Acknowledgements

The MHCC would like to acknowledge the authors of this report. Merv Gilbert PhD and Dan Bilsker PhD from the Centre for Applied Research in Mental Health and Addiction Simon Fraser University.

The views represented herein solely represent the views of the Mental Health Commission of Canada. Production of this document is made possible through a financial contribution from Health Canada.

© 2012 by the Mental Health Commission of Canada and the Centre for Applied Research in Mental Health & Addiction. All rights reserved.
There is thus a strong and compelling business case to be made for making the workplace an environment that is conducive to mental health, since the payback for greater productivity will outweigh the costs of the investment required to significantly reduce mental health risk factors in the workplace.

(The Standing Senate Committee on Social Affairs, Science and Technology, 2006, p. 180)
Common mental health problems such as depression or anxiety have significant prevalence in the workforce. Thirteen percent of workers report a troublesome level of depression at any particular time and eighteen percent of the working population report having missed work or cut back on workload because of depressive symptoms (Dunnigan, Peterson & Haynes, 2003). Kessler, Greenberg, McKelson, Menendez, Zivin & Struening (2000) note that mental health problems and illnesses are estimated to account for nearly 30% of short- and long-term disability claims in Canada. Saranen, S, Matzarke, D, & Smead, D. (2018) The Business Case: Collaborating to help employees maintain their mental well-being. (Healthcare Papers). In 2018, 40% of Canadians experiencing mental illness were between the ages of 20-39. (Smetanin, P, Suf, D, Brante, C, Aslar, C, Ahmad, S, & Khan, M. 2017) The importance of mental health in the workplace is critical. However, the usual approach to managing mental health problems in the workforce is to focus on actions that are effective in supporting the mental well-being of employees with mental health-related disabilities. Workplace mental health issues are complex and dynamic. They require involvement and action at both an individual and organizational level, and relevant participants and actions change across systems and over time. Actions that are effective in supporting the mental well-being of employees without evident problems involve different policies, programs and participants than effective actions for employees with mental health disabilities. Coordination and communication across systems and over time is critical. However, the usual approach to management of mental health in the workplace is poorly integrated. As noted in the pivotal Canadian mental health report, Out of the Shadows, there is a need for better integration between business and the health care system in addressing workplace mental health. (The Standing Senate Committee on Social Affairs, Science and Technology, 2006, p. 124).

An integrated response is coordinated and comprehensive across several critical dimensions. First, integration across stakeholders – the unique contributions and roles of various concerned parties (employees, managers, human resources personnel, union representatives, rehabilitation consultants, health care providers, etc.) should be complementary rather than uncoordinated or conflicting. (Goetzel, Ozminkowski, Bowmen & Tabiro, 2000) Second, integration across time – organizational responses should be consistent and appropriate to different points in the development of, and response to, workplace mental health problems. Third, integration across stages of intervention – there should be systematic delivery of promotion, prevention and treatment interventions (Field, Highe & Robinson, 2002, Goldberg & Steury, 2000). Mino, Babazono, Tsuda & Yasuda. (2006). Fourth, integration across systems – in particular, communication between and coordination of the workplace and health care organizations should be achieved (Grove, 2006; Blisker, Godin & Jones, 2007). Lim, Von Kortt, Russo, Kabon, Simon, Unutzer, Bush, Walker & Ludman, 2000. Kabon, Russo, Von Kortt, Lin, Simon, Bush, Ludman & Walker, 2002; Koest, Craven, Crustolo, Nikolaou, Allen & Fanar, 1997). Fifth, integration across diverse populations – workplace interventions cannot generally be characterized as one-size-fits-all. Interventions are likely to be most effective when they are adapted to individual variations such as gender and ethnic or linguistic group as well as to organizational variations such as small versus large employer and business sector (Bunce 1997; Mart, Sanderson, Scott & Brough, 2009). Finaly, there should be an integrated approach to stigma, mobilizing organizational leadership, knowledge and culture to overcome the stigma often attached to psychological health conditions (Department of Health, 2006).

This report has two aims. First, to critically analyze currently available models for guiding efforts to improve psychological health and safety in the workplace. We analyze these models in terms of generally accepted quality standards and the extent to which the models support an integrated approach to workplace mental health. Second, to present a pragmatic approach to improving workplace psychological health and safety in Canada, drawing upon the various models that have been reviewed. This pragmatic approach is guided by the fundamental goal of integrating the response to workplace psychological health issues. In the service of a more consistent response to the enhancement of psychological health and safety, we will define the components of a pragmatic approach and identify core ingredients and practices that exemplify each of these elements.

The report is based on an extensive review of the literature on workplace mental or psychological health, including both the existing empirical literature and the grey literature in a range of key informants with experience and expertise in the Canadian workplace to ensure that the report is consistent with current policies and practices.

SCOPE

Our discussion will focus upon common psychological problems involving low mood and depression, tension and anxiety, and inappropriate substance use. We will not focus upon actions targeting persons with severe and persistent mental illness, e.g., Supported Employment. Nor will we consider the entire workplace stress and stress management literature, but rather only stress-related models or practices focused explicitly upon mental psychological health. This will often involve studies of stress management interventions designed to prevent the occurrence of common mental health problems. We will not be limited in scope to interventions targeting individuals suffering from mental health conditions, but will also examine interventions aimed at the entire workforce, with a view to promoting good psychological health or preventing mental health conditions.

CANADIAN CONTEXT

Canada is by no means unique amongst industrialized nations with respect to the social and financial impact of mental health concerns. (Lim, Jacobs, Ohinmaa, Schopflocher & Dewa, 2008). Although this issue is widespread internationally, certain aspects of the Canadian context are critical determinants in the creation of an appropriate model for improved psychological health and safety in the Canadian workplace. The nature and size and structure of an organization and its workforce play a role in determining the type and prevalence of psychological problems present, their impact on safety, liability and risk, and the degree of organizational readiness and capacity to take action. (Goetzel, Ozminkowski & Bresnahan, 1999). If not addressed, the impact of mental health problems involving low mood and depression, tension and anxiety, and inappropriate substance use can be substantial. According to the Canadian Mental Health Commission, over three million Canadians aged 15 and older suffer from a mood or anxiety disorder. (Due to absenteeism, presenteeism and turnover) will be systematic delivery of promotion, prevention and treatment interventions (Field, Highe & Robinson, 2002, Goldberg & Steury, 2000). Mino, Babazono, Tsuda & Yasuda. (2006). Fourth, integration across systems – in particular, communication between and coordination of the workplace and health care organizations should be achieved (Grove, 2006; Blisker, Godin & Jones, 2007). Lim, Von Kortt, Russo, Kabon, Simon, Unutzer, Bush, Walker & Ludman, 2000. Kabon, Russo, Von Kortt, Lin, Simon, Bush, Ludman & Walker, 2002; Koest, Craven, Crustolo, Nikolaou, Allen & Fanar, 1997). Fifth, integration across diverse populations – workplace interventions cannot generally be characterized as one-size-fits-all. Interventions are likely to be most effective when they are adapted to individual variations such as gender and ethnic or linguistic group as well as to organizational variations such as small versus large employer and business sector (Bunce 1997; Mart, Sanderson, Scott & Brough, 2009). Finaly, there should be an integrated approach to stigma, mobilizing organizational leadership, knowledge and culture to overcome the stigma often attached to psychological health conditions (Department of Health, 2006).
is changing rapidly. Across the country there have been a number of court rulings and legislative changes that place an increasing onus on employers to invest due diligence to ensuring that no harm comes to their employees’ psychological health in careless, negligent or intentional ways (Gilbert, 2009). Furthermore, a recent initiative gives the psychological health and safety of employees the same attention as physical health and safety. On November 7, 2012 the Mental Health Commission of Canada, launched the National Standard for Psychological Health and Safety in the Workplace. MHC championed the development of the standard in collaboration with the Bureau de Normalisation du Quebec (BNQ) and CSA Standards. The standard provides organizations with benchmarks and tools to achieve measurable improvement in psychological health and safety for Canadian employees which will, in turn, enhance engagement, productivity and the bottom line. Canada will thus be amongst a number of other jurisdictions, primarily in Europe and Australia, with similar standards.

An integrated workplace psychological health framework that is appropriate for Canada will need to accommodate the changing economic and labour climate, as well as trends in legal, regulatory and health care domains. The three aspects of integration are: organizational, mental health and safety, and social and cultural. Each of these domains is changing rapidly. Across the country there have been a number of court rulings and legislative changes that place an increasing onus on employers to invest due diligence to ensuring that no harm comes to their employees’ psychological health in careless, negligent or intentional ways (Gilbert, 2009). Furthermore, a recent initiative gives the psychological health and safety of employees the same attention as physical health and safety. On November 7, 2012 the Mental Health Commission of Canada, launched the National Standard for Psychological Health and Safety in the Workplace. MHC championed the development of the standard in collaboration with the Bureau de Normalisation du Quebec (BNQ) and CSA Standards. The standard provides organizations with benchmarks and tools to achieve measurable improvement in psychological health and safety for Canadian employees which will, in turn, enhance engagement, productivity and the bottom line. Canada will thus be amongst a number of other jurisdictions, primarily in Europe and Australia, with similar standards.

This report identifies and describes several prominent approaches relevant to psychological health and safety (PHS) in the workplace. This does not include models focused on general health without a clear relevance to psychological health, nor does it include models which broadly address workplace stress, unless they incorporate a significant emphasis upon psychological health. In addition, to addressing the empirical and theoretical consistency of the small set of models selected, we will consider how useful they are, particularly in the Canadian context. Our review will also consider the extent to which the models provide practical information, resources and tools as well as guidance for implementation. We have selected six widely-accepted quality criteria as our framework for examining models of psychological health in the workplace: appropriateness, acceptability, accessibility, effectiveness, efficiency and safety.

The six quality criteria are:

1. Appropriateness
2. Acceptability
3. Accessibility
4. Effectiveness
5. Efficiency
6. Safety

These criteria are highly relevant to the domain of psychological health services and initiatives. It is not sufficient to simply define the six general quality criteria. We must also articulate how they apply to the domain of organizational mental health, highlighting key issues to be considered when applying the criteria to models or practices in this domain. It should further be noted that models cannot, strictly speaking, be evaluated with regard to how well they satisfy criteria such as effectiveness; only interventions or practices can be evaluated this way. Rather, models can be evaluated in terms of how well they address the six criteria and provide direction to employers or other workplace leaders in developing and sustaining high-quality organizational initiatives and interventions that can, in turn, be evaluated for effectiveness and other such criteria.

This report identifies and describes several prominent approaches relevant to psychological health and safety (PHS) in the workplace. This does not include models focused on general health without a clear relevance to psychological health, nor does it include models which broadly address workplace stress, unless they incorporate a significant emphasis upon psychological health. In addition, to addressing the empirical and theoretical consistency of the small set of models selected, we will consider how useful they are, particularly in the Canadian context. Our review will also consider the extent to which the models provide practical information, resources and tools as well as guidance for implementation. We have selected six widely-accepted quality criteria as our framework for examining models of psychological health in the workplace: appropriateness, acceptability, accessibility, effectiveness, efficiency and safety.

