Improving Psychological Health & Safety in the Workplace:
Critical Analysis and Pragmatic Options

August 31, 2011
www.mentalhealthcommission.ca

Mental Health Commission of Canada

Commission de la santé mentale du Canada

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.

CONTENTS

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)

Mental health problems have a powerful and expanding impact in the workplace. As their burden on the public and private sectors in Canada increases, the management of workplace mental health issues will be of increasing importance. Yet, strategies for the assessment, prevention and treatment of mental health problems in the workplace are underdeveloped and underused. The gap between the need for and use of effective models can be partially explained by limited access to relevant knowledge. While there is considerable literature on the prevalence and nature of mental health problems in the workplace, practical solutions to these problems are harder to identify.

In order to foster a pragmatic integrated approach to workplace mental health in Canada, the Workforce Advisory Committee (WAC) of the Mental Health Commission of Canada (MHCC) collaborated with the Centre for Applied Research in Mental Health and Addiction (CARMHA) at Simon Fraser University to examine the relevant scientific and 'grey' literature on approaches to improving the mental health of employees.

On the basis of this review, Mental Health Commission of Canada has issued three companion documents:

- A report reviewing select models for improving workplace mental health and providing recommendations for an integrated approach
- An employer's guide to improving mental health care in the workplace
- A plan for knowledge exchange to maximize dissemination and utilization of the findings and reports

This report, the second of the three Mental Health Commission of Canada documents, is based on the literature review and represents a critical analysis of currently available models for guiding efforts to improve psychological health and safety in the workplace. These models are described and reviewed in terms of generally accepted quality standard, the extent to which the models support an integrated approach to workplace mental health, and the extent to which they are relevant to the Canadian workplace context. On the basis of this review, a pragmatic approach to improving workplace psychological health and safety in Canada is presented. The proposed approach, the P6 Framework, is intended to facilitate an integrated response to workplace psychological health issues across the continuum of employment and between the key employer, regulatory, labour and mental health care stakeholders who may play a role in addressing and enhancing workplace psychological health and safety. A definition of each of the six complementary components of the model (policy, planning, promotion, prevention, process and persistence) is provided along with core ingredients and exemplary practices. Finally, in anticipation of the creation of national standards for psychological health and safety, the comparability of each element with those of the International Standards Organization (ISO) is described.

BACKGROUND

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 (Dunnagan, Peterson & Haynes, 2001; Kessler, Greenberg, Mickelson, Meneades & Wang, 2001; Grzywacz & Ettner, 2000). Mental health problems and illnesses are estimated to account for nearly 30% of short- and long-term disability claims in Canada. Sairanen, S., Matzanke, D., & Smeall, D. (2011) The Business Case: Collaborating to help employees maintain their mental well-being. Healthcare Papers).In 2011, 40% of Canadians experiencing mental illness were between the ages of 20-39. (Smetanin, P., Stiff, D., Briante, C., Adair, C., Ahmad, S., & Khan, M. (2011) The list and economic impact of major mental illnesses in Canada: 2011 to 2041. RiskAnalytica, on behalf of the Mental Health Commission of Canada)) Mental health problems are associated with considerable individual suffering, functional impairment and productivity loss, with corresponding costs to the employer (Berndt, Bailit, Keller, Verner & Finkelstein, 2000; Kessler, Barber, Birnbaum, Frank, Greenberg, Rose, Simon & Wang, 1999; Dewa & Goering, 2000). In fact, A 2011 study by the Mental Health Commission of Canada predicts that, if not addressed, the impact of mental health problems (due to absenteeism, presenteeism and turnover) will cost Canadian businesses $198B in lost productivity over the next 30 years. (Smetanin, P., Stiff, D., Briante, C., Adair, C., Ahmad, S., & Khan, M. (2011) The list and economic impact of major mental illnesses in Canada: 2011 to 2041. RiskAnalytica, on behalf of the Mental Health Commission of Canada) Clearly, the effective management of mental health problems in the workforce should be a major priority for employers and for the Canadian health care system (Bilsker, Gilbert, Myette & Stewart-Patterson, 2004). The urgency of the situation is heightened by rapidly evolving case law and regulatory requirements that make it incumbent upon employers to address the psychological health and safety of their employees (Shain, 2004).

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-related disabilities. Coordination and communication across systems and over time is critical. However, the usual approach to management of mental health problems in the workforce 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, Bowen & Tabrizi, 2008). 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, Highet & Robinson, 2002; Goldberg & Steury, 2001; 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; Bilsker, Goldner & Jones, 2007; Lin, Von Korff, Russo, Katon, Simon, Unutzer, Bush, Walker & Ludman, 2000; Katon, Russo, Von Korff, Lin, Simon, Bush, Ludman & Walker, 2002; Kates, Craven, Crustolo, Nikolaou, Allen & Farrar, 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; Martin, Sanderson, Scott & Brough, 2009). Finally, 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 addition, we consulted with 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, or 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 conditions and substance misuse. A recent study concluded that mental health concerns cost the Canadian economy an estimated C$51 billion annually, half of which reflects loss of health-related quality of life (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, 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. In 2009, approximately 60% of adult Canadians held a job, with slightly more men than women in the workforce. Currently, slightly less than one-third of employed Canadians belong to a union (Human Resources and Skills Development Canada, 2010). More than 95% of Canadian businesses have fewer than 50 employees (Industry Canada, Key small business statistics, 2008). Canadian businesses span the full range of employment sectors. An integrated model needs to be relevant and incorporate this diversity of workplaces and workers.

Canada's health care system includes a mix of public and private services. The former fall under the financial and regulatory scope of the provincial and territorial governments, while the latter are funded, to varying degrees, by organizations, insurance providers, benefits programs and individuals. Access to health care, particularly mental health care, in the public sector remains a challenge in all provinces. The public health care system is ill-informed and ill-equipped to deal with workplace issues (The Standing Senate Committee on Social Affairs, Science and Technology, 2006). There is poor access to evidence-based, non-pharmacological treatments, such as those provided by psychologists, which is of particular concern given that such interventions have been found particularly relevant for addressing employee psychological health issues (Hirschfeld, Dunner & Keitner, 2002). Private services can help fill this gap but are not accessible for many employees. Communication between employers, private providers and the public health care system is lacking.

In Canada, legal requirements, human rights legislation and employment standards with respect to workplace health and safety fall under both provincial and federal jurisdiction. For the most part, psychological illnesses or injuries are not considered to be within the scope of provincial or territorial workers compensation boards. Therefore, there it has not been mandatory for Canadian employers to attend to workplace psychological health and safety, nor are there common policies or guidelines for them to follow should they decide to do so as a matter of good governance. This

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 (Shain, 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. MHCC championed the development of the standard in collaboration with the Bureau de Normalisation du Québec (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.

AUDIENCE

This report is primarily intended for:

- Canadian employers, whether represented by business owners, executive leadership or staff associated with human resources management
- Canadian leaders with decision-making roles regarding workplace mental health policy: union representatives, occupational health professionals, disability managers, and others
- Other stakeholders: occupational health researchers, employees dealing with psychological health problems, care providers outside of the occupational health field and public policy makers

It is our hope that reviewing models and their application to psychological health and safety will provide a more secure basis for employers to implement policies and practices that are well-founded and likely to promote integrated responses to psychological health issues in the workplace. This report provides employers, policy makers and researchers with an approach that is consistent with existing and emerging legislation and regulatory requirements, theoretical models, business practices and empirical findings.

ORGANIZATIONAL MENTAL HEALTH MODELS & THEIR DISCONTENTS

This report will identify, describe and comment on several prominent approaches relevant to psychological health and safety (PH&S) 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 evaluating models, i.e., high-level approaches to the identification, planning and implementation of workplace psychological health 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 relevant 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:

APPROPRIATENESS

This criterion raises the issue of whether a model in question is relevant to user needs. As noted, the prototypic user is an employer or human resources manager who has been tasked with planning and implementing organizational interventions to enhance employee psychological health; therefore, we ask whether each model is appropriate to the knowledge requirements and scope of influence for this role. One aspect of this criterion is that the model provides adequate guidance to formulating an integrated approach across the range of potential interventions in the psychological health domain, whether related to psychological health promotion, stages of prevention, treatment access, rehabilitation or work return. A second aspect is whether the model provides adequate guidance to an integrated approach that comprehensively identifies a range of workplace risk factors and thus areas for appropriate intervention. A third aspect is whether the model is appropriate for the Canadian context, responding to the realities and unique challenges of this country's workplace and mental health care environment. A fourth aspect is whether the model is appropriate to intervention at both an organizational and individual level, i.e., whether it supports an integrated approach across these levels.

ACCEPTABILITY

This criterion references the extent to which the model is respectful and responsive to user needs, preferences and expectations. This requires an approach that integrates the perspectives of various stakeholders, including management, unions (when applicable) and employees. For example, this might include active involvement of employees in what has been described as a 'bottom up' approach.

ACCESSIBILITY

This criterion refers to the availability of interventions in the most suitable setting at a reasonable cost in terms of resources, distance or time, without being impeded by barriers of language or privacy infringement. Within the Canadian context, this certainly includes attention to potential access barriers such as the geographic dispersion of employee groups, as well as linguistic barriers, particularly access across the two official languages.

EFFECTIVENESS

This criterion refers to the extent to which the model incorporates available scientific knowledge regarding methods for achieving the desired outcomes. It must be acknowledged that the empirical literature concerning effective interventions to enhance workplace mental health is fairly limited. Nonetheless, a model should be consistent with the available evidence and should be informed by this research evidence as much as possible. It is worth noting a cogent observation by the authors of one model under consideration:

The medical clinical and natural science paradigm... may not be appropriate for judging interventions in the (working) population and, more particularly, the absence of such high quality data in the public-health sphere should not be an excuse not to take action. (MacKay, Cousins, Kelly, Lee & McCaig, 2004, p. 93)

EFFICIENCY

This criterion refers to the extent to which the model addresses the optimal and feasible use of resources (finances, personnel and infrastructure) in order to achieve the desired outcomes. It recognizes that there may well be interventions shown in controlled research to be effective, the implementation of which under real-life conditions would not be feasible. The model must address the issue of feasibility and cost effectiveness in order to be comprehensive and relevant. This criterion speaks to another aspect of integration, namely integration of a more academic approach, focused on testing theoretically derived interventions under controlled conditions, and an implementation approach, focused on putting into practice interventions in a manner consistent with available resources and employer priorities/capacity. From the perspective of a human resources manager, a model that fails to take into account pragmatic realities of real-life business settings will have little utility.

SAFETY

This criterion involves the extent to which risks are evaluated and mitigated in order to avoid unintended or harmful results. It must be kept in mind that workplace interventions carried out with the best intentions may have unforeseen effects, some of which may be negative, on workers and workplaces. For example, a workplace intervention designed to provide an early response to emerging mental health difficulties may be experienced by some employees as intrusive or punitive. Although a model cannot, of course, identify all intervention risks, it should acknowledge and address the issue and provide guidance for dealing with potential negative impacts.

CRITICAL ANALYSIS OF ORGANIZATIONAL MENTAL HEALTH MODELS

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 complex approach, including 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.[1] 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" (MacKay et al., 2004, p. 93). Although stress is understood to have negative impacts across all domains of health, it is psychological health that is most directly affected.

Fundamental to this model is a taxonomy of six organizational psychosocial risk factors that have been demonstrated to be associated with workplace stress:

Demands (including such issues as workload, work patterns and the working environment)
Control (how much say the person has in the way they do their work)
Support (which includes the encouragement, sponsorship and resources provided by the organization, line management and colleagues)
Relationships at work (which includes promoting positive working practices to avoid conflict and dealing with unacceptable behaviour)
Role (whether people understand their role within the organization and whether the organization ensures that the person does not have conflicting roles)
Change (how organizational change, large or small, is managed and communicated in the organization)

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 approach to making change. 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 factors related 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 is provided with respect to the business case for the standards and their relevance as a component of corporate social responsibility. There is sparse information concerning secondary[2] or tertiary[3] 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 authority and resources. 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 onset and severity of individual outcomes is not as strong, although there have been some promising recent studies (Kelloway, Teed & Kelley, 2008; Kerr, McHugh & McRory, 2009).

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

1 Colin MacKay, Personal Communication, April 17, 2009

2 These interventions happen after an illness or serious risk factors have already been diagnosed. The goal is to halt or slow the progress of disease (if possible) in its earliest stages; in the case of injury, goals include limiting long-term disability and preventing re-injury. (Institute for Work and Health, http://www.iwh.on.ca/wrmb/primary-secondary-and-tertiary-prevention)

3 This focuses on helping people manage complicated, long-term health problems such as diabetes, heart disease, cancer and chronic musculoskeletal pain. The goals include preventing further physical deterioration and maximizing quality of life. . (Institute for Work and Health, http://www.iwh.on.ca/wrmb/primary-secondary-and-tertiary-prevention)

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 organizational contexts that have the potential for causing psychological or physical harm. These include, but are not limited to: job content, workload and job pace, work schedule, control, environment and equipment, organizational culture and function, interpersonal relationships at work, role within the organization, career development and home-work interface. There are five key elements to psychosocial risk management within the model, which are linked to worker, organizational and societal outcomes (see Figure 1):

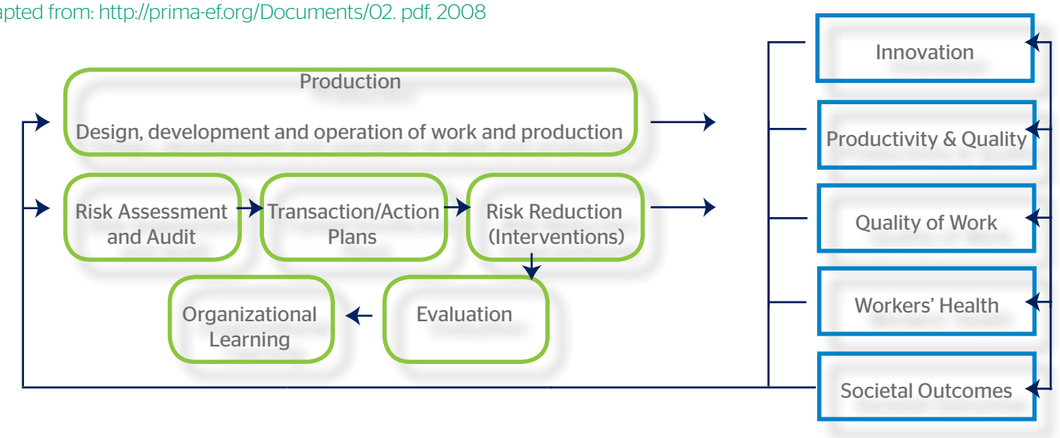
- Identification of a specific work population, workplace or set of operations for focus
- Assessment of psychosocial risks and their underlying causes
- Development and implementation of appropriate actions to remove or reduce risks
- Evaluation of both the process and outcome of intervention
- Ongoing monitoring and improvement of the risk management process

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 application within the 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.

Figure 1: PRIMA-EF Guidance Sheets, Psychosocial Risk Management – European Framework: Enterprise Level
Adapted from: http://prima-ef.org/Documents/02. pdf, 2008



ACCEPTABILITY

As the project involved a consortium of health and safety organizations, consultation in each participating European country was extensive and included employee and employer 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 terminology 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 change and improvements in health and safety. While there is supportive evidence for the effectiveness of 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.

EFFICIENCY

The PRIMA-EF materials are available online, at no cost, to employers and policy makers. Successful implementation of the framework requires organizational knowledge, readiness and effort by potential users. A guide is available in multiple languages for potential users (PRIMA: Psychosocial Risk Management, Excellence framework). This may be relatively straightforward for organizations and countries that recognize the impact of workplace stress and workplace violence, bullying and harassment and have the commitment, resources and infrastructure to take action. However, it will be more difficult for organizations or systems where these are lacking. The developers acknowledge this issue, noting that there are great differences in existing capabilities within the EU. In countries where only minor capabilities are available, this is a major limiting factor for successful PRIMA practice (PRIMA: Psychosocial Risk Management, Excellence framework).

SAFETY

The PRIMA-EF model is based on the premise that identifying and addressing risks and hazards to employees will reduce the likelihood of problems emerging. This approach is less likely to be disruptive and lead to unintended negative consequences than the more intensive, expensive and invasive actions that are required after problems have emerged. Nevertheless, it is worth noting that any intervention intended to have a positive impact has the theoretical potential of a negative outcome. As noted previously, an organization that identifies areas of risk but fails to act, or undertakes ineffective actions, could decrease employee trust and increase stress. This is of particular concern with the PRIMA framework, given the explicit inclusion of workplace harassment, bullying and violence, which may be incendiary events if not addressed effectively.

3. The World Health Organization Healthy Workplace Framework

DESCRIPTION

In 2007, the World Health Organization (WHO), in collaboration with the International Labour Organization, created an overall framework and model for a healthy workplace with the primary focus on protecting and promoting health in the workplace. According to this model (World Health Organization, 2010, p 11):

> *A healthy workplace is one in which workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and well-being of all workers and the sustainability of the workplace by considering the following, based on identified needs:*
>
> - *health and safety concerns in the physical work environment;*
> - *health, safety and well-being concerns in the psychosocial work environment including organization of work and workplace culture;*
> - *personal health resources in the workplace; and*
> - *ways of participating in the community to improve the health of workers, their families and other members of the community.*

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.

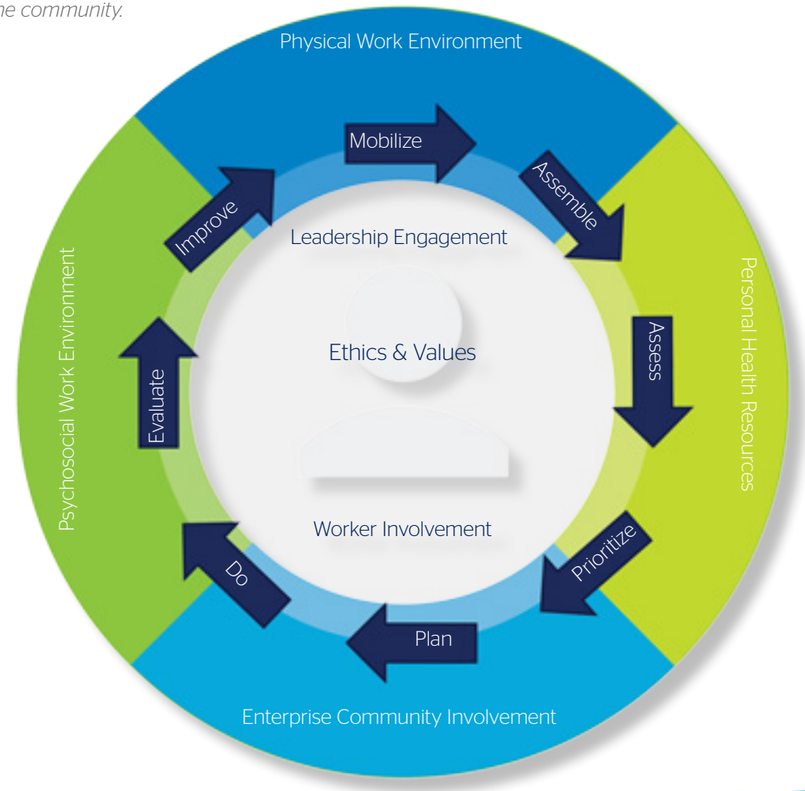


Figure 2: Source: World Health Organization, 2010, p. 13

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 how work is organized, overall 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 model) provides guidance for action at the workplace level, particularly when the employer, workers and their representatives work together in a collaborative manner. However, workplaces exist in a much larger context. Governments, national and regional laws and standards, civil society, market conditions and primary health care systems all have a tremendous impact on workplaces, for better or for worse, and on what can be achieved by workplace parties. (Healthy Workplaces: A model for action: For employers, workers, policy-makers and practitioners, 2010, p. 32)*

On the basis of this framework, WHO has hosted and collaborated with a number of international partners in organizing conferences, symposia and research. In addition, WHO has provided training and documentation on effective practice and policies based on the Healthy Workplace framework. These are available in multiple languages, designed for diverse audiences and cover a range of topics relevant to workplace mental health and addictions (World Health Organization, 2005).

APPROPRIATENESS

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.

ACCEPTABILITY

In view of the broad consultation undertaken and the active participation of policy makers, researchers, unions and employers in its creation and dissemination, the WHO framework is likely to be acceptable to all concerned parties. The partnership with ILO in the creation of the framework provides endorsement by organized labour. Inclusion of both physical and psychosocial factors within the model will likely increase acceptability and help reduce stigma associated with mental health conditions. Furthermore, the WHO framework is particularly noteworthy in its inclusion of government and community within the model. This allows opportunities for enhanced dialogue and collaboration between business, insurers, occupational health professionals and providers of mental health care.

ACCESSIBILITY

There is a wealth of material readily available on the WHO Healthy Workplace website as well as cross-links 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 found a relative 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 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 review found moderately 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 problems. 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 implementations 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. (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 behaviours, as they are supported by the organizational culture, and in turn, positive systemic changes will be consistent with and complemented by employee behaviours.

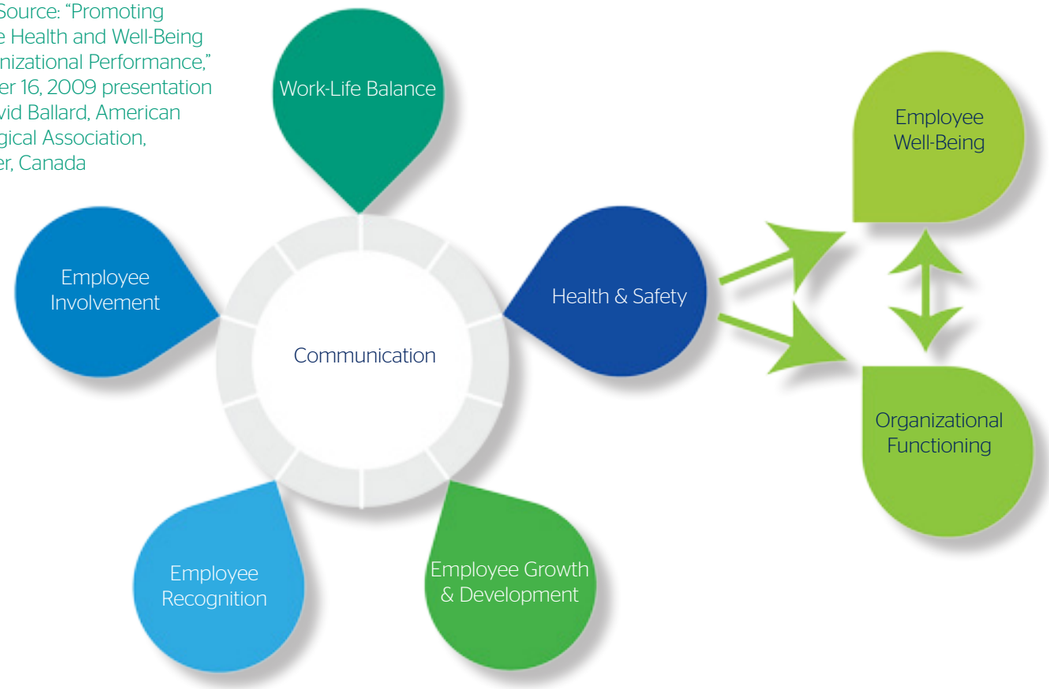


Figure 3: Source: "Promoting Employee Health and Well-Being and Organizational Performance," an October 16, 2009 presentation by Dr. David Ballard, American Psychological Association, Vancouver, Canada

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.phwa.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, 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 from 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 emphasizes 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 well-being, 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.

ACCEPTABILITY

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 organizations and employees; however there is no explicit role for organized labour, regulatory bodies or government. This is again reflective of the US context but may make the program less acceptable in Canada.

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 PHWC 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 41 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 intentionally 'business friendly'. 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 this 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 Prevention and Rehabilitation (Durand, Loisel, Charpentier, 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 simply 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 environmental) related to the involvement of the various stakeholders. (Briand, Durand, St-Arnaud & Corbière, 2007, p. 445)*

The MHTRW model addresses the following factors: psychological factors (for example, psychological distress, depression, stressful life events and expectations regarding work return); work environmental factors (for example, physical and organizational demands, relationships with colleagues and supervisors, and organizational 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 providers with disability managers, employers and employees through a process of consultations and frequent 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 within the timeframe 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 recovery. 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, early identification of 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, inviting 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.

EFFECTIVENESS

Interventions based upon this model have been well tested, at least with regard to musculoskeletal rehabilitation. The TRW program is based on a well-documented theoretical model and is supported by evidence-based data on the return-to-work process (Durand, Vachon, Loisel & Berthelette, 2003). The overlap between work disability related to musculoskeletal and mental health problems is sufficient to make it likely that model-based interventions will show comparable effectiveness for the latter. At a minimum, we can say that the model supports the development of interventions that can be systematically tested and has a good track record of leading to successful interventions in the area of rehabilitation and return to work. Further research will be needed to determine whether interventions based on this model prove as effective for mental health problems as they have for musculoskeletal issues.

EFFICIENCY

It is evident that application of this model to rehabilitation and work return for individuals with mental health problems will require significant investment in new resources and infrastructure for provinces other than Québec. It may be that reorganization of existing services and infrastructure would be more efficient for some provincial occupational health systems, but in any case the model makes significant demands upon existing systems. Employers wishing to improve mental health within their organization might find the financial requirements of this model onerous; it may be that a scaled-down version of the model, or specific model elements, would be more feasible for implementation by an employer. For example, a large employer may find that enhanced collaboration between occupational health staff, insurance company disability managers, the employee assistance provider, mental health care providers in the community and the disabled employee would yield many of the benefits of the TRW model without excessive cost.

SAFETY

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.

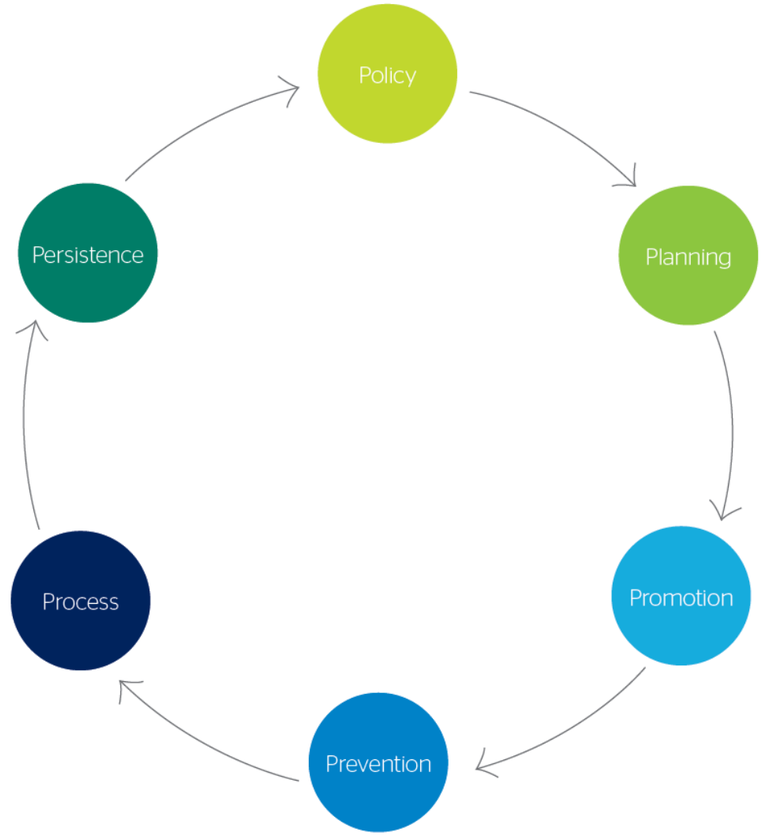
SUMMARY

Each of the five models reviewed shares several common characteristics, including the perspective that work and workplace factors impact health and productivity, that 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 P6 FRAMEWORK FOR PSYCHOLOGICAL HEALTH AND SAFETY



Policy
Commitment by organizational leadership to enhance psychological health and safety through workplace interventions

Planning
Determination of key mental health indicators, across the organization, selection of actions, and specification of objectives

Promotion
Actions taken to promote the general psychological health of the workforce

Prevention
Actions taken to prevent the occurrence of significant psychological or mental disorders – may occur at the primary, secondary, or tertiary level

Process
Evaluation of implementation and results of actions taken to enhance psychological health and safety

Persistence
Sustainment of effective actions in a process of continuous improvement

We have developed a framework to assist employers in addressing psychological health and safety in the workplace. This framework is based upon our review of models for improving psychological health and safety. Each of the models 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 (Sheldon, 1997). The compatibility between our 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 ISO approach, while using concepts specifically relevant to the psychological and mental health domains. The proposed framework is also designed in consideration of the Canadian workplace context and the emergence of provincial and federal legislation and regulatory policy specific to psychological health and safety.

We now present each of the P6 Framework components in terms of: (1) its definition; (2) its relationship to ISO; and (3) examples of promising practices, based on available research literature.

POLICY

In this framework component, the organization establishes an overall policy, or statement of principle, designed to explicitly emphasize the commitment to enhancement of workplace mental health or, more specifically, promotion and protection of psychological health and safety in the workforce. Strong leadership is essential: active endorsement and support by organizational leaders sends a message to workers and managers regarding the importance of workplace mental health issues and the intent to take effective action. Where unions or other forms of employee association are present, support of these leaders will also be needed. At this first stage, the foundation for action is laid. In a larger company, policy development may be initiated by the HR department, who take on the role of engaging leadership and other key members of the organization.

This component is comparable to ISO Policy & Commitment, which involves a clear statement of the organization's commitment to protection of psychological health and safety in the workplace. This includes a commitment to appropriate and effective action to enhance psychological health and safety in a process of continuous improvement. This commitment is to be communicated through policy statements so that it will be understood as an organizational priority. Furthermore, policy must serve as the basis for clear and actionable objectives: "policies are not merely motherhood statements but intentions for action. By deriving objectives from the policy you initiate a process for bringing about compliance with policy" (Hoyle, 2006, p. 249).

Promising Practices

- Formulate the rationale for acting to enhance workplace mental health. 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 employees on sickness absence or present with reduced function due to mental health difficulties, as well as the cost of finding and training new employees to replace those on disability leave. Note that difficulties with stress and 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 experience reduced organizational productivity and performance (Taris & Schreurs, 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, Birnbaum, Frank, Greenberg, Rose, Wang & Kessler, 2001; Lo Sasso, Rost & Beck, 2006; Wang, Simon & Kessler, 2008).

Ethical: As a reflection of corporate responsibility most organizations affirm as a key value their concern 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 (Stansfeld & Candy, 2006).

Legal/Regulatory: Courts and regulatory bodies have increasingly recognized organizational responsibility for protecting the psychological health and 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 even 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, 2010)

- 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; that financial targets (e.g., reduced absenteeism or short-term disability rate) be linked to workplace mental health initiatives; and that the workplace provide clear policies, practices and training protocols as well as the necessary professional advice for both employers and employees to accommodate the very particular return-to-work requirements of workers disabled by depression.

- Increase understanding among key organizational stakeholders of the benefits of addressing workplace mental health. It will be critical to communicate the case for intervention to a wide range of internal and external organizational stakeholders, particularly the notion that occupational health and safety includes psychological injury as much as it does physical injury. For this purpose, handouts may be distributed in the context of small group meetings to discuss key issues. Briefing material of this kind may be downloaded at no cost from several Canadian websites, including Guarding Minds @ Work, the Great-West Life Centre for Mental Health in the Workplace and the Canadian Centre for Occupational Health and Safety.

- 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 fiscally 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 survey 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,

Rieckmann, Nunes, Miller, Arfken, Edmundson & McCarty, 2007). This can help guide efforts to enhance change readiness, increasing the likelihood that policies will be implemented effectively (Cunningham, Woodward, Shannon, MacIntosh, Lendrum, Rosenbloom & Brown, 2002).

- Use a 'systems level' approach (Myette, 2008). Systems approaches look at the various steps by which stress or mental health problems develop and consider the complex interactions between the employee, workplace environment and health care provider. Such approaches:

  ...emphasize primary prevention or focusing on stressors as the upstream determinants of job stress. Additionally, systems approaches integrate primary with worker directed secondary and illness directed tertiary intervention, include the meaningful participation of groups targeted by intervention, and are context sensitive. (LaMontagne, Keegel & Vallance, 2007, p. 221)

From this perspective, policy designed to address systems-level issues in an integrated way, although perhaps more challenging to formulate, will ultimately prove more effective.

PLANNING

It is essential to consider from the outset the specific goals and objectives for this workplace intervention plan, including what sorts of inputs (investment, staffing) will be required and what indicators will determine the impact of the plan. By considering in advance how the intervention plan should be evaluated, the organization is more likely to track its effectiveness in a meaningful way and (if it does create positive effects) to continue it as part of standard operating procedure. There is no 'one size fits all' approach to workplace psychological health and safety. Organizations differ in their particular needs, resources and context; the approach taken by one may not be appropriate for another. This is especially relevant for the small- or medium sized businesses that are the basis of the Canadian economy. In larger organizations, the strategy should be developed and implemented under the guidance of a dedicated action team composed of key players from management, unions, occupational health and HR, as well as other key stakeholders who can act as champions. Smaller businesses are less likely to have personnel in all such positions, and thus the responsibility for planning lies with owners and management, preferably with participation from select employees.

Planning must be based upon a careful assessment to spot particular issues or risk factors of highest relevance for a designated workplace or team. This will identify problems that need most attention, opportunities for making specific change, and organizational strengths that can be built upon in order to enhance psychological health and safety. Profiling an organization using various data sources will allow the employer to identify specific targets for change. Targets can be identified that are of high priority (where the status quo is associated with substantial cost, impact on employee health or disruption to workplace processes) and high feasibility (i.e., change is practical given constraints on financial resources, staff skills or time). In particular, research literature indicates the importance of determining which employee groups are at highest risk for psychological problems and who therefore warrant focused intervention and careful evaluation. As stated in a review of stress management interventions:

> It is crucial to start by determining which workers are at risk and what constitutes risky working conditions; screening instruments can be used, a stress audit can be organized or absenteeism and turnover rates analyzed. (Van der Hek & Plomp, 1997, p. 140)

In the ISO model, the Planning element is defined as "part of quality management focused on setting objectives and specifying necessary operational processes and related resources to fulfill the quality objectives" (Hoyle, 2006, p. 267). There is an emphasis upon a clear connection between policy, objectives and processes implemented to meet these objectives; furthermore, objectives are themselves performance measures for quality improvement. In effect, the ISO model calls upon those planning quality initiatives to lay out a logic model for change: what is the commitment underlying this change, what are the exact objectives, by which processes will the change be accomplished, and how will accomplishment of the objectives be measured?

Promising Practices

Several types of information-gathering have been shown relevant to careful planning of interventions focused on psychological health and safety:

- Collect of existing organizational data that may be related to mental health issues, such as rates of absenteeism, turnover, accidents/injuries and short- and long-term disability rates. Absenteeism rates are, of course, important indicators of negative impacts caused by health and safety risks. Similarly, rates of absence due to health problems and disability are critical indicators. Admittedly, it can be difficult to determine what proportion of absenteeism or disability absence is specifically related to psychological health issues, but it is important to establish a baseline for consideration in planning interventions and determining their effectiveness. Other forms of data that are more easily tied to psychological health are extended health plan utilization of items related to mental health care, rates of usage of psychotropic medications covered by employer drug plans and utilization of employee and family assistance counseling services (Aldana & Pronk, 2001). Furthermore, it is valuable to obtain information related to presenteeism, that is, time during which the individual is at work but functioning at a reduced capacity because of mental health or substance use problems. Of course, presenteeism will not appear in any database – but it can be evaluated through employee surveys (Sanderson, Tilse, Nicholson, Oldenburg & Graves, 2007). Quantitative data can be complemented by qualitative data obtained from employee performance reviews, health and safety committee reports and exit interviews.

- Implement surveys or audits designed to measure organizational risk factors relevant to psychological health and safety. A number of survey tools have been developed to identify psychosocial risk factors in the workplace, mostly focused on the concept of 'work stress' (Tabanelli, Depolo, Cooke, Sarchielli, Bonfiglioli, Mattioli & Violante, 2008). As noted previously, an excellent resource is Guarding Minds@ Work, which includes an employee survey designed to measure a set of twelve organizational risk factors shown to affect psychological health and safety (Consortium for Organizational Mental Health, 2009-2010). Examples of these risk factors are Workload Management, Organizational Culture, Psychological Support and Psychological Job Fit. Guarding Minds@ Work also includes an audit tool as a complement or alternative to the employee survey. A more specific approach to the evaluation of workplace risks might focus on a particular factor that is seen as high-priority or that has been identified as relevant to a specific workplace. For example, workplace bullying or harassment might have been raised as an issue, in which case a specific measure would be appropriate (Einarson, Hoel & Notelaers, 2009).

- Use self-report surveys of employee mental health or substance use problems (Arthur, 2005; Hermansson, Helander, Huss, Brandt & Ronnberg, 2000). This form of data collection must be carried out with strict protection of anonymity and may not be possible in smaller organizations where anonymity cannot be guaranteed. Furthermore, there is a moral, if not legal, obligation to follow up such surveys with ready access to appropriate mental health resources. Accompanying this strategy may be measurement of presenteeism, as noted above, helping to demonstrate the bottom-line impact of mental health interventions (Sanderson, Tilse, Nicholson, Oldenburg & Graves, 2007). It is worth keeping in mind that measurement need not be focused only on problems or pathology – a number of studies have focused on measurement of employees' psychological well-being. Workplace factors can either enhance or diminish employees' psychological well-being and thus workplace interventions might seek either to reduce the negative impacts of workplace factors or increase their beneficial impact (Loretto, Popham, Platt, Pavis, Hardy, MacLeod & Gibbs, 2005).

PROMOTION

At this stage, the focus is upon actions that help foster the overall psychological health of the workforce. Psychological health is more than the absence of illness; it involves an array of personal qualities and strengths that are integral to an individual's sense of self and his or her contribution to society. It is worth noting that work is, or should be, an integral component of good psychological health. Work provides structure and identity, a means 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 emotional 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, Anne & Paivi, 2008). Psychological health promotion has been related to 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 stresses in life and to influence the social environment, the ability to work productively and fruitfully and to make contributions to the community, and a state of emotional, spiritual and mental well-being (Hosman, 1997; WHO, 2001). Mental health is an integral part of overall health and well-being and in a broad sense, reflects the equilibrium between the individual and the environment. (Jane-Llopis, Barry, Hosman & Patel, 2005, p. 9)*

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 positive 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 resiliency at an organizational level. A resilient organization, in the context of supporting psychological health, is one that 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 psychological health promotion 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 a 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 to ensure the intervention is working as planned (Hoyle, 2006, p. 171).

Promising Practices
Interventions to promote psychological health in the workplace 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 integrate the promotion 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. 8)

  Although not specific to mental health, there has been a gradual shift in 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-encompassing approach that empowers workers and employers to improve all facets of their health (Chu, Driscoll & Dwyer, 1997). Although this represents a very ambitious approach and 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 (Komisin & Placone, 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 management, and 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 (Stevens, Plaut & 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 (Ely & 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 employee psychological health it is essential that there be educational and informational initiatives to address and reduce the stigmatization of employees with mental disorders (Brohan &Thornicroft, 2010). An excellent resource 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 (Couser, 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 program enhanced the resilience and mental well-being of employees through a training program using cognitive behavioural principles (Millear, Liossis, Shochet, 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. Reassuringly, a recent review by Canadian researchers finds a significant body of research supporting the effectiveness of workplace interventions in preventing mental health problems (Corbière, Shen, Rouleau & Dewa, 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 staff understands the commitment and reasons 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 levels. 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 tasks as a means to 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 job redesign strategies likely to positively impact employee mental health include such interventions as "job enrichment, ergonomic improvements, reduction of noise, lowering the workload" as well as "improving role clarity and social relationships" (Jane-Llopis, Barry, Hosman & Patel, 2005, p. 11). In addition, this organizational-level intervention seeks to modify employment risk factors such as excessive/unpredictable workload, 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/elder care support (Hurrell & Murphy, 1996). This has also been described as encompassing "increasing job autonomy, control or both 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 & Harstall, 2009, p. 18). For example, one organizational intervention study included "a participatory stress reduction committee, more and smaller teams with sub-supervisors, more on-the-job training, and economic improvements" (Bergerman et al., 2009, 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 situation, 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 & Griffiths, 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; conflict management to handle disagreements with coworkers; 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 (Johansson, 1991; Heaney, Price & Refferty, 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 (Rahe, Taylor, Tolles, 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, 2001). 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 workforce, have obtained positive results (Richmond, Kehoe, Heather & Wodak, 2000; Anderson & Larimer, 2002). In one trial, an alcohol use reduction program was associated with substantially reduced rates of employee injury (Spicer & Miller, 2005). This form of intervention mobilizes organizational culture as a means to influence individual behaviour.

- Provide relaxation training for employees. Relaxation training is closely related to stress management, but is easier to implement and involves giving 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 & Wiitala, 2005, p. 221)

- Deliver internet-based training of employee 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, Takao & Tsutsumi, 2005; Matano, 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 difficulties 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 (Dainas & Beien, 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 capacity to identify and respond to alcohol overuse that falls short of alcohol dependence is a promising practice in the secondary prevention domain (Blum & Roman, 2002). The EAP can serve a valuable function in early intervention for employees showing "at-risk drinking" (Chan, Neighbors & Marlatt, 2004). A controlled trial demonstrated a significant reduction in alcohol-related problems after a brief intervention delivered via EAP counselors (Osilla, Zellmer, Larimer, 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, mentoring 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, 2009, 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)

  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 certainly can be classified 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/or training in mood self-management. An effective means of enhancing employees' capacities to manage stress or emotional challenge is to provide self-management skills via workbooks or interactive websites and workshops. A tool piloted in the Canadian context is Antidepressant Skills @ Work, a workbook that gives step-by-step instructions in effective skills for managing mood and handling stressful workplace situations (Bilsker, Gilbert & Samra, 2009). 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 (Couser, 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 promptly 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; Glozier, 1998).

- Screen workforce 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 not, 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; Dowrick & Buchan, 1995). But when screening programs are combined with enhanced access to high-quality mental health treatment, researchers have found positive impacts on depression symptoms and work productivity (Wang, Simon, Avorn, Azocar, Ludman, McCulloch & Petukhova, 2007). Screening is most likely to be feasible and effective when reserved for specific high-risk groups. These might include employees who complain of being burnt out, employees showing a high level of unexpected work absence or employees attending employee assistance programs.

- Provide crisis intervention. This involves a rapid response to acute distress linked to potentially traumatic events, with the hope of averting more serious mental health difficulties. Available research indicates that the workplace can be a useful platform from which to provide crisis intervention programs (Everly, Sherman, Stapelton, Barnett, Hiremath & Links, 2006). At the same time, it must be noted that the most commonly deployed forms of crisis intervention following traumatic events, Critical Incident Stress Debriefing or Critical Incident Stress Management, remain controversial with regards to their degree of positive impact and the risk of unintended negative psychological effects (Devilly & Cotton, 2003; Devilly, Gist & Cotton, 2006).

Tertiary Prevention

This stage of intervention is focused upon reducing the distress and dysfunction associated with psychological health problems or mental disorders. This might involve ensuring prompt access to appropriate treatment, delivering rehabilitation to limit functional deficits, or instituting sophisticated return-to-work programs so that psychological health conditions do not cause sustained 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 impacted individuals will have sustained success in their personal and work lives. Furthermore, if they encounter difficulties or a recurrence of symptoms, these will be dealt with in a timely and effective fashion. Researchers in Québec 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) work improvement and career advancement (Wasiak, Young, Roessler, McPherson, Van Poppel & Anema, 2007). Unfortunately, many treatment and rehabilitation efforts pay little attention to the third and fourth phases – a substantive gap given 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 (Bilsker, 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 return-to-work planning 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 (Bilsker, 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 ready access to behavioural 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 treatment to the roster of services covered by extended health plans (a small cost when distributed across the entire workforce (Center for Prevention and Health Services, 2010). Behavioural treatments have been shown to have a specific positive effect upon restoration of work function in depressed individuals (Sherbourne, Wells, Duan, Miranda, Unutzer, Jaycox, Schoebaum, Meredith & Rubenstein, 2001; Mynors-Wallis, Davies, Gray, Barbour & Gath, 1997). One researcher concluded that "[cognitive behavioural] psychotherapy has a direct effect on psychosocial functioning through therapeutic work on issues that have relevance to psychosocial functioning, such as the building of social skills" (Hirschfeld, Dunner & Keitner, 2002, p. 131). There is evidence that enhanced treatment for depression that not only targets clinical symptoms, but also addresses recovery of occupational function, reduces days of work loss and is cost-effective for employers (Schene, Koeter, Kikkert, Swinkels & McCrone, 2007; Lo Sasso, Rost & Beck, 2006).

- Enhance the role of occupational health professionals in design and implementation of organizational responses to workforce mental health problems. It has been argued that occupational health professionals (in larger organizations) are well-positioned to champion enhanced organizational response to employee depression: "Occupational health professionals are the most qualified to design and deliver destigmatized, customer friendly programs and services for employees to access for help with depression, and to integrate their services with other departments such as benefits, health promotion, EAP, and human resources, to create an effective, organization-wide depression initiative (Putnam & McKibbin, 2004, p. 122).

- Improve integration of services to address mental health disabilities. The fragmentation of services for individuals off work due to mental disorders leads to prolongation of suffering, exacerbation of inactivity and functional degradation, and increased costs to the employer. 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 psychiatrically disabled employees, providers and clients exhibited reduced disability duration and higher program satisfaction.

- Enhance management of disability associated with common mental disorders. This would include maximizing the effectiveness of return-to-work arrangements for these individuals. Promising interventions in this area include active case management of individuals disabled by depression or anxiety and provision of treatment focused on resolution of workplace problems (Burton & Conti, 2000). Note that these interventions serve to enhance integration across systems, coordinating the response of health care providers with that of disability managers and frontline managers.

  A similar move towards more integrated and sophisticated rehabilitation has been remarkably successful in the area of physical injury or illness, in particular with regard to back injuries at work. It is expected that the gains achieved through sophisticated disability management of physical disorders will extend to the mental health domain:

  Disability management strategies have been successful in preventing or accommodating physical disabilities in the workplace. Similar success has not been realized in the realm of psychological/mental health related disabilities. Integration of the principles and strategies of psychosocial rehabilitation and disability management programs can assist employers to control costs related to psychological/mental health disabilities and protect individual workers' employability. (Olsheski, Rosenthal & Hamilton, 2002)

PROCESS

This component involves evaluating the impact of interventions and outcomes with respect to psychological health and safety in the organization. The results of this stage allow for modifications of actions that are not meeting desired objectives. We use the term 'process' because: (1) the evaluation phase of a workplace initiative is the time to process what has occurred and the results obtained in order to guide further action; and (2) employer-generated initiatives are best suited to process evaluation, which focuses on the process of change rather than final outcomes. Process evaluation (and the closely related formative evaluation) examines the implementation and short-term results of interventions, then adjusts the intervention and repeats the cycle. It is a process of ongoing innovation, feedback and refinement, rather than a final 'report card' to say whether you have ultimately failed or succeeded (Dehar, Casswell & Duignan, 1993).

There really is no downside to evaluation. If intended objectives are not reached, this is an opportunity to consider whether the goals were realistic, whether the actions were appropriate and whether they were carried out in the manner intended. If they are successful, the evaluation process provides an opportunity for celebration followed by consideration of how the initiatives might be

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, 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 level of self-reported depression were measured in a survey – and an intervention was carried out to enhance mental resilience – then it would make sense to repeat the survey and look for changes in self-reported depression in this employee group.

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, effectiveness, efficiency and safety. It is also suggested that impact be evaluated using short-term, as well as long-term, outcomes (Saksvik, Nytrø, Dahl-Jørgensen & 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 (Zechmeister, Kilian, McDaid & MHEEN group, 2008). In contrast, the impact of improved mental health literacy upon stigmatizing attitudes is likely to be more immediate (Billings, Cook, Hendrickson & Dove, 2008; Kitchener & Jorm, 2004).

- 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-intended, empirically-based intervention plans that are gathering dust because they were never implemented or implemented badly (Randall, Griffiths & Cox, 2005). This can occur when the staff responsible for implementation are not given proper training regarding the intervention, lack the necessary authority, time or support for actual delivery, or are not provided with useful feedback based on an evaluation of the effectiveness of their efforts (Murta, Sanderson & Oldenburg, 2007). An employee questionnaire (the Intervention Process Measure) has been developed specifically to identify implementation problems that may have resulted in disappointing outcomes (Randall, Nielsen & Tvedt, 2009).

- Focus evaluation on outcomes for particular employee groups at higher risk for psychological problems. Interventions may not show much impact for the entire employee group, yet show considerable impact for particular employee groups who are at higher risk. Smart use of baseline data from the screening component will enable identification of particular employee groups likely to benefit most from interventions such as stress management training, resilience building, enhanced employee engagement, psychological self-care support, etc. High-risk employee groups worth particular attention may be those subject to high levels of interpersonal stress in their jobs, male or female employees depending on the kind of risk factor, younger or older workers, etc.

- 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-rated 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/wordpress/wp-content/uploads/2010/03/WMHP-Guide-Final1.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. (Nytro, Saksvik, 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 increase the likelihood that it will last.

Promising Practices

- Use the framework for maximizing sustainability in health promotion 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, someone 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 a set 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 countervailing 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. Employers, researchers and policy makers are encouraged to consider initiatives that build attributes such as resiliency, optimism, engagement and self-efficacy at both an individual and organizational level.

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.

REFERENCES

Aldana, S. G., & Pronk, N. P. (2001). Health promotion programs, modifiable health risks, and employee absenteeism. Journal of Occupational & Environmental Medicine, 43(1), 36-46.

American Psychological Association. (2010). Five organizations receive APA's Psychologically Healthy Workplace Award, ten honored for best practices. Retrieved from http://www.apa.org/news/press/releases/2010/03/workplace-awards.aspx

Anderson, B. K., & Larimer, M. E. (2002). Problem drinking and the workplace: An individualized approach to prevention. Psychology of Addictive Behaviors, 16(3), 243-251.

Arthur, A. R. (2005). When stress is mental illness: A study of anxiety and depression in employees who use occupational stress counselling schemes. Stress and Health, 21(4), 273-280.

Bergerman, L., Corabian, P., & Harstall, C. (2009). Effectiveness of organizational interventions for the prevention of workplace stress. Institute of Health Economics, and Alberta Health Services: Calgary. Retrieved from http://www.ihe.ca/documents/Interventions_for_prevention_of_workplace_stress.pdf

Berndt, E. R., Bailit, H. L., Keller, M. B., Verner, J. C., & Finkelstein, S. N. (2000). Health care use and at-work productivity among employees with mental disorders. Health Affairs, 19(4), 244-256.

Berwick, D. (1996). A primer on leading the improvement of systems. British Medical Journal, 312, 619.

Billings, D. W., Cook, R. F., Hendrickson, A., & Dove, D. C. (2008). A web-based approach to managing stress and mood disorders in the workforce. Journal of Occupational and Environmental Medicine / American College of Occupational and Environmental Medicine, 50(8), 960-968.

Bilsker, D., Gilbert, M., Myette, L., & Stewart-Patterson, C. (2004). Depression and work function: Bridging the gap between mental health care and the workplace. Centre for Applied Research in Mental Health & Addiction, Simon Fraser University, Vancouver, Canada. Retrieved from www.comh.ca/publications/resources/dwf/Work_Depression.pdf

Bilsker, D., Gilbert, M., & Samra, J. (2009). Antidepressant Skills @ Work. Retrieved from www.camh.ca/selfcare/

Bilsker, D., Goldner, E. M., & Jones, W. (2007). Health service patterns indicate potential benefit of supported self-management for depression in primary care. Canadian Journal of Psychiatry, 52, 86-95.

Bilsker, D., Wiseman, S., & Gilbert, M. (2006). Managing depression-related occupational disability: A pragmatic approach. Canadian Journal of Psychiatry, 51(2), 76-82.

Blum, T. C., & Roman, P. M. (2002). The workplace and alcohol problem prevention. Alcohol Research & Health, 26(1), 49-58.

Briand, C., Durand, M., St-Arnaud, L., & Corbière, M. (2007). Work and mental health: Learning from return-to-work rehabilitation programs designed for workers with musculoskeletal disorders. International Journal of Law and Psychiatry, 30(4-5), 444-457.

Brohan, E., & Thornicroft, G. (2010). Stigma and discrimination of mental health problems: Workplace implications. Occupational Medicine, 60, 414–420.

Bunce, D. (1997). What factors are associated with the outcome of individual-focused worksite stress management interventions? Journal of Occupational and Organizational Psychology, 70, 1-17.

Burton, W. N., & Conti, D. J. (2000). Disability management: Corporate medical department management of employee health and productivity. Journal of Occupational and Environmental Medicine, 41(10), 1006-1012.

Center for Prevention and Health Services. (2010). An employer's guide to behavioral health services. Retrieved from http://www.businessgrouphealth.org/pdfs/fullreport_behavioralhealthservices.pdf

Chan, K. K., Neighbors, C., & Marlatt, G. A. (2004). Treating addictive behaviors in the employee assistance program: Implications for brief interventions. Addictive Behaviors, 29, 1883-1887.

Chu, C., Driscoll, T., & Dwyer, S. (1997). The health-promoting workplace: An integrative perspective. Australian and New Zealand Journal of Public Health, 21, 377-385.

Conference Board of Canada (2005). A tool for managers: What you need to know about mental health. Retrieved from http://www.virtualwellness.ualberta.ca/docs/VW/MentalIllness/WhatYouNeedToKnowAboutMentalHealth.pdf

Consortium for Organizational Mental Health. (2009-2010). Guarding Minds @ Work. Retrieved from www.guardingmindsatwork.ca

Cooper, C. L., Sadri, G., Allison, T., & Reynolds, P. (1990). Stress counselling in the Post Office. Counselling Psychology Quarterly, 3, 3-11.

Corbière, M., Shen, J., Rouleau, M., & Dewa, C. S. (2009). A systematic review of preventive interventions regarding mental health issues in organizations. Work, 33(1), 81-116.

Couser, G. P. (2008). Challenges and opportunities for preventing depression in the workplace: A review of the evidence supporting workplace factors and interventions. Journal of Occupational and Environmental Medicine, 50, 411-427.

Cox, T., Karanika, M., Griffiths, A., & Houdmont, J. (2007). Evaluating organizational-level work stress interventions: Beyond traditional methods. Work and Stress, 21(4), 348-362.

Cunningham, C. E., Woodward, C. A., Shannon, H. S., MacIntosh, J., Lendrum, B., Rosenbloom, D., & Brown, J. (2002). Readiness for organizational change: A longitudinal study of workplace, psychological and behavioural correlates. Journal of Occupational and Organizational Psychology, 75, 377-392.

Dainas, C., & Beien, L. (2003). Targeting depression: An employer's approach. Business and Health Archive, May 15.

Dehar, M-A., Casswell, S., & Duignan, P. (1993). Formative and process evaluation of health promotion and disease prevention programs. Evaluation Review, 17, 204-220.

Department of Health. (2006). Action on stigma: Promoting mental health, ending discrimination at work. Retrieved from: www.shift.org.uk

Devilly, G. J., & Cotton, P. (2003). Psychological debriefing and the workplace: Defining a concept, controversies and guidelines for intervention. Australian Psychologist, 38(2), 144-150.

Devilly, G. J., Gist, R., & Cotton, P. (2006). Ready! fire! aim! the status of psychological debriefing and therapeutic interventions: In the work place and after disasters. Review of General Psychology, 10(4), 318-345.

Dewa, C., & Goering, P. (2000). Bridging academia and business: Exploring the workplace burden of mental illness. TEN, 2(6), 47-49.

Dowrick, C., & Buchan, I. (1995). Twelve-month outcome of depression in general practice: does detection or disclosure make a difference? British Medical Journal, 311, 1274-1276.

Dunnagan, T., Peterson, M., & Haynes, G. (2001). Mental health issues in the workplace: A case for a new managerial approach. Journal of Occupational and Environmental Medicine, 43(12), 1073-1080.

Durand, M. J., Loisel, P., Charpentier, N., Labelle, J., & Hong, Q. N. (2004). Le programme de retour therapeutique au travail (RTT). Un programme de réadaptation au travail base sur les données probantes: Centre de recherché clinique en réadaptation au travail PREVICAP de L'Hôpital Charles LeMoyne.

Durand, M., Vachon, B., Loisel, P., & Berthelette, D. (2003). Constructing the program impact theory for an evidence-based work rehabilitation program for workers with low back pain. Work, 21(3), 233-242.

Edwards, J. A., Webster, S., Van Laar, D., & Easton, S. (2008). Psychometric analysis of the UK Health and Safety Executive's Management Standards Work-related Stress Indicator Tool, Work and Stress, 22(2), 96-107.

Egan, M., Bambra, C., Petticrew, M., Whitehead, M., & Thomson, H. (2007). The psychosocial and health effects of workplace reorganization. 1. A systematic review of organizational level interventions that aim to increase employee control. Journal of Epidemiology and Community Health, 61, 945-954.

Einarson, S., Hoel, H., & Notelaers, G. (2009). Measuring exposure to bullying and harassment at work: Validity, factor structure and psychometric properties of the Negative Acts Questionnaire-Revised. Work & Stress, 23, 24-44.

Ely, R. J., & Thomas, D. A. (2001). Cultural diversity at work: The effects of diversity perspectives on work group processes and outcomes. Administrative Science Quarterly, 46, 229-273.

Estes, B., & Wang, J. (2008). Integrative literature review: Workplace incivility: Impacts on individual and organizational performance. Human Resource Development Review, 7, 218-240.

Everly, G. S., Jr., Sherman, M. F., Stapelton, A., Barnett, D. J., Hiremath, G. S., & Links, J. M. (2006). Workplace crisis intervention: A systematic review of effect sizes. Journal of Workplace Behavioral Health, 21(3), 153-170.

Field, K., Highet, N., & Robinson, E. (2002). beyond blue – the National Depression Initiative: preventing depression in the workplace. In M. L. V. I. W. E (Ed.), Mental health and work – Issues and perspectives. Adelaide: Auseinet: The Australian Network for Promotion, Prevention and Early Intervention for Mental Health. Retrieved from http://www.beyondblue.org.au/index.aspx?link_id=4.1028

Franche, R. L., Cullen, K., Clarke, J., Irvin, E., Sinclair, S., & Frank, J. (2005). Workplace-based return-to-work interventions: A systematic review of the quantitative literature. Journal of Occupational Rehabilitation, 15(4), 607-631.

Fuller, B. E., Rieckmann, T., Nunes, E. V., Miller, M., Arfken, C., Edmundson, E., & McCarty, D. (2007). Organizational readiness for change and opinions toward treatment innovations. Journal of Substance Abuse Treatment, 33(2), 183-192.

Gilbody, S. M., House, A. O., & Sheldon, T. A. (2001). Routinely administered questionnaires for depression and anxiety: Systematic review. British Medical Journal, 322, 406-409.

Global Business and Economic Roundtable on Addiction and Mental Health (2002). 12-step business plan and action toolbar to combat mental health disorders at work. Retrieved from http://www.mentalhealthroundtable.ca/aug_round_pdfs/12%20Step%20Plan%20Tool%20Bar.doc.pdf

Glozier, N. (1998). Workplace effects of the stigmatization of depression. Journal of Occupational and Environmental Medicine, 40, 793-800.

Goetzel, R., Ozminkowski, R., Bowen, J., & Tabrizi, M. (2008). Employer integration of healthy promotion and health protection programs. International Journal of Health Management, 1(2), 109 – 122.

Goldberg, R. J., & Steury, S. (2001). Depression in the workplace: Costs and barriers to treatment. Psychiatric Services, 52, 1639-1643.

Great-West Life: Centre for Mental Health in the Workplace. (2005-2011). Workplace strategies for mental health. Retrieved from http://www.gwlcentreformentalhealth.com/

Green, C. A., & Pope, C. R. (2000). Depressive symptoms, health promotion, and health risk behaviors. American Journal of Health Promotion, 15, 29-34.

Grove, B. (2006). Common mental health problems in the workplace: how can occupational physicians help? Occupational Medicine, 56, 291-293.

Grzywacz, J. G., & Ettner, S. L. (2000). Lost time on the job: The effect of depression versus physical health conditions. TEN. 2(6): 41-46.

Halter, M. J. (2004). The stigma of seeking care and depression. Archives of Psychiatric Nursing, 18, 178-184.

Health Communication Unit, Dalla Lana School of Public Health, University of Toronto & the Canadian Mental Health Association, Ontario. (2001). Overview of sustainability. Retrieved from http://www.thcu.ca/resource_db/pubs/698133998.pdf

Health & Safety Executive. How to tackle work-related stress: A guide for employers on making the management standards work (2009). Retrieved from http://www.hse.gov.uk/pubns/indg430.pdf

Health & Safety Executive. What are the Management Standards? Retrieved May, 2011 from www.hse.gov.uk/stress/standards/

Heaney, C. A., Price, R. H., & Refferty, J. (1995). Increasing coping resources at work: A field experiment to increase social support, improve workteam functioning, and enhance employee mental health. Journal of Organizational Behaviour, 16, 211- 215.

Hermansson, U., Helander, A., Huss, A., Brandt, L., & Ronnberg, S. (2000). The alcohol use disorders identification test (AUDIT) and carbohydrate-deficient transferrin (CDT) in a routine workplace health examination. Alcohol Clinical and Experimental Research, 24(2), 180-187.

Hirschfeld, R. M., Dunner, D. L., & Keitner, G. (2002). Does psychosocial functioning improve independent of depressive symptoms? A comparison of nefazadone, psychotherapy, and their combination. Biological Psychiatry, 58(7), 123-133.

Hoyle, D. (2006). ISO 9000 quality systems handbook (Fifth edition). Oxford, UK: Butterworth-Heinemann.
Hoyle, D. (2009). ISO 9000 quality systems handbook (Sixth Edition). Oxford, UK: Butterworth-Heinemann.

Human Resources and Skills Development Canada. (2010, October 2) Retrieved from www.hrsdc.gc.ca

Hurrell, J. J., Jr., & Murphy, L. R. (1996). Occupational stress interventions. American Journal of Industrial Medicine, 29, 338-341.

Industry Canada. Key small business statistics, July, 2008. Retrieved from http://www.ic.gc.ca/eic/site/sbrp-rppe.nsf/eng/rd02300.html#table1

Jane-Llopis, E., Barry, M., Hosman, C., & Patel, V. (2005). Mental health promotion works: A review. Promotion & Education, Supplement 2, 9-25.

Johansson, N. (1991). Effectiveness of a stress management program in reducing anxiety and depression in nursing students. Journal of American College Health, 40(3), 125-129.

Kagan, N. I., Kagan, H., & Watson, M. G. (1995). Stress reduction in the workplace: the effectiveness of psychoeducational programs. Journal of Counseling Psychology, 42, 71-78.

Kates, N., Craven, M. A., Crustolo, A. M., Nikolaou, L., Allen, C., & Farrar, S. (1997). Sharing care: The psychiatrist in the family physician's office. Canadian Journal of Psychiatry, 42, 960-965.

Katon, W. (2003). The Institute of Medicine "Chasm" report: Implications for depression collaborative care models. General Hospital Psychiatry, 25, 222–229.

Katon, W., Russo, J., Von Korff, M., Lin, E., Simon, G., Bush, T., Ludman, E., & Walker, E. (2002). Long-term effects of a collaborative care intervention in persistently depressed primary care patients. Journal of General Internal Medicine, 17(10), 741-748.

Kawakami, N., Araki, S., Kawashima, M., Masumoto, T., & Hayashi, T. (1997). Effects of work-related stress reduction on depressive symptoms among Japanese blue-collar workers. Scandinavian Journal of Work, Environment and Health, 23(1), 54-59.

Kawakami, N., Kobayashi, Y., Takao, S., & Tsutsumi, A. (2005). Effects of web-based supervisor training on supervisor support and psychological distress among workers: A randomized controlled trial. Preventive Medicine, 41(2), 471-478.

Kelloway, K., Teed, M., & Kelley, E. (2008). The psychosocial environment: Towards an agenda for research. International Journal of Workplace Health Management, 1(1), 50-64.

Kerr, R., McHugh, M., & McRory, M. (2009). HSE Management Standards and stress-related work outcomes. Occupational Medicine, 59(8), 574-579.

Kessler, R. C., Barber, C., Birnbaum, H. G., Frank, R. G., Greenberg, P. E., Rose, R. M., Simon, G. E., & Wang, P. (1999). Depression in the workplace: Effects on short-term disability. Health Affairs, 18(5), 163-171.

Kessler, R. C., Greenberg, P. E., Mickelson, K. D., Meneades, L. M., & Wang, P. S. (2001). The effects of chronic medical conditions on work loss and cutback. Journal of Occupational and Environmental Medicine, 43(3), 218-225.

Kitchener, B. A., & Jorm, A. F. (2004). Mental health first aid training in a workplace setting: A randomized controlled trial (ISRCTN13249129). BMC Psychiatry, 4, 23.

Komisin, L., & Placone, R. (2003). Building a respectful workplace. CUPA-HR Journal, Summer 2003, 54(2).

Kuoppala, J. L., Anne, H., & Paivi, M. S. (2008). Work health promotion, job well-being, and sickness absences: A systematic review and meta-analysis. Journal of Occupational & Environmental Medicine, 50(11), 1216-1227.

LaMontagne, A. D., Keegel, T., & Vallance, D. (2007). Protecting and promoting mental health in the workplace: Developing a systems approach to job stress. Health Promotion Journal of Australia: Official Journal of Australian Association of Health Promotion Professionals, 18(3), 221-228.

Leka, S., & Cox, T. (Ed). (2008). The European Framework for Psychosocial Risk Management: PRIMA-EF, 2008. Institute of Work, Health and Organizations, Nottingham, UK. Retrieved from http://prima-ef.org/Documents/03.pdf

Lim, K-L., Jacobs, P., Ohinmaa, A., Schopflocher, D., & Dewa, C. (2008). A new population-based measure of the economic burden of mental illness in Canada. Chronic Diseases in Canada, 28(3), 1-7.

Lin E. H., Von Korff, M., Russo, J., Katon, W., Simon, G. E., Unutzer, J., Bush, T., Walker, E., & Ludman, E. (2000). Can depression treatment in primary care reduce disability? A stepped care approach. Archives of Family Medicine, 9, 1052-1058.

Lo Sasso, A. T., Rost, K., & Beck, A. (2006). Modeling the impact of enhanced depression treatment on workplace functioning and costs: A cost-benefit approach. Medical Care, 44(4), 352-358.

Loretto, W., Popham, F., Platt, S., Pavis, S., Hardy, G., MacLeod, L., & Gibbs, J. (2005). Assessing psychological well-being: A holistic investigation of NHS employees. International Review of Psychiatry, 17(5), 329-336.

Mackay, C. J., Cousins, R., Kelly, P. J., Lee, S., & McCaig, R. H. (2004). 'Management Standards' and work-related stress in the UK: Policy Background and science. Work & Stress, 18, 91-112.

Martin, A., Sanderson, K., & Cocker, F. (2009). Meta-analysis of the effects of health promotion intervention in the workplace on depression and anxiety symptoms. Scandinavian Journal of Work, Environment & Health, 35, 7-18.

Martin, A., Sanderson, K., Scott, J., & Brough, P. (2009). Promoting mental health in small-medium enterprises: An evaluation of the "Business in Mind" program. BMC Public Health, p 239.

Martin, R. (1998). ISO 14001 Guidance Manual, National Centre for environmental decision-making research: Technical report. Retrieved from http://www.usistf.org/download/ISMS_Downloads/ISO14001.pdf

Matano, R. A., Koopman, C., & Wanat, S. F. (2007). A pilot study of an interactive web site in the workplace for reducing alcohol consumption. Journal of Substance Abuse Treatment, 32(1),71-80.

McCulloch, J. M., Ozminkowski, R. J., Cuffel, B., Dunn, R. L., Goldman, W., Kellher, D., & Comporato, A. (2001). Analysis of a managed psychiatric disability program. Journal of Occupational and Environmental Medicine, 43(2), 101-109.

Millear, P., Liossis, P., Shochet, I. M., Biggs, H., & Donald, M. (2008). Being on PAR: Outcