choice for both genders. What is surprising, however, is that males and females differed in the specific categories. Males overwhelmingly chose active coping, with instrumental social support in second place, while women chose instrumental social support, then active coping. Turning now the employment and assistance workers (EAW), role alignment theory seems to have a stronger influence, as the next section outlines.

5.11 Workplace Wellness Journal: Responses by Work Role: EAWs
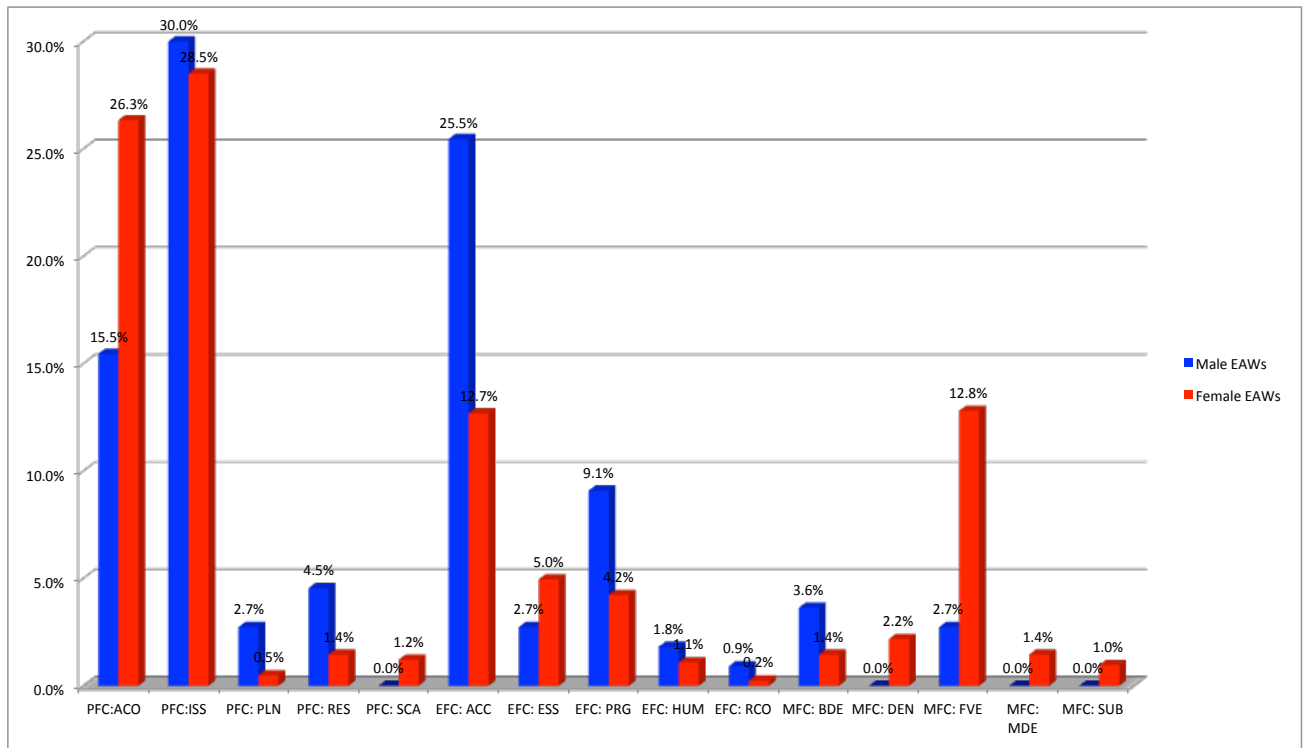
Figure 43: Coping Responses by Work Role: Employment and Assistance Workers

Legend:

- PFC = Problem Focussed Coping; ACO = Active Coping; ISS = Instrumental Social Support; PLN = Planning; RES = Restraint;   SCA = Suppression of Competing Activities

- EFC = Emotion Focussed Coping; ACC = Acceptance; ESS = Emotional Social Support; PRG = Positive Re-Interpretation and Growth; Hum = Humour; RCO = Religious Coping;

- MFC = Maladaptive Focussed Coping; BDE = Behavioural Disengagement; DEN = Denial; FVE = Focus on Venting Emotions; MDE = Mental Disengagement; SUB = Substance Use

The responses for male and female employment and assistance workers suggest the influence of role alignment theory (Rosario et al., 1988). To effectively problem solve, all EAWs need to establish an emotional understanding with their clients. The results indicate that both male and female EAWs take a very strong instrumental social support approach when problem solving. In addition, males were considerably lower on active coping than females, again suggesting a finding that runs contrary to traditional socialization theory for both genders (Barnett and Baruch, 1987), and aligns more closely with role alignment (Rosario et al. 1988). Further, male responses on the acceptance coping strategy were much higher than

female staff, again suggesting the influence of role alignment. The following example illustrates a male EAW using the emotion focussed coping strategy of acceptance:

> *"...I just responded to my work as best I could..."* (Male EAW, ID: 308488510).

The one area that did appear to align with socialization theory was the maladaptive focussed coping (MFC) cluster. Female EAWs had a much higher response rate on the focus on and venting of emotions (FVE) coping strategy, which involves a level of interpersonal and intrapersonal ruminating, and is often a negative emotional spiral (Matud, 2004).

When looking at the remaining work cohorts, the influence of role alignment seems to provide the best explanation for coping responses, as will be detailed in the next section.

5.12 Workplace Wellness Journal - Responses by Work Role: Female Family Maintenance Workers, Female Investigative Officers, and Female Client Service Workers
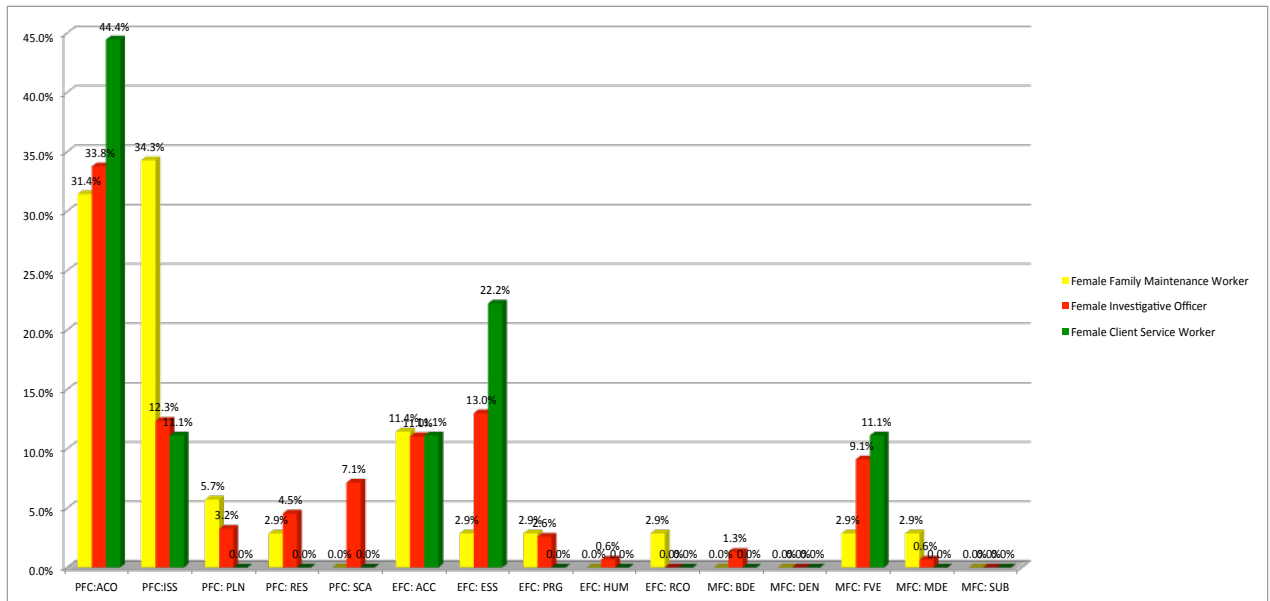
Figure 44: Coping by Work Role: Female Family Maintenance Workers (FMWs), Female Investigative Officers (IOs), Female Client Service Workers (CSWs

Legend:

- PFC = Problem Focussed Coping; ACO = Active Coping; ISS = Instrumental Social Support; PLN = Planning; RES = Restraint; SCA = Suppression of Competing Activities

- EFC = Emotion Focussed Coping; ACC = Acceptance; ESS = Emotional Social Support; PRG = Positive Re-Interpretation and Growth; Hum = Humour; RCO = Religious Coping;

When looking at FMWs, IOs, and CSWs, only female staff are represented within these cohorts. The CSW data is ambiguous, due to the small number of CSWs in the study. Role alignment theory provides more of an explanation for these work roles. FMWs had close to 75% of their responses in the PFC cluster, with specific attention to instrumental social support and active coping. They also had the highest rate on the planning (PLN) category, and this is reasonable given that FMWs are involved with moving cases through the court system.

In summary, across work cohorts, the responses of staff reflect the influence that their work role has upon problem responses. Since the issues faced by staff are

social/relational, staff appear to step outside their traditional gender socialization, and when their work requires a more task focussed approach, they are able to adapt.

As revealed to this point, both the problems identified and the coping responses were primarily social/relational. The next section details that the resources utilized by staff were also social/relational.

5.13 Worksite resources were primarily social/relational

The resources used by staff to resolve problems reveals a link to social/relational support. The first choice was to turn to colleagues/team members. Arguably, the categories of people in authority and combination of colleagues and people in authority results in a mega-category that is the first choice across all work roles, and represents a strong social/relational coping choice.

Social support is strongly associated with positive wellness within social services environments. Many jurisdictions are now including social support as a provincial, state or national wellness indicator. For example, in 2009 Oregon included social support as one of its top seven wellness indicators for the state (Foster et al. 2011). In this study, the second coping choice for staff was to take an autonomous stance, to problem solve on their own. However, even when workers chose to rely on their own judgment as a resource, they often peripherally referenced social/relational support (i.e., colleagues and/or supervisors). In addition, their intrapersonal self-talk revealed social/relational support aspects. This trend is found when examining various work roles.
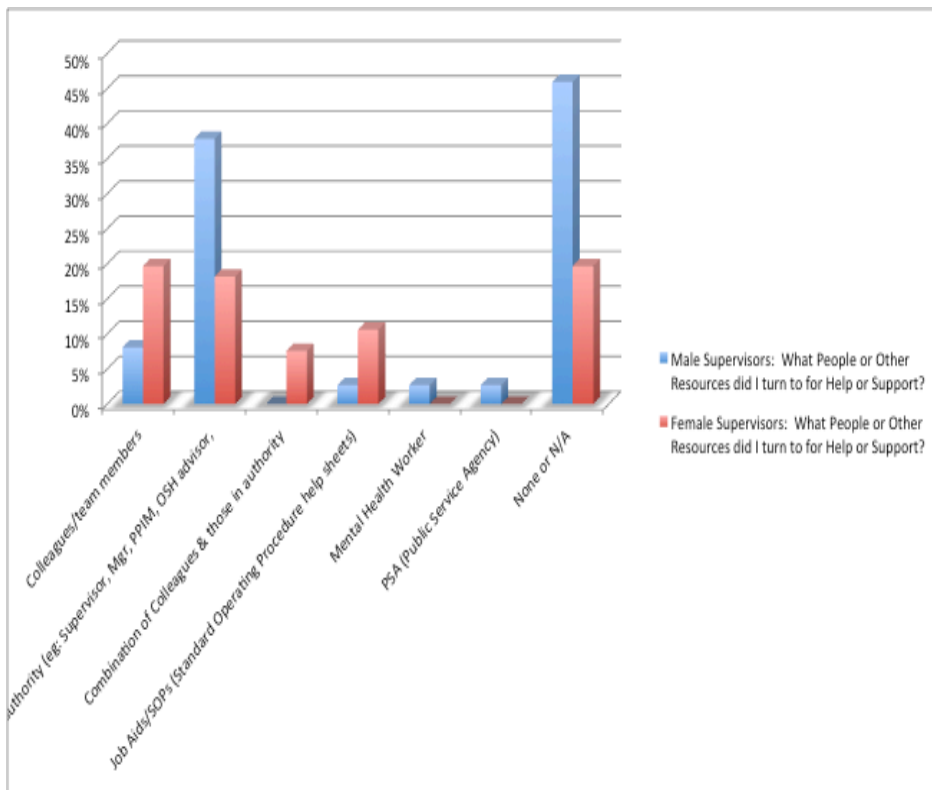
For example, both male and female supervisors had a tendency to problem solve on their own, but there was still a strong social support connection.

Figure 45: Worksite People/Resources Used

Male supervisors, for example, would check with someone in authority for assistance:

> *"…my manager available today…"* (Male supervisor; ID: 4578492902)

Compared with male supervisors (45%), female supervisors handled things themselves about 20% of the time, but were equally likely to turn to either colleagues or someone in authority as a resource:

> *"…Bounced one scenario off my supervisor to see if there is ever more I can or should do to assist…"* (Female supervisor; ID: 91483099).

Male and female EAWs reported that colleagues/team members were a major resource. The following example highlights the importance of social/relational support for both genders. There is evidence, however, that male interactions are more concrete and task-focussed, and tend to omit emotional content, while female

staff share emotions:

> "*I turned to co-workers for assistance in help setting up benefit plans to issue cheques, and setting up ongoing eligibility.*" (Male EAW, ID: 308488510);
>
> "*I mentioned my feelings to a coworker who understood the trials of a long commute.*" (Female EAW, ID: 9152317578).

Like EAWs, female CSWs cited the importance of colleagues when dealing with issues. FMWs also had a pronounced preference for turning to colleagues as a resource. Female investigative officers also saw colleagues as a primary resource, as referenced in the following example:

> "*…My colleague was a bit on the fence too, but leaning more towards approval than I was, so she suggested further clarification and what questions to ask to help me decide...*" (Female IO, ID: 3413400808)

5.14 Conclusions

This chapter detailed the answers to the following research questions: How do public sector welfare services staff perceive their own wellness? How satisfied are they in their work? What are their preferences and actual behaviours when coping with problems in the workplace? Using the lens of intersectionality, the interplay between age, gender, work role, experience and geography was examined, with particular attention to age and gender.

Staff across all work classifications perceived their wellness as only satisfactory. With age, men expressed lowered wellness perceptions and job satisfaction, while women maintained satisfactory to above average wellness and job satisfaction perceptions. This theme was found across work role, years of experience, and work location. Crose et al. (1992) surmised that women have a higher likelihood to reach out for assistance than men, and this social/relational support had a positive impact. As introduced earlier, Kerr, McHugh and McCrory (2009) and Edwards et al. (2008) both affirmed that the HSE's 6 foundation indicators were crucial to understanding the increased levels of stress in the work environment. These

factors included workplace demands on employees, the level of control staff have over their work, the amount of collegial and supervisory support available, the presence of positive relationships in the workplace, role clarity for staff, and the level of change management support available for staff. Of these six, study participants reported that "support" and "relationships" were the critical factors underlying increased stress, but also the primary resource in resolving issues. Overall, social/relational support was cited as the primary coping preference, behavior, and resource. It was the key coping response found in the two months of journal narratives, and staff reported these measures were effective in helping to mitigate work issues (Johnson, 1989).

Astvik and Melin, (2013) found three coping strategies being used by social workers. The first strategy involved reducing the quality of service to compensate for increased workload demands. The second involved relying on themselves alone. The third major cluster focussed on communicating to those in authority about excessive demands, combined with actively seeking social/relational support from colleagues and supervisors. Similar to this study, it was found that the seeking of social/relational support was the most helpful.

Turning now to Chapter 6, the implications of these findings will be presented. As discussed previously, the welfare state is framed within an overarching public management reform model. Each model contains systemic factors that affect staff perceptions, attitudes, values and behaviors, thus influencing employee wellness. Chapter 6 will re-visit the Canadian welfare state and public management reform context, detailing conclusions and recommendations. In addition, research limitations, future directions, and practice implications for the enhancement of staff wellness will be discussed.

Chapter 6: Conclusions and Recommendations

6.1 Introduction

The intent of this study is to define and operationalize wellness for employees working within a public sector welfare work environment. Essentially, what is involved in helping the helpers with their wellness? In defining wellness, the literature and the findings from this study emphasized the central role of coping, and the research questions explored both theoretical coping preferences, and actual coping behaviors. The research questions posed by this study included: How do welfare staff perceive their wellness? How is the job satisfaction of welfare staff? What are their coping style preferences? What are their coping behaviours? These types of questions are starting to be examined for other helping professions (Astvik and Melin, 2013; Ben-Zur, 2009; Smith and Shields, 2013; Udod and Care, 2012), but not for welfare employees. The current study addresses this research gap.

The chapter begins by re-visiting the Canadian public management reform welfare state context, in light of the results of this study. Following this, the holistic wellness concept is reviewed and a case is made that enhancing staff wellness does not mean that all wellness components should be weighted equally. Instead, there should be a specific focus on social/relational factors. Participants clearly indicated that the problems identified, the coping responses to those problems, and the resources accessed all had a social/relational foundation. The author's Workplace Wellness Continuum construct was re-configured given that only a subset of the myriad components was of importance for staff. Flowing from this, conclusions and recommendations are detailed, with limitations and future research directions outlined.

6.2 Welfare Workers and Public Management Reform

As discussed earlier, although the welfare state is considered a crucial aspect of western democracy, it has become increasingly hybridized (Leibfried and Zurn, 2005), and public management reform has moved along this same trajectory (Gottschall et al. 2015). Public management reform in Canada has been a blend of NWS, NPM and NPG. Of the three, NWS has been central as Canadians have a strong historical bias toward traditional institutions, particularly welfare and healthcare (Tomblin, 2009), although welfare has elements of both NPG and NPM.

Employees have to adjust to the stressors present within the welfare state as well as the 6 foundational work environment stressors. The welfare state stressors include: categorisation, caregiving, choice, and decision-making (Esping-Andersen, 1990; Lipsky, 2010). The 6 foundational workplace stressors (Edwards et al. 2008; Kerr, McHugh and McCrory, 2009) include workplace demands, control, support, relationships, role clarity and change management issues. Of import to this study, staff identified support and relationships as both central wellness problems and key resources, with social/relational support reported as the primary coping behavior. It is suggested that the hybridized public management reform platform is a contributing factor to this duality. Each reform model has systemic factors within it that either undermine or enhance employee social/relational engagement, as the following sections detail.

6.3 NPM and Social/Relational Engagement

If considered on a gradient from lower to higher focus regarding social/relational engagement, NPM would fall on the lower end of the spectrum (Pollitt and Bouckaert, 2011). New Public Management (NPM) makes the assumption that since many government services are a monopoly, employees will develop a self-serving instead of a client serving orientation (Farnham and Horton, 1996). It therefore has a focus on private sector-type contracted services (Osborne and Gaebler, 1992) to help resolve this dilemma. The process is market driven and clients deemed employable are expected to transition quickly off the system. The

contractors are evaluated based on these performance outcomes (Ferlie and Geraghty, 2005), and aspects of client categorisation, caregiving, client choice, and decision-making are delegated to them.   Welfare staff see this as de-skilling of their positions. McDonough and Polzer (2012) assert that Canadian staff in an NPM environment experienced high stress levels, with little sense of control over their work demands. This "low trust" work atmosphere resulted in male and female staff disengaging. Male staff emotionally disengaged, while female staff exhibited a negative workaholic stance, striving to provide quality service, while also achieving fiscal performance targets (McDonough and Polzer, 2012).

NPM offered the promise of enhancing staff engagement and accountability with an increase in the market-based performance processes (MacCarthaigh, 2012), but as Newman (2008) highlighted, true accountability is rooted in social/relational engagement, not in arbitrary performance targets.   Welfare is designed to help citizens in crisis, and Hoggett (2000) maintained that dependency was historically considered part of the human condition. With NPM, an assumption is made that clients can be treated as consumers who are able to rationally make their own decisions, with staff simply there to facilitate.   Some clients struggle with making rational decisions (Gibson, 1995), and staff have to provide support and counsel. Accordingly, employees require a work environment that provides social/relational engagement and support. The focus of NPM, however, is not on staff, but on outcomes, and Osborne and Gaebler (1992) highlight that NPM structures tend to undermine control for staff, and lower the potential for positive social/relational engagement between staff and supervisors.   Moving to a discussion of New Public Governance (NPG), this model displays a stronger focus on social/relational support.

6.4 NPG and Social/Relational Engagement

While NPM has a focus on business-type processes and structures, New Public Governance has a focus on participatory partnerships, with decision-making and goal setting accomplished through this networking framework (Bellamy and Palumbo, 2010). For NPM, social/relational engagement is not a priority. Instead, the focus is on efficient and effective government services, and usually involves some form of staff reduction, which is particularly disengaging to employees. New Public Governance has a more overt focus on social/relational engagement, and given the involvement of multiple stakeholders, it is considered crucial to maintain positive relationships. The recent developments in Digital-Era Governance (DEG) are a subset of NPG, and result in a significant rise in virtual service offerings by government (Pollitt and Bouckaert, 2011), as has been the case within the Canadian welfare state context.

NPG's impact on welfare staff has been mixed. In regard to categorisation, caregiving, choice and decision-making, the participatory environment fosters a certain level of synergy and innovation (Pollitt and Bouckaert, 2011), however accountability is challenging. The participatory NPG framework helps mitigate workplace pressures, and the move toward virtual services also fosters more flexibility and control for staff, and allows for enhanced social/relational engagement. On the negative side, Dunleavy et al. (2006) highlight that virtual service delivery can lead to more intensive staff monitoring and adherence to performance targets, which can result in lowered social/relational engagement. Journal narratives exhibit elements of this, as some staff report less control and support. Overall, however, the NPG reform model has a stronger focus than NPM in areas of trust building, employee development, and collegial decision-making (Christensen and Laegreid, 2007). Within the NPG model, staff have more input, increased role clarity and a work environment in which social/relational engagement is considered seriously (De Jonge et al. 2008). Looking now to NWS, there is a significant focus on social/relational engagement as this is an integral aspect of maintaining staff professionalism.

6.5 NWS and Social/Relational Engagement

The goals of all reform models are similar, with an accent on improving efficiency and effectiveness of government services. While NPM maintains a business focus, and NPG advances a collaborative network approach, NWS advocates core public sector experience. Referencing again the focus gradient from low to high, NWS highlights social/relational engagement as part of building and maintaining a professional public sector culture (Rochet, 2008). Seeing themselves as valued insiders, staff directly handle issues around categorisation, caregiving, choice and decision-making (Lynn, 2008), and this promotes a strong sense of organizational loyalty (Akerlof and Kranton, 2005). There is a significant level of role clarity for staff within a NWS model, with positions generally full time and permanent, which adds to stability. There is a vertical chain of command, which facilitates flexibility around work demands and control (Collins and Cradden, 2007). McDonough and Polzer (2012) highlight that NWS values quality client service, which arguably promotes social/relational engagement between staff and supervisors.

In conclusion, the fact that staff self-reported a duality around social/relational engagement is not surprising, given the blurring of both the welfare state and public management reform boundaries (Pollitt and Op de Beeck, 2010). As discussed, each of the models has elements that frame social/relational factors both as problems and as solutions. Within the Canadian experience, NWS is a central driver, but there are definite aspects of NPM, including a measure of sub-contracting, performance aligned salaries, and business-type accounting (Pollitt and Bouckaert, 2011). Open government, the expansion of virtual service networks, and public/private partnerships are aspects of NPG found within the Canadian experience.

Returning to the gradient on social/relational engagement within the welfare work environment, NPM falls into the lowest quadrant of the three models, due to an overly focussed concern on quantitative instead of qualitative measurement (Rose, 1976). In addition, promoting only market-based approaches when considering client needs does a disservice to citizens in crisis (Dominelli, 1996). Further,

Kirkpatrick and Ackroyd (2003) assert that there is a disconnect between welfare staff values and NPM values, causing significant disengagement. It bears stating that every reform model creates a level of tension for staff between the twin pressures of concurrently maintaining fiscal accountability and quality service to marginalized clients. These pressures become intense within the NPM reform model, given the minimal concern for social/relational factors, and contribute to staff identifying social/relational factors as problematic.   Conversely, both NPG and NWS have a high concern for social/relational engagement, which contributes to staff self-reports of social/relational factors as primary wellness coping responses and resources.

The discussion, to date, has been on the welfare state, as situated within the public management reform context, and the pressures staff experience within this environment. The next section discusses the question of whether the holistic view of wellness is the most suitable paradigm for the welfare work setting.

6.6 Holistic Wellness

Although wellness is a socially constructed concept, the prevailing view reflected in the literature is the holistic paradigm (Clark, 1996; Hansen, 2006; Jonas, 2005; Lafferty, 1979; Myers, Sweeney and Witmer, 2005; Sackney, Noonan and Miller, 2000). This view of wellness is intuitively attractive as it appeals to the sense of incremental improvement, in line with theories like Dunn's (1959) wellness continuum, and Maslow's (1943) hierarchy of needs. It was Maslow's belief that certain basic needs had to be met before it was possible to move to a higher level, finally arriving at the self-actualization/wellness pinnacle.

The intent of holistic approaches is to both improve the overall health and wellness of staff, and to diminish the growing costs associated with employee absences due to illness and injury (Henke et al. 2011). Physical health and wellness take a prominent position, and many programs also have environmental, psychological, social, occupational, emotional and spiritual components. Are they warranted? For example, some studies that promote physical wellness (Bell and Blanke, 1989;

Lechner and de Vries, 1997) show either ambiguous or marginally positive outcomes in regard to improving absenteeism. In addition, the link between physical wellness and job satisfaction is somewhat gray. For example, those who are physically fit and involved in a regular fitness routine report higher levels of job satisfaction (Baun, Bemacki and Tsai, 1986). However, higher job satisfaction might linked to an employee's perception that the organisation has a concern for their wellness. This is described by Eisenberger, Fasolo and Davis-LaMastro (1990) as POS [Perceived Organisational Support]. Staff receiving physical fitness passes perceive an organisation very positively and job satisfaction ratings are high, even though the person may not actually use the resource. In the current study, staff narratives showed that POS was present with social/relational coping. Staff reported that they had the social/relational support needed, or perceived they had it, and this positively influenced their wellness.

Parks and Steelman (2008), in a meta-study looking at organisational wellness programs, examined the relationship between wellness programs, absenteeism and job satisfaction. The assumption was that wellness involvement lowered absenteeism, and enhanced job satisfaction, and the results did indicate this correlation. However, it was not clear whether the results were due to the content of the program or other factors. Clearly, enhanced physical fitness has been correlated to better health, reduced absenteeism and higher job satisfaction (Iwasaki, Zuzanek and Mannell, 2001). However, as seen above, there were other studies that revealed that when staff perceive that the organisation cares for them, it enhances wellness, which can impact absenteeism and enhance job satisfaction (Rhoades and Eisenberger, 2002; Rudman and Steinhardt, 1988). It could be argued that it was the presence of social/relational supports, not the holistic wellness program, that resulted in the increase in job satisfaction. Thus, is it really necessary to provide an in-depth holistic program, when perhaps significant results can be garnered through funding specific wellness components? For example, in regard to physical fitness, there was evidence to suggest that offering cursory fitness initiatives (e.g., fitness centre discounts) was just as helpful as establishing

a full blown in-house fitness structure (Kossek, Ozeki and Kosier, 2001). Although a comprehensive program is useful, it may be equally helpful to look at select elements, as in the current study, where staff benefitted from a focus on social/relational factors.