These criteria are highly relevant to the domain of psychological health services and initiatives. It is not sufficient to simply define the six general quality criteria. We must also articulate how they apply to the domain of organizational mental health, highlighting key issues to be considered when applying the criteria to models or practices in this domain. It should further be noted that models cannot, strictly speaking, be evaluated with regard to how well they satisfy criteria such as effectiveness; only interventions or practices can be evaluated this way. Rather, models can be evaluated in terms of how well they address the six criteria and provide direction to employers or other workplace leaders in developing and sustaining high-quality organizational initiatives and interventions that can, in turn, be evaluated for effectiveness and other such criteria.

The six quality criteria are:

1. Appropriateness
2. Acceptability
3. Accessibility
4. Effectiveness
5. Efficiency
6. Safety

These criteria are highly relevant to the domain of psychological health services and initiatives. It is not sufficient to simply define the six general quality criteria. We must also articulate how they apply to the domain of organizational mental health, highlighting key issues to be considered when applying the criteria to models or practices in this domain. It should further be noted that models cannot, strictly speaking, be evaluated with regard to how well they satisfy criteria such as effectiveness; only interventions or practices can be evaluated this way. Rather, models can be evaluated in terms of how well they address the six criteria and provide direction to employers or other workplace leaders in developing and sustaining high-quality organizational initiatives and interventions that can, in turn, be evaluated for effectiveness and other such criteria.

This report identifies and describes several prominent approaches relevant to psychological health and safety (PHS) in the workplace. This does not include models focused on general health without a clear relevance to psychological health, nor does it include models which broadly address workplace stress, unless they incorporate a significant emphasis upon psychological health. In addition, to addressing the empirical and theoretical consistency of the small set of models selected, we will consider how useful they are, particularly in the Canadian context. Our review will also consider the extent to which the models provide practical information, resources and tools as well as guidance for implementation. We have selected six widely-accepted quality criteria as our framework for examining models of psychological health in the workplace: appropriateness, acceptability, accessibility, effectiveness, efficiency and safety.

These criteria are highly relevant to the domain of psychological health services and initiatives. It is not sufficient to simply define the six general quality criteria. We must also articulate how they apply to the domain of organizational mental health, highlighting key issues to be considered when applying the criteria to models or practices in this domain. It should further be noted that models cannot, strictly speaking, be evaluated with regard to how well they satisfy criteria such as effectiveness; only interventions or practices can be evaluated this way. Rather, models can be evaluated in terms of how well they address the six criteria and provide direction to employers or other workplace leaders in developing and sustaining high-quality organizational initiatives and interventions that can, in turn, be evaluated for effectiveness and other such criteria.

The six quality criteria are:

1. Appropriateness
2. Acceptability
3. Accessibility
4. Effectiveness
5. Efficiency
6. Safety

These criteria are highly relevant to the domain of psychological health services and initiatives. It is not sufficient to simply define the six general quality criteria. We must also articulate how they apply to the domain of organizational mental health, highlighting key issues to be considered when applying the criteria to models or practices in this domain. It should further be noted that models cannot, strictly speaking, be evaluated with regard to how well they satisfy criteria such as effectiveness; only interventions or practices can be evaluated this way. Rather, models can be evaluated in terms of how well they address the six criteria and provide direction to employers or other workplace leaders in developing and sustaining high-quality organizational initiatives and interventions that can, in turn, be evaluated for effectiveness and other such criteria.

This report identifies and describes several prominent approaches relevant to psychological health and safety (PHS) in the workplace. This does not include models focused on general health without a clear relevance to psychological health, nor does it include models which broadly address workplace stress, unless they incorporate a significant emphasis upon psychological health. In addition, to addressing the empirical and theoretical consistency of the small set of models selected, we will consider how useful they are, particularly in the Canadian context. Our review will also consider the extent to which the models provide practical information, resources and tools as well as guidance for implementation. We have selected six widely-accepted quality criteria as our framework for examining models of psychological health in the workplace: appropriateness, acceptability, accessibility, effectiveness, efficiency and safety.

These criteria are highly relevant to the domain of psychological health services and initiatives. It is not sufficient to simply define the six general quality criteria. We must also articulate how they apply to the domain of organizational mental health, highlighting key issues to be considered when applying the criteria to models or practices in this domain. It should further be noted that models cannot, strictly speaking, be evaluated with regard to how well they satisfy criteria such as effectiveness; only interventions or practices can be evaluated this way. Rather, models can be evaluated in terms of how well they address the six criteria and provide direction to employers or other workplace leaders in developing and sustaining high-quality organizational initiatives and interventions that can, in turn, be evaluated for effectiveness and other such criteria.

The six quality criteria are:

1. Appropriateness
2. Acceptability
3. Accessibility
4. Effectiveness
5. Efficiency
6. Safety

These criteria are highly relevant to the domain of psychological health services and initiatives. It is not sufficient to simply define the six general quality criteria. We must also articulate how they apply to the domain of organizational mental health, highlighting key issues to be considered when applying the criteria to models or practices in this domain. It should further be noted that models cannot, strictly speaking, be evaluated with regard to how well they satisfy criteria such as effectiveness; only interventions or practices can be evaluated this way. Rather, models can be evaluated in terms of how well they address the six criteria and provide direction to employers or other workplace leaders in developing and sustaining high-quality organizational initiatives and interventions that can, in turn, be evaluated for effectiveness and other such criteria.

The six quality criteria are:

1. Appropriateness
2. Acceptability
3. Accessibility
4. Effectiveness
5. Efficiency
6. Safety

These criteria are highly relevant to the domain of psychological health services and initiatives. It is not sufficient to simply define the six general quality criteria. We must also articulate how they apply to the domain of organizational mental health, highlighting key issues to be considered when applying the criteria to models or practices in this domain. It should further be noted that models cannot, strictly speaking, be evaluated with regard to how well they satisfy criteria such as effectiveness; only interventions or practices can be evaluated this way. Rather, models can be evaluated in terms of how well they address the six criteria and provide direction to employers or other workplace leaders in developing and sustaining high-quality organizational initiatives and interventions that can, in turn, be evaluated for effectiveness and other such criteria.

The six quality criteria are:

1. Appropriateness
2. Acceptability
3. Accessibility
4. Effectiveness
5. Efficiency
6. Safety

These criteria are highly relevant to the domain of psychological health services and initiatives. It is not sufficient to simply define the six general quality criteria. We must also articulate how they apply to the domain of organizational mental health, highlighting key issues to be considered when applying the criteria to models or practices in this domain. It should further be noted that models cannot, strictly speaking, be evaluated with regard to how well they satisfy criteria such as effectiveness; only interventions or practices can be evaluated this way. Rather, models can be evaluated in terms of how well they address the six criteria and provide direction to employers or other workplace leaders in developing and sustaining high-quality organizational initiatives and interventions that can, in turn, be evaluated for effectiveness and other such criteria.
1. The HSE Model

DESCRIPTION
The Health and Safety Executive (HSE) is the lead authority in the United Kingdom responsible for maintaining standards for the protection of health and safety in the workplace. Over the last 15 years, it has carried out a sophisticated process to identify strategies for reducing work-related stress. This process has included a comprehensive literature review of organizational interventions for reducing stress as well as a wide-ranging set of consultations to elicit views of stakeholders in this area. Although the HSE had initially planned a regulatory approach, it was decided to take a more collaborative and consultative approach, working closely with stakeholders to develop clear, agreed standards of good management practice. Rather than regulating reduced workplace stress, it was decided to collaboratively formulate standards and provide tools to make change practical and appealing, encouraging and supporting workplaces to change rather than enforcing change in a more heavy-handed manner. This is a standards-based approach that is essentially based on a method of controlling risks and hazards. The HSE Management Standards take a preventive approach, based on identifying organizational-level problems that raise risk factors associated with workplace stress and then taking systematic action to ameliorate these risks, helping to ensure the health and safety of employees. The HSE model views stress as a psychological state with both cognitive and emotional components, including the “presence of demands, a set of evaluative processes through which those demands are perceived as significant, and the generation of a response that typically affect the well-being of the individual.” 

Although the standards are voluntary, the HSE will investigate complaints and issue “improvement notices” for organizations that refuse to assess risks or to take action on unsatisfactory risk levels.

Educational material has been developed and disseminated to employers that teaches how to assess these organizational risk factors using key workplace indicators (such as sickness absence rates and duration) as well as an employee survey developed by the HSE, and how to adopt a systematic risk management and proactive approach. In order to assist employers to implement the standards, a second employee survey has been created: the Management Standards Indicator Tool. This has been translated into several languages and is complemented by online resources to facilitate assessment of risks and appropriate follow-up actions. Materials have also been developed specifically for certain types of organizations such as small to medium-sized businesses. Since the launch of the standards in 2004, subsequent research has supported the psychometric robustness of the Indicator Tool and the positive impact of reducing risk exposure on employee job satisfaction, anxiety, depression and workplace errors (Edwards, Webster, Van Laar & Easton, 2008; Kerr, McHugh & McRory, 2009).

APPROPRIATENESS
The HSE model was based on an extensive review of available evidence and consultation with relevant stakeholders with respect to workplace stress. The focus is primarily on identifying and addressing workplace conditions that may be precursors to employee distress, rather than responses to employees who are exhibiting signs of distress and possible compromised mental health or responses to employees with an identified mental illness who may be at work or off on disability leave. Within this primary prevention approach, the emphasis is on organizational factors, with little attention to individual predisposing factors. Although the standards were developed for use within the United Kingdom, the underlying model of workplace risks and responses has universal applicability.

ACCEPTABILITY
The HSE has engaged in ongoing consultation with all those impacted by the standards, which has led to the creation of a number of documents and guidelines to facilitate effective implementation. These have been directed to a broad audience including organizational directors, managers, human resources personnel, union representatives, occupational health and safety personnel, and employees. Information with respect to the business case for the standards and their relevance as a component of corporate social responsibility. There is sparse information concerning secondary3 or tertiary prevention and the interface of the standards with the mental health care system.

ACCESSIBILITY
All materials are readily available on the HSE website. In addition, there are regular updates on relevant research, publications and regulatory or legal changes. These have been complemented by podcasts, case studies, video clips and online forums for discussing implementation issues. The assessment survey is available in eighteen languages, and links to related tools and resources are provided. Given the national regulatory and advisory mandate of the HSE and the provision of national health care within the United Kingdom, there are few regional barriers with respect to accessibility. This is not the case in Canada, where there are provincial and territorial differences in legislation, authority and health care delivery.

EFFECTIVENESS
The HSE Management Standards are based on an extensive and well-established evidentiary base demonstrating the relationship between organizational workplace factors and employee stress, which, when addressed properly, can mediate the onset, severity and functional impact of mental illness. While there is supportive evidence for the effectiveness of organizational interventions in reducing these psychosocial risks, the evidence that such interventions are effective in reducing the severity of other individual outcomes is not as strong, although there have been some promising recent studies (Kelloway, Teed & Kelley, 2008; Kerr, McHugh & McRory, 2009).

