Authors:

Donna Baines, Karen Hadley, Bonnie Slade, Shoshana Pollack, Ann Sylvia Brooker, Krissa Fay, Susan Preston, Dima Dimitrova

The authors of this report wish to thank the staff, management and clients of Site Two for their cooperation and commitment to this project. Funding for the project from the Worker’s Safety Insurance Board of Ontario is gratefully acknowledged.

Introduction

Research has shown that health care and social services workers experience the highest rates of non-fatal workplace violence and injury among Canadian workers (Pizzino, 2000; Boyd, 1995; Wigmore, 1995; CUPE, 1994; PSAC, 1994). The purpose of this study is to generate a detailed portrait of work life within three case study sites in order to identify factors that precipitate and contribute to injuries, stress and health problems in the social services. Further, the study will make recommendations and identify prevention strategies and “best practices” that would contribute to the reduction or elimination of injuries, stress and health hazards in social service workplaces.

The study was conducted by a research team centred at McMaster University that included experts on work organization, social work, violence and health and safety. Site Two provided the research team with very generous access to workers, managers and supervisors, day program and vocational sites
and residences, and made available extensive documentary data.¹

The Agency

Site Two is a not-for-profit, grass roots, community agency providing support to people with intellectual disabilities. It provides services in the form of residences and community-based adult day programs emphasizing personal and social growth. Programs are located in various sites throughout the city in which the agency is based. The agency provides services to adults (and some teenagers) with intellectual disabilities (27 in group homes and 19 in day programs). Some of the clients are considered to be have support needs far in excess of those ordinarily found in this sector. There are 44 full-time, front-line staff including 4 front-line supervisors. The work force also includes 23 part-time workers, 30 casual workers and 2 managers.

Methodology

This study undertook eleven in-depth, audio tape recorded interviews, four participant observations, and a review of documents related to health and safety (including policy documents, incident reports, first aid reports, serious occurrence reports and minutes from committees such as the Joint Health and Safety Committee). A snowball sample (Glesne and Peshkin, 1992; Grinnell, 1985) was used for the front-line worker sample and a purposive (Lincoln and Guba, 1985) sample was built for the key informants such as the executive director, union president, managers and so forth. The average age of those interviewed was 34 with an average of 6.7 years employment in the agency. Similar to the broader

¹ For a more detailed discussion of the methodology please contact Donna Baines, Labour Studies and Social Work, McMaster University - bainesd@mcmaster.ca.
social services field, the sample was approximately 75% female\(^2\). The workers were employed in the day programs and the residences. Interviews were transcribed verbatim and read multiple times for similarities and differences.

The four participant observation sites were selected through a process in which key informants were asked to suggest program sites that might provide valuable data. Field notes were taken at the participant observations which ranged from four to ten hours depending on when saturation was achieved, that is when no new information could be generated from further observation. Field notes were typed up and coded along with the interviews using a master code list. Data was analysed for commonalities and differences using a qualitative data processing package called NUD\*IST 5 until a mapping of the data could occur. Document data was compiled and compared across reporting forms, and statistical profiles were developed.

**Broader Social Context**

The developmental services field has undergone extensive changes in the last thirty years. In the 1970s, people with developmental disabilities were usually institutionalized and treated as “patients”. De-institutionalization meant that between 1970 and 2000, the number of people with intellectual disabilities living in institutions in Ontario fell from 10,900 to less than 1000. While some argue that cost cutting was underlay deinstitutionalization, the introduction of the Canadian Charter of Rights and Freedoms during the

\(^2\) In order to ensure confidentiality in this site, certain details on the composition of the sample have been omitted although they will be included in the final report as the data pool will be larger and it will be possible to provide anonymity to research participants. Please refer questions on the methodology to Donna Baines, Labour Studies and Social Work, McMaster University - bainesd@mcmaster.ca.
same period reflected a growing recognition of the rights of people with disabilities and society's responsibility to provide services that facilitate individual growth and self reliance in the context of a caring community. Unfortunately, resources have not been sufficient to realize these goals.

Often at the forefront in lobbying for rights and resources, agencies working with people with intellectual disabilities have significantly altered how they provide services. Supports for people with intellectual disabilities have tended to be medically- (hospital) or family-based. Community services have sought to include aspects of both as well as a recognition of the individual in relation to a larger social system of opportunities and responsibilities. At present, most community agencies work within an “empowerment model” wherein people with disabilities and their families are encouraged to make choices regarding work, education, residence and lifestyle. Funding cuts across the health and social services sector has made many of these choices difficult or impossible to fulfill as a general lack of resources has limited meaningful options for well being and individual development.