Senior management will sometimes assume that offering a holistic buffet of wellness services and resources will meet everyone's needs. Wellness is assumed to be on a scale from low to high, and as employees enhance various wellness components (e.g., physical, emotional, spiritual, social and occupational wellness etc.) they will move toward total wellness (Clark, 1996; Halfon, 2005; Jonas, 2005; Lafferty, 1979; Myers, Sweeney and Witmer, 2005; Sackney, Noonan and Miller, 2000). The World Health Organisation's definition of wellness is aligned with this holistic view *(WHO, 1948).*   What can be concluded when staff indicate that only one or more wellness components are of primary importance? That is the case with this study, and a discussion of the research results will illuminate this focus.

6.7 Discussion of Study Results

The intent of this study is to understand how staff perceive their wellness, job satisfaction, coping preferences and behaviors, and academically how this might advance our understanding of welfare worker wellness. In order to understand the data from the PWS, COPE and the WWJ, the Workplace Wellness Continuum (WWC) was developed by the author. This construct was designed based on the assumption that there was a linear connection between wellness perception, coping preferences and coping behaviour, which equated to above average, average or below average wellness.

(See Figure 46)

Figure 46: Original WWC

Positive Perceived Wellness	Positive Perceived Coping	Positive Actual Coping Behaviours	=	Above Average Wellness
Satisfactory Perceived Wellness	Satisfactory Perceived Coping	Satisfactory Actual Coping Behaviours	=	Satisfactory Wellness
Negative Perceived Wellness	Negative Perceived Coping	Negative Actual Coping Behaviours	=	Below Average Wellness

The data revealed that these relationships were not linear. For example, it was thought that the group volunteering for the study would be extremely enthusiastic about wellness, and would likely score very highly on the perceived wellness survey. However, wellness perceptions were only just satisfactory, with female perceptions being more positive than male. For men, increasing age and experience meant lowered wellness perceptions. For women, the trend was more positive, and their wellness perceptions tended to be either average or above average. Indeed, the data revealed that wellness perceptions tend to generally erode over time, with the lowest scores in those over 60 years of age. If it takes energy to maintain a positive outlook, it suggests that male staff were less able to generate that energy, given that they appeared to be less likely to reach out for the support they required. Having been involved in this work environment for over 34 years as a front line worker, supervisor and manager, the author's experience has been that the pressures tend to be cumulative and that male staff are less likely to reach out for support than female staff. Crose et al. (1992) asserted that women were more likely to identify when they needed support in building and maintaining their wellness. They were more open to reaching out for social/relational support and accepting it when offered. It is suggested that this factor was in play with wellness perceptions, and the data reveals this same connection with job satisfaction, coping preferences and coping behaviours.

Female staff were higher in their job satisfaction ratings than men. Women also rated more days problem free, and their descriptions of those days differed as well. Men rated days as problem free only when there were clearly no issues whatsoever, whereas women still often rated days that were very full and challenging as problem free. With age, there was again gender disparity. Levels of satisfaction were lower for men than for women. In terms of work role, female staff were more positive in their estimations of job satisfaction. As with wellness, there appeared to be a gender difference, and it was linked to social/relational support. Chappell and Badger (1989) found that men have a larger range of social acquaintances, but women have social/relational support that is more in-depth. These social supports result in enhanced self-efficacy, with increased capacity to deal with stressors, leading to more positive wellness and job satisfaction (Duxbury et al. 1984; Schwarzer and Leppin, 1989; Sulsky and Smith, 2005). Looking now to coping preferences, the same pattern appears.

COPE scale results demonstrated that both men and women had a strong preference for problem focussed coping (PFC). However, women in this study also showed a strong preference for emotion focussed coping. Concerning work role, male staff (i.e., supervisors and EAWs) were strongly focussed on problem focussed coping, while female staff (i.e., supervisors, EAWs, CSWs, FMWs and IOs) had almost equally strong preferences for emotion focussed coping approaches, which aligns with social/relational support. When looking at actual coping behaviours, there was again validation of the significance of social/relational support.

Examining the workplace wellness journal narratives revealed that the problems identified, the coping responses, and the resources utilized all had a social/relational base. The top problems identified across all work roles, ages and gender were issues with clients, issues with staff/colleagues/stakeholders, personal issues and issues with supervisors/managers. Wallace (2013) demonstrated that social/relational factors can be a duality, both a source of strain

and a source of support. Thoits (1995) outlined situations where relationships may create role strain, overload, or conflict, where the demands on the individual exceeds their capacity to comply.

The primary coping responses had a strong social/relational support alignment. Active coping (ACO) and instrumental social support (ISS) were the primary problem focussed strategies and these both had strong intrapersonal and interpersonal social/relational support links. Emotion focussed coping strategies were primarily those of acceptance (ACC), emotional social support (ESS) and positive re-interpretation and growth (PRG), again revealing the social/relational linkage. Males had a stronger preference for acceptance as a coping strategy, while women had a strong preference for emotional social support, suggesting linkage to role alignment theory. Given that both genders are called upon to emotionally relate to clients and co-workers, it suggests that males increased their use of EFC strategies, in spite of the fact that traditional socialization might dictate primary adherence to PFC strategies. The one major maladaptive focussed coping strategy used by both men and women was a focus on venting of emotions (FVE), which is a maladaptive form of social/relational support, expressing itself as social strain or social overload.

In addition to the problems identified and the coping responses, even the resources accessed had social/relational support alignment. The categories of colleagues/team members, people in authority and combination of colleagues and people in authority represent a super-category of social/relational support. In summary, social/relational support as a coping strategy is the major factor running through the study findings on wellness, and this theme is strongly represented in the literature, as detailed in the next section.

6.8 Social/relational support and Wellness

Wang et al. (2014) described social support as help or care from others. As a coping strategy, it has a positive impact on mental and physical health and behaviour, serving to mitigate the impacts of stress, and assisting in maintaining emotional balance. Social/relational support was also shown to enhance overall perceived coping, while assisting the individual in realistically seeing problems as manageable (Wang et al. 2014). Wang, Wu and Liu (2003) in a meta analysis on the social/relational support, found 4 positive impacts on health and wellness, using the following definitions. First, health and wellness was seen as the absence of disease. Second, it was seen as the above average ability to perform assigned social roles. Third, health and wellness was defined in terms of adaptability, specifically the ability to flexibly deal with events in the environment in a proactive manner.   Fourth, it was defined as enhanced overall wellness.

The results indicated that social/relational support had impacts on all four of the domains designated above. In terms of overall wellness, social/relational support had a positive impact on coping ability, quality of life and psychosocial balance. It assisted the employee in their actions and thought processes. It enhanced overall coping capacity and coping strategies and also enhanced motivation to improve overall health.

Farrell and Geist-Martin (2005) determined that health and wellness is strongly connected to relationships both on and off the worksite, highlighting the importance of social support from colleagues and supervisors within the work environment, and social support from family when away from work. Siedlecki et al. (2014) conducted a study that traced wellness and social/relational support with over 1,000 subjects, across an age cohort from 18 to 95. The intent was to determine what positive or negative influences social/relational support exerted on wellness, plus whether social/relational support had impacts on levels of overall life satisfaction. For purposes of the study, various aspects of social/relational support were delineated. These included: enacted support, perceived support, provided

support and embedded support, all of which were found in the present study.

Enacted support referenced the actual receiving of support in the form of emotional or informational backing, and was strongly linked to enhanced life, and arguably, work satisfaction. This equates to instrumental social support (ISS) or emotional social support (ESS) in the coping repertoire (Carver, Scheier and Weintraub 1989), and is strongly represented in the current study.

Perceived support was defined as the anticipation of support, if required. That is to say, the belief that support was available when needed. Siedlecki et al. (2014) found that perceived support was also positively linked with levels of satisfaction, and the ability to deal with stressors. In the current study, staff journal narratives revealed regular examples of this type of support.

Embedded support references the contact frequency with those in one's social network, but not necessarily the quality of those interactions. For Siedlecki et al. (2014), contacts with family were found to be particularly useful in mitigating stressful events, and arguably, this could be due to the enhanced quality of those linkages. In the current research, it appeared that women had a more comprehensive social network, both in terms of quantity and quality of contacts, and this was reported to be very helpful.

Provided support was the final social support category and was defined as the giving of social support to others, and it was positively linked to overall wellness. In the current study, there was a strong reciprocity of social support reported, particularly for women, who often exhibited a strong others focus, as in the following example:

> *"In telling the stories of others, the stories of the clients, I shifted focus from myself, making me feel comfortable and at ease…" (Female EAW, ID: 696103843)*

Siedlecki et al. (2014) overall found that subjective wellness could be predicted based on the level of social/relational support. Overall, social/relational support had a positive influence on wellness across not only young and middle aged participants, but older adults as well. With the current study, wellness levels dropped significantly with older males. Based on the author's experience, stress is cumulative within the welfare work environment, and it's reasonable to assume that wellness levels are likely to drop with age, unless there are factors to mitigate this erosion. Given the enhanced quantity and quality of women's social/relational support network, it arguably may have mitigated those cumulative stressors, resulting in more positive wellness reporting for older women.

