Chapter 8
Systemic Consulting for Organizational Health Development: Theory and Practice

Georg F. Bauer, Katharina Lehmann, Anita Blum-Rüegg, and Gregor J. Jenny

Abstract The present chapter outlines the practical steps of a targeted organizational health development (OHD) process. It summarizes the theoretical background of capacity building (CB) for OHD of the previous chapter X and introduces principles of consulting based on systems theory as a useful practical approach to CB in organizations. It then shows how this theoretical background transfers into practice. The initiation phase includes contracting between the consultant/client system, developing a project architecture that specifies which perspective is involved in which phase of the project, and finally building competence of managers of the organization for going through the second phase of a participatory optimization/renewal process with their teams. This second phase builds on existing team structures and applies a common four-step project cycle of analysis, planning, implementation, and evaluation. For each of these steps of systemic consulting it is specified how it contributes to CB for OHD in organizations – supporting practical implementation and theory-driven evaluation of this approach.

Keywords Organizational health • Organizational health development • Capacity building • Systemic consulting • Consultant/client system • Optimization/renewal cycle • Cockpit • Indicators • Intervention theory

G.F. Bauer (✉) • A. Blum-Rüegg • G.J. Jenny
Division of Public and Organizational Health, Institute of Social and Preventive Medicine, University of Zürich, Hirschengraben 84, 8001 Zürich, Switzerland
e-mail: gfbauer@ifspm.uzh.ch; anita.blum@uzh.ch

K. Lehmann
Polizei Kanton Solothurn, Personal- und Organisationsentwicklung (POE), Leitung Psychologischer Dienst, Schanzmühle, Werkhofstr. 33, 4500 Solothurn, Switzerland
e-mail: katharina.lehmann@kapo.so.ch

G.F. Bauer and O. Hämmig, *Bridging Occupational, Organizational and Public Health: A Transdisciplinary Approach*, DOI 10.1007/978-94-007-5640-3_8,

8.1 Introduction

In Chap. 7 of this book, Hoffmann, Jenny, and Bauer presented a basic conceptualization of organizational health development (OHD) as "both the ongoing re-production and targeted improvement of health in organizations as social systems, based on the interaction of individual and organizational capacities" (for the original source, see Bauer & Jenny, 2012). To pursue the targeted improvement of health in organizations, the authors suggested basing OHD on the generic concept of capacity building (CB). Chapter 7 outlined the overarching concept and principles of CB and adapted it to the specific context of OHD, defining CB principles for OHD. However, the chapter did not show the practical steps to be taken in this type of process of targeted OHD based on CB principles. Thus, the aim of the present chapter is to outline the practical steps of a targeted OHD process and thereby introduce systemic consulting as a useful approach to building health capacities in organizations.

In part I, we briefly outline the theoretical background of CB for OHD and of systemic consulting. In part II, we show how this theoretical background transfers into practice and how systemic consulting contributes to CB for OHD in organizations. The chapter overall and particularly the second part result from the in-house research/practice partnership in our research division, which includes an OHD consulting center that regularly implements systemic consulting for OHD in various public and private organizations.

8.2 Part I: Theoretical Background

8.2.1 OHD and Capacity Building Principles

In Chap. 7, the concept of CB was proposed to guide the sustainable improvement of OHD in organizations. CB was defined as an intentional and targeted OHD approach that (1) addresses both the process ("building") and the outcomes of OHD ("health capacities"), (2) comprises health-oriented and health-relevant interventions on multiple levels, i.e., the organization, its units and teams, its members (individuals), and relevant environments such as families, customers, governmental agencies, etc., (3) refers to systemic thinking by viewing organizations as complex social systems in which reciprocal relationships and multiple perspectives are to be considered, and (4) enables the organization and its members to deal with internally defined health-relevant issues and become free from external support.

As an intentional and targeted OHD approach, CB requires in most cases (at least initially) external support and consulting of organizations. Systemic consulting offers a suitable practical approach to implement the principles of CB mentioned. In the following, principles of the systemic consulting approach will be described before outlining its practical implementation.

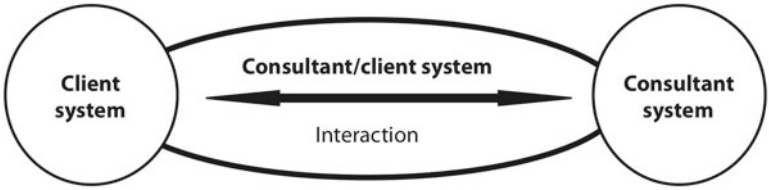

Fig. 8.1 Consultant/client system (Köngiswieser et al., 2006)

8.2.1.1 Systemic Consulting

Sociological systems theory points to organizations as *self-organizing* systems, reproducing themselves over time within their own logic (e.g., Luhmann, 1984). In the process of consulting, a *consultant/client system* emerges (see Fig. 8.1), in which consultants view the client system with their own logic models but also become part of the client system themselves (see second-order cybernetics, von Förster & Pörkson, 2003). Taking up this view, systemic consulting does not try to influence the organization's (self-declared) problems directly but rather supports it to find its own solutions (Willke, 1999). Consultants explicate their own views and models and offer them to the client system as one possibility of many. Particularly, systemic consultants work with *hypotheses*, i.e., assumptions about key relationships and perspectives to be addressed during the consulting process. The hypotheses are offered to the client system and trigger differential replies by various stakeholders (Königswieser & Exner, 2006). As the consultants work with differing logic models and possess diverging blind spots compared to their client system, *new perspectives* emerge (Wimmer, 1995), which provides opportunities for organizational learning. Mostly, systemic consultants design this process of change and simultaneously offer specialized expert knowledge, integrating *process and expert consulting* (on complementary consulting, see Königswieser, Sonuç, & Gebhard, 2006).