2 These interventions happen after an illness or serious risk factors have already been diagnosed. The goal is to halt or slow the progression of disease in its earliest stages, in the case of injury, goals include limiting long-term disability and preventing medical and financial consequences (retirement, treatment, etc.);

3 This focus on helping people manage complications, long-term health problems such as diabetes, heart disease, cancer and chronic musculoskeletal pain The focus is on physical/behavioral and maximizing quality of life - (bundled for Work and Health, http://www.who.int/violence/prevention/secondary_and_tertiary_prevention/en/)

2010

EFFICIENCY
The HSE Management Standards and accompanying resources are available online at no cost to employers, regardless of sector or size. This includes opportunities for training and consultation. Nevertheless, successful implementation of the standards requires organizational knowledge, readiness and effort. This may be relatively straightforward in organizations that recognize the impact of workplace stress on their productivity and financial bottom line: demonstrate commitment across the organization, and have the necessary personnel, infrastructure and resources to conduct the assessment and act on the results. It will be more difficult in organizations that are not aware of workplace psychological health issues, lack commitment (particularly from senior management), or have insufficient resources.

SAFETY
The HSE model is based on the premise that identifying and addressing risks to employees will reduce the likelihood of problems occurring in general; such a primary prevention approach is less likely to be disruptive and lead to unintended negative consequences than the more intensive, expensive and invasive actions that are required once problems have emerged. Nevertheless, it is worth noting that any intervention intended to have a positive impact has the potential of resulting in a negative outcome. In the case of the HSE approach, an organization that identified areas of risk but failed to act, or undertook ineffective actions, could decrease employee trust and increase stress. In addition, the focus on primary prevention may reduce attention and effort towards secondary and tertiary prevention and treatment.

2. The PRIMA-EF Model

DESCRIPTION
The European Framework for Psychosocial Risk Management (PRIMA-EF) was produced by a consortium of occupational health organizations funded by the European Union (PRIMA: Psychosocial Risk Management, Excellence Framework). The mandate of this consortium is the development of a framework for psychosocial risk management and national standards amongst all participating countries (Leka & Cox, 2008).

The model developed is relevant to both the enterprise level and the wider macro policy level – in particular challenges in relation to psychosocial risks exist at both these levels. On the enterprise level, there is a need for systematic and effective policies to prevent and control mental health problems such as diabetes, heart disease, cancer and chronic musculoskeletal pain.
the various psychosocial risks at work, clearly linked to companies’ management practices. On the national and EU levels, the main challenge is to translate existing policies into effective practice through the provision of tools that will stimulate and support organizations to undertake that challenge, thereby preventing and controlling psychosocial risks in our workplaces and societies alike. At both levels, these challenges require a comprehensive framework to address psychosocial risks (Leka & Cox, 2008, p. 175).

The focus of the framework is the creation of policies, indicators and practices that help prevent and manage work-related stress and workplace violence, harassment, and bullying. Fundamental to the model are the principles that effective psychosocial risk management is ongoing, based on solid evidence, tailored to the needs of a particular organization and requires participation by all relevant parties. Within the PRIMA-EF model, work-related psychosocial risks are viewed as involving those aspects of the design and management of work and its social and psychological content, which can cause psychological or physical harm. These include, but are not limited to: job content, workload and job pace, roles and responsibilities, control, environment and equipment, work schedule, etc., but are not limited to: job content, workload and job pace, roles and responsibilities, control, environment and equipment, work schedule, etc., but are not limited to: job content, workload and job pace, roles and responsibilities, control, environment and equipment, work schedule, etc.

Rather than prescribing specific instruments or actions, the PRIMA-EF approach recognizes the diversity of organizations and national contexts and leaves it to the discretion of participants to select the tools, policies and interventions appropriate to their needs. For example, the assessment process may involve employee surveys, workplace audits, group discussions and/or direct observation. A web-based inventory of best-practice interventions for addressing work-related stress and violence, bullying and harassment is broken down by participating country and by level of intervention (PRIMA Psychosocial Risk Management, Excellence framework: Inventory of best practice). In follow-up to adoption of the framework, there is a current project (Psychosocial Risk Management – Vocational Education and Training, PRIMAeT) aimed at creating a web-based set of resources to train employers, managers, occupational health specialists and other practitioners in the framework’s principles and practices (PRIMA Psychosocial Risk Management, excellence framework: Psychosocial Risk Management, 2008).

**APPROPRIATENESS**

The PRIMA-EF model is based on a review of available scientific evidence and stated needs of the participating countries and organizations. The focus is on identifying and addressing organizational and national factors that may be precursors to workplace stress and mistreatment as well as employee mental health issues. Recognition and management of these factors, as well as creation of appropriate national policies, are expected to benefit distressed or disabled workers. There is, however, no consideration of integration with the provision of mental health care. The PRIMA-EF framework is aimed explicitly at organizational and regulatory legal and governance structure of the participating countries. Although the broad principles of primary prevention, continuous risk management and creation of national standards and policies are relevant to the Canadian context, the specific content of this model is less applicable.

**ACCEPTABILITY**

As the project involved a consortium of health and safety organizations, consultation in each participating European country was intensive and included employer and employee groups as well as national bodies. Fundamental to the PRIMA-EF approach is the concept of ‘social dialogue’, which requires regular and meaningful collaboration between government agencies, employers, workers, and their representatives with the goal of identifying and addressing problems, developing effective policies and creating joint agreements. Dissemination of the framework is ongoing and supported through the World Health Organization and International Labour Organization Occupational Health and Safety Information Portal, which will permit continuing consultation, revision and improvement. There is an implicit expectation that employers will utilize the framework because it is the ‘right thing to do’ (and they may be subject to regulatory or legal sanctions if they don’t), rather than a compelling case that psychosocial risk management will reap productivity, human resources or cost containment benefits. This argument may not convince organizations to participate, particularly in Canada where there are fewer relevant standards or legal requirements.

**ACCESSIBILITY**

The PRIMA-EF framework reflects a collaborative partnership amongst a number of EU countries and consulting organizations and is therefore aimed at the broad policy and process level rather than specific practices, sectors or organizations. Background and implementation guidelines are provided in multiple languages. The web-based inventory of best-practice interventions, broken down by country and level of intervention, will enhance access. However, the extent to which employers, particularly small to medium sized organizations, will find the framework useful has yet to be determined. The tendency and references to European policy and research organizations, regulatory requirements and standards will be of little relevance for Canadian organizations.

**EFFECTIVENESS**

The PRIMA-EF framework recommends a process of assessment, action and evaluation but leaves the selection of specific tools, templates and practices to the user. This overall model is consistent with the evidence for organizational interventions in reducing psychosocial risks, the evidence that such interventions are effective in reducing the prevalence and severity of negative health outcomes is not as strong (Kelloway, Teed & Kelley, 2008). The inclusion of overall organizational risks as well as specific occurrence of workplace violence and bullying may be confusing, as the effective interventions for one may not impact the other. The effectiveness of the PRIMA-EF approach has yet to be determined.
This definition is intended to prevent illnesses and injuries from happening. It is, in other words, based on primary prevention. It also, however, includes secondary and tertiary prevention, return-to-work planning and the creation of an environment that minimizes the likelihood of re-injury or recurrence of an illness. According to this model, employers can enhance worker health, as well as organizational productivity, efficiency and competitiveness, by impacting four avenues of influence:

1. the physical environment
2. the psychosocial work environment
3. personal health resources
4. enterprise community involvement

Each of these areas of content is addressed using a process of continual improvement that ensures that health, safety and well-being programs meet the needs of all concerned and are sustainable over time. The success of these efforts is dependent on adherence to the fundamental principles of leadership engagement and worker participation, both guided by a shared set of core values. The model incorporating these principles, process steps and content areas is illustrated in Figure 2.

The WHO Healthy Workplace model is intentionally holistic, incorporating a broad definition of health as a state of comprehensive physical, mental and social well-being, rather than just the absence of disease. Of greatest importance for the current review, is the psychosocial work environment factor, which includes variables such as management, organizational culture and the prevalent values, practices and behaviours regularly demonstrated in a particular workplace. When these are negative they can serve as risk factors or potential stressors that may cause emotional or mental stress for workers. Efforts to address such risk factors include reducing or eliminating them at their source and, recognizing that some risks are inherent in many workplaces, providing policies or programs to lessen their impact and protect the worker from undue harm. Adjustments in the psychosocial environment can also aid employees who are off work due to an illness or injury by increasing the likelihood of successful work return and decreasing the potential for relapse. While the psychosocial domain may be the most relevant domain, the other areas are also important to workplace mental health. There is a relationship between the psychosocial and physical work environment; exposure to hazards in either of these domains increases the risk of both physical and psychological illness, as well as the likelihood of accidents, incidents or injuries. Similarly, the availability of personal health resources such as comprehensive benefits, flexible work arrangements, wellness initiatives and self-care programs will impact mental health. Finally, organizational involvement in the larger community and society influences mental health, particularly when this includes involvement in community-based mental health initiatives, collaboration for improved communication and access to public mental health care, and participation in the creation of regional or industry standards with respect to psychological health and safety.

The WHO Healthy Workplace model was based on extensive and ongoing international consultation and a review of the scientific and grey literature (World Health Organization, 2010). The framework is intentionally non-prescriptive. Rather than providing a ‘one size fits all’ template, the framework is intended to provide flexible guidance to users across organizations, sectors and countries.

The WHO Healthy Workplace model is intentionally holistic, incorporating a broad definition of health as a state of comprehensive physical, mental and social well-being, rather than just the absence of disease. Of greatest importance for the current review, is the psychosocial work environment factor, which includes variables such as management, organizational culture and the prevalent values, practices and behaviours regularly demonstrated in a particular workplace. When these are negative they can serve as risk factors or potential stressors that may cause emotional or mental stress for workers. Efforts to address such risk factors include reducing or eliminating them at their source and, recognizing that some risks are inherent in many workplaces, providing policies or programs to lessen their impact and protect the worker from undue harm. Adjustments in the psychosocial environment can also aid employees who are off work due to an illness or injury by increasing the likelihood of successful work return and decreasing the potential for relapse. While the psychosocial domain may be the most relevant domain, the other areas are also important to workplace mental health. There is a relationship between the psychosocial and physical work environment; exposure to hazards in either of these domains increases the risk of both physical and psychological illness, as well as the likelihood of accidents, incidents or injuries. Similarly, the availability of personal health resources such as comprehensive benefits, flexible work arrangements, wellness initiatives and self-care programs will impact mental health. Finally, organizational involvement in the larger community and society influences mental health, particularly when this includes involvement in community-based mental health initiatives, collaboration for improved communication and access to public mental health care, and participation in the creation of regional or industry standards with respect to psychological health and safety.

The WHO framework comprehensively addresses the full array of factors that determine a healthy workplace, describing the particular principles used to achieve this, and indentifying the principles underlying success. The holistic model of health adopted by WHO acknowledges the integration of physical and psychological health, the importance of both individual and organizational factors, and the interaction between businesses and the communities in which they operate. The focus is on primary prevention, but explicit inclusion of secondary and tertiary prevention and work return factors within the model increase the likelihood that the continuum of workplace mental health issues will be addressed. Although most users can identify their particular needs within this model, the broad spectrum covered detracts from specific guidance with respect to mental health issues. Similarly, the international scope of the framework and accompanying documentation limits relevance for the Canadian workplace.

The WHO framework comprehensively addresses the full array of factors that determine a healthy workplace, describing the particular principles used to achieve this, and indentifying the principles underlying success. The holistic model of health adopted by WHO acknowledges the integration of physical and psychological health, the importance of both individual and organizational factors, and the interaction between businesses and the communities in which they operate. The focus is on primary prevention, but explicit inclusion of secondary and tertiary prevention and work return factors within the model increase the likelihood that the continuum of workplace mental health issues will be addressed. Although most users can identify their particular needs within this model, the broad spectrum covered detracts from specific guidance with respect to mental health issues. Similarly, the international scope of the framework and accompanying documentation limits relevance for the Canadian workplace.

**Figure 2.** Source: World Health Organization, 2010, p. 13
ACCESSIBILITY
There is a wealth of material readily available on the WHO Healthy Workplace website as well as crosslinks to partner organizations in multiple countries. These are available in multiple languages and supported by guidance and documentation on specific topics such as stress, harassment and workplace violence. In addition, given the broad mandate of WHO, there is an extensive collection of resources on workplace health and safety issues as well as general health topics. That said, it should be reiterated that the scope of the model and breadth of topics may serve to limit access by individual Canadian employers.

EFFECTIVENESS
In support of the WHO model, the authors relied on existing literature reviews, such as the Cochrane Collaboration, regarding the negative consequences of harmful work environments and the effectiveness of workplace interventions. While there is a wealth of evidence highlighting the implications of harmful work environments, the authors have noted the paucity of convincing research on the effectiveness of workplace interventions. Acknowledging that the traditional health research paradigm may not be appropriate for the dynamic world of work, they have expanded their criteria for effectiveness to include degree of participation in the intervention by employees as well as the cost-effectiveness of the interventions. The search was also extended to include the grey literature and focused on evidence related to interventions addressing each of the ‘avenues of influence’. With respect to psychosocial interventions, the reviewers found modestly positive evidence that such interventions were effective (World Health Organization, 2010).

EFFICIENCY
The WHO framework is intentionally broad in scope. While researchers and policy makers will find the model useful, individual Canadian employers seeking guidance on how to address particular workplace mental health issues will likely have difficulty identifying resources useful in the course of business as usual.

SAFETY
The WHO model is based on the premise that early identification and reduction of and addressing risks and hazards to employees will reduce the likelihood and severity of employee health issues. The developers of this model acknowledge that there is a need for further research and practical trials to determine evidence-based actions but caution that lack of conclusive proof should not hinder action. As Joan Burton, one of the authors of the WHO background documents, notes:

The (precautionary) principle states that in the case of serious or irreversible threats to the health of humans or the ecosystem, acknowledged scientific uncertainty should not be used as a reason to postpone preventive measures. In other words, in the context of this paper, employers and workers should not delay implementing actions to improve workplace conditions and promote health simply because there is no strong scientific evidence of the intervention’s effectiveness. This may be a rather heretical statement to some, and of course comes with one major caveat: it must be clear without a doubt that the intervention will do no harm, either to the health of workers or to the sustainability of the enterprise. (WHO, World Health Organization, 2010, p. 43)

4. The American Psychological Association Psychologically Healthy Workplace Model

DESCRIPTION
The Psychologically Healthy Workplace Program (PHWP) was initiated as a collaborative effort between the American Psychological Association (APA) and the APA Practice Organization. It is designed to help employers optimize employee well-being and organizational performance. The PHWP model integrates organizational effectiveness and employee benefits approaches intended to optimize outcomes for both employees and organizations. The model includes a multi-level approach that incorporates primary-, secondary- and tertiary-level interventions to address problems, reduce risks, prevent problems from developing and optimize organizational and individual functioning. Implementing the model is dependent on an ‘action research’ approach that includes needs assessment, customized program design and implementation and ongoing evaluation. The model recognizes that organizations are complex systems and that initiatives, programs and policies in one area interact with others, as well as with the broader organizational and societal context. The PHWP approach encourages organizations to customize their approach to meet the needs of their workforce. The model is based on psychological research with respect to individual and organizational functioning and change, as well as research and practice in public health, economics and occupational health areas. The PHWP model is not specifically focused on mental health but rather on broad organizational practices that inform and impact employee behaviour, health and lifestyle. By using this socio-ecological approach, it is believed that individuals will be more successful in adopting and sustaining positive health behaviors, as they are supported by the organizational culture, and in turn, positive systemic changes will be consistent with and complemented by employee behaviours.

The PHWP model identifies five broad categories of healthy workplace practices, policies and programs, all of which need to be fundamentally linked by clear and consistent communication (see Figure 3). The five categories are:

- Employee Involvement
- Health and Safety
- Employee Growth and Development
- Work/Life Balance
- Employee Recognition

In support of the model, the APA Practice Organization maintains a website (www.phwp.org) that provides information and resources for interested parties. These include regular podcasts and e-newsletters, relevant research findings and case studies. In addition to education, PHWA also supports a recognition and awards program for employers. Since 1999, Psychologically Healthy Workplace Awards have been presented to organizations by state, provincial and territorial psychological associations on the basis of a competitive application and selection process. The award program highlights a variety of workplaces, large and small, and profit and non-profit, in diverse settings. Winners at a local level are also eligible for recognition at an international level for either their overall psychological health or for specific practices that embody the PHWP principles. To date, more than 450 organizations across North America have been recognized for their efforts by 52 professional associations.

APPROPRIATENESS
The PHWP provides a cogent case for the merits of creating psychologically healthy workplaces in terms of relevant business outcomes such as increased productivity and reduced costs. Rather than identifying areas of concern or risk, the PHWP empowers areas where organizations can take effective and positive action. This aspirational, rather than judgmental, approach is likely to be more compelling and engaging for businesses. As the program focuses on overall wellbeing, there are relatively few resources specific to workplace mental health. Although the PHWP has had significant involvement by Canadian professional bodies and businesses, the program is oriented to the US system, where health care is not universal but rather provided on the basis of a patchwork of individual and organizational funding. This may limit the PHWP’s appropriateness for Canadian users.

Figure 3 Source: "Promoting Employee Health and Wellness and Organizational Performance.” An October 16, 2009 presentation by Dr. David Ballard, American Psychological Association, Vancouver, Canada.
ACCCEPTABILITY
The primary audience for the PHWP is employers, with secondary audiences being the general public and professionals, particularly psychologists. In this regard the program is very successful in using appropriate language to identify the kinds of issues and solutions of concern to human resources or other organizational personnel, and is thus likely to be quite acceptable. This is strengthened by the recognition component of the program, which provides an incentive for organizations to improve their workplace. The stated goal of the program is to benefit both workplace. The stated goal of the program is to benefit both

ACCESSIBILITY
The PHWP is highly accessible. All content is readily available on the website and bolstered by accompanying materials including a database of relevant research and multimedia presentations on how to create a psychologically healthy workplace and the benefits that accrue. Of particular value are case studies that describe practices and programs various North American companies have used. The fact that the PHWP has been adopted by numerous state and provincial professional associations means there is a greater likelihood that interested parties will be exposed to the model, have opportunities for further education, and receive recognition for their efforts.

EFFECTIVENESS
The PHWP model was created on the basis of the current literature on organizational and individual determinants of health and productivity. The five PHWP domains are descriptive rather than empirically determined. Nevertheless, in order for organizations to be recognized for their PHWP practices, they are expected to provide quantitative and/or qualitative evidence that their efforts are effective. This is complemented by site visits to the applicant organizations, during which employees and management are interviewed. In an effort to demonstrate the beneficial value of such practices, a recent study compared PHWP winners with industry base rates for some key indicators.

These five organizations reported an average turnover rate of just 9 percent in 2009—significantly less than the national average of 46 percent as estimated by the U.S. Department of Labor. Bureau of Labor Statistics. Surveys completed by the winning organizations show that only 30 percent of employees reported experiencing chronic work stress compared to 41 percent nationally, and 73 percent of employees reported being satisfied with their jobs, compared to only 65 percent nationally. Additionally, 67 percent of employees said they would recommend their organizations to others as a good place to work, compared to 54 percent nationally; and only 12 percent said they intend to seek employment elsewhere within the next year, compared to 31 percent nationally. (American Psychological Association, 2010. http://www.apa.org/news/press/releases/2010/03/ workplace-awards.aspx)

EFFICIENCY
The PHWP model and accompanying resources are intended to be easy to implement. The economic realities faced by North American employers are readily acknowledged and effective action in the five categories need not require extensive resources. The explicit inclusion of small business and not-for-profit categories within the recognition process provides an opportunity for such organizations to utilize the model, and provides practical examples and case studies of successful practices.

SAFETY
As noted previously, any organizational intervention intended to create positive outcomes may produce unexpected negative outcomes. Practices, programs and policies implemented within the PHWP framework are no exception. Nevertheless, this may be less of a concern for the approach in view of the ‘strength-based’ focus, inclusion of both employer and employee goals which provides a more balance perspective, and the expectation that organizations seeking recognition for their PHW practice undergo a rigorous multi-rater, multi-method evaluation.

5. The Mental Health Therapeutic Return to Work (MHTRW) Model

DESCRIPTION
This model is based upon the Therapeutic Return to Work (TRW) program of the Centre for Action in Work Disability Research (Durand, Labelle & Hong, 2004; Durand, Vachon, Loisel & Berthelette, 2003). The model and the TRW program draw upon the Sherbrooke Model of rehabilitation for individuals with musculoskeletal disorders, which is applied to rehabilitation and tertiary prevention for individuals with mental health problems. The aim is to take the knowledge gained from rehabilitation of individuals with musculoskeletal disorders and show how it can be applied beneficially and profitably to individuals with work disability related to mental health problems. The approach to work rehabilitation in this model emphasizes integration across many of the dimensions we have identified as critical.

Clinical practice has evolved from a medical and fragmented perspective (in which the focus was on reducing the impairment or, more positively, on improving the individual’s capacities) towards a global perspective centred on the disability paradigm, in which psychosocial and socio-economic factors, and, more recently, workplace-based interventions and early intervention are taken into account (Loisel et al., 2001). Long-term work disability is thus no longer seen as the consequence of an illness (or impairment), but rather as the result of interactions between the worker and three main systems: the health care, work environment and financial compensation systems. RTW interventions must consider the influence of a complex set of interrelated factors (clinical, psychological, work environment related) to the involvement of the various stakeholders. (Briand, Durand, St-Arnaud & Corbère, 2007, p. 449)

The MHTRW model addresses the following factors psychological factors (for example, psychological distress, depression, stressful life events and expectations regarding work return); work multifactorial environment (for example, physical and organizational demands, relationships with colleagues and supervisors, and occupational culture); and factors related to stakeholder involvement in the rehabilitation process (for example, the compensation system and available health care services).

Within this model, critical objectives/steps of the rehabilitation process are:

1. Identify obstacles to work return
2. Increase readiness to commit to work return
3. Support commitment to work return
4. Maintain at work

APPROPRIATENESS
The MHTRW model provides an integrated framework for workplace mental health intervention across several key dimensions. First, it addresses the integration of action across care providers, providing guidelines for integrating health care professionals with disability managers, employers and employees through a process of consultations and feedback meetings to ensure that consistent goals are addressed and potential barriers are identified on an ongoing basis. Second, this approach addresses the integration of workplace intervention over time, at least to the time relevant to rehabilitation of work function for an individual who has been off work due to a mental health problem, helping to ensure that intervention will be appropriate to the stage of rehabilitation relevant to work return. Third, this approach addresses integration across systems, incorporating clear channels of communication between health care providers and the workplace, as well as with representatives of disability insurance carriers.

