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Protocol for evaluating a workplace intervention within the framework of consultations for suffering at work in French-speaking Switzerland

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ABSTRACT

Introduction: Psychosocial suffering involves diverse human, social and economic costs. Some 34.4% of workers in Switzerland report chronic stress related to their jobs. Medical consultations for suffering at work aim to maintain—or renew—patients' abilities to make decisions and act following a diagnosis of psychological suffering related to their work; they also aim to help workers return to their workstations or remain there. Workplace interventions by consulting occupational physicians can go beyond the subjective issues: they can be offered to employees, in anticipation of a return to work when this appears feasible from the outset.

Objective: To qualitatively evaluate perceptions of workplace interventions and identify their effects by collecting the verbatim statements of employees and their employers.

Materials and methods: Qualitative single-centre study of workplace interventions conducted by the Consultation Service for Suffering at Work's occupational physicians for patients seen between January 2015 to December 2017. Nineteen workplace interventions took place, out of 184 different consultations. The verbatim statements of employees and their employers will be collected over a variable timeframe, using semi-structured face-to-face interviews. These will then be recorded, transcribed and analysed. Fourteen patients refused the workplace intervention. Their professional path will be collected for comparison and exploratory purposes.

Conclusion: This exploratory research project will provide a better understanding of the issues surrounding work-related psychological suffering and of which strategies support patients most effectively.

1. Introduction

Many studies have linked work-related stress with health status, whether cardiovascular diseases such as coronary diseases [1,2], metabolic syndrome [3], stoke [4], musculo-skeletal disorders [5] or mental health troubles such as depressive disorders [1,6,7] and anxiety [7].

Burnout occupies a special place given the persistent difficulty in defining and classifying this concept [8]. Recently, the WHO organization classified burn out as a problem associated with employment or unemployment and as a factor influencing health status [9]. As the classification states, burn out is a syndrome resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and 3) reduced professional efficacy. According to this classification, burnout refers specifically to phenomena in the occupational context. Never the less, others factors or the lack of can contribute to the onset of burnout such as demographic factors (age, marital status and children) [10] or personality traits such as neuroticism [11]. Some professions are at higher risk of burn out such as health care providers, teachers and helping professions [12].

In Switzerland, findings from recent studies on mental health among employees have been worrying. Rates of employee-reported chronic stress linked to their occupations rose from 26.6% in 2000 to 34.4% in 2010 [13]. Those figures result from a repeated telephone survey of a representative sample of the active Swiss population in the frame of the European Working Conditions Survey. The Swiss health survey conducted in 2012 on a representative sample of the permanent resident population of Switzerland aged over 15 (more than 21,000 people) showed that 12% of men and 10% of women professionally active considered that their work negatively affected their health. Fourteen percent of men and 20% of women with a professional activity in 2012

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had symptoms of psychological distress [14].

These findings are part of a context in which the workforce task represents 5.042 million in 2017 [15] out of a Swiss population of a little more than 8.5 million [16]. The Swiss labor market is characterized by a high rate of companies in the tertiary sector (76%), with a predominance of the healthcare sector. Small companies are the most numerous [17]. In 2017, the Swiss and EU unemployment rates were 4.8% in Switzerland according to the ILO definition [18] and 6.6% in the EU [19]. Employment conditions are dependent on cantonal laws, employee's contract, and employer's general terms. The average working hours are around 41 h per week with a maximum of 45 h per week for normal working hours according to Swiss employment law. Employees in industry sector work around 40 h per week while workers in the service sector work slightly longer hours. Part time work is frequent, especially for women.

Comparisons between Swiss and (EU) data have showed that the country's workers perceived the professional pressures to be greater [20,21], Switzerland's working environment provides its workers with greater decision-making options about their jobs and better support from their management [20]. In 2015, five year after these results, more than six out of ten employees say that their activity involves high work rates or work under very strict and very short deadlines [22].

The protection of employees' health with respect to psychosocial risk factors is stated for in Article 6 of the Labor Law. The State Scretariat for Economic Affairs provides information and prevention measures such as the production of information leaflets for employers [23]. Faced with a proven case of suffering at work, the Cantonal Labor Inspectorate is competent. To meet article 6 demands and to protect the health of employees, the employer may use associations (stressnostress.ch) or public occupational health institutes such as unisanté. Otherwise occupational physicians, occupational psychologists or ergonomists offer their services in the form of a mandate.