Within all phases of systemic consulting, the same cycle applies: Based on the collection of data, hypotheses are formulated and interventions planned and conducted, whereupon the same process repeats itself again – i.e., new information is collected constantly, upon which any further action will be based (*systemic loop*). Königswieser et al. (2006) describe the dynamics as follows: When consultants pose a question at initial contact, they do it on the basis of more or less vague prior information on and assumptions about the client's wishes and the part the consultants ought to play. Simultaneously, the consultants build hypotheses about possible answers to and larger consequences of their questions – guiding the selection of appropriate questions. Thus, consultants do not make an "objective" analysis of the organization and its problems but construct an initial perspective in conjunction with the client system. This will then be further refined in interaction with additional stakeholder groups in the client system.

In relation to the CB principles, systemic consulting of organizations considers multiple levels in the organization and in its environment, strengthens systems

thinking by introducing hypotheses that account for multiple perspectives and reciprocal, non-linear relationships, and enables the organization by triggering responses to externally offered hypotheses as well as by providing support to the organization in finding its own solutions. By repeatedly going through systemic loops, systemic consulting also emphasizes CB as a process in organizations. However, the capacities to be built up in organizations as the desired outcome of CB are not specified by the systemic consulting approach. This missing element is provided by linking the approach of systemic consulting of organizations to the concept of OHD. Part II below outlines how systemic consulting is applied to OHD in practice.

8.3 Part II: Systemic Consulting for OHD in Practice

Traditionally, health-oriented intervention approaches in public health (Institute of Medicine, 1988), health promotion (Godin, Gagnon, Alary, Levy, & Otis, 2007), organizational development (Noblet & LaMontagne, 2009), and occupational health (Nielsen, Randall, Holten, & Gonzalez, 2010) follow several phases. Typically, these phases include analysis, planning, implementation, and evaluation of interventions.

In systemic consulting for OHD, the initial contracting and organizational assessment as well as developing the appropriate project architecture are additional key elements for building a well-functioning consultant/client system. Further, practical experience shows that first an initial top-down awareness raising and competence development of the managers for OHD is needed to obtain their broad buy-in into the following actual 4-step cycle. This cycle follows the typical steps of analysis, planning, implementation, and evaluation. Following the new St. Gallen management model (Rüegg-Stürm, 2003), an improvement cycle of this kind might encompass more superficial optimization or more in-depth renewal of the organization, depending on the degree of need for change.

Thus, systemic consulting for OHD encompasses an initiation phase with the first three steps as well as a subsequent optimization/renewal cycle with four steps that in a first round is also accompanied by external systemic consulting (see Fig. 8.2).

To convert the initial, externally supported OHD process into ongoing, company-driven OHD, both the initiation phase and the initial optimization/renewal cycle are based on the four principles of CB (namely, considering process and outcomes, multiple levels, systemic thinking, and enablement) to the greatest possible extent. CB is particularly facilitated by the step-by-step introduction of an underlying OHD model into the client system. This model serves as common conceptual ground and action theory for the consultant/client system. In the following, each step of systemic OHD will be described and summarized with a short note on its contribution to CB for OHD.

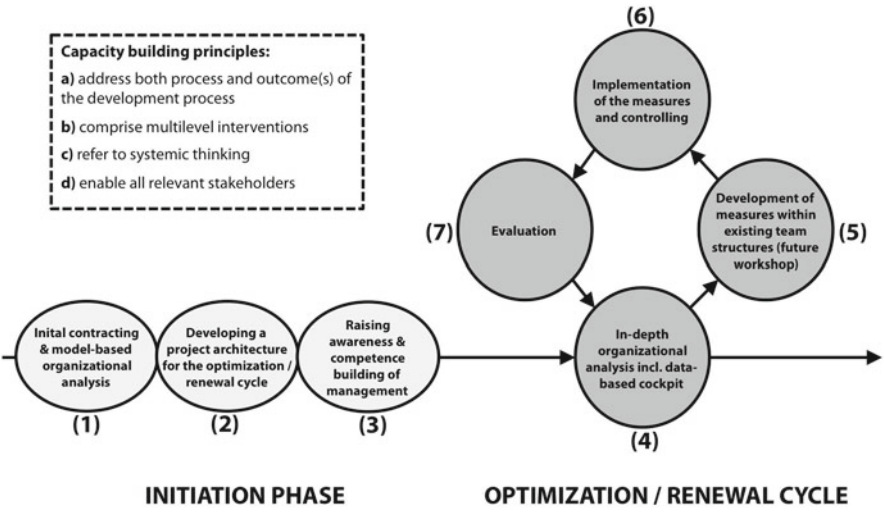

Fig. 8.2 Systemic consulting to build capacities for organizational health

8.3.1 Initiation Phase

8.3.1.1 Initial Contracting and Model-Based Organizational Assessment

Initial contracting refers to the need for primary clarification of the OHD assignment, where external consultants and internal experts and decision-makers discuss and clarify (a) the goals to be achieved with OHD, (b) the potential scope of measures to be taken, (c) their respective roles in the project, and (d) their respective degree of commitment to the project.

Based on this contracting, consultants are entitled to conduct an initial organizational assessment in regard to OHD. The OHD model (See Fig. 8.3 and Fig. 7.1 in Chap. 7; Bauer & Jenny, 2012; Jenny et al., 2011) is introduced as a mind map for structured data collection, e.g., via document analysis, key informant interviews, or focus groups. On the level of organizational capacities, the initial assessment covers, for instance, the system's employee and health orientation (culture), participatory decision-making structures (structure), or strategic corporate governance and organizational readiness for change (strategy). On the level of individual capacities, the educational level and job-related skills of employees (competency), individual readiness for change (motivation), and personal values relevant to OHD such as health orientation (identity) are assessed, for example. Further, prevailing job demands and job resources and related health and performance outcomes are identified.

Regarding existing organizational optimization and renewal processes to build on, both structural and strategic elements such as OHD-relevant management systems (e.g., human resources management, quality management, occupational

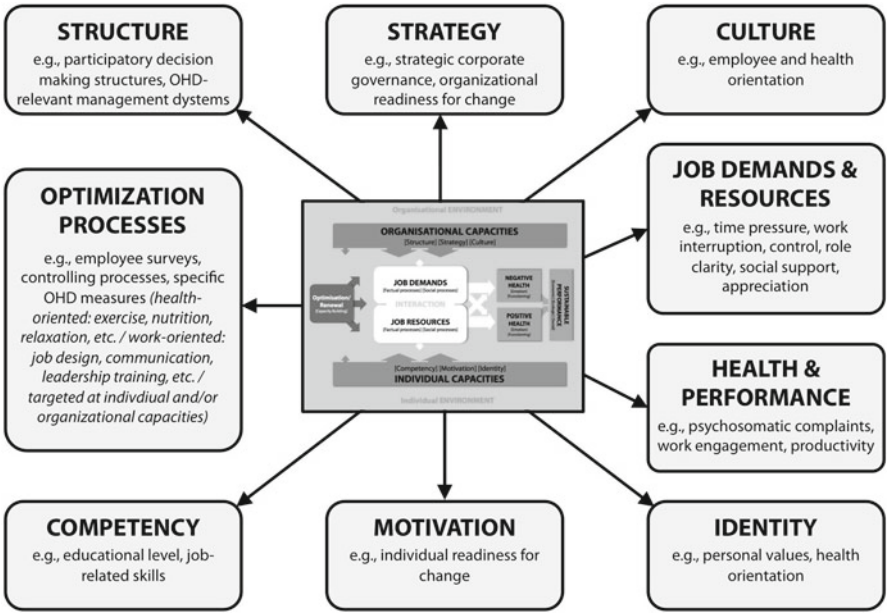

Fig. 8.3 Initial organizational assessment regarding OHD; for the core model at the center, see Fig. 7.1 in Chap. 7

safety/health protection) and ongoing OHD-relevant processes and activities (e.g., employee surveys, controlling processes, specific OHD measures) are assessed. The specific OHD measures are differentiated into explicitly health-oriented measures (e.g., exercise, nutrition, relaxation) and work-oriented measures (e.g., job design, communication, leadership training), targeted at individual and/or organizational health capacities (see Fig. 8.6, at left). Here it is of importance to consider to what extent existing OHD measures are well justified based on the results of preceding organizational analyses and targeted towards common, clearly defined aims.

The initial organizational assessment identifies both the strengths to build on and the weaknesses to be reduced through targeted capacity building for OHD. The OHD model allows for mapping and structured communication of the key results of the initial appraisal. Further, the mapping identifies knowledge gaps – potential blind spots of the organization to be filled by later in-depth analysis of organizational health. Finally, the model facilitates the development of hypotheses concerning how key dimensions of the OHD model are interrelated and what dimensions need to be improved to achieve the initially agreed-upon OHD aims.

Contribution to CB: Mapping and building on existing health capacities and OHD activities per se is a genuinely capacity-oriented approach. More specifically, initial organizational analysis introduces an OHD mind map into the client system that reflects the CB principles. The mind map facilitates systemic thinking by viewing organizations as complex social systems; it shows multiple levels (individual, organization, environment) to be addressed by OHD, shows individual and organizational capacities as outcomes to be achieved through CB processes, and enables the organization to engage in self-observation and to reduce blind spots regarding OHD.