It should be highlighted that social/relational support is a positive force within the welfare work environment, but it is not present as a tangible program entity. It is a developmental interpersonal and intrapersonal process. Most organisations, however, continue to develop holistic wellness structures to address workplace stress, and enhance overall health and wellness (Harris, 1994; Schott, 1999). Priolcar (2014) looked at India, for example, and found that the growth in the holistic wellness movement was often seen as more of a business opportunity than a movement to address staff wellness. Because the costs for undertaking holistic wellness are formidable, Priolcar (2014) found that only the very largest organisations were able to sustain such programming. In smaller organisations, Priolcar (2014) found that many programs were simply a patchwork of activities with thinly veiled links to wellness, and included such disparate items as dancing classes, pilates, free tickets to entertainment events, and yoga. In view of the findings from this current study, an alternative approach is to focus in on those specific areas clearly identified by staff as critically important to their individual and collective wellness.

6.9 Conclusions

Wellness has historically been touted as an absence of disease paradigm, with the preventative aspects of wellness only emerging over the last several decades. The disease paradigm had a focus on illnesses, and was successful in that many medical scourges have been eradicated. With the disease model, physical health was paramount. With the holistic paradigm, a growing list of wellness domains was added, including: social, emotional, intellectual, psychological, spiritual, occupational, and environmental (Clark, 1996; Hettler, 1980; Jonas, 2005; Lafferty, 1979; Myers, Sweeney and Witmer, 2005; Sackney, Noonan and Miller, 2000). Many public and private sector organisations have subscribed to this model, including the Ministry of Social Development and Social Innovation. The Ministry offers a range of wellness options including retirement planning, employee and family counseling, career counseling, conflict resolution, assisting with aging parents, personal counseling, health resources (e.g., flu shots, smoking cessation, nutrition, weight management, fitness centre passes). Resources for supervisors and managers include: assistance in working with staff who have issues (e.g., addictions, relationship issues), and e-learning courses on various topics (e.g., change, retirement, career transitions, ethical dilemmas, bullying). In addition, all staff have access to an online site called My Good Health, which covers a number of similar resources to the above, plus additional resources as well (e.g., legal, financial, safety).

Holistic wellness continues to grow, and Reese et al. (2014) recently coined the term "ecowellness" to describe the respect, appreciation and enhancement of human wellness flowing from exposure to the natural environment. The Reese Ecowellness inventory (REI) was developed to gauge this impact on wellness. Further, Brown et al. (2014) developed the Holistic Wellness Assessment (HWA), an instrument designed to provide an integrative, trans component assessment of holistic wellness. As Thomas Kuhn (1970) might assert, a tipping point has occurred. The holistic paradigm has captured the academic high ground, and has become the new norm. Indeed, the holistic wellness movement is closely aligned

with the humanist credo that holism is sacrosanct. It is now assumed that human beings cannot be imagined as less than whole, and thus the understanding of human wellness must use a holistic lens (Hansen, 2006; Myers and Sweeney, 2008).

This study questioned the holistic paradigm and contends that although there is a case to be made for holism, all wellness components may not be of equal importance to employees. Instead of adopting a holistic approach, where numerous wellness components are given equal weighting, a focus on a smaller subset of wellness sectors might be beneficial. Holland (1997) maintained that an individual's choice of career aligned with their personality. For example, those within the social career cluster were attracted to social occupations because it allowed the person to work, engage and help others. Given this, it is suggested that wellness for those in these social career clusters more closely align with the social, emotional and psychological components of the holistic wellness spectrum.

The following section details the significant importance welfare workers accorded to social/relational support as a wellness coping strategy.

Cox, Leather, and Cox (1990) asserted that wellness should be put into the context of both the work content and the work environment. The content of welfare work centers around financially and vocationally assisting marginalized individuals and families, with coping and wellness being integrally linked. In fact, coping is a major factor present across all wellness components (Adams, Bezner, and Steinhardt,1997; Anspaugh, Hamrick and Rosato, 2004; Crose et al. 1992; Durlak, 2000; Ingersoll, 1994; Renger et al. 2000; Ryan and Deci, 2001; Ryff and Singer, 2006).   De Jonge et al. (2008) in their DISC (Demand-Induced Strain Compensation) model, contended that there were three types of problems that employees faced: social/emotional, mental/cognitive, and physical. Further, when employees faced one or more of these problem clusters, matching resources to the issue would assist in mitigating the pressure, and thus enhance staff well-being.

For example, workers faced with having to resolve complex mental/intellectual issues would benefit from having mental/intellectual resources (e.g., information databases). Further, those who have to cope with demanding or aggressive clients or patients would benefit from supportive colleagues who can provide social/relational support. For purposes of this study, resources were not arbitrarily matched to staff problems. Staff self-selected resources to meet their needs. Social support was the primary coping strategy, with relational links to the emotional, psychological and mental clusters, as seen below (Figure 47).

Figure 47: Coping Strategies chosen by welfare staff
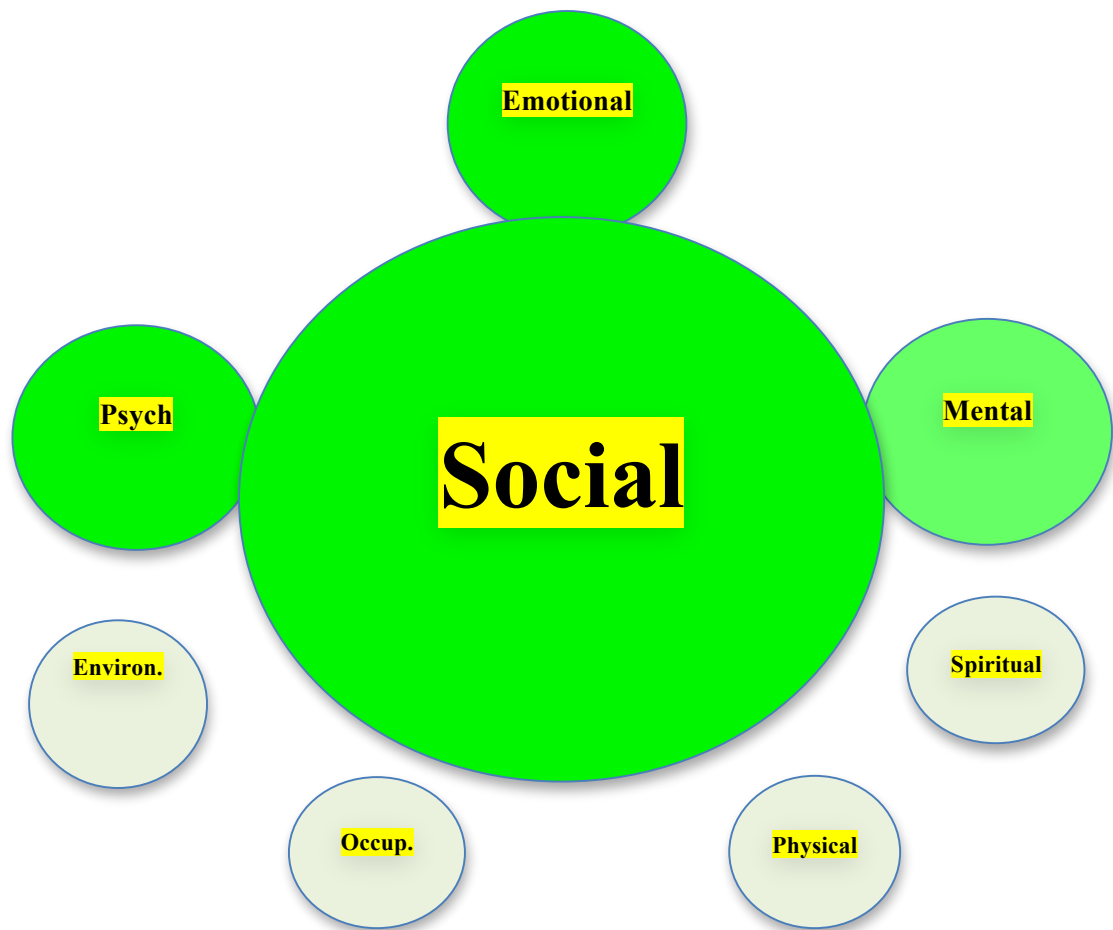
The diagram above represents the social/relational aspects of the problem focussed and emotion focussed coping clusters (Carver, Scheier and Weintraub 1989). The primary wellness resources accessed are represented in bright green,

social support being the largest silo, with emotional, psychological and mental wellness components being relationally linked. The remaining circles represent those clusters that were not reported as being at the same level of significance by staff in the study. The data reveals that both men and women utilized social support strategies as a primary resource, and that this was very useful in the enhancement of wellness and work satisfaction levels. Women experienced even higher levels than men, perhaps due to their more in-depth social support networking.

The fact that staff selected social/relational support strategies to support and enhancing their wellness runs contrary to the assumptions of the holistic wellness model. These include the assumption that the "whole person" has to be the focus, and that all wellness components are of equal value to staff. This study shows that welfare staff do not value all components equally. Second, the holistic paradigm does not consider the wellness/unwellness duality, the reality that individual and organisational factors (e.g., public management reform) may be a source of both unwellness as well as wellness. This study revealed social/relational factors as a source of both unwellness and wellness. Third, the holistic paradigm focuses primarily on individual responsibility for wellness (CIPD, 2007), minimizing the role of the organisation. This study highlights the importance of interdependent responsibility for wellness, as employees reach out socially and relationally.