This approach, however, has a narrowly defined scope, focusing on tertiary prevention and rehabilitation/return to work, having little to say about earlier phases of potential intervention – primary prevention at the organizational or individual level. Nevertheless, this model may be relevant to mental health problems, etc. It provides no guidance to appropriate intervention at earlier stages of the process through which mental health problems emerge in workplace settings. With regard to the knowledge that employers require in order to plan and implement workplace mental health interventions, this is a fundamental limitation.

ACCEPTABILITY
The MHTRW model takes an impressively respectful attitude toward workers with mental health difficulties and their employers, invoking each of these as well as other stakeholders to engage in a collaborative problem-solving endeavour. It has been the experience in Québec, where this approach has been widely adopted with regard to musculoskeletal rehabilitation, that workers, employers and others find the approach quite acceptable and suitable to their perceived needs. It seems very likely that a similar degree of acceptance would emerge in applying this model to the mental health domain.

ACCESSIBILITY
The MHTRW approach assumes a fairly high level of cooperation between health care providers, employers, insurers and government policy makers. Although the occupational health system in Québec has been exemplary in creating this level of cooperation, it cannot be said to exist in this way across all provinces. Achieving the degree of cooperation needed for this model to operate optimally would be a major challenge at a national level.

Nonetheless, key elements of the MHTRW model are present across the country: occupational health care providers, insurance industry disability managers, other health care providers with an interest in occupational mental health, etc. It may be possible to make this rehabilitation model accessible across the country in an attenuated form, scaling down interventions to preserve key aspects of the model without necessarily implementing the full approach. However, a major barrier to accessing the MHTRW model across the country would be the availability of psychological support and interventions, identified as a key feature of this model across the steps of rehabilitation. Psychological services appear to be more readily accessible in Québec than in other provinces.
SUMMARY

Each of the five models reviewed shares several common characteristics, including the perspective that work and workplace factors impact health and productivity. These factors are amenable to change by way of appropriate programs, policies and practice interventions, and that these may include actions aimed at the individual employee as well as the overall workplace. The models differ in varying degrees, however, across a number of areas including the following:

- The degree of active participation, engagement and accountability by employers, employees, unions and government
- The extent to which application of the model is intended to produce improved employee health, better business outcomes and/or reduced regulatory or legal risk
- The degree to which the model explicitly addresses employee mental health problems as opposed to workplace conditions that may impact the likelihood of such problems occurring, becoming worse or recurring
- The extent to which the model focuses on the various stages within the trajectory of workplace mental health issues: primary, secondary or tertiary interventions
- The degree to which the model incorporates the larger social, governmental and regulatory context, particularly with respect to access to mental health care

We have seen that each of the models reviewed possesses a particular balance of advantages and disadvantages. Each emphasizes some segment of the range of potential interventions that might be undertaken by an employer wishing to improve workplace mental health. Some of the models are primarily concerned with organizational-level interventions of a primary prevention nature, others with recovery and rehabilitation of workers with mental health-related disability. But from the perspective of our target audience, this fragmented approach is unsatisfactory. We will propose a framework that considers employer actions in terms of integration of different levels and stages of intervention. The aim is to provide our audience with a practical approach to issues and options to inform the selection of effective and feasible interventions.

The emphasis in this model upon ongoing communication and collaboration between stakeholders in the mental health rehabilitation process should allow for early detection of unintended negative consequences and unforeseen safety concerns. For example, encouraging active commitment to work return for individuals in safety-sensitive positions may prove to be a delicate matter, potentially risking premature work return and resultant safety issues. Ongoing communication could prove effective for limiting risks in situations such as this.
We have developed a framework to assist employers in addressing psychological health and safety in the workplace. This framework is the result of our review of models for improving psychological health and safety. Each of the models we reviewed has strengths and weaknesses, and we attempted to incorporate their merits and avoid their flaws. Overall, we sought to foster an integrated approach to psychological health and safety. We refer to the framework as the ‘P6 Framework’ to highlight its foundation upon six key ‘P’ components as shown below. The framework is based on facilitating the involvement of critical stakeholders, encouraging organizational responses that address different stages in the development of workplace mental health problems, suggesting interventions along the spectrum from health promotion to rehabilitation, supporting communication and coordination across organizational and health care systems, adapting recommendations to diverse employee and employer groups, and advocating for organizational initiatives to reduce stigma associated with psychological conditions.

The P6 Framework was developed to be compatible with a widely-accepted approach to improvement of organizational quality, that of the International Standards Organization (ISO). Organizational interventions based on the ISO model have an excellent track record for achieving enhanced conformity to legislative and regulatory requirements as well as significant economic benefits (Geldert, 1997). The implementation of this framework and the ISO model becomes evident when we map each of our components onto those of ISO. ISO Policy & Commitment corresponds to our Policy component, ISO Planning corresponds to our Planning component, ISO Implementation & Operation corresponds to our Promotion and Prevention components, ISO Checking & Corrective Action corresponds to our Process component, and ISO Review & Improvement corresponds to our Persistence component (Martin, 1998). We will tie our framework to the psychological and mental health domains. The case for workplace mental health intervention has been described as a “perfect storm” in which workplace factors that raise undue risk to workers’ mental health and safety have been described as a “perfect storm” in which every worker bears a substantial penalty for reasonable foreseeable injury to the mental health of employees [and over time] and every employee bears a substantial proportion of employees experience reduced function or disability for mental injuries sustained by employees. (Shain, 2006). The case for intervention to a wide range of internal and external stakeholders must be made.

**Promising Practices**

- **Formulate the rationale for action**. This serves to make the case for action (and its associated costs) and to secure buy-in from key stakeholders in the organization. A compelling case for change will capture the interest and active engagement of organizational leaders (executive, board, senior management, union representatives, occupational health representatives, and external stakeholders. The case for workplace mental health intervention typically rests on three pillars.

**Financial**: It has been determined that mental health problems contribute substantially to organizational costs through reduced productivity associated with workers on sickness absence or present with reduced function and work-related psychological health may well strike employees who are highly competent and conscientious, resulting in the partial or complete loss of valuable workers. Furthermore, it has been demonstrated that organizations in which a substantial proportion of employees experience reduced mental well-being and ‘emotional exhaustion’ are also likely to have reduced organizational productivity and performance (Taris & Schaufeli, 2009). Significant cost-savings are possible through well-targeted workplace mental health initiatives, with the most sophisticated analyses having been conducted for workplace-based depression interventions (Simon, Barber, Breitbaum, Frank, Greenberg, Rose, Wang & Keissler, 2003; Lu, Sasso, Root & Beck, 2006; Wang, Simon & Keissler, 2008).

**Ethical**: As a reflection of corporate responsibility and organizational values, actions taken by organizations with attending to the health and safety of employees. Workplace factors that raise undue risk to workers’ psychological health and safety must be addressed as an expression of this organizational value. There is a large body of scientific research establishing that workplace factors, such as high work demands combined with low control over job tasks or high job effort combined with low recognition and reward, are associated with increased rates of common mental disorders such as depression and anxiety (Stanislaw & Candy, 2006).

**Legal/Regulatory**: Courts and regulatory bodies have increasingly recognized organizational responsibility for protecting the psychological safety of employees. This is directly comparable to the widely accepted onus upon organizations to ensure the physical health and safety of their employees, or at least to prevent excessive physical risk. Where legal or regulatory bodies have determined that employers failed to take reasonable steps to reduce psychological risks in the workplace, substantial penalties have been imposed. The increasing tendency for legal and regulatory bodies to require that organizations protect their employees’ psychological health and safety has been described as a ‘perfect storm’ in which a number of factors have combined to increase the legal pressure on employers. As stated by a prominent Canadian legal expert in this area:

> There is an emerging legal duty in Canada to provide and maintain a psychologically safe workplace. A psychologically safe workplace is one that does not permit harm to employee mental health in careless, negligent, reckless or intentional ways. It is one in which every practical effort is made to avoid reasonably foreseeable injury to the mental health of employees (and over time) it has become ever more evident that such a duty exists, that it is becoming more and more coherent, and that employers who ignore the omens are increasingly at risk of liability for mental injuries sustained by employees. (Shain, 2006).

**Use the business plan for addressing mental health disorders in the workplace developed by the Global Business and Economic Roundtable on Addiction and Mental Health (Global Business and Economic Roundtable on Addiction and Mental Health). The plan, for example, recommends that business leaders empower the whole organization to develop the information and procedures needed to detect the symptoms of mental health problems early.**

- **Include active participation across the organization**. Employees will embrace and utilize programs; policies and procedures intended to build psychologically safe and healthy workplaces, and will be more attentive to their own psychological health if they have been part of the process of creating these initiatives. This does not preclude senior management’s authority and responsibility to ensure that any actions taken are operationally and functionally sustainable and consistent with the underlying strategic priorities of the organization.

**Consider organizational readiness for change when developing policies or interventions related to workplace mental health or substance abuse**. It has been found that a lack of organizational readiness for change can identify which administrators or front-line staff are most positively disposed toward new practices and which are likely to be more uncomfortable or resistant to the change (Fuller).

- **Be a reflection of corporate responsibility and organizational values.** Actions taken by organizations with attending to the health and safety of employees. Workplace factors that raise undue risk to workers’ psychological health and safety must be addressed as an expression of this organizational value. There is a large body of scientific research establishing that workplace factors, such as high work demands combined with low control over job tasks or high job effort combined with low recognition and reward, are associated with increased rates of common mental disorders such as depression and anxiety (Stanislaw & Candy, 2006).

**Legal/Regulatory**: Courts and regulatory bodies have increasingly recognized organizational responsibility for protecting the psychological safety of employees. This is directly comparable to the widely accepted onus upon organizations to ensure the physical health and safety of their employees, or at least to prevent excessive physical risk. Where legal or regulatory bodies have determined that employers failed to take reasonable steps to reduce psychological risks in the workplace, substantial penalties have been imposed. The increasing tendency for legal and regulatory bodies to require that organizations protect their employees’ psychological health and safety has been described as a ‘perfect storm’ in which a number of factors have combined to increase the legal pressure on employers. As stated by a prominent Canadian legal expert in this area:

> There is an emerging legal duty in Canada to provide and maintain a psychologically safe workplace. A psychologically safe workplace is one that does not permit harm to employee mental health in careless, negligent, reckless or intentional ways. It is one in which every practical effort is made to avoid reasonably foreseeable injury to the mental health of employees (and over time) it has become ever more evident that such a duty exists, that it is becoming more and more coherent, and that employers who ignore the omens are increasingly at risk of liability for mental injuries sustained by employees. (Shain, 2006).

**Use the business plan for addressing mental health disorders in the workplace developed by the Global Business and Economic Roundtable on Addiction and Mental Health (Global Business and Economic Roundtable on Addiction and Mental Health). The plan, for example, recommends that business leaders empower the whole organization to develop the information and procedures needed to detect the symptoms of mental health problems early.**

- **Include active participation across the organization**. Employees will embrace and utilize programs; policies and procedures intended to build psychologically safe and healthy workplaces, and will be more attentive to their own psychological health if they have been part of the process of creating these initiatives. This does not preclude senior management’s authority and responsibility to ensure that any actions taken are operationally and functionally sustainable and consistent with the underlying strategic priorities of the organization.