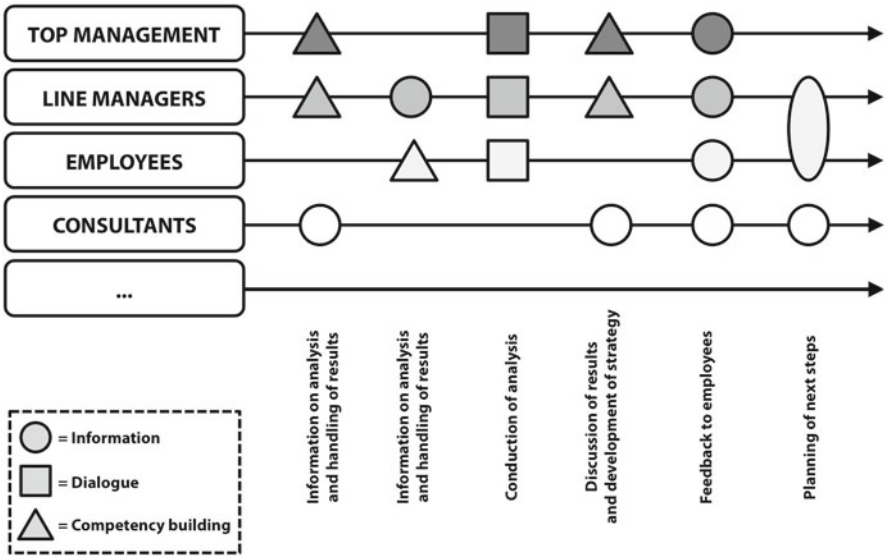

Fig. 8.4 Project architecture example, analysis phase. *Left column*: perspectives to be involved; *bottom*: detailed steps; symbols: degree of involvement

8.3.1.2 Developing a Project Architecture for the Optimization/Renewal Cycle

Based on the appraisal's findings, a project architecture suitable to the client system is created. The project architecture determines for each step of the initiation phase and optimization/renewal cycle of OHD what stakeholder groups or perspectives (top management, line managers, employees, consultants, etc.) are to be involved. The degree of complexity of the project architecture will depend on the organization's size and number of hierarchical levels and units. Following Königswieser and Exner (2006), Fig. 8.4 shows an excerpt from an example project architecture. We recommend adding an indication of the degree to which the respective stakeholder groups (horizontal lines) are to be involved: just to receive information, to engage in a dialogue, or to go through a competency building process.

In this way, an overview is established of who is involved at what stage and in what way and thus whether the relevant perspectives have been considered or which perspectives were left out. Visualization of this architecture can also be integrated into the OHD-related communication strategy of the company to prepare members for the role assigned to them in the project.

It is important to point out that the project architecture of OHD differs from previous project architectures in the field of worksite health promotion. Traditionally, problem-solving groups such as "health circles" (see Aust & Ducki, 2004) or design teams (Henning et al., 2009) are established as a structure parallel to pre-existing group structures in organizations. Within these mostly externally moderated problem-solving groups, employees from diverse organizational units jointly draft health- and

work-oriented measures to be implemented by the organization. However, our previous experiences particularly with health circles showed that managers were often taken by surprise by the amount and scope of measures developed by their employees – and by the degree to which they might interfere with existing operational procedures and corporate culture. Since managers often have little experience with this kind of bottom-up, participatory improvement processes, they can easily perceive the health circle itself and the proposed measures as a threat to their own decision-making authority. Although these threats can be ameliorated by step-wise involvement of decision makers in the various sessions of the health circles, application of a parallel structure of this kind still impedes the translation of this participatory improvement process itself into everyday practice of the organization.

Therefore, the systemic consulting for OHD presented here aims to acknowledge and build on existing social and decision-making structures in organizations, such as regular leadership, team, or division meetings. To still make a difference in the routine functioning of the organization, managers are systematically prepared for taking a more employee-oriented and health-oriented approach in future regular group processes, as outlined in the following steps.

If regular social and decision-making structures do not as yet exist, introducing them as a non-transient, continuous structure will be the first step of developing structural capacities in the organization. Further, the project architecture needs to consider if the subsequent optimization/renewal cycle may be implemented in the entire organization at the same time. Particularly in organizations with little experience with such participatory optimization processes it is advisable to first run a pilot project in parts of the organizations to slowly build up this capacity for participation. After the evaluation of the pilot, the organization may decide to roll out the OHD process in the entire system.

Contribution to CB: By means of the project architecture, involvement of multiple levels and the exchange of multiple perspectives of the organization as a social system are explicated and facilitated. Planning explicit steps for competency building, such as implementation of management training and development of participatory decision-making structures, will further enable the organization for OHD.

8.3.1.3 Awareness Raising and Competence Building of Management

In the first two steps, the systemic consulting for OHD is limited to a few members of the organization, including the internal project leader, top decision maker(s), and key informants involved in the initial organizational analysis. In order to obtain the buy-in and active support of the entire management, in step 3 this group is activated for OHD by means of awareness raising and competence building workshops. During the development of the project architecture, the consultant/client system will have decided on the number and duration of these workshops and who will participate. To facilitate the transfer of knowledge from these workshops to the routine functioning of management teams in the future, ideally existing meeting structures are to be used for the workshops (e.g., regular board meetings, line managers' meetings).