6.10 Recommendations

Farrell and Geist-Martin (2005) demonstrated that many companies are funding wellness programs in a holistic fashion. These often include a wide range of wellness components and resources. They emphasize, however, that many staff do not avail themselves of these resources due to personal embarrassment surrounding the particular issue, or a sense of distrust regarding the organisation's ability to keep their issues confidential. Given the results of this study, it might be useful to explore alternatives to a strictly holistic wellness program. The first step in this exploration would be to conduct an assessment, to understand how workers define their wellness, and whether all wellness components are of equal

importance to them. In this study, staff identified social wellness (i.e., social/relational support) as being important, and Farrell and Geist-Martin (2005) highlighted that social health and wellness needs specific emphasis. The social capital that is created serves as a foundation for wellness, and there is evidence to support the premise that social/relational support both sustains and enhances other wellness components (Wang, Wu and Liu, 2003; Wang et al. 2014).

In the current study, social/relational support was not identified or linked with any program or organisational initiative. It was part of the overall work environment experience, in the exchanges between co-workers, and between co-workers and supervisors. In addition, social/relational support was evidenced between workers and friends/family. There is evidence to suggest that these interactions helped build and maintain enhanced motivation, resilience, coping capacity, organisational loyalty and feelings of worth, value and engagement, which all align and support psychological, emotional, and spiritual wellness components (Farrell and Geist-Martin, 2005; Wang, Wu and Liu, 2003; Wang et al. 2014). It also helps to mitigate stressors in the work environment, thus arguably enhancing overall physical health and wellness. In addition, positive social interactions with supervisors/managers help to blur the bureaucratic hierarchy. It allows a leveling of the organisational playing field and enhances feelings of mutual respect, equality, personal worth, and sense of community.

This research was initiated to bring a better understanding of the wellness needs of welfare workers. The overarching question was: What factors contribute to health and wellness for front line staff within a public sector social services work environment?" Flowing from this, four research questions were delineated:

1. How do public sector welfare staff perceive their wellness?

2. How is the job satisfaction of public sector welfare staff?

3. What are the coping style preferences for public sector welfare staff?

4. What are the primary coping behaviours of welfare services staff?

The data suggest several directions, on philosophic and pragmatic levels. Lowe (2010) suggests two primary starting points for linking organisational goals with employee wellness. The first deals with how the work is organized. The second explores the needs employees have in balancing organisational priorities while attaining and maintaining their wellness.

First, the philosophical foundation stone of welfare services is the acknowledgment that dependency is part of the human condition both for those providing services and those who receive them (Hoggett, 2000). As a society, we have moved to a place where there is overt or covert negativity expressed toward not only the concept of dependency, but also to those in a position of dependency. We place value only on independency, which itself is a myth. Those working within the welfare services environment need to be able to express the tensions they feel in this occupational setting, and the reality that both staff and clients interact in a setting of interdependency. For existing staff, guided dialogue sessions may assist in easing the inherent contextual pressures and tensions when faced with service delivery justice and mercy issues. For new staff, this systemic contextual pressure could be explored during the new worker's orientation.

Second, given that staff across all classifications cope within a context of relationship, it's important to explore ways to make the work environment more amenable to enhancing social/relational supports. Public sector management reform should support those models that facilitate social/relational engagement at all levels. Particular attention should be given to utilizing elements of NWS and NPG, rather than the continued emphasis on what Dominelli (1996) referenced as NPM's morally bankrupt vision, with its superficial concern for both staff and marginalized citizens.

Third, Lave and Wenger's (1991) research on communities of practice reveal that the formalizing of social interactions can be counterproductive, with the accompanying rules and structure causing disengagement. Lowe, Shannon and

Schellenberg (2003) demonstrated that workplace health and wellness is best determined by listening to the staff. In looking at data representative of the Canadian labour force, there were specific elements that related to workers' perceptions of positive wellness, and the majority had an interpersonal and/or intrapersonal alignment. These included: positive and helpful relationships with co-workers, positive supervision, respect, trust, positive co-worker communication, safe environment, work control, career security, and work/life balance (Lowe, Shannon and Schellenberg, 2003).

Fourth, although staff journaling did not significantly reference existing wellness resources, it does not follow that these resources were totally neglected. In addition to the major themes, there were ancillary comments that suggested staff do use traditional wellness resources like physical activity and nutrition. There is a significant body of literature supporting the benefits of traditional wellness resources. The findings from this study, however, would suggest that more emphasis should be made on supporting social/relational coping strategies and resources, rather than general support for a broad base of wellness resources.

Fifth, one of the problems identified by staff across all classifications was work volume. Clearly, work overload results in lowered perceptions of control, and therefore lowered wellness. The question Lowe (2010) proposed around how the institution organizes the work would suggest that if there are systemic workload issues, these need to be addressed at a higher level than the front line workers. It is important to combine both bottom up and top down approaches. Given that wellness is akin to happiness, it cannot be legislated. Telling staff to be well is akin to telling them to be happy. This study demonstrates that employees will take the action they need to attain and maintain their wellness, and these actions strongly align within a social/relational framework. With the exception of workload volume and technology issues, the types of problems identified are primarily linked with client, co-worker and supervisor interactions. Resolving them involves social/relationship engagement. When asked what resources they access to

resolve problems, the overwhelming choices included: colleagues/team members, those in authority, or a combination of the two. Drury et al. (2014) in a study on factors that assist front line health care staff in coping with workplace stress, found that relational support was an important factor. Using qualitative interviews, they determined that the ability to cope effectively was improved when collegial social support and affirmation was readily available.

Organisations often use too much top down structure. Management needs to support a social/relational engagement culture, and allow staff the freedom to use resources in a manner that will empower them to obtain and maintain their wellness. This has the twin benefit of enhancing both wellness and self-efficacy. Ganster and Fusilier (1989) found that when individuals are facing a problem event, their perception of their own capacity is a key factor. They experience better outcomes, with limited negative impacts if they perceive that they have the resources to be able to cope with the challenge.

6.11 Limitations and Future Research Directions

Despite the fact that the study sample reflected a reasonable cross section of staff across the welfare services sector, those who volunteered could arguably be seen as committed or at least significantly interested in their own wellness. In addition, although the gender composition accurately reflected the current ministry composition, it would have been useful to have a larger cohort of male participants.

It was not within the scope of this study to provide a blue print for enhancing organisational wellness. It is designed as a starting point and, as such, it presents flags for further exploration within the public management reform welfare environment. For example, women tend to be more socially connected than men. This study also indicates, however, that male welfare workers are increasing their use of social/relational support strategies. Further research could explore these changes in male attitudes and behaviours.

Public management reform is the foundation of the modern welfare state. This study suggests that the reform model used may enhance or undermine social/relational engagement, thus impacting employee wellness. More research would be recommended on the long-term implications of public management reform on employee health and wellness.

This study had a focus on front line staff and supervisors. Managers also expressed an interest in being involved in the study, and future research might take a specific focus on the wellness needs of this cohort.

Further research is needed on the usefulness of maintaining the holistic wellness model. This study suggests that it would be important to assess which resources are deemed most useful by public sector welfare services staff, and then allocate funding and support to those sectors.

Finally, coping effectively is one of the golden threads for attaining and maintaining staff wellness. Pienaar (2008) highlighted that it is important both to understand how staff cope and the effectiveness of coping strategies. This study detailed staff coping strategies, and the fact that social/relational coping approaches were helpful in enhancing wellness. Further to this, it would be useful to conduct research on long-term coping effectiveness within the welfare services work environment.

Appendix:

Figure 1: Research Study Information and Consent Form

Research Study Information *(i.e., As shared during Information Sessions Prior to the start of the study)*

RESEARCH STUDY:

- *Helping the Helpers: What factors contribute to health and wellness for front line staff within a public sector social services work environment?*

Invitation to Participate:

- You are being asked to take part in a research study on health and wellness for front line staff within a public sector social services work environment (i.e., Ministry of Social Services, Province of British Columbia)

- The intent is to determine what factors contribute to health and wellness for front line staff at the individual and organisational levels.

- This study has been approved by the Centre for Labour Market Studies, University of Leicester, England.

- This study has also been approved by the Ministry of Social Development, Province of B.C.

What you will be asked to do:

As part of this study, you will be asked to:
- Fill out a scale designed to determine your feelings about your overall health and wellness. It is called the Perceived Wellness Survey (PWS)
- Fill out a scale designed to determine how you feel you deal with problem experiences that occur. It is called the Coping Orientation to Problems Experienced (COPE) Scale

- **Daily** fill out the Workplace Wellness Journal (WWJ) – detailing your responses to problem experiences you may encounter on a daily basis. (ie: based on the following guiding statements:

    1.What problem(s) did I have to deal with today?

    2.How did I deal with this problem?

    3. In what way did I find it a helpful or unhelpful response?

    4. What other people or resources helped me with my response?

    5.In what ways were these other people or resources helpful or unhelpful in helping me deal with this problem?

Time Commitment:

- PWS and COPE: It typically takes 20-30 minutes to complete each scale
- Workplace Wellness Journal (WWJ): approximately 5-7 minutes/day, over 40 working days
- Touchbacks: 5-10 minutes/week (if required) - for Q and A, and feedback to/from the researcher
- Exit Interview: A few minutes - to garner any additional comments, observations, insights
- Note: It is anticipated that work time will be allowed for your involvement in this study.

Rights of Participants:

- You have the right to stop being part of the research study at any time without explanation, and to request that any information you've given for the study be eliminated.
- You have the right to refuse to answer any question or request put to you throughout the study, without fear of penalty.