**Consider organizational readiness for change when developing policies or interventions related to workplace mental health or substance abuse**. It has been found that a lack of organizational readiness for change can identify which administrators or front-line staff are most positively disposed toward new practices and which are likely to be more uncomfortable or resistant to the change (Fuller).
for a designated workplace or team. This will identify
unions, occupational health and HR, as well as other
in larger organizations, the strategy should be developed
to workplace psychological health and safety. Organizations
operate procedure. There is no 'one size fits all' approach
required and what indicators will determine the impact of
It is essential to consider from the outset the specific
PLANNING
• Use a 'systems level' approach (Myette, 2008).
• Systems approaches look at the various steps by
which stress or mental health problems develop
• Use self-report surveys of employee mental health or
• Implement surveys or audits designed to measure
• Rates of usage of psychotropic medications covered
• Promising Practices
• Collect of existing organizational data that may be
relevant to careful planning of interventions focused on
psychological health and safety
• Collect of existing organizational data that may be
relevant to careful planning of interventions focused on
• Important indicators of negative impacts can be
• The concept of positive mental health:
Positive mental health refers to human qualities and
life skills such as cognitive functioning, positive
self-esteem, social and problem solving skills, the
ability to manage major changes and stressors in
life and to influence the social environment, the
ability to work productively and fruitfully and to
contribute to the community, and an opportunity to interact with
others, not to mention an income, all of which contribute
to psychological health and well-being. The primary focus
of psychological health promotion is not on addressing
specific mental disorders or individuals dealing with
distress, but rather upon assisting the average
employee to increase his or her psychological well-being and
resilience. This enhanced well-being will indirectly
create greater resistance to psychological health difficulties,
and, if difficulties do occur, can help individuals to engage in
adaptive coping, seek appropriate assistance (if needed),
and recover more quickly (Kuoppala, Anns & Pavi, 2008).
Psychological health promotion has been related to the
concept of positive mental health.
The aim of health promotion in this context is to increase the capacity of employees to manage stress or emotional challenges in a way that reduces the likelihood of onset of psychological health conditions (Rutter, 1985). Interestingly, it has been found that individuals suffering from psychological health difficulties are more likely than others to adopt negative health behaviours (Green & Pope, 2000). Encouragingly, it has been demonstrated that health promotion interventions in the workplace, even those not specifically focused on mental health, show a positive effect with regard to reducing depression and anxiety symptoms in employees (Martin, Sanderson & Cocker, 2009). Promotion also involves building resilience at an individual level. A prerequisite in the context of supporting psychological health is that one adopts flexible programs and policies and is able to adjust and adapt these to meet changing employee characteristics and needs.

At first glance, it may seem difficult to clearly distinguish between a psychological health promotion intervention and primary prevention, as described in the next section. In general, psychological health promotion is aimed at individuals who are not experiencing significant psychological health difficulties or distress and focuses upon enhanced well-being rather than reduction of psychological health problems. Some interventions are appropriate to either category and will be assigned where they most logically fit.

Promotion of psychological health and safety falls within the Implementation & Operation phase of the ISO model. Implementation & Operation involves the requirement to resource, operate and manage plans and processes to deliver outputs that achieve the planned results (Hoyle, 2009, p. 15). This phase involves ensuring that staff involved in psychological health-related intervention understand its objectives and how its performance will be measured. Responsibilities for actions and decisions are properly assigned, effective actions are undertaken and delivered in a timely manner. Areas to change are identified and addressed, indicators are in place to measure the quality of implementation and results obtained, and ongoing reviews are carried out. This intervention is working as planned (Hoyle, 2006, p. 17).

Promising Practices

Implement interventions to promote psychological health in the workplace that can be implemented at the organizational or individual level.

- Get organizational commitment to promoting psychological/mental well-being in the workforce. This organizational-level intervention element received strong endorsement in a comprehensive and sophisticated report produced by the UK National Institute for Health and Clinical Excellence (NICE) (National Institute for Clinical Excellence, 2009). This commitment requires that organizational leaders:

  - adopt an organization-wide approach to promoting the mental well-being of all employees, working in partnership with them. This approach should be participatory and recognize the importance of mental well-being into all policies and practices concerned with managing people, including those related to employment rights and working conditions. (National Institute for Health and Clinical Excellence, 2009, p. 6)

  Although not specific to mental health, there has been a gradual shift in the emphasis from health promotion initiatives aimed at changing individual behaviour to strategies that seek to create a health-promoting workplace, moving, in other words, toward an all-embracing approach that empowers workers and employers to improve all facets of their health (Chu, Driscoll & Dwyer, 1997). Although this represented an ambitious method, one that may be unrealistic in some workplace contexts, it draws attention to the importance of shifting organizational values towards promotion of health in general and mental health in particular.

  - Create a respectful workplace. Individual and organizational psychological health is more likely to flourish in a workplace environment that supports the physical, social and psychological well-being of all employees (Estes & Wang, 2008). Such environments are often referred to as respectful workplaces where people are valued, communications are polite and courteous, and disrespectful behaviour (including harassment and bullying) is dealt with promptly and effectively (Kosmin & Pacione, 2003). This expectation for how people treat one another extends across all levels of the organization, including relationships with customers, clients and the public. The expectation is created and sustained in the orientation of new employees, ongoing education and training for employees, and in the creation and communication of effective policies and procedures for dealing with breaches.

  - Celebrate diversity. Mental health promotion is enhanced by organizational initiatives, programs and policies that recognize, respect and address employee diversity (Steiens, Paut & Sanchez-Burks, 2008). This should be embedded within the organizational culture and reflected across the entire course of employment including selection, orientation, training and advancement (EY & Thomas, 2001). Such efforts serve to reduce conflict and misunderstandings that can lead to bullying, harassment and discrimination, and are a requirement under the human rights legislation at provincial, territorial and federal levels. In order to protect employees’ rights, it is essential that there be educational and informational initiatives to address and reduce the stigmatization of employees with mental disorders (Brohan & Thomasson, 2010). An excellent avenue to facilitate this is the Opening Minds campaign from the Mental Health Commission of Canada.

- Promote mental health at the individual level to by increasing psychological well-being, competence and resilience (Cousier, 2008). An example of mental health promotion focused on the individual is a project carried out with emergency personnel over a three-year period, these employees were taught stress management skills involving conflict resolution, improved communication and relaxation—and they underwent a significant improvement in depressive symptoms (Kagan, Kagan & Watson, 1995). Another programme enhanced the emotional well-being of employees through a training program using cognitive behavioural principles (Müller, Liosso, Schönhet, Biggs & Donald, 2008).

PREVENTION

This kind of intervention is designed to prevent the onset or reduce the severity and functional impact of mental health problems in the workplace. Recently, a recent review by Canadian researchers finds a significant body of research supporting the effectiveness of workplace interventions in preventing mental health problems (Corbière, Shi, Rouleau & Deva, 2009). There are three kinds of prevention, which will be considered separately: primary prevention, which seeks to change individual or organizational conditions that may contribute to mental health problems, secondary prevention, which addresses mental health problems when these are in a relatively mild state or organizational situations that place employees at significant risk, such that prompt response will forestall more serious problems, and tertiary prevention, focused upon reducing the distress and dysfunction associated with mental health problems.

Prevention falls within the Implementation & Operation phase of the ISO model. Again, it is essential to ensure that interventions are thought through and that the commitment and resources for prevention activities, that effective interventions are chosen and implemented in an appropriate and timely manner, and that indicators are in place to measure the quality of implementation and results of these interventions.

Primary Prevention

Primary prevention may be carried out at the organizational or individual level. At the organizational level, one might seek to change workplace risk factors associated with increased likelihood of psychological health problems. For example, one might increase the level of control a worker has over particular aspects of their job, reduce job stress, and thus the likelihood of psychological health problems. At the individual level, one might provide employees with particular forms of support or skill that reduce the risk of psychological health problems. For example, a stress management course might be offered to employees. Much of the empirical literature in the workplace mental health arena is concerned with the effectiveness of individual-focused approaches to primary prevention.

Promising Practices

Implement job redesign strategies to enhance psychological health and safety and reduce risks. A review of research in mental health promotion concluded that there is a need for “a participatory stress reduction committees, more and smaller teams, and the recognition of all employees as ‘key actors’ in workplace decision making, and providing workplace stress management training” (Overton, 1987, p. 11). In addition, this organizational-level intervention seeks to modify employment risk factors such as excessive unpredictability, unclear job expectations, or lack of perceived control, all of which have been linked to increased mental health risk. The literature identifies specific primary prevention practices such as enhancing the clarity of job descriptions, developing employee-manager committees to increase worker participation in decision making, and providing child-care and eldercare support (Hurrell & Murphy, 1995). This has also been described as encompassing “increasing job autonomy, control and/or by allowing employees to make more decisions around their work, enhancing skill discretion by allowing workers to use their skills, knowledge, and abilities to perform complex tasks, and redistributing power among all employees to create a more democratic workplace and increase an employee’s sense of control” (Bergerman, Corabian & Harstell, 2009, p. 18). For example, one organizational intervention strategy was called “a participatory stress reduction committee, more and smaller teams with sub-supervisors, more on-the-job training, and economic improvements” (Bergerman et al., 2005, p. 23). A second study cited in this review involved an
intervention in which factory manual workers formed workgroups to control production (Egan, Bambra, Petticrew, Whitehead & Thomson, 2007). Another study showed that identifying stressful factors for a group of factory workers, then implementing organizational change to reduce stressful aspects of the workplace environment, resulted in a significant reduction in depressive disorders and associated sick leave (Kawakami, Araki, Kawashima, Masumoto & Hayashi, 1997).

- Provide stress management programs. Training in stress management is a form of primary prevention at the individual level that has been well-evaluated and shown to have positive effects (Mimura & Griffths, 2003). It teaches employees skills for managing stress more effectively. Examples of stress management skills are: structured problem solving to appraise and respond to problems more effectively, interpersonal strategies for mobilizing support in the workplace, relaxation techniques to reduce maladaptive tension, and communication training to clearly and assertively express one’s viewpoint (Stein, 2001). A number of research studies have examined the impact of stress management training on mental health symptoms in workers, most showing significant improvements (Johnsson, 1998; Heaney, Price & Refaffy, 1995). For example, one study, conducted in the context of a US health maintenance organization, provided small group training in stress coping skills and found notable reductions in reported anxiety, health care utilization and illness days (Rühé, Taylor, Toles, Newhall, Veach & Bryson, 2002). Yet another study delivered a comprehensive stress-management intervention that included job redesign as well as coping training, this intervention resulted in reduced depressive symptomatology and absenteeism (Munz, Kohler & Greenberg, 2003). Generally, it appears that the most effective workplace stress management interventions, with regard to improved psychological health, are those based on cognitive-behavioural principles (Richardson & Rothstein, 2008).

- Mobilize peer influence and support to reduce alcohol use accompanied by early intervention for risky drinking. Such interventions, intended to reduce the incidence of alcohol abuse in the workplace, have obtained positive results (Richmond, Kenoe, Heathcote & Wodak, 2002). In one trial, an alcohol use reduction program involving employees specific skills for handling physical or mental tension. One notable program taught relaxation skills to employees of small businesses, instructing them in positive skills for unwinding from stress. It is reassuring to find a simple stress management program to be effective in the small-business context, despite the challenges of this setting.