Funding began to be restricted in the human services sector starting in the early 1980s. In most cases, funding for community agencies serving people with intellectual disabilities has not been increased in eight years. Diminished hospital and home-based supports have increased demands on these agencies resulting in program and staffing stress. Similar to many other agencies in the sector, Site Two has minimized its management component rather than reduce front-line service providers (it has only 4 supervisors and 2 managers including the Executive Director). This produces a management team who are stretched thinly across numerous sites and programs. It also means that they frequently are not available to provide support to their employees and have less time for planning, furthering their own
skills or investigating new approaches to problems and programming. Similarly, staff feel stretched and under resourced. Money is rarely available for equipment and programs that would enhance client care and well being. Opportunities for upgrading and fine tuning skills are rare and over work is a common problem.

Site Two has come through a difficult time in which employees and senior management were in direct and open conflict. In 1996/97 a struggle over worker-client ratios resulted in an eight month strike/lock out and the eventual hiring of a new executive director. Health and Safety policies introduced by the new executive director and a generally constructive attitude coming from both management and the employees have moved a number of issues forward. However, several unresolved issues continue to be observable health hazards.

**Work Organization and the Management-Worker Relationship**

Site Two works with some of the most challenging clients in Ontario. We observed a very commendable commitment by workers to their clients and their work place. The affection and respect for clients was genuine and enduring. Workers parlayed this affection and respect into highly sophisticated ways of micro managing the behaviors of clients in order to provide an environment conducive to growth and well being as well as to reduce violent actions and outbursts from clients. Thus, while the work site does have a high level of violence perpetrated by clients (see charts below) workers displayed an extensive knowledge of how to reduce, deflect and work with the violent behaviors.

Workers generally felt that their **praxis knowledge**, that is, knowledge developed through the direct
experience of working closely with the same clients over a long period of time, was not valued nor attended to by management. Rather than make use of what workers knew about how to help clients best participate in the social world, thus reducing violence and the stress associated with violence for both clients and workers, therapy plans that disrupted day-to-day ways of helping clients have been imported and imposed on the clients and workers. We are not evaluating the appropriateness of the therapeutic plans, we are asserting that better interplay between the everyday praxis knowledge of the workers and formal behavior management plans would improve conditions for those who are the target of the plans (clients) as well as those who are made responsible for implementing them (employees). Creating procedures and policies for how praxis knowledge can be integrated into the agency’s program model is an important way to improve the quality of the working and living environment.

Secondly, many staff work a very high number of hours with little time off. In order to ensure that a vulnerable client population are not left without care, the collective agreement at this work site permits employees to work in excess of guidelines set out in the Labour Relations Act which contributes to overwork and burnout. Our data shows that high rates of workers failing to report for work (although calling in sick) has meant that it is not uncommon for people to work double or even triple shifts. A portion of this problem may be the result of “shift-hogging” or piling up shifts in order to increase one’s pay cheque, although given the prevalence of overtime in Site Two, much of this problem finds its origins in a cycle of unscheduled overtime followed by exhaustion and the need for time off from a stressful work environment. Efforts to find solutions to work related stressors such as overtime will require compromises from management and employees. In some work sites, unions have agreed to a cap on overtime and reasonable guidelines for periods of rest in which workers cannot be called upon to work
in exchange for the **hiring of a full shift complement of full-time, full benefit staff.** Clients in this sector dislike change and the clients in this agency, in particular, are disrupted by uneven patterns of staffing such as the use of casual staff who are unfamiliar with the preferences and needs of individual clients. This disruption increases the stress, work load and level of work related violence for the staff, which in turn influence levels of injuries and work related illnesses. Obviously, the over time practices make the environment less safe and comfortable for clients which generally further increases staff stress as they are the ones who absorb the confusion and anxiety of clients when they receive less than optimal care. An expansion of the full-time staff complement can provide stability for clients, an improved work environment for workers and clients, as well as a decrease in the overtime and burn out problem.

Thirdly, the agency needs to develop an alternative to the current policy that requires staff to work continue through to a second or even third shift if their replacement fails to show up. A large amount of staff time is spent on the phone trying to locate replacements when people call in sick. This increases staff stress, lowers the quality of the client’s experience and the circle of work environment stress, violence, injury and decreased well being escalates. Finding no replacement, workers often end up staying extra shifts, which again negatively impacts on the quality of care and overall staff and client well being.

New policies have been introduced rapidly in the last few years reflecting the change in E.D. and a growing need for clearly articulated goals and practices. The overall lack of resources in this sector seems to have contributed to a situation in which an after-the-fact disciplinary approach to monitoring the implementation of new policies is used rather than the trouble shooting and problem solving model
favored by many human service managers. In a tight knit staff group such as exists in Site Two, a disciplinary approach is quickly discussed throughout the staff complement and a, not unreasonable, culture of fear, stress and lowered morale finds root. This kind of culture contributes to increased worker error and creates conditions ripe for further injury and work related illness. Although resources are tight, management training in problem solving and trouble shooting models would have positive repercussions in this work place.

**Work Load, Stress, Violence and Well Being**

Our data show that staff perform a great deal of unpaid work for the agency in the form of volunteer work, client field trips, overnight visits, week long holidays and so forth. While this caring labour contributes to the overall well being of the clients, policies need to be developed that ensure that staff members are also taking care of themselves in both the short and the long term. Capping overtime, hiring of more full-time staff and establishing of guidelines for periods in which workers will not be called in to work will strengthen the boundaries between home and work life and encourage worker self-care. Training directed specifically at ways to nurture self-care and the avoiding burnout are also recommended as are policies that require that vacation days be taken within reasonable time frames. Hiring full-time, full benefit staff will lend itself to this agenda as part-time and casual staff rarely have paid vacation days and often feel they must work whatever shift comes their way in order to survive financially. This again, leads to staff burnout, reduced client care and increased opportunities for stress, injury and illness.
The Site Two staff are a tight knit group who not only care for clients outside of work hours but often socialize with each other. This work culture has advantages for Site Two as unsupportive work environments have been identified as major stressors for workers. In addition, information can be disseminated quickly through informal lines of communication and staff members turn to each other for support and ideas. This work culture also has some disadvantages such as the normalization of work conditions that those outside the agency and sector find unacceptable. In particular, the level of violence and violence related injury in this work place are very high. Workers brush this particular work place hazard off saying that it is the diagnosis beating them up, not the clients. While this may be an excellent coping strategy and maintains a respectful perspective on the clients, it helps to mask a key stressor on this job. Research shows that where violence is present, stress is always present (Northwestern National Life, 1993). Injury is also likely to be present as the chart below highlights. Over a four year period from 1998 to 2001, a total of 166 injuries resulting from violent incidents were reported for a full-, part- and casual staff of less than 100. In addition many of the 71 head injuries and 91 strains also resulted from violence and it is impossible to know how many incidents went unreported for a variety of reasons. The staff to injury ratio is slightly less than 2 reported injuries due to violence per worker per year in each of the four years studied. In other words, staff can expect about 2 violence related injuries per year although our data shows that some residences report much higher rates indicating that injuries are not spread evenly among all staff.
A vigorous campaign initiated by the Executive Director and union to improve reporting practices most likely explains the increase in level of reports displayed in the chart below.
Some workers noted that an ongoing "culture of bravado" among staff, particularly among male staff and most notable within certain residences, has meant that victims of violence are less likely to report injuries sustained on the job. This may partly explain why female workers seem to absorb a disproportionate amount of the violence as well as why some work sites have higher reported injury rates than others. However, female workers are the more common victims of violence in our other study sites as well indicating that women are at higher risk of violent injury. Also, it is widely accepted at Site Two that some of the clients are much more violent than others hence the residences in which they live will and do have higher levels of reported injuries caused by client violence.
Incidents which can lead to sick time and WSIB claims vary dramatically by location in Site Two as seen in the chart below. This most likely reflects differences in work place hazards across sites caused by differences in the level of client function. Our qualitative and quantitative data support the notion that there are significant differences in the client mix in each site and suggests that standardizing sick time across the agency will not reflect the difficulty of work in each site or the workers' needs for time off to recover from injuries and stressful incidents.
Conclusion and Recommendations

This site specific report attempts to address issues unique to this work site. More general recommendations and discussion across the sector will be available in the final report. Our research shows that managers and workers in Site Two are grappling with ways to provide quality and safe client care in the context of government restraint and cutbacks. However, more needs to be done. Overwork, stress and work place violence seem to be issues that emanate from the way that the work is organized in Site Two. Large amounts of overtime and absenteeism, a sense of fear among staff due to management disciplinary models, and high levels of staff burnout create the conditions in which clients are less likely to get the dependable, quality care they require and are more likely to lash out and cause unintended injuries. The cycle of stress then escalates with workers experiencing higher levels of stress which is inadvertently communicated to clients who react increasingly negatively, stress increases which
leads to higher levels of absenteeism and exhausted staff filling in extra shifts and so on. Decisive interventions are required. Management, in negotiation with the union, should establish reasonable guidelines for number of hours worked and number of hours in which one cannot be called into work and hire a reasonable number of full-time, full benefit workers to cover all shifts. While funds are very tight in this sector, we have made recommendations that can save money such as caps on over time and policies that promote self care and the taking of vacation days. These measures can lower the rate of injuries and lost time in Site Two which saves money. These measures should also reduce management and legal costs relating to disputed claims, union grievances, potential arbitrations and so forth. These savings can and should be put into client care in the form of new, full time, full benefit staff positions thus improving the level of well being for those providing as well as those receiving care in this high demand environment.

Bibliography

Public Service Alliance of Canada. (1992). *Stopping violence at work.* Ottawa: PSAC