A Systems Approach to Worker Health and Wellbeing

CAMPBELL INSTITUTE™

NATIONAL SAFETY COUNCIL

Introduction and Background

For the past few decades, workplace safety has been recognized as an essential component of running a business well and sustainably. In the past few years, the concept of worker health and wellbeing has increasingly been seen as another fundamental part of operating a sustainable business. With the advent of recent programs like NIOSH Total Worker Health® and academic partnerships between the American College of Occupational and Environmental Medicine (ACOEM) and UL (Loeppke et al., 2015), the connection between occupational safety and worker health and wellbeing is becoming more prominent.

A previous Campbell Institute white paper re-introduced the concept of integrated health and safety, which was coined by Loeppke and colleagues (2015), and how Campbell Institute companies are striving to implement integrated health and safety strategies. Integrated health and safety is defined as the blending of health and safety programs along a continuum of organizational, personal, and occupational activities to enhance overall worker wellbeing and prevent work-related injuries and illnesses (Ibid). Underlying this definition is the belief is that a true culture of health and safety is dependent not only on a robust safety program, but also a program that focuses on worker wellbeing.

The metrics that the ACOEM/UL team brainstormed for measuring maturity and effectiveness of integrated health and safety aligned along three dimensions: economic, work environment, and social. A closer look at what is included in these dimensions demonstrates in more detail how this integrated health and safety index is comprehensive of both on- and off-the-job health and safety concerns.

Economic	Work Environment	Social
Workers' compensation	Incident rate	Participation in wellness programs
Absenteeism	Hazard recognition	Prevalence of health conditions and risks
Presenteeism	Worker participation	DART due to health conditions
Turnover rate	Closure rate	Workforce demographics
	Education and training	

Dimensions of Integrated Health and Safety and Selected Metrics from ACOEM/UL (Loeppke et al., 2015)

The belief that a culture of health and safety hinges upon strong safety and wellbeing programs is in part what lead the National Institute for Occupational Safety and Health (NIOSH) to launch the Total Worker Health® initiative in 2011. Essentially, NIOSH saw a gap in caring for the wellbeing of workers – workplace safety and health programs tend to focus solely on safety and protecting workers from hazards associated with the work environment, while workplace health programs tend to focus only on lifestyle conditions outside of the workplace that may put workers at risk. The Total Worker Health® program was designed to integrate workplace safety protection with off-the-job health promotion.

Essentially, the TWH perspective is that worker health and wellbeing can be protected and advanced by looking specifically at the conditions of work. This means not only a safe work environment (created through things like preventive maintenance, ergonomic controls, daily toolbox talks, etc.), but also other job-related factors like wages, work hours, workload, stress, and workplace interaction and culture. The TWH approach combines traditional workplace safety initiatives with activities that are designed to advance the overall wellbeing of workers. The following table provides a short summary of some of the issues relevant to advancing worker wellbeing through Total Worker Health®.

Control of Hazards/Exposures	Organization of Work	Built Environment Supports
Chemicals	Fatigue and stress prevention	Safe access to workplace
Physical agents	Overtime management	Healthy air quality
Psychosocial factors	Flexible work arrangements	Access to healthy food options
Leadership	**Compensation and Benefits**	**Community Supports**
Commitment to S+H, wellbeing	Adequate wages	Safe and affordable housing
Supportive leaders	Paid time off	Access to affordable healthcare
Worker recognition	Workers compensation	Safe and clean environment
Changing Demographics	**Policy Issues**	**New Employment Patterns**
Aging workforce	Equal employment opportunity	Contracting and subcontracting
Multinational workforce	Health information privacy	Financial and job security
Workers with disabilities	Family and medical leave	Precarious employment

Selected issues relevant to advancing worker wellbeing through TWH® (CDC/NIOSH, 2015)

Integrated Health & Safety
or **WELLBEING**

Combining the concepts of health protection, health promotion, and integrated health and safety as presented by NIOSH and ACOEM/UL, the Campbell Institute put forth its summary of these definitions. Health protection can broadly be summarized as "safety," and refers to the protection of workers from occupational injury and illness through things like safety training, use of personal protective equipment, machine or equipment enhancements, and general improvements to the work environment. Health promotion can be broadly summarized as "wellness," and refers to the maintenance and improvement of workforce health through things like health risk assessments, immunizations, illness management, etc.

Integrated health and safety, or wellbeing, thus lies at the intersection of health protection and health promotion. As Loeppke and colleagues (2015) noted earlier, integrated health and safety refers to the use of personal, social, and workplace activities to improve worker wellbeing and eliminate occupational injuries and illnesses. "Wellbeing" is inclusive of all different kinds of health, such as physical, mental, emotional, social, and economic health.

Complementary Frameworks

The previous Campbell Institute research found that Institute members are still in the process of improving and maturing their workplace wellbeing programs, and integrating these programs with their safety management systems. Of issue is that Institute members, like many other companies, launched activities around wellbeing in a piecemeal manner. The most popular of these wellbeing initiatives were smoking cessation programs or weight-loss challenges.

These activities, while potentially effective in their promotion of health, are not necessarily targeted at strategic, measureable outcomes or connected to occupational safety or a company's safety management system. These activities are what most people conceive of as "workplace wellbeing," but are far from what is defined as integrated health and safety, and far from being inclusive of off-the-job health issues that can affect workplace safety.

In the U.K., Tim Marsh of RyderMarsh and Plymouth University has started implementing an approach to a wellbeing management system that the Campbell Institute has used as a starting point. Like the frameworks put forth by ACOEM/UL and NIOSH Total Worker Health®, Marsh proposes a holistic model of thriving that takes into account personal habits around energy/ alertness creation and resilience, home life, and work environment. His recommendation is to screen people and processes to find who or what is most in need of intervention and discover which activities have gaps to be filled. As has long been known, the non-technical (NT) skills of front line management and supervision appear utterly central. After the assessment phase, workplaces should develop a variety of tools, skills, and interventions at their disposal to address issues, such as mental health first aid, or training/workshops to address specific wellbeing areas of sleep/fatigue, finance, or even meditation. Marsh also suggested workplace culture enhancement teams to improve aspects of the workplace environment, with particular attention paid to occupational health and safety. For example, it is almost impossible to give a worker too much traction (understanding of where they fit into a bigger picture), but it is possible to give certain people too much autonomy. Tailoring needs dialogue and a supportive culture needs high levels of NT skills throughout.
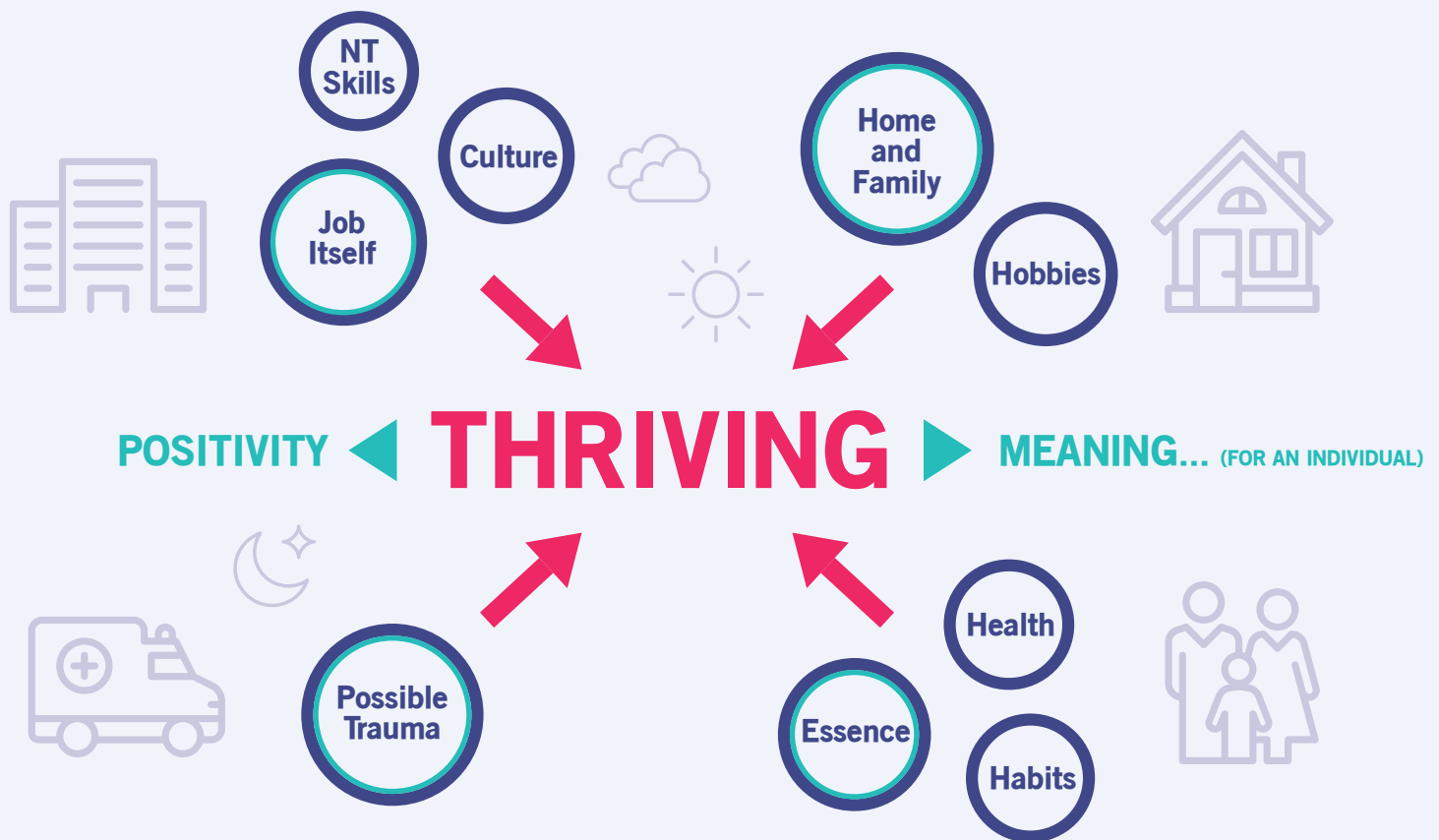
HOLISTIC MODEL OF "THRIVING"   (MARSH, 2017)

Marsh (2017) distinguishes his model of "thriving" from traditional models of "coping" or "resilience." Under traditional models of health and wellbeing, the individual is almost entirely responsible for balancing the pressures of home life and work stress. This typically results in the individual merely learning to cope as best they can with the stresses and trauma experienced in everyday life. The "coping" model is strictly for stress management. In the model of "thriving," workplaces assume a large part of the responsibility to create a positive culture in which individuals can thrive. Worker assistance programs, mental health first aid, and health workshops can build the type of environment for individuals to not just cope with stresses and possible trauma, but to thrive under even challenging circumstances. Also different in the "thriving" model is that home life and work culture are treated as interrelated elements: stressors or exposures, or mediating factors, not merely just external factors that are related to wellbeing.

The Health and Safety Executive (HSE) in the U.K. has developed a framework and tool for understanding the six key areas of workplace design that have the most impact on worker health and wellbeing. When improperly managed, these six areas can result in lower productivity and increased time away from work due to illness.

1. Demands	Issues related to workload, work patterns and the work environment
2. Control	How much agency a person has regarding the way they do their work
3. Support	Encouragement, sponsorship and resources from the organization, line management and colleagues
4. Relationships	Promotion of positive working to avoid conflict and deal with unacceptable behavior
5. Role	How people understand their roles within the organization and whether the organization ensures that they do not have conflicting roles
6. Change	How organizational change is managed and communicated in the organization

Management Standards for Work-Related Stress (HSE)

The HSE Management Standards Indicator Tool (see Appendix) is a 35-item questionnaire with sections for each of the six primary stress areas. The tool is designed to provide organizations an understanding of how much work-related stress their worker population may be experiencing and which areas are in most need of intervention. This questionnaire, intended to gather the opinions of the workforce, is seen as a model for the worker survey referred to in the next section.

Proposed Framework

Up to this point, the models and definitions described from ACOEM/UL, NIOSH, Marsh (2017), HSE, and the Campbell Institute are essentially theoretical frameworks. What we seek with this white paper is to synthesize these existing theoretical frameworks and models and transition them to applied research and strategy. We thus propose a systems approach to assessing and add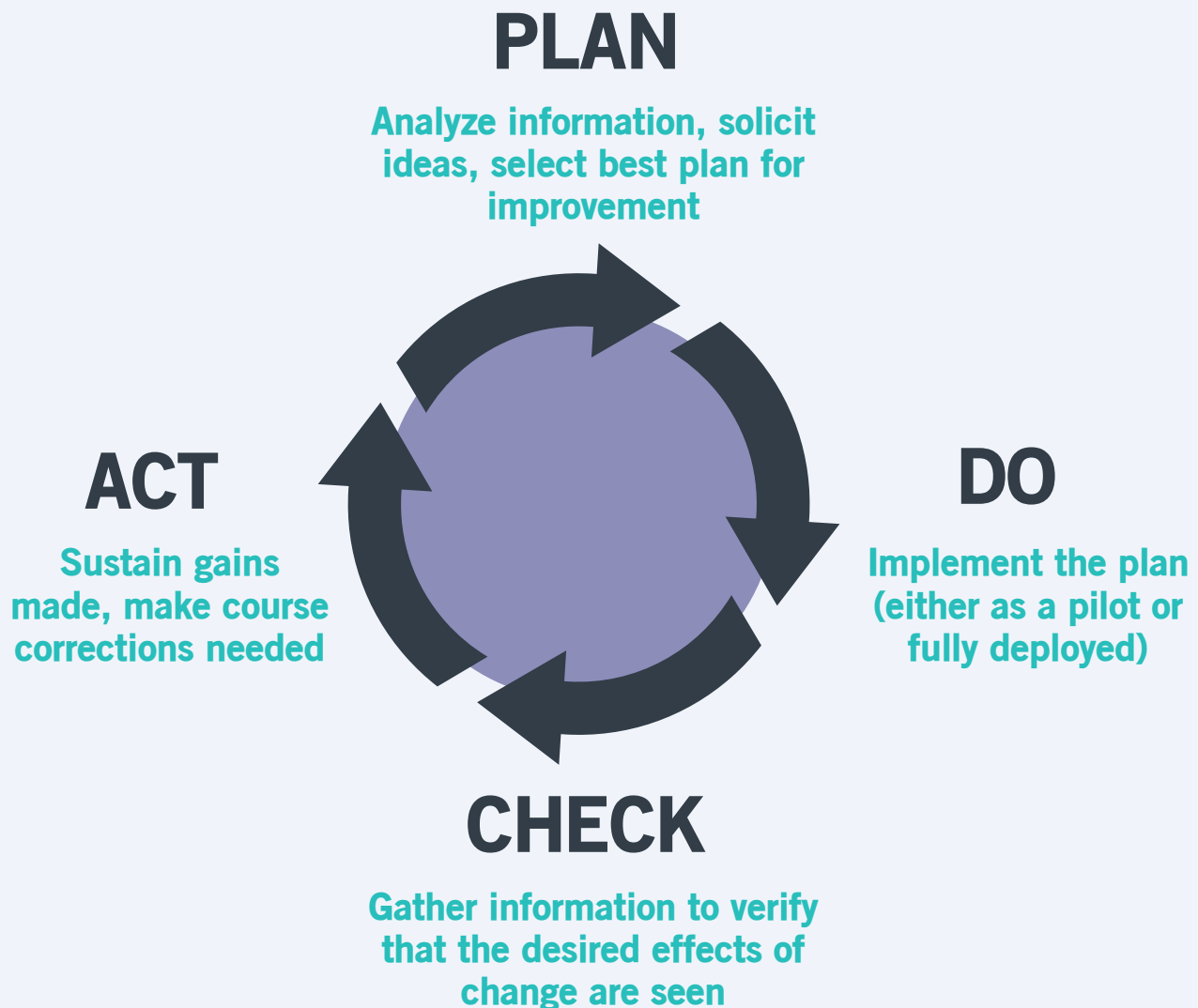ressing total worker health and wellbeing. In the same way that occupational safety in many workplaces has evolved from ad-hoc safety initiatives to a more comprehensive safety management system, we are putting forth a similar maturity model for worker health and wellbeing.

In a traditional safety management system, safety professionals generally use a risk matrix to assess where there is the most need for intervention and change. Areas and activities are prioritized based on the conventional trifecta of exposure, frequency, and severity. Several safety professionals (Lyon & Popov, 2016; Walline, 2015) recommend this risk-centric approach to safety management systems because the level of risk is perceived as actual harm. This priority focus on risk results in a more proactive approach to predicting potential incidents and preventing them. We see this same risk-based method for assessing and prioritizing safety risks as applicable to the realm of health and wellbeing. Strategies for targeting health and wellbeing issues can be based on risk factors and data that organizations can collect (at a non-individual, aggregate level) and benchmark to evaluate efficacy and improvement.

The traditional "Plan Do Check Act" model, or the Deming cycle, is a process for continual improvement in quality management that is well known among creators of safety management systems (Van Scyoc, 2008). The steps of the PDCA model are intended to not only discover and implement improvements, but ensure that those improvements are maintained. The PDCA model has served as the basis for various standards including ISO 9000, ISO 14001, and OSHAS 18001 and can be applied to almost any activity or system that requires management (Downs, 2003). General descriptions of the steps are:

"PLAN - DO - CHECK - ACT" MODEL DESCRIPTION (VAN SCYOC, 2008)

PLAN
Analyze information, solicit ideas, select best plan for improvement

DO
Implement the plan (either as a pilot or fully deployed)

CHECK
Gather information to verify that the desired effects of change are seen

ACT
Sustain gains made, make course corrections needed

Loud (2016) notes that every effective safety management system should include the steps of the PDCA model. At the crux of the model is the understanding that the majority of safety improvements and reductions of risk are brought about through addressing the system, not individual behavior (Loud, 2016). This is the same understanding that we propose in our approach to worker health and wellbeing – using the PDCA model to identify the areas of highest risk and develop intervention strategies at a systemic, organizational level to address those risks.

The risk assessment process for health and wellbeing system management follows the same steps of the PDCA or Deming model. The first step, or the "Plan" stage, should be focused on generating worker, leadership, and stakeholder support of the health and wellbeing management system. The organization should be upfront and transparent about their reasons for implementing such a system, namely that they genuinely care about the wellbeing of all workers and do not collect individual worker health information. The anonymity of health data cannot be overemphasized by workplaces in gaining support for the health and wellbeing management system.

The "Do" stage could include the launch of the worker survey and biometric screenings. Collection of this type of data can be controversial because of how the data could potentially be used. Here is where organizations need to be self-policing, making commitments to not use worker health data for hiring/firing purposes and ensuring that wellbeing program vendors do not sell the data they collect. If biometric screenings are the primary form of data collection, all data from these screenings should be analyzed only in the aggregate; no individual-level health data should be available to the organization.

Depending on organizational culture or workforce composition (e.g. highly unionized worker population), worker surveys and biometric screenings may not be feasible for some organizations. Data could be collected in other ways, however, namely by looking at insurance claims or information from doctor visits. Ultimately, what remains more important to our proposed approach is not the method of data collection, but rather the fact that it is a data-driven process.

The "Check" stage is characterized by the creation of a heat or risk map of the most prevalent health behaviors and conditions among the worker population. An example for how this heat map is generated is explained in the next section. Finally, the "Act" stage could include the development of plans/strategies to address the areas of highest risk that were identified in the previous stage.

▼

Plan
Obtain workforce buy-in
Guarantee anonymity
Agree on data collection process

▼

Do
Conduct worker survey
Conduct biometric screenings

▼

Check
Create heat/risk map
Decide where to allocate resources

▼

Act
Create plans to address highest risks
Determine metrics to track

PLAN DO CHECK ACT MODEL for a Systems Approach to Health and Wellbeing

Sample Approach

The process that the Campbell Institute proposes for assessing and managing risk in health and wellbeing focuses on how workplaces can identify, prioritize, and target for intervention the health conditions of highest risk in the worker population. The proposed process is similar to those that have already been proposed for assessing and managing occupational safety risk. A thorough process of developing and implementing safety interventions typically begins with exposure assessments and obtaining a complete understanding of the work performed. In much the same way, creating and employing interventions for health and wellbeing should begin with a survey of the worker population, biometric screenings, or pulling insurance claim data.

1. Establish risk criteria and context	**Establish a risk assessment matrix to categorize combinations of severity, frequency, and/or likelihood**
2. Select/modify risk assessment method	**Select method based on complexity and uncertainty of work; may include checklists, PHAs, what-if analysis, etc.**
3. Identify hazards	**Identify hazards and risk levels with selected method**
4. Analyze and evaluate risks	**Score risks according to risk matrix criteria**
5. Treat risks	**Develop and implement corrective actions and mitigation strategies**
6. Monitor and review	**Evaluate effectiveness of corrective actions and mitigations actions**

Risk Assessment Process Steps (adapted from Lyon & Popov, 2016)

Typically, the data from worker surveys and biometric screenings will reveal the following: nutrition habits (e.g. consumption of fruits, vegetables, alcohol, water), physical activity (e.g. time spent in aerobic exercise, number of hours of sleep), tobacco use, height and weight, body mass index, blood pressure, and cholesterol level. Insurance claim data will reveal which health conditions are being treated in the worker population and the cost of medical claims related to specific health issues. The surveys, screenings, and claims data serve as collection tools to understand which health behaviors and conditions are most prevalent within the worker population and, therefore, which conditions are most in need of intervention strategies.

This risk-assessment process is not novel for traditional safety management systems, but is something that does not seem applied often (or ever) to workplace health and wellbeing programs. More commonly seen are workplaces that implement smoking cessation programs, weight loss challenges, or physical fitness activities because this is what they have seen other workplaces do. Such organizational isomorphism is not necessarily unsound, as a tobacco-free and physically active lifestyle is beneficial to anyone. Yet this is usually the extent of a typical organization's health and wellbeing strategy, regardless of other (perhaps more pressing) health and wellbeing issues that are present in the worker population.

Developing an integrated
safety, health, and wellbeing
management system is a method
to measure what is occurring
within an organization and how to
triage and address any concerns.

The next step after gathering data from various sources (e.g. worker surveys, screenings, claims data) is to use that information to create a heat or risk map of the health behaviors and conditions that are of most prevalence and concern. This step is crucial to determining where resources should be invested and which health behaviors and conditions should be prioritized. While the areas of biggest concern may coincide with the tobacco cessation and weight loss programs an organization already had planned for implementation, the surveys and biometric screenings may also reveal health and wellbeing conditions that were previously unknown as concerns for an organization.

	Condition may result in…minimal ad hoc treatment	…medical treatment, but no lost time	…lost time, but worker will recover fully	…lost time and some permanent impairment	…death or permanent disability
>80%					
60-80%					
40-60%					
20-40%					
<20% of worker population affected					

Another consideration for the severity x-axis is to rank or quantify the likelihood of a condition to contribute to ill health or death. This sample ranking is based in part on the Modified Rankin Scale (van Sweiten et al., 1988) to measure the degree of disability following a stroke:

No impact ▶ **Minimal/slight impact** ▶ **Moderate impact** ▶ **Severe/extreme impact (death)**

Sample Severity Scale for Impact on Health

SAMPLE RISK MATRIX FOR HEALTH AND WELLBEING:
Severity (x-axis) and Frequency (y-axis)
(Severity axis adapted from Nevada Chapter of RIMS)

	Neglible	Minor	Moderate	Major	Catastrophic
All Workers and/or **Very Short Timeframe**		DIET & EXERCISE			
Most Workers and/or **Short Timeframe**				STRESS & FATIGUE	
Many Workers and/or **Medium Timeframe**		TOBACCO USAGE			
Few Workers and/or **Long Timeframe**				SEVERE DEPRESSION	
No Workers and/or **Very Long Timeframe**					

FREQUENCY
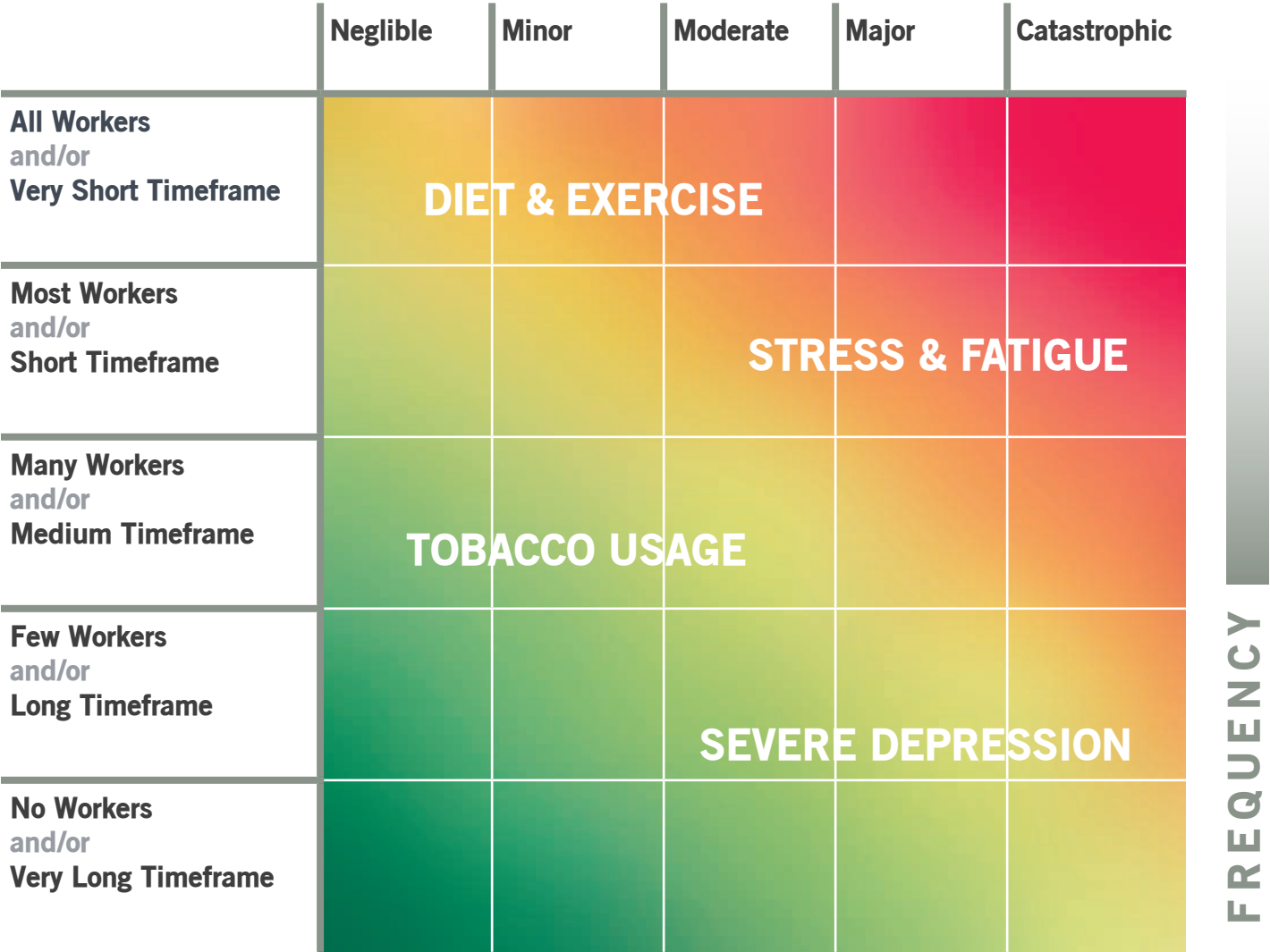
SEVERITY

Yet another example for the severity x-axis is an index comprised of variables from medical and hospital claims data (Mossey & Roos, 1987). This index to measure health status could be based on a number of quantitative variables, such as:

Medical claims	Number of physician visits with different (unique) diagnoses
	Number of physician visits for chronic diagnoses
	Number of physician visits for serious diagnoses
Hospital claims	Number of admissions to acute or chronic care hospitals
	Number of days in acute or chronic care hospitals
	Average number of diagnoses per admission to acute hospitals
	Number of surgical procedures

Sample Variables for a Health Status Index Based on Medical and Hospital Claims
(adapted from Mossey & Roos, 1987)

An organization may also want to consider "softer" variables for inclusion in a risk matrix, such as the potential for "thriving," (Marsh, 2017), the co-benefit to safety, or the feasibility to develop mitigating actions. The broader idea is that there are many ways to operationalize the importance of health conditions in a workforce. Like safety risk analyses, this risk assessment for health and wellbeing can be more of an art than a science, requiring frequent checks for efficacy and input from multiple stakeholders.

The last step in our proposed risk assessment-based process is to create action plans to address these areas of highest risk. If the highest risks to the worker population are excess body weight and high cholesterol, an organization may want to focus efforts on creating opportunities for physical fitness and healthier diet. Or if the highest risks are worker stress and depression, an organization might consider implementing/improving a worker assistance program, rearranging work schedules, or teaching meditation techniques.

Future Directions

Essentially, this systems- and risk-based approach to worker health and wellbeing is based on the adage that what is not measured is not managed. Developing an integrated safety, health, and wellbeing management system is a method to measure what is occurring within an organization and how to triage and address any concerns. Marsh, NIOSH, ACOEM/UL, and no doubt several others have proposed variations of this comprehensive and integrated approach to health and wellbeing. The focus of the Campbell Institute's research will be to combine these approaches and introduce a risk-assessment approach for implementation strategies. With the help of Institute members and partners, we hope to gather case studies and provide organizations a roadmap for a systemic approach to health and wellbeing. What we propose with this framework is a more systematic way to confirm where the gaps are in an occupational safety, health, and wellbeing system and identify strategies to fill those gaps.

Currently the Campbell Institute is working with contacts and researchers at NIOSH Total Worker Health® to develop an intervention-based research project for TWH principles. The objective here is to involve Campbell Institute member sites in a TWH intervention based on a risk-based needs-assessment/gap analysis performed by NIOSH and Institute researchers. Over the course of this longitudinal study, the Institute hopes to find support not only for the proposed risk-assessment approach for health and wellbeing implementation strategies, but also for the overall TWH/integrated health and safety management system.

The Institute also hopes to bring an international perspective to this comprehensive health and wellbeing framework by partnering with the Health and Safety Laboratory (HSL) and other similar organizations in the United Kingdom. As noted in the Campbell Institute's previous research on workplace wellbeing, the areas of mental health, work strain, and stress are sometimes overlooked or not granted as much attention in U.S. workplaces. These are areas where partnerships with HSL and/or other European organizations would be particularly fruitful, as the issues of stress and mental health in European nations have gained more traction in regards to workplace safety.

Through these partnerships and collaborations, the Campbell Institute seeks to put forth a new perspective on how health, safety, and wellbeing is approached in workplaces in the U.S. and Europe. This perspective would not only make the connection between worker health and safety, as many others have already suggested, but also suggests a risk assessment-based approach to identifying the health, safety, and wellbeing issues of highest concern for prioritized intervention. The proposed framework brings us closer to establishing an integrated health, safety, and wellbeing system that can move organizations along the maturity curve for workplace safety and health.

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HSE MANAGEMENT STANDARDS INDICATOR TOOL

The HSE Management Standards Indicator Tool is a 35-item questionnaire with sections for each of the six primary stress areas - demands, control, support, relationships, role, and change. The tool is designed to provide organizations an understanding of how much work-related stress their worker population may be experiencing and which areas are in most need of intervention. This example questionnaire is intended to gather the opinions of the workforce and can be used as a model for a worker health and wellbeing survey.

Health and Safety Executive

1. I am clear what is expected of me at work

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

2. I can decide when to take a break

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

3. Different groups at work demand things from me that are hard to combine

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

4. I know how to go about getting my job done

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

5. I am subject to personal harassment in the form of unkind words or behaviour

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

6. I have unachievable deadlines

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

7. If work gets difficult, my colleagues will help me

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

8. I am given supportive feedback on the work I do

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

9. I have to work very intensively

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

10. I have a say in my own work speed

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

11. I am clear what my duties and responsibilities are

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

12. I have to neglect some tasks because I have too much to do

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

13. I am clear about the goals and objectives for my department

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

14. There is friction or anger between colleagues

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

15. I have a choice in deciding how I do my work

NEVER · SELDOM · SOMETIMES · OFTEN · ALWAYS

16. I am unable to take sufficient breaks

☐	☐	☐	☐	☐
NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS

17. I understand how my work fits into the overall aim of the organisation

☐	☐	☐	☐	☐
NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS

18. I am pressured to work long hours

☐	☐	☐	☐	☐
NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS

19. I have a choice in deciding what I do at work

☐	☐	☐	☐	☐
NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS

20. I have to work very fast

☐	☐	☐	☐	☐
NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS

21. I am subject to bullying at work

☐	☐	☐	☐	☐
NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS

22. I have unrealistic time pressures

☐	☐	☐	☐	☐
NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS

23. I can rely on my line manager to help me out with a work problem

☐	☐	☐	☐	☐
NEVER	SELDOM	SOMETIMES	OFTEN	ALWAYS

24. I get help and support I need from colleagues

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

25. I have some say over the way I work

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

26. I have sufficient opportunities to question managers about change at work

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

27. I receive the respect at work I deserve from my colleagues

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

28. Staff are always consulted about change at work

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

29. I can talk to my line manager about something that has upset or annoyed me about work

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

30. My working time can be flexible

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

31. My colleagues are willing to listen to my work-related problems

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

32. When changes are made at work, I am clear how they will work out in practice

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

33. I am supported through emotionally demanding work

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

34. Relationships at work are strained

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

35. My line manager encourages me at work

☐	☐	☐	☐	☐
STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE

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