For epidemiological surveillance purposes, Switzerland participates in the European Working Conditions Survey (EWCS) held every five years by the European Foundation for the Improvement of Living and Working Conditions (EUROFOUND).

Of the 31858 physicians practicing in Switzerland in 2012, 142 practice occupational health, most of the time in institutions with internal occupational health services [24]. Therefore, most companies do not have an occupational doctor or a health management system. Resources must be optimized.

Unisanté and the Community Psychiatry Unit began work together in 2009 to develop an occupational health consultation service specifically dedicated to psychological suffering in the workplace named the Consultation Service for Suffering at Work (CSSW). If it is thought necessary, these consultations can be supplemented by a workplace intervention by one of the Unisanté's occupational physicians.

Different types of work intervention tried to ensure return to work or maintain employees in the workplace. Usually, companies do not initiate these interventions unless a legislative intervention forces them.

A recent synthesis [25] reported on systematic reviews on work place interventions that impact absenteeism and productivity. The overall conclusion is that work intervention that intended to improve both mental and physical health together, psychosocial intervention and real work conditions implementation for anxiety disorders, had moderate impact on mental health. Positive workplace intervention outcomes result when disability management programs existed in the workplace.

A finish study examined how companies manage work related stress in collaboration with health occupational services [26]. It was based on the premise that interventions involving employees, health practitioners and employers, and implementing adaptations to the context of work are more effective than other interventions types. Forty companies participated to the survey. The result showed a lack in stress management and a variable cooperation with occupational health services, sometimes seen as the responsible of stress management and sometimes not. Overall, work-related stress management activities in the workplace have been conducted in only few enterprises.

Some country like Japan enacted official "guideline of promotion of mental health for employees in the workplace [27]. Consequently, Employee Assistance Programmes (EAP) were developed.

EAP are employer-sponsored systems to help workers who experience mental health problems that may affect their job. Comprehensive EAP engage in identification, assessment, motivation, referral, short-term counselling, monitoring and follow-up activities and help with a variety of personal problems [28].

An evaluation of EAP conducted in the first decade of the millennium [29] found 42 programs, mostly conducted in the USA. These programs use a broad range of methodologies. The study concluded that those programs produced positive outcomes including saving organisations money as well as positive change in those who sought counselling. Nevertheless, the authors raise the problem of non-consensual indications for these programs and the stigmatisation that the use of these techniques still generates in the companies.

Other workstation intervention models have been proposed, such as "Organisational interventions", and evaluated [30]. These interventions target the stressors in the work environment, rather than the stress response of the individual employee. They aim to alter the psychosocial work environment by changing some aspect of the organisation, such as structures, policies, processes, climate, programmes, roles, tasks.

Individual intervention from outside the companies/organisations such as the ones we practice at our consultation are, to our knowledge, not evaluated.

Considering that the subjective experience, which an employee might report during a consultation, needs to be expanded upon in light of the employer's vision, workplace interventions by occupational physicians were proposed at the CSSW.

When considering a work place intervention, the occupational physician from the CSSW evaluates the following criteria:

- whether a poor relational situation at work is deemed reversible,
- whether the employee's perception of their professional situation can be reconfigured,
- How strongly the employee is attached to their job, career, role, working environment, line of business, employer and the values they see in any of these elements.

1.1. The framework for a workplace intervention

According to our practice, the workplace intervention involves an occupational physician visiting a company independently of any established patient-care plan or return-to-work plan (case management).

It does not signify the presence of an ongoing acute psychological disorder, nor the continued need for support from a caregiver for the patient to recover.

Our workplace intervention does not allow us access to the modes of adaptation or collective defences that might appear in the company. As a result, one dimension of the analysis eludes us, and this might create an obstacle to the changes initiated.

Our workplace intervention is a one-off; it does not lead to follow-up intervention. The employee remains involved in his recovery and will lead pre-recovery contact with his employer. The intervention is careful not to over-medicalise what is essentially an occupational situation.

As to legal aspects, the workplace intervention framework is strict and subject to the rules of medical and professional secrecy and medical deontology. Professional confidentiality is a guarantee vis-à-vis the employer.

After the workplace intervention, a restitution consultation is performed with the patient. It is not an account of what was said with the employer but an opportunity to specify the conditions for returning to the workplace.

1.2. Carrying out the intervention

Our design of a workplace intervention consists of a single meeting between the Unisanté's occupational physician and the employee's management. It occurs with the agreement of the employee, his doctors and the employer. The employee agrees to the intervention in writing either during the consultation or after consultation with his attending physician and/or specialist. The employee must have informed his superiors or management that he is in a care situation and that an occupational physician wishes to meet with them. The patient's occupational physician and general practitioner subsequently communicate and must both agree to an intervention.

When there is favourable feedback from the employer, consenting to a meeting, the intervention is planned via email with the company manager, a direct supervisor or the human resources department. On average, a workplace intervention takes up about 1 h of the employee's company's time. The employee is not present.

After the intervention, the employee comes to the CSSW for a second consultation both in order to clarify or expand upon the initial analysis and to support the resumption of communication with his workplace and management. This restitution respects professional confidentiality vis-à-vis the employer and respects each party's specific roles. It is not about reporting the interview transcript.

If necessary, the occupational physician will have further telephone contact with the patient's attending doctor. The collaborative nature of the CSSW allows it to call upon a psychiatrist when necessary to provide additional focus on the intervention.

To the best of our knowledge, no studies to date have qualitatively or indeed otherwise evaluated such workplace interventions by occupational physicians. We chose a qualitative approach to this evaluation because it allowes for a more comprehensive and precise understanding of the mechanisms underlying the workplace intervention we provide.

2. Study objective

This study aims to qualitatively assess perceptions of workplace interventions by occupational physicians and their effects by gathering the verbatim statements of employees and their employers.

3. Materials and methods

This is a qualitative single-centre study protocol examining the workplace interventions conducted by occupational physicians from French-speaking Switzerland's CSSW. A qualitative design was chosen because of the selection bias involved in consultations. In addition, some of the Unisanté's occupational physicians prefer to deal with situations of suffering at work whereas others deal with cases of more general practice-type occupational diseases and disorders. Moreover, the indications for a workplace intervention depend on each consultant's practices and experience, and those indications are neither systematic nor standardised. The advantage of a qualitative design is that it allows a finer-grained analysis of the information and answers given and it generates research hypotheses that can be tested later using other methods.

From January 2015 to December 2017, the CSSW saw 184 new patients. Nineteen workplace interventions were performed, and 14 further indications for workplace interventions were refused by the patients.

3.1. Population

The present study protocol concerns the 19 patients seen by the CSSW occupational physicians between January 2015 and December 2017 and for whom a workplace intervention was carried out.

All patients consulting the CSSW were eligible for inclusion, whether or not they had a work-associated somatic problem, whether or not their case had involved a workplace intervention by another healthcare professional prior to the consultation and regardless of the duration their medical care by the Unisanté or another institution.

Refusal to participate in the study, whether by the employee or his employer, will be the sole criterion for non-inclusion.

Patients for whom a workplace intervention by an Unisanté occupational physician was carried out but for whom no follow-up consultation could be made to discuss it, or who cannot be reached with regards to the present study, will be considered as lost patients.

As a comparison, the career trajectories of the 14 patients who refused the workplace intervention will also be collected.

3.1.1. Collection of consent

Patients who had the workplace intervention and their employers will receive written consent forms inviting and encouraging them to sign up and participate in the present study [Annexes 1a and 1b]. A stamped addressed envelope to the Unisanté will be included. It will be made clear that any refusal to participate in the research project will in no way influence any possible future request for medical care by the Unisanté. Participants will be informed of anonymity and their right to withdraw from the study at any point. Permission to tape-record the interviews and use material anonymously will be asked for each participant. In the absence of any answer after one month, a follow-up telephone call will be made, or email will be sent, every month for three months. After this period, no answer will be considered a refusal to participate in the study. Both written informed consent forms will be attached to the patient's clinical record.

Consent to participate in the study will also be collected from patients who have not had the intervention at the workplace (appendix 1 c).

3.1.2. Data collection

The study protocol includes a short, descriptive, quantitative component in order to better illustrate its qualitative aspects. For the purposes of the consultation, the Unisanté's occupational physician collected information relating to the patient's antecedents and socio-occupational situation [Appendix 2] and noted the recommendations made to the patient in his clinical file. The following data will be extracted from the consultation's medical notes for use in this research : age, sex, level of education, profession, type of company, years in the company, career path, hierarchical composition of work unit, breaks in the career path, medical history and addictions, the professional situation's current impact on health, means invisaged for improving all aspects of the situation, elements indicating the need for a workplace intervention, and recommendations made to the patient.

For the qualitative part of the study protocol, concerning the employee and their employer who had the workplace intervention, we have chosen a semi-structured, face-to-face interview approach, which will last 30–45 min, and be audio-recorded and transcribed.

One interview will be conducted with the patient and another with his employer. An interview guide has been produced to harmonise patients' (Appendix 3) and employers' interviews (Appendix 4). The analysis of their perceptions of the workplace intervention will seek answers to the following questions:

3.1.2.1. For the employee

- Did you have any prior information about the workplace intervention? What information did you receive in addition to that from the Unisanté doctor?
- What did you think when you were informed about the possibility of a workplace intervention? Were you reassured, worried or suspicious?
- Did the procedure for the intervention suit you?
- Was the workplace intervention helpful to you with regards to your health, balancing professional concerns against personal ones,

support for the resumption of your professional activity, your relationship with your employer later on, and so on?
- Was the workplace intervention followed by your return to work? How long afterwards?
- Was a single workplace intervention sufficient?
- Has the workplace intervention helped to stabilise your professional situation in the company?
- How did you perceive the consultation for suffering at work prior to the workplace intervention?
- Have you had the opportunity to inform your colleagues about the workplace intervention? What were their reactions?
- How do you think your employer and your colleagues perceived the workplace intervention?

3.1.2.2. For the employer

- Did you have any prior information about the workplace intervention? What information did you receive about the workplace intervention from the Unisanté doctor?
- What did you think when you were informed about the possibility of a workplace intervention? Were you reassured, worried or suspicious?
- Was the procedure for the intervention consistent with what you had imagined when it was presented to you by telephone or email?
- Did you appreciate the intervention? Was it helpful? Was it sufficient? Was it followed by the employee's return to work? Did it stabilise his work situation?
- How do you think your other employees perceived the workplace intervention?

The end of data collection is planned at 15 months from the beginning of the study; the end of the data entry period is planned at 16 months. Data analysis is planned to end at 36 months.

3.1.2.3. For the employees who had not had the workplace intervention. After collecting consent to a phone interview, patients will be asked by phone to give details about their professional career starting from the consultation date. The interviewer will fill in a questionnaire that contains the same topics as the original professional questionnaire (Appendix 5), with emphasis on transitions and their causes.

4. Analysis

A quick descriptive analysis of the population will be carried out using the following variables extracted from the patient's consultation report: age, sex, level of study, profession, type of company, years in the company, career path, hierarchical composition of the work unit, breaks in the career path, medical history and addictions, the professional situation's current impact on health, means invisaged for improving all aspects of the situation, elements indicating the need for a workplace intervention, and recommendations made to the patient.

All the face-to-face interviews will be audio-recorded, transcribed in full and read by the authors several times to obtain an overview of the data. Emerging themes will be identified, coded with tags and categorised according to conceptual frame outlined above without a pre-established code list. Similar themes will be combined in categories. Categories will be compared and contrasted in the employees group, the employers group and both. These categories will be used to generate interpretations and scenarios.

Interpretations and scenarios about their professional path will also be built from the data collected by the professional questionnaire of patients who refused the intervention in the workplace.

5. Ethics

This research study, the confidential data generated and its management will be in line with the principles set out in the current versions of the Declaration of Helsinki, the Essentials of Good Epidemiological Practice issued by the Swiss Federal Office of Public Health, Swiss law and the requirements of the relevant Swiss regulatory authorities. The protocol will be submitted to SwissEthics [31] for validation.

6. Discussion

The present study should lead to a better understanding of which support strategies are the most effective and enable us to better adjust consultations for suffering at work, as well as their link to possible adaptations in the workplace. This study should help us to promote the practice of workplace intervention for the benefit all patients who consult for suffering at work.

Our individual workplace interventions are isolated projects with respect to time and organisational structure, and not integrated into company strategy, as authors recommend [32]. Our approach may result in short term and limited effects [33]. Moreover, a memory bias is likely to occur.

Another limitation of our study is that it does not have a control group. The 14 people for whom a workplace intervention was desirable but refused could not constitute a valid comparison group because of a likely different or even altered relationship between the employer and the patient employee making this patient group not comparable with that of the patients who had received the intervention. We have nevertheless been keen to describe their characteristics and career paths for explorative purposes.

Despite these limitations, this study can help us better understand the underlying mechanisms and factors that could make a workplace intervention successful. From there, other design interventions in the workplace could be proposed. Their validation will probably require to use more robust protocols such as randomized controlled trials.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.conctc.2019.100400.

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