Within *awareness raising workshops*, the relevance of OHD for organizations and their members is highlighted. Discussion of the OHD model (Fig. 8.3) fosters a shared mind map on OHD within the organization. In many companies OHD is initially limited to safety issues and health offers that focus on individuals (e.g., regarding exercise, nutrition, relaxation). The OHD model serves as a visual to explicate and broaden the perspective to include individual and organizational health capacities and their effects on individual health, job quality, and organizational performance. Further, the project architecture is presented to show at what stage and how the diverse stakeholder groups including the managers themselves will be involved. Potential benefits and threats of OHD are discussed from the managers' perspective to overcome possible resistance to OHD. Now managers can reach a well-considered decision concerning the extent to which the organization and specifically their own management unit wish to become involved in a comprehensive OHD process.

Competency building workshop: The aim of the systemic consulting for OHD is to enable managers to continuously go through organizational, health-oriented, participatory optimization/renewal cycles as part of their management routine. This enablement takes place in two phases: First, a competency building workshop prepares them to develop measures themselves in cooperation with their employees. Second, consultants accompany managers in the first round of this participatory optimization/renewal cycle, applying the format of a future workshop described in step five.

The half- to full-day competency building workshop provides managers with the opportunity to reflect upon their own job demands and resources and more generally on organizational aspects relevant to their health and performance. On this basis, they can develop general ideas for improving their own work situation. Further, managers are introduced to how to conduct a future workshop with their own employees and their exact role in it. If a full day is available for the workshop, ideally these two elements of the competency building workshop are combined. In this case, managers themselves go through the process of a future workshop in interaction with their supervisors and moderated by the external consultant. Thus, they can directly experience what attitude and leadership behavior their employees might expect if they jointly go through a similar process in the next step. Also, managers may reflect more generally upon their own leadership style in a protected and supportive setting.

Further, potential benefits and threats of following the OHD cycle and increasing participation in their own leadership unit can be discussed. Managers frequently fear that expectations – for example, regarding wages, personnel resources, and additional infrastructure – on the part of the employees are too high and cannot be met. A related, frequently discussed issue is that employees should take on their share of responsibility for change and not leave everything to the management. Strategies are developed jointly to overcome these potential difficulties, for example by declaring clearly existing restrictions, i.e., not changeable boundary conditions in the organizations to be acknowledged during the later future workshop.

It is clearly emphasized that managers will play a double role during the future workshops: as supervisors and as moderators. Should conflicts be anticipated in this

respect, the organization should give managers the option to rely on external consultants to take over the moderation in their managerial units. Following the consulting approach of systemic loops, information from the awareness raising and competence building workshops will be integrated into refining hypotheses and project aims and into further planning of the project architecture.

Contribution to CB: During awareness raising, the systemic, multilevel mind map for OHD is strengthened. An OHD strategy emerges that is oriented towards building individual and organizational capacities for OHD as key outcomes – to the degree acceptable to the organization. During competency building, managers are enabled to play a leadership role in OHD in their own organizational units. Also, the prior "test run" of a future workshop, including in-depth reflection, eases managers' subsequent interaction with their own employees, fostering exchange of perspectives and joint development of measures.

8.3.2 Optimization/Renewal Cycle

8.3.2.1 In-Depth Organizational Analysis Including Data-Based Cockpit

Depending on the results of the initial organizational assessment, it can be decided what additional information is needed from what perspectives. If available, results of pre-existing, routine employee surveys can be mapped into the dimensions of the OHD model – to show areas with currently existing blind spots that should be filled by further analysis. As the data quality of routine surveys is mostly limited, in most cases an in-depth employee survey is recommended covering all relevant dimensions of the OHD model and relying on scientifically validated scales. To strengthen the company's reflections about their own company as a multidimensional social system, the OHD model is visualized on the questionnaire to show what dimension of the model is covered in each part of the survey.

During analysis, data are aggregated into organizational units and subperspectives that are meaningful to the organization. Well-planned feedback to these stakeholder groups and discussion of the findings are of utmost importance. Processing of the findings highlights different perspectives and initiates dialogue and thus has an activating impact and motivates people in terms of a health-oriented change process (for more details on change-oriented organizational analysis, see Inauen, Jenny, & Bauer, 2011).

A clear advantage of collection and analysis of employee survey data based on the OHD model is that the results can be mapped into the model as well. This leads to an "OHD cockpit" (Fig. 8.5) that highlights key areas of strengths and of improvement opportunities in the organization in a comprehensible way. Figure 8.5 shows the key dimensions of the OHD model, with each dimension operationalized by one or more mostly validated scales. Beyond the results from the employee survey, the OHD cockpit can be fed with other existing data, such as absenteeism or performance data.

The cockpit can show mean values for the entire company or can be split into sub-cockpits with data for individual departments and teams, depending on the pre-set

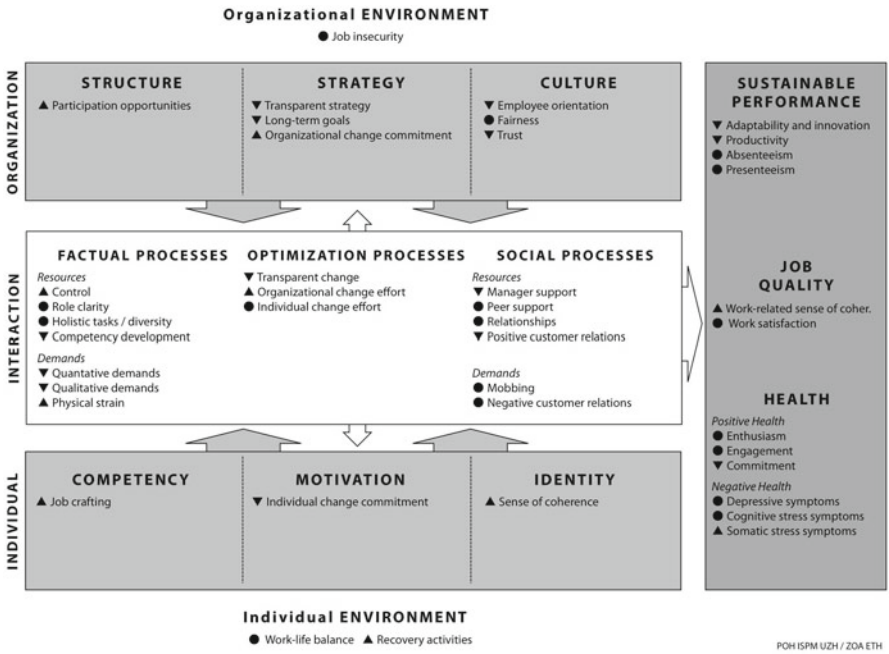

Fig. 8.5 OHD cockpit; see text for details. Icons: ▼ urgent need for improvement, ● middle value, to be discussed and further observed, ▲ assets to be maintained. In this example icons are assigned to dimensions for illustrative purposes only

degree of differentiation and considering the system's inner borders. Visualization of need for improvement (i.e., enhance low resources and/or decrease high demands) and need for maintenance (i.e., maintain high levels of resources) can make use of simple icons: ▼ for urgent need for improvement, ● for OHD dimensions scoring on a middle level and thus to be discussed and further observed, ▲ for OHD dimensions to be considered as assets to be maintained (Fig. 8.5). Comparing results across sub-units of the organization allows identification of common issues to be addressed on the overall organizational level and unit-specific issues to be addressed on this sublevel.

The OHD cockpit aims to support managers in setting up well-justified OHD priorities together with their employees and in making health a binding, institutionalized issue that is given explicit attention within the company. As it shows likely relations between different dimensions of the OHD model, the cockpit can serve as a tool for reducing the complexity of OHD for all members of the organization and particularly for decision makers. For the experts responsible for OHD in an organization, it can serve as an instrument for observation, coordination, and evaluation of OHD across the company. The existing OHD measures mapped during the assessment phase (Fig. 8.6, at left) can be contrasted with the need for action depicted in the OHD cockpit (Fig. 8.6, at right) to analyze whether current action priorities still meet the current need for improvement.

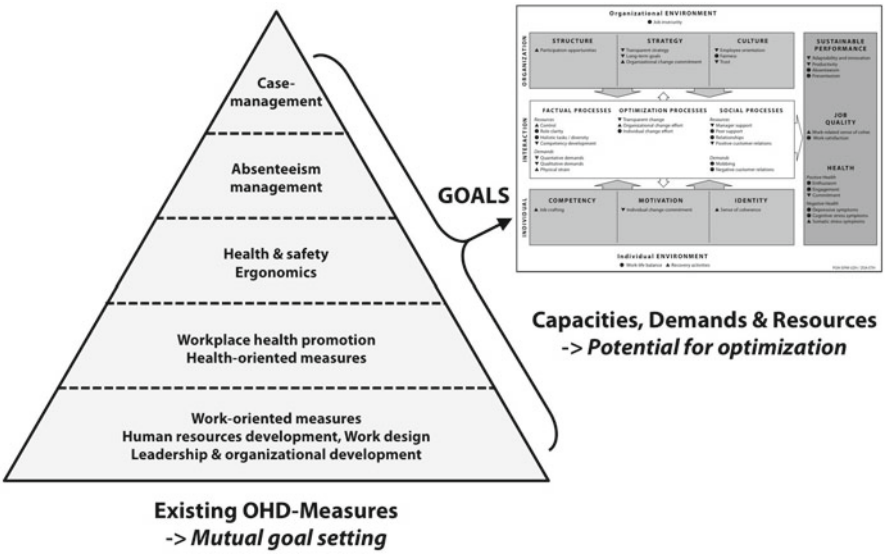

Fig. 8.6 Relation between existing OHD measures and strengths/weaknesses identified in organizational analysis

8.3.2.2 Development of Measures within Existing Team Structures (Future Workshop)

As explained above, in systemic consulting for OHD the design of the 1-day *future workshop* is preferable to traditional small-group processes where only 1–2 representatives of organizational units may participate at a time. A *future workshop* is a large group process with up to 100 participants. Thus – depending on its size – an entire company or at least entire departments may participate simultaneously. This approach guarantees involvement of everyone – that is, everyone who was designated to be involved when building the project architecture – potentially allowing for integration of many different perspectives and broad know-how. Since executives and employees alike are on site, communication across hierarchical levels can be promoted and the adoption of different perspectives fostered. Specific solutions have to be developed for manufacturing plants or health services with shift work.