Workers can relax and unwind from stress through positive behaviors (e.g. exercise, meditation, reading) or substances (alcohol, medication, drugs or tobacco). This study explored unwinding and prevention training among small business workers (N = 539). Personal and workplace protective factors contributed to greater positive unwinding and less substance unwinding. Positive unwinding is an important resource with potential relevance to small businesses (Patterson, Bennett & Witka, 2005, p. 521).

- Deliver internet-based training of employees skills related to psychological health and safety. Several studies have shown that Internet-based training can effectively enhance the coping skills of employees as well as the support skills of managers (Kawakami, Kobayashi, Takahashi & Tsurumi, 2005; Malats, Koopman & Wanat, 2007). Internet delivery of interventions is an inexpensive method, worthy of consideration as a component of any psychological health enhancement program.

Secondary Prevention

Secondary prevention seeks to detect mental health problems in an early phase and mild form, so as to intervene quickly and hopefully prevent the emergence of more serious disorder (Cooper, Sadri, Allison & Reynolds, 1990; Reynolds, 1997).

Promising Practices

- Identify relatively mild psychological health problems through the Employee & Family Assistance Program. The EFAP (or EAP) is an excellent place to enhance early intervention. Individuals are likely to attend EFAP counseling when they are experiencing trouble with emotional distress or specific depression symptoms in a large US corporation, 40% of employees utilizing Employee and Family Assistance services were found to have symptoms of depression (Dansis & Beern, 2003). Those with diagnosed disorders are likely to fall in the milder range and thus be appropriate for secondary prevention. Risky alcohol use is a problem with substantial negative impact in the workplace, especially for safety-sensitive positions, and may be identified in the EAP. From the perspective of policy and training, ensuring that EAP providers have the capability to implement and respond to alcohol overuse that falls short of alcohol dependence is a promising practice in the secondary prevention domain (Blum & Rumpal, 2002). The EAP can serve a valuable function in early intervention for employees showing ‘at-risk drinking’ (Chan, Normals & Marlatt, 2004). A controlled trial demonstrated a significant reduction in alcohol-related problems after a brief intervention delivered via EAP counselors (Quilla, Stillme, Larrime, Neighbors & Marlatt, 2008).

- Provide manager training to assist managers to deal with employee behaviours that may be the result of a mental health issue. This organizational level intervention is also strongly endorsed by the above-mentioned NICE report and involves: promoting a management style that encourages participation, delegation, constructive feedback, monitoring and coaching; ensuring that policies for the recruitment, selection, training and development of managers recognize and promote these skills; ensuring that managers are able to identify and respond with sensitivity to employees’ emotional concerns, and symptoms of mental health problems. (National Institute for Health and Clinical Excellence, 2000) p. 12)

Reinforcing the importance of manager training, a recent review of workplace stress-reduction interventions concluded that:

Changes at the job level in objective job characteristics will have a modest but highly predictable outcome. However, it is argued that it seems likely that the biggest gains will be found with management/supervisor training aimed at managing employee perceptions of the work situation. (Morrison & Payne, 2003)

Promising Practices

Secondary prevention seeks to detect mental health problems in an early phase and mild form, so as to intervene quickly and hopefully prevent the emergence of more serious disorder (Cooper, Sadri, Allison & Reynolds, 1990; Reynolds, 1997).

Secondary prevention is a m modest but highly predictable outcome. However, it is argued that it seems likely that the biggest gains will be found with management/supervisor training aimed at managing employee perceptions of the work situation. (Morrison & Payne, 2003)

- Implementing an approach to early detection that falls short of alcohol dependence is a promising practice in the secondary prevention domain (Blum & Rumpal, 2002). The EAP can serve a valuable function in early intervention for employees showing ‘at-risk drinking’ (Chan, Normals & Marlatt, 2004). A controlled trial demonstrated a significant reduction in alcohol-related problems after a brief intervention delivered via EAP counselors (Quilla, Stillme, Larrime, Neighbors & Marlatt, 2008).

- Provide manager training to assist managers to deal with employee behaviours that may be the result of a mental health issue. This organizational level intervention is also strongly endorsed by the above-mentioned NICE report and involves: promoting a management style that encourages participation, delegation, constructive feedback, monitoring and coaching; ensuring that policies for the recruitment, selection, training and development of managers recognize and promote these skills; ensuring that managers are able to identify and respond with sensitivity to employees’ emotional concerns, and symptoms of mental health problems. (National Institute for Health and Clinical Excellence, 2000) p. 12.

Reinforcing the importance of manager training, a recent review of workplace stress-reduction interventions concluded that:

Changes at the job level in objective job characteristics will have a modest but highly predictable outcome. However, it is argued that it seems likely that the biggest gains will be found with management/supervisor training aimed at managing employee perceptions of the work situation. (Morrison & Payne, 2003)

Promising Practices

Secondary prevention seeks to detect mental health problems in an early phase and mild form, so as to intervene quickly and hopefully prevent the emergence of more serious disorder (Cooper, Sadri, Allison & Reynolds, 1990; Reynolds, 1997).

Secondary prevention is a m modest but highly predictable outcome. However, it is argued that it seems likely that the biggest gains will be found with management/supervisor training aimed at managing employee perceptions of the work situation. (Morrison & Payne, 2003)

Note that a similar recommendation to train managers in identifying and responding helpfully to employee mental health issues emerged from a recent focus group of Canadian business leaders regarding optimal approaches to improving workplace mental health. While empirical investigations of the effectiveness of such organizational-level interventions remain sparse, such interventions can be classed as promising. A recent review of health promotion interventions not specific to mental health (i.e., focused on general well-being) found these interventions to have significant positive effects on symptoms of depression and anxiety (Martin, Sanderson & Cocker, 2009).

- Support an enhanced role for coworkers in recognition of psychological distress. Fellow employees may be well-positioned to identify coworker distress at an early stage of difficulty. Implementing an approach to early detection that is designed to protect the employee’s rights and be conducted in a confidential manner would allow secondary prevention (Conference Board of Canada, 2005).

- Provide tools and training in mood self-management. An effective means of enhancing employees’ capacities to manage stress or emotional challenges is to provide self-management skills via workbooks or interactive websites and workshops. A tool piloted in the Canadian context is Antidepressant Skill Builders Workshop, which provides 10 one-hour sessions, as well as an employee-manual. This workbook has been distributed to a large number of Canadian workers via free download from the Internet or distribution through employee health programs, and is highlighted in a review of workplace interventions to reduce the incidence of depression (Causar, 2008).

- Enhance mental health literacy. One form of secondary prevention at the individual level is to improve mental health literacy educating employees about mental health problems as well as treatment or management options. Such education can help reduce the stigma associated with mental health problems or disorders so that individuals will be more likely to recognize these in themselves and promptily seek assistance; managers will be more aware of early manifestations of mental health difficulties and more able to assist the employee to find appropriate support, and coworkers will have less tendency to stigmatize and a greater disposition to help the distressed individual (Halter, 2004; Glazer, 1998).
ongoing efforts to ensure that impacted individuals will and/or work return (if absence is required), including A critical aspect of tertiary prevention is ensuring that treatment, effective rehabilitation and supported work disability. An individual who obtains appropriate psychological health conditions do not cause sustained delivering rehabilitation to limit functional deficits, or distress and dysfunction associated with psychological This stage of intervention is focused upon reducing the prolonged suffering, exacerbation of inactivity and functional degradation, and increased costs to the employee. In an effort to address these issues, a behavioural health care organization developed an integrated approach to manage all the psychiatric disabilities affecting people within an organization (McCulloch, Ozminkowski, Cuffel, Dunn, Goldman, Kellher & Comporato, 2001). This included early identification of all psychiatric disability cases, specialty training in mental health for disability providers, ongoing communication between organizational representatives, EFAP providers, benefits manager and the rehabilitation team, and expedited assessment, treatment and rehabilitation. In comparison with a non-randomized cohort of psychically disabled employees, providers and clients exhibited improved disability duration and higher program satisfaction.

Tertiary Prevention
This stage of intervention is focused upon reducing the distress and dysfunction associated with psychological health problems or conditions that might evolve ensuring prompt access to appropriate treatment, delivering rehabilitation to limit functional deficits, or instituting sophisticated return-to-work programs so that the worker recovers within a reasonable period of time and work disability. An individual who obtains appropriate treatment, effective rehabilitation and supported work return is less likely to experience lasting negative impacts and recurrence of psychological health conditions.

Screening for common mental health problems such as depression or anxiety. It has been suggested that employers should implement screening of the entire employee group. There is, however, a sufficient basis of evidence to justify such a costly and invasive workplace intervention, one that raises significant privacy concerns. Even for medical settings, it has not been established that screening for depression results in improved patient outcomes (Gilbody, House & Sheldon, 2001). Moreover, an additional significant concern is that of cost effectiveness. Researchers in Quebec have noted that there are four phases to disability (1) being off work (and receiving treatment), (2) work reintegration, (3) work maintenance (and relapse prevention) and (4) career advancement (Wassi, Young, Roeske, McPherson, Van Poppel & Anerma, 2007). Unfortunately, many treatment and rehabilitation efforts pay little attention to the third and fourth phases – a situation that results in the high risk of relapse for many forms of mental illness. Another challenge for tertiary prevention is that treatment and rehabilitation services are poorly integrated (Bisker, Gilbert, Myette & Stewart-Patterson, 2004). Diagnosis and treatment of symptoms is provided through the public health care system typically by a family doctor with minimal understanding and knowledge of the individual’s job and work situation. Rehabilitation, anti-stigma interventions and work training, is conducted by an internal or external disability management service focused primarily on functioning rather than symptoms. Employers are often minimally involved despite their responsibility for providing accommodations, if needed, and ensuring successful work return. There is a need for improved communication and collaboration amongst all stakeholders (Bisker, Wiseman & Gilbert, 2006).

Promising Practices

• Improve access to behavioural treatments. This is a promising strategy to enhance recovery symptomatically and functionally in workers suffering from common mental disorders. It is notable that the vast majority of Canadian workers lack access to treatment for psychological health difficulties. This has been identified as a quality of care issue (Katon, 2003). This could feasibly be implemented by ensuring that Employee Assistance programs include staff with recognized training in delivery of behavioural interventions for common psychological conditions, or by adding behavioural health problems or conditions that might evolve ensuring prompt access to appropriate treatment, delivering rehabilitation to limit functional deficits, or instituting sophisticated return-to-work programs so that the worker recovers within a reasonable period of time and work disability. An individual who obtains appropriate treatment, effective rehabilitation and supported work return is less likely to experience lasting negative impacts and recurrence of psychological health conditions.

A critical aspect of tertiary prevention is ensuring that treatment and rehabilitation extends beyond acute symptom relief and restoration of prior functioning and/or work return (if absence is required), including ongoing efforts to ensure that impaired individuals will have sustained success in their personal and work lives. Furthermore, if they encounter difficulties or a recurrence of symptoms, these might be dealt with in a better and more timely and fashion. Researchers in Quebec have noted that there are four phases to disability (1) being off work (and receiving treatment), (2) work reintegration, (3) work maintenance (and relapse prevention) and (4) career advancement (Wassi, Young, Roeske, McPherson, Van Poppel & Anerma, 2007). Unfortunately, many treatment and rehabilitation efforts pay little attention to the third and fourth phases – a situation that results in the high risk of relapse for many forms of mental illness.