- You have the right to receive feedback throughout the course of the study, and to have all of your questions answered in a timely fashion.

Benefits:

- The information obtained from this study will be used to enhance/build the body of health/wellness literature and resources useful to front line staff within public sector social services work environments.
- Each participant will receive feedback on the results of this study.

Risks:

- There are no known risks to being involved in this research study.

Voluntary Nature of the Study:

- Participation in this research study is voluntary.

Confidentiality/Anonymity:

- The researcher (Robert W. King) will have no knowledge of who is participating in the study.
- Only generic foundation identifiers will be collected. (i.e., gender, age, work role, yrs. of experience, etc.)
- No personal identifying information will be collected (e.g., name, address, personal phone or email, etc.)
- The information collected will form part of a Doctoral thesis by Robert W. King, entitled: *Helping the Helpers: What factors contribute to health and wellness for front line staff within a public sector social services work environment?*

FOR FURTHER INFORMATION

- Robert King will be happy to both provide feedback, and respond to your questions about the study at any time.

- You can contact him at:

  ◦ Email: Rob.king@gov.bc.ca

  ◦ Phone: 250-863-5784 (Cell)

Figure 2: Informed Consent

Research Study Informed Consent

(Covered during information sessions; this is also included in a popup dialogue box prior to opening the APP for the first time)

PROJECT TITLE:

- ◦ *Helping the Helpers: What factors contribute to health and wellness for front line staff within a public sector social services work environment?*

PROJECT SUMMARY:

- *The intent is to determine what factors contribute to health and wellness for front line staff at the individual and organisational levels.*

By providing your (electronic) approval via email, you are agreeing that:

- You've read and understood the **Research Study Information.**
- You have had your questions about this study answered appropriately.
- You are aware of risks (if present).
- You are voluntarily deciding to become involved in this research study.

_____

Date

Figure 3: Instructions for Use of the Workplace Wellness Journal (WWJ)

(Covered during information sessions;)

The instructions will be as follows:

"For the next 40 days, please take 5 – 10 minutes at the end of each day to reflect on your work day. Ideally make it the same time each day.   Particularly reflect on what you considered to be "problems" or "difficulties that you had to deal with during the day, and jot down your responses to the following questions:

1. *What problem did I have to deal with today?*

2. *How did I deal with this problem?*

3. *In what way did I find it a helpful or unhelpful response?*

4. *What other people or resources helped me with my response?*

5. *In what ways were these other people or resources helpful or unhelpful in helping me deal with this problem?*

Figure 4: Demographic Information (Categories included in the "My Information" section of the APP)

1. Unique Numeric Identifier

2. **Gender:** (check)

        Male: ____   Female: ____

3. **Age:**

        Under 30 years:____   30 to 40 years:____   31 to 40 years:____
        41 to 50 years:____   51 to 60 years:____   Over 60 years:____

4. **Education:**

        Less than Grade 12:____ 1-2 Year Diploma:____

        Undergraduate Degree:____   Masters Degree:____

        Other (Please detail):_____

5. **Years of Social Services Experience:**

Less than 1 year____1-2 years_____   3-5 years_____   6-10 years____

   11-15 years____   16-20 years____   21-25 years____   Over 25 years____

6. **Work Environment**:

Primarily Urban_____   Primarily Rural_____

7. **Work Context:**

Primarily F2F____   Primarily Phone____ Other____

Detail_____

8. **Work Role:**

        EAW____   CSW____   Investigative Officer_____

        Family Maintenance Worker_____ Supervisor____   Manager_____

        Director_____   Other____

9. **Major Work Duties:** (Detail – e.g., admin, med trans, case mgt., intake, etc.)

_____

_____

_____ _____

Figure 5: Study Background Information (for stakeholder approval process)

Health and Wellness Research Study Information

RESEARCH STUDY:

- *Helping the Helpers: What factors contribute to health and wellness for front line staff within a public sector social services work environment?*

Background:

- Front line staff are the face of government and their health and wellness is a priority.   Indeed, as Sauter et al. (1996) asserts, worker health and wellness should be given the same priority as the organisation's goals for productivity.   Given that work takes up to 35% of our lives, and job satisfaction has been found to account for up to 25% of life satisfaction (Harter et al. 2003), it is not surprising that there is increased interest in worker wellness.   In firms with more than 50 staff, Aldana (2001) highlights that close to 90% are involved in some form of health/wellness resourcing. In practical terms, this makes sense, given the increasing costs incurred when staff health and wellness are not given priority.   Cooper (1994) emphasized that nearly 50% of workplace absence was related to the work environment. Griffeth et al. (2000) found that employee wellness correlated positively with job satisfaction. It is thus critical to focus on both individual and organisational health and wellness factors.

Intent of Study:

- The intent of this study is to apply a holistic, interactive lens on a public sector social services setting (i.e., Ministry of Social Development), to

understand and identify factors that contribute to the health and wellness of front line staff.

Communication

- Communication with stakeholders about the intent, purpose and processes surrounding the study will be on-going. The researcher will endeavour to address questions or concerns in a timely manner.

Confidentiality/Anonymity:

- **Technology**: Communication with IMB will be undertaken, to ensure the study conforms to Ministry technological regulations and directives. Appropriate technology will be used to ensure the maximal level of data security.   SPSS will be used for statistical analysis, and thematic software (e.g., N-Vivo) will be used for qualitative analysis of journaling.
- **Demographics:**   Generic foundation data (i.e., gender, age, education, years of experience, work role, etc.) will be collected.   It will **not** contain personal data (name/address/email, etc.), or any other personal identifiers. All data will remain both confidential and anonymous, and will be used for research purposes **only**.

- **Disclaimer:** With the exception of the disclosure of harm to self or others, all information shared by staff members is completely confidential, and will be used for research purposes **only**.

- The information collected will form part of a Doctoral thesis by Robert W. King.   It will be submitted to the Centre for Labour Market Studies, University of Leicester, and is entitled: *Helping the Helpers: What factors contribute to health and wellness for front line staff within a public sector social services work environment?*

Study Participants:

- Study participants will come from a variety of staff work classifications within the Ministry of Social Development.   Of the staff involved with front line work, the largest cohort of participants will be Employment and Assistance Workers (EAW) and Client Service Workers (CSW).   The aim is to obtain a sample size of at least 60 staff, composed primarily of a mix of these above two classifications.

Staff Selection:

- All staff will have an equal opportunity to participate in the study. Information sessions will be held via virtual sessions, conference calls, and face to face discussions. This sessions will explain to all subjects that the intent of the study is to understand what factors contribute to health and wellness for front line staff within a public sector social services work environment, and that involvement is totally **voluntary**.   Each staff member will be fully informed of the intent and purpose of the study, and their benefits and rights as a participant.

Methods

- There are both quantitative and qualitative methods used in this study. Staff will be asked to fill out two points in time quantitative health/wellness assessments.   The Perceived Wellness Survey (PWS) is designed to ascertain perceptions about overall health and wellness.   The Coping Orientation to Problems Experienced Scale (COPE) is designed to determine how one deals with problem experiences that occur during daily work.

- The qualitative method consists of a daily journal that participants are asked to keep. This will assist in bringing both understanding and empowerment to

staff as they reflect and monitor their attitudes and actions when dealing with daily work experiences. Over a 40 work day period, they will be asked to fill out this Workplace Wellness Journal (WWJ), detailing their responses to problem experiences they may encounter on a daily basis. The following reflective statements are provided in the journal to assist participants in articulating their thoughts and feelings about each day:

1. What happened today that I would describe as a problem?
2. How did I respond to this event?
3. In what way did I find it a helpful or unhelpful response?
4. What other people or resources did I turn to for help?
5. In what way did I find these people or resources helpful or unhelpful?

Time Commitment:

- PWS and COPE: Completed at the start of the study.   It typically takes 20 minutes to complete each scale.
- Workplace Wellness Journal (WWJ): Completed at approximately the same time at the end of each day.   It will take approximately 5-7 minutes/day, over 40 working days.

Rights of Participants:

- The right to stop being part of the research study at any time without explanation, and to request that any information given for the study be eliminated.
- The right to refuse to answer any question or request put to them throughout the study, without fear of penalty.
- The right to receive feedback throughout the course of the study, and to have all of their questions answered in a timely fashion.
- The right to receive feedback on the results of the study.

Benefits:

- The information obtained from this study will be used to enhance/build the body of health/wellness resources and programs available to staff within the Ministry of Social Services, Province of British Columbia.
- The information obtained from this study will also be used to enhance/build the body of health/wellness literature and resources useful to front line staff within public sector social services work environments.

Risks:

- There are no known risks to being involved in this research study. As mentioned previously (see Confidentiality/Anonymity section), information shared by staff members is completely confidential, and will be used for research purposes **only**.

Voluntary Nature of the Study:

- Participation in this research study is voluntary.

- A consent process will be followed with each participant, to ensure that they understand the intent and purposes of the study, as well as the rights, benefits and any risks associated with the study. (*See Informed Consent Form*)

FOR FURTHER INFORMATION

- Rob King will be available to provide feedback, and respond to questions in a timely manner from participants, management or union representatives.

- Contact Email/Phone:

  ◦ Email: Rob.king@gov.bc.ca

  ◦ Phone: 250-863-5784 (Cell)

Figure 6:   PWS and COPE Codebook

SPSS Code Book – PWS and COPE		
Variable	**SPSS variable name**	**Coding instructions**
Numeric Identifier	**ID**	**Number assigned to each survey**
		Unique Numeric Identifier
Gender	**Gender**	**Number assigned to Gender**
		0 = No Further Details
		1 = Males
		2 = Females
Age	**Age**	**Number assigned to Age Groupings**
		0 = No Further Details
		1 = Under 30
		2 = 30 to 40
		3 = 41 to 50
		4 = 51 to 60
		5 = Over 60
Education	**Education**	**Number assigned to Level**
		0 = No Further Details
		1 = Less than Grade 12
		2 = Some post secondary
		3 = 1 to 2 yr. Diploma
		4 = Undergraduate Degree

		5 = Masters Degree
		6 = Other (Detail...)
Education Other	**EducOther**	**Number assigned to EducOther**
		0 = No Further Details
		1 = Sciences
		2 = Masters Degree in progress
		3 = B.A. – Business
		4 = Psychology
		5 = Two Degrees
		6 = Social Sciences
		7 = Certification
		8 = BA in Environmental Geography
		9 = 2 yr. Human Service Diploma
		10 = Human Service Worker Certification
		11 = Undergrad Degree/Technical Certificates
Yrs. of Exp. in MSD	**MSD Exp.**	**Number assigned to Yrs. of Exp.**
		0 = No Further Details
		1 = Less than 1 year
		2 = 1 to 2 years

		3 = 3 to 5 years
		4 = 6 to 10 years
		5 = 11 to 15 years
		6 = 16 to 20 years
		7 = 21 to 25 years
		8 = Over 25 years
Work Environment	**Wk. Env.**	**Number assigned to type**
		0 = No Further Details
		1 = Primarily Urban
		2 = Primarily Rural
Region	**Region**	**Number assigned to Region**
		1 = Region 1
		2 = Region 2
		3 = Region 3
		4 = Region 4
		5 = Region 5
		6 = Prefer not to say
Work Context	**Wk. Context**	**Number assigned to context**
		0 = "No Further Details"
		1 = Primarily F2F
		2 = Primarily Phone
		3 = Other (Detail)
Work Context Other	**WkContextOther**	**Number assigned to WkContextOther**

		0 = No Further Details
		1 = Phone and F2F
		2 = LTC Billings
		3 = Self Employment
		4 = Virtual Worker
		5 = Service Request Team
		6 = Primarily Email
		7 = Case Mgt.
		8 = Technical Work
		9 = Intake
		10 = Live Meeting and F2F with stakeholders
		11 = Contract and Partnership Agent
Work Role	**Wk. Role**	**Number assigned to role**
		1 = EAW
		2 = CSW
		3 = IO
		4 =FMW
		5 = Supervisor/SAS
		6 = Mgr./Director
		7 = Other
Work Role Other	**Work Role Other**	**Number assigned to "Other" role**
		0 = No Further Details
		1 = Administrative
		2 = Start
		3 = Specialized in HITT (Housing Integrated Task Team

		4 = Mental Health Liaison for Office
		5 = Acting Supervisor
		6 = Program Analyst
		7 = Live Meeting and F2F Meetings with stakeholders
		8 = ICM Wk.
Major Work Duties	**Wk. Duties**	**Number assigned to duties**
		0 = No Further Details
		1 = "Information collect, Determine Eligibility and Conduct Interviews"
		2 = "Supervision, Administration and OSH"
		3 = "Primarily Intake"
		4 = "Primarily Case Mgt."
		5 = "Intake and Case Mgt."
		6 = "LTC Billing"
		7 = "Primarily Telephony SR Creation"
		8 = "Telephony or F2F SR Creation"
		9 = "Health Supplements - Med Trans etc."
		10 = "Employment Planning"
		11 = "Self Employment Program"
		12 = "Intake, crisis supplements, med transportation, employment planning, case management."
		13 = "Case Mgt. and Outreach"
		14 = "Investigative Officer duties: Assess/investigate re: eligibility and correct errors and add overpayments"
		15 = "Assessment"

		16 = "FMW Duties: Completing assessments, pursuing and enrolling maintenance orders"
		17 = "ICM Project"
		18 = "Reconsiderations, ICM, OSH, Employment Planning"
		19 = "Administrative"
		20 = "IO Duties: Intake - Third party checks for intake"
		21 = Software Development
		22 = "Intake Prospecting; PWD Pending SR's; MH Liaison"
		23 = "Eligibility for program/supplements, employment planning, A/supervisor, A/PPIM, Eaw coach, icm trainer, forum moderator"
		24 = "IO/EAW Training; Program Development; Development of Info Sharing agreements; Analysis of program integrity; PLMS strategies"
		25 = "Case management, employment planning, assessment."
		26 = "POC; Stub processing; 3rd party checks; WebAOB checks for office; Intake; Trib.Ministry_Rep;"
		27 = "Telephony - Case Management"
		28 = "Telephony - Case Management and Intake"
		29 = "CorrectionsIntake; Case mgt; Integration with comm. corrections; EAW Contact - IOM/HIP Corrections project"

		30 = "Intake, front line, Rural Network, case mgt, emp planning, multi-disordered offenders meetings"
		31 = "Contract and Partnership Agent"

Figure 7: Sample Supervisor Journal Response

This is an example of a supervisor who asserts there were a number of problems, but demonstrates an example of "active coping" – part of the Problem Focussed Coping cluster:

Demographic Information:

- *ID: 7127430416   Entry 24   Date: 19/02/2013   Age: 41 to 50*
  Gender: Male   Education: 1-2 Year Diploma   Exp. 6-10 yrs.
  Primarily Phone   Primarily Rural   Region: 5   Wk. Role: Supervisor

What Happened Today that I would describe as a Problem?

- *Too many to count... I told the PPIM {Policy and Program Implementation Manager} that I had several mini strokes today. The issues ranged from conflicting Vacation requests to regional/provincial process disagreements, to OSH {Occupational Safety and Health} issues involving potentially violent clients to an information incident.*

How did I respond to the Problem(s)? (i.e., How did I cope??)

- *I sped through the day non stop in an attempt to resolve these issues today. Not finished, but I accomplished enough under each one to keep the ball rolling today. These situations will all continue tomorrow.*

What was the result of my (Coping) Response to the Problem(s)

- *The team got through the day, and I will continue to work on these issues through out the week.*

What People or Other Resources did I turn to for Help or Support?

- *PPIM {Policy and Program Implementation Manager}*

How did support of assistance affect my response to the problem…. In what way did I find these people or resources helpful or unhelpful?

- *Invaluable. PPIM {Policy and Program Implementation Manager} was a huge support in letting me vent and providing insight into some of the situations, and even taking on one of them to take forward for a change.*

General Comments

- *This actually turned out to be a good day. I was in emergency mode all day and feel that I responded well and am pleased that we are still afloat at the end of the day.*

Rating for the Day
- *5 = The day was extremely positive. I felt that the way I dealt with problems was very effective. At the end of the day, I left work with a strong sense of accomplishment and had a very enjoyable evening.*

Figure 8: Global Invitation to Research Study

The general format of the initial invitations used the following structure:

- ◦ *Hi everyone. We are almost through October (2012) now, where we've brought workplace health into focus through activities in Healthy Workplace Month. In the spirit of carrying on the theme of a healthy workplace, I would like to invite all front line staff to consider being involved in a research study looking at Health and Wellness in our work environment. This study is part of a doctoral thesis by Rob King, Manager of Organisational Health and Development. The research is approved and supported by both the Ministry and by the Centre for Labour Market Studies, University of Leicester, England.*

- ◦ *The Title of the study is: **Helping the Helpers: What factors contribute to health and wellness for front line staff within a public sector social services work environment.***

- ◦ *The results from this study are going to be used to build staff health and organisational wellness within our Ministry.*

- ◦ *The study will be conducted over 40 working days, beginning in **January, 2013**, and your input is very important!   If you'd like to hear more about this exciting, ground-breaking research, **please use the voting buttons (above).***

- ◦ *You will then receive an invitation to an information session where the study will be explained, and you will have the opportunity to "walk-through" the research APP. If you need more information, please connect with Rob King. Thanks!*

Figure 9: Invitation to hear more about the study through a virtual online meeting

- ◦ *Hello Everyone. We have received a very strong response to the initial email describing the upcoming Health and Wellness Study. As mentioned previously, this is a research study looking at Health and Wellness in our work environment.   The research is approved and supported by both the Ministry and by the Centre for Labour Market Studies, University of Leicester, England.*
- ◦ *At this point, we are setting up a number of short information sessions to explain what the study is all about; Note: Of the invites you receive, please check out the one that is operationally feasible for you to attend!*
- ◦ *Each LiveMeeting information session will explain:*
- ◦ *The 3 parts of the study, what you will be asked to do, and the benefits of the study, the research study APP, and an opportunity for a "walk-through" of the site.*
- ◦ *Note: If anyone missed the initial invitation, feel free to forward this invitation to them*
- ◦ *The Title of the study is: Helping the Helpers: What factors contribute to health and wellness for front line staff within a public sector social services work environment.*
- ◦ *The results from this study are going to be used to build staff health and organisational wellness within our Ministry.   The study will be conducted over 40 working days, beginning in January, 2013, and your input is very important!*

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