At the beginning of the 1-day event, the executive of the participating unit(s) explicates the aims and boundary conditions to be considered during the process. Afterwards, together with their employees, team leaders implement what they have learnt in the competency workshop and moderate the development of the measures in their teams themselves. As mentioned, if conflicts are anticipated or lack of trust inhibits communication and change of perspectives, this process should be supported by external moderators, who in any case ensure the smooth order of events at the workshop. Further, in each team, networkers are appointed; their task is to collaborate with other teams during the future workshop and to bring back helpful ideas to their own team. This promotes networking among the teams, which

activates synergies and the mutual adoption of other perspectives and the uncovering of blind spots.

During the development of measures, building up both organizational and individual health capacities is considered, as conveyed through the OHD model and cockpit. When developing measures for building/maintaining resources and/or reducing demands, it is considered what *organizational* and what *individual* health capacities contribute to these job demands and resources. The *future workshop* results in specific, structured action plans containing issues to be addressed, responsible actors, and time line. At the end of this workshop, the main results are presented to the executive, who makes initial comments regarding the feasibility of the developed measures.

Contribution to CB: Managers and their teams are enabled to exchange perspectives and to jointly improve their job demands-resources by building individual and organizational capacities within and beyond their team. Applying the OHD model further strengthens multilevel, systemic thinking – reflecting on the most effective measures and their possible desired and undesired outcomes.

8.3.2.3 Implementation of the Measures and Controlling

The action plans resulting from the future workshops specifically define the measures to be taken and who will be in charge of them. Thus, the implementation is primarily left to these designated actors. However, team leaders are in charge of controlling the implementation of measures and reporting back the state of affairs to their teams and to their superiors on a regular basis. This includes clearly communicating why certain measures can be implemented and why others cannot.

Approximately 8–10 months after the implementation of the measures, a half-day *refresher for managers* (participants of the competency workshop – see above) takes place, where achievements, challenges, and barriers are discussed and the follow-up event to the future workshop is planned. At this half-day *refresher of the future workshop*, the participating teams assess the degree of implementation of the earlier planned measures and how this process could be enhanced in the future. They form hypotheses on why certain objectives were not achieved, for instance, or why job demands could be optimally reduced. Further, new job demands and resources can be collected and appropriate measures developed.

Contribution to CB: The systematically controlled implementation of the developed measures is expected to finally build up the identified key individual and organizational capacities influencing job demands-resources and health in the organization. Further, the refresher for managers of the future workshop is intended to build capacity for continuous self-observation and self-improvement in organizations, increasing the likelihood that the health- and productivity-oriented optimization or renewal cycles will be ongoing.

8.3.2.4 Evaluation

To further assure that the health- and productivity-oriented optimization or renewal cycles will be ongoing, an additional, more formalized evaluation is recommended

as a complement to the controlling mechanism and refresher workshops mentioned above. Ideally, the broad employee survey and/or other data collection methods used during the initial organizational analysis will be reapplied approximately 1–1.5 years after the first analysis. This will allow the assessment of the extent to which the initial goals of the project have been achieved and whether they should be modified or replaced for the following improvement/renewal cycle. To this purpose, the results of this follow-up evaluation can again be entered into the OHD cockpit.

Contribution to CB: The evaluation will refresh the picture of OHD in the organization – including the key individual and organizational capacities to be improved. This will trigger the next, targeted optimization/renewal cycle – for which the capacities have been built up through all the earlier steps taken together.

8.4 Conclusion

In the field of human resource management (Delery & Doty, 1996; Grawitch, Gottschalk, & Munz, 2006), three intervention approaches are distinguished: (a) the universalistic approach: practices which are effective regardless of the setting to which they are applied, (b) the contingency approach: the effectiveness of an organizational practice is dependent on its consistency with other organizational components such as structure and strategy, and (c) the configurational approach: the total system of organizational practices needs to be improved (i.e., reconfigured to an ideal, synergistic pattern of factors).

Classifying our approach of systemic consulting to build capacities for OHD according to this system shows that it best corresponds to the configurational intervention approach (Bauer & Jenny, 2012). As a previous study already summarized key steps and success-factors in a contingency approach (Nielsen et al., 2010), this chapter highlighted those aspects that are key to a configurational approach. Specifically, we presented central steps to be taken by (mostly external) consultants to build capacities for ongoing, sustainable OHD in organizations. In sum, the initiation phase plays a key role in initial CB in the organization by providing good contracting, introducing model-based organizational assessment, developing a project architecture that involves diverse perspectives appropriately, and raising managers' awareness and competence for OHD.

However, it should be noted that CB is continued during each step of the optimization/renewal cycle, as outlined above. Thus, in the end, when the consulting system disconnects from the client system, the organization should be ready to continue the cycles on an ongoing basis on its own.

As explained in the section on the project architecture, there is one particularly important difference compared to other approaches for OHD, such as health circles or ergonomic design teams that purposefully build parallel structures outside of existing power relationships to overcome barriers of change. It was pointed out that this advantage might be diminished by limited acceptance of the resulting measures and impeded translation of this participatory improvement process into everyday

practice of the organization. Thus, our systemic consulting to build long-lasting capacities for OHD uses existing social and decision-making structures in organizations, such as regular leadership, team, or division meetings. In order to still make a difference in the routine functioning of the organization, managers are systematically prepared for taking a more employee-oriented and health-oriented approach in the future. Also, introducing the OHD cockpit, related employee surveys, and structured future workshops is expected to expand the scope of self-observation to include previous blind spots and to assure that participatory improvement/renewal cycles become binding routines in the organization.

Although this approach demands a much more active role of already very busy managers, building their individual capacities for OHD is envisaged to facilitate their general leadership task by making them better able to deal with complexity. Also, the approach is expected to improve managers' relationships with their team members by making them being better able to engage with diverse perspectives, practice participatory decision making, and receive more recognition for their improved leadership skills.

As the extent to which these expected advantages set off potential disadvantages of this more management-driven OHD approach is currently unknown, it needs to be thoroughly studied by means of systematic process and outcome evaluation in the future. This kind of intervention research will be facilitated by the fact that the "systematic consulting to build capacities for OHD" approach is based on a clearly defined intervention theory that is presented in this chapter and in the previous chapter on CB principles.

References

Aust, B., & Ducki, A. (2004). Beyond individual behavior change toward workplace intervention: Experiences from Germany. *Journal of Occupational Health Psychology, 9*, 258–270.

Bauer, G. F., & Jenny, G. J. (2012). Moving towards positive organisational health: Challenges and a proposal for a research model of organisational health development. In J. Houdmondt, S. Leka, & R. Sinclair (Eds.), *Occupational health psychology: European perspectives on research, education and practice*. Oxford, England: Wiley-Blackwell.

Delery, J. E., & Doty, D. H. (1996). Modes of theorizing in strategic human resource management: Tests of universalistic, contingency, and configurational performance predictions. *Academy of Management Journal, 39*, 802–835.

Godin, G., Gagnon, H., Alary, M., Levy, J. J., & Otis, J. (2007). The degree of planning: An indicator of the potential success of health education programs. *Promotion & Education, 14*, 138–142.

Grawitch, M. J., Gottschalk, M., & Munz, D. C. (2006). The path to a healthy workplace: A critical review linking healthy workplace practices, employee well-being, and organizational improvements. *Consulting Psychology Journal: Practice and Research, 58*, 129–147.

Henning, R., Warren, N., Robertson, M., Faghri, P., Cherniack, M., & Research Team, C. P. H.-N. E. W. (2009). Workplace health protection and promotion through participatory ergonomics: An integrated approach. *Public Health Reports, 124*, 26–35.

Inauen, A., Jenny, G. J., & Bauer, G. F. (2011). Design principles for data- and change-oriented organisational analysis in workplace and other setting-based health promotion. *Health Promotion International. Advance online publication.*. doi:10.1093/heapro/dar030.

Institute of Medicine. (1988). *The future of public health*. Washington, DC: National Academies Press.

Jenny, G. J., Inauen, A., Brauchli, R., Füllemann, D., Müller, F., & Bauer, G. F. (2011). *SWiNG Project: Final report of the evaluation.* Retrieved from: http://www.gesundheitsfoerderung.ch/swing/

Königswieser, R., & Exner, A. (2006). *Systemische Intervention: Architekturen und Designs für Berater und Veränderungsmanager* (9th ed.) [Systemic intervention: Architectures and designs for consultants and change managers]. Stuttgart, Germany: Klett-Cotta.

Königswieser, R., Sonuç, E., & Gebhard, J. (2006). *Komplementärberatung* [Complementary consulting]. Stuttgart, Germany: Klett-Cotta.

Luhmann, N. (1984). *Soziale System: Grundlegung einer allgemeinen Theorie* [Social system: Foundations of a general theory]. Frankfurt, Germany: Suhrkamp.

Nielsen, K., Randall, R., Holten, A.-L., & Gonzalez, E. R. (2010). Conducting organizational-level occupational health interventions: What works? *Work & Stress, 24*, 234–259.

Noblet, A., & LaMontagne, A. (2009). The challenges of developing, implementing and evaluating interventions. In S. Cartwright & C. Cooper (Eds.), *The Oxford handbook of organizational well-being*. Oxford, England: Oxford University Press.

Rüegg-Stürm, J. (2003). *Das neue St. Galler Management-Modell* (2nd ed.) [The new St. Gallen management model]. Bern, Switzerland: Paul Haupt.

von Förster, H., & Pörksen, B. (2003). *Wahrheit ist die Erfindung eines Lügners* [Truth is the invention of a liar]. Heidelberg, Germany: Carl-Auer-Systeme-Verlag.

Willke, H. (1999). *Interventionstheorie: Grundzüge einer Theorie der Intervention in komplexe Systeme* [Intervention theory: Fundamentals of a theory of intervention in complex systems]. Stuttgart, Germany: Lucius & Lucius.

Wimmer, R. (1995). Was kann Beratung leisten? Zum Interventionsrepertoire und Interventionsverständnis der systemischen Organisationsberatung [What can consulting achieve? On the intervention repertory and intervention understanding of systemic organizational consulting]. In R. Wimmer (Ed.), *Organisationsberatung: Neue Wege und Konzepte*. Gabler: Wiesbaden, Germany.