Another challenge for tertiary prevention is that treatment and rehabilitation services are poorly integrated (Bisker, Gilbert, Myette & Stewart-Patterson, 2004). Diagnosis and treatment of symptoms is provided through the public health care system typically by a family doctor with minimal understanding and knowledge of the individual’s job and work situation. Rehabilitation, anti-stigma interventions and work training, is conducted by an internal or external disability management service focused primarily on functioning rather than symptoms. Employers are often minimally involved despite their responsibility for providing accommodations, if needed, and ensuring successful work return. There is a need for improved communication and collaboration amongst all stakeholders (Bisker, Wiseman & Gilbert, 2006).

Promising Practices

• Improve access to behavioural treatments. This is a promising strategy to enhance recovery symptomatically and functionally in workers suffering from common mental disorders. It is notable that the vast majority of Canadian workers lack access to treatment for psychological health difficulties. This has been identified as a quality of care issue (Katon, 2003). This could feasibly be implemented by ensuring that Employee Assistance programs include staff with recognized training in delivery of behavioural interventions for common psychological conditions, or by adding behavioural health problems or conditions that might evolve ensuring prompt access to appropriate treatment, delivering rehabilitation to limit functional deficits, or instituting sophisticated return-to-work programs so that the worker recovers within a reasonable period of time and work disability. An individual who obtains appropriate treatment, effective rehabilitation and supported work return is less likely to experience lasting negative impacts and recurrence of psychological health conditions.

A critical aspect of tertiary prevention is ensuring that treatment and rehabilitation extends beyond acute symptom relief and restoration of prior functioning and/or work return (if absence is required), including ongoing efforts to ensure that impaired individuals will have sustained success in their personal and work lives. Furthermore, if they encounter difficulties or a recurrence of symptoms, these might be dealt with in a better and more timely and fashion. Researchers in Quebec have noted that there are four phases to disability (1) being off work (and receiving treatment), (2) work reintegration, (3) work maintenance (and relapse prevention) and (4) career advancement (Wassi, Young, Roeske, McPherson, Van Poppel & Anerma, 2007). Unfortunately, many treatment and rehabilitation efforts pay little attention to the third and fourth phases – a situation that results in the high risk of relapse for many forms of mental illness.

Another challenge for tertiary prevention is that treatment and rehabilitation services are poorly integrated (Bisker, Gilbert, Myette & Stewart-Patterson, 2004). Diagnosis and treatment of symptoms is provided through the public health care system typically by a family doctor with minimal understanding and knowledge of the individual’s job and work situation. Rehabilitation, anti-stigma interventions and work training, is conducted by an internal or external disability management service focused primarily on functioning rather than symptoms. Employers are often minimally involved despite their responsibility for providing accommodations, if needed, and ensuring successful work return. There is a need for improved communication and collaboration amongst all stakeholders (Bisker, Wiseman & Gilbert, 2006).

Promising Practices

• Improve access to behavioural treatments. This is a promising strategy to enhance recovery symptomatically and functionally in workers suffering from common mental disorders. It is notable that the vast majority of Canadian workers lack access to treatment for psychological health difficulties. This has been identified as a quality of care issue (Katon, 2003). This could feasibly be implemented by ensuring that Employee Assistance programs include staff with recognized training in delivery of behavioural interventions for common psychological conditions, or by adding behavioural health problems or conditions that might evolve ensuring prompt access to appropriate treatment, delivering rehabilitation to limit functional deficits, or instituting sophisticated return-to-work programs so that the worker recovers within a reasonable period of time and work disability. An individual who obtains appropriate treatment, effective rehabilitation and supported work return is less likely to experience lasting negative impacts and recurrence of psychological health conditions.
improved and disseminated more broadly throughout the organization, as well as setting the stage for subsequent efforts towards change.

The Process component relates to the Checking and Corrective Action element of the ISO standards approach, which emphasizes the need to audit the adequacy of newly developed policies as well as to evaluate the outcomes of actions that have been undertaken. Evaluation of initiatives leads to an action plan designed to address unforeseen difficulties or particular deficiencies in the initiatives (Cox, Karanika-Murray, Griffiths & Houdmont, 2007). The ISO approach to continuous improvement, Plan-Do-Study-Act, is strikingly similar to the process/formative evaluation described above, involving repeated cycles of action and feedback in a process of continuous improvement. The Plan-Do-Study-Act cycle has proven to be a successful model for guiding change across a wide range of organizational settings (Berwick, 1996).

If organizational mental health factors were measured in the Planning component, these would be natural targets for repeat measurement in order to discover whether change has occurred. For example, if a survey carried out as part of Planning pointed to low employee engagement, and an intervention was therefore carried out to better engage the workforce, then it would be valuable to repeat the survey and determine whether this particular factor exhibited change. Similarly, if individual mental health factors such as resilience – then it would make sense to repeat the survey and an intervention was therefore carried out to enhance mental health and safety within the organization. Persistence requires implementation of strategies to ensure that successful actions are celebrated and maintained over time. It relates to the ISO Review element, emphasizing the role of management and organizational leadership in seeking continued improvement, using the results from previous outcomes to change organizational policies and programs in a lasting way. The aim is to incorporate a continuous improvement cycle that keeps the psychological health initiative sustainable and relevant to changing conditions.

Promising Practices

• Determine evaluation strategies in the Policy and Planning stages. The specific indicators to be evaluated depend on the nature and needs of the particular workplace. It is suggested, however, that consideration be given to determining impact in terms of quality criteria such as appropriateness, acceptability, accessibility, and efficiency and safety. It is also suggested that impact be evaluated using short-term, as well as long-term, outcomes (Salunkhe, Nytra, Dahi, Jergensen & Mikkelsen, 2002). For example, while reducing disability costs by providing employees with mental health education is a desirable goal, it is impacted by multiple factors and is likely to take time to show effect. Similarly, it is difficult to determine the impact of training on workplace stress within a single time period. Hence, the evaluation process must be designed to evaluate outcomes at multiple time periods, such as before and after the intervention.

• Evaluate implementation. It is important to evaluate the process of implementation, how the intervention was actually carried out, in addition to evaluating intervention outcomes. Although this may seem obvious, rest assured that there are filing cabinets and bookshelves filled with well-intentioned, empirically-based intervention plans that are gathering dust because they were never implemented or implemented badly (Randall, Griffiths & Cox, 2003). If your intervention is beginning to have an impact. Measure short-term (proximal) outcomes. There may be an extended delay, months or perhaps one to two years, before changes in organizational psychological health can be observed. Those kind of ultimate changes are called distal outcomes and may be too delayed to supply information about intervention effectiveness when the information is needed for planning. It is helpful therefore, to note proximal outcomes, things that are likely to change if your intervention is beginning to have an impact. Proximal outcomes might include the number of employees volunteering to participate in a resilience workshop (showing that the intervention is perceived as relevant and valuable), satisfaction ratings by employees who have participated in a workshop or other intervention, self-reported changes in stress levels or mood by participating employees after a few months, etc.

• Use the Canadian Mental Health Association Ontario evaluation strategy tool. This is a summary table of Factors to consider when deciding on an evaluation type. This table is part of a guide to workplace mental health promotion and is available at: http://wmhp.cmhaontario.ca/wp-content/uploads/2010/03/WMHP-Guide-Final.pdf

Persistence

This component involves communicating and sustaining actions that have been shown to protect psychological health and safety within the organization. Persistence requires implementation of strategies to ensure that successful actions are celebrated and maintained over time. It relates to the ISO Review element, emphasizing the role of management and organizational leadership in seeking continued improvement, using the results from previous outcomes to change organizational policies and programs in a lasting way. The aim is to incorporate a continuous improvement cycle that keeps the psychological health initiative sustainable and relevant to changing conditions.

If positive organizational change is to take place, it is critical that the employers and employees involved in the change efforts are willing to continually verbalize, test, and revise their espoused theories and harvest lessons from interventions that do not produce expected results, thereby making the organization more adaptive to future challenges (Nytra, Salunkhe, Mikkelsen, Bohle & Quinlan, 2000, p. 223). Even where workplace interventions have been successful in meeting goals, it is challenging to ensure that they are maintained. It is common for successful projects to be one-time demonstrations, failing to become an integral part of business as usual (Franche, Cullen, Clarke, Irvin, Sinclair & Frank, 2005). A change in leadership, priorities, or financial situation may lead to discontinuation of a successful intervention. The outcomes must be well-documented, communicated effectively to key decision makers and championed by influential players in the organizational hierarchy. Change is more likely to `stick` if it becomes part of the organizational culture and has wide support across all levels. Creation of a sustainability plan in conjunction with the development and implementation of an intervention will reduce the likelihood that it will last.

Promising Practices

• Use the framework for maximizing sustainability in workplace mental health initiatives developed by the Centre for Health Promotion, University of Toronto (Health Communication Unit, Dalla Lana School of Public Health, University of Toronto & the Canadian Mental Health Association, 2001). This framework emphasizes that: (1) a program designed to enhance organizational health should have a champion within the organization who assumes responsibility for integrating the program into usual organizational function, (2) partnerships should be established so that several leaders or departments collaborate in maintaining this program, (3) planning and implementation should ensure that the program is consistent with organizational values, objectives and operations, (4) continuity of personnel from initial implementation to the sustainment phase should be ensured, perhaps on a staff training or consultancy basis, and (5) the program should be evaluated continually, as its goals may be long-term and new barriers to program effectiveness may need to be addressed over time. Use Workplace Strategies for Mental Health, a toolkit developed by the Great-West Life Centre for Mental Health: This provides examples of sophisticated tools to support implementation and sustainment of positive change (Great-West Life Centre for Mental Health in the Workplace, 2005-2011). From the perspective of sustaining workplace mental health initiatives, this toolkit helps communicate the benefits of protecting psychological health and safety, reinforces the message that protection of psychological health is becoming a standard practice among Canadian employers, and shows how it can be sustained as a part of organizational policy and operations.
CONCLUSIONS

The P6 Framework for improving psychological health and safety is intended to be suggestive rather than prescriptive, supportive rather than prohibitive. Organizations, be they large or small, public or private, will need to be flexible in applying the framework. They are encouraged to utilize and adapt relevant research findings and/or promising practices from other settings where they see fit, and to be creative and innovative in determining courses of actions where such information does not exist. These efforts are most likely to be successful if they are collaborative and actively involve stakeholders from throughout the organization.

There are a number of excellent Canadian resources that provide current and practical information, tools and programs that employers can use at each of the stages.

Most research, policy and practice with respect to workplace mental health has focused on identifying and ameliorating the potentially negative or harmful aspects of work. Relatively little attention has been paid to the positive aspects of work, despite the fact that the majority of working Canadians find their work experience to be a source of identity, meaning and accomplishment, as well as support, structure and income. This positive impact of work is equally true for those struggling with psychological health problems. A number of leading organizational psychologists recommend greater attention to augmenting countering forces in organizations, that is, programs, policies and practices focused on increasing positive features of work rather than decreasing negative aspects (Kelloway, Teed & Kelley, 2008). Such an approach is consistent with the values of mental health promotion as well as the burgeoning Positive Psychology movement.

Improving psychological health and safety in the workplace requires a process of continuous improvement; it is a journey rather than a destination. The outcome will be invaluable to Canadian employers and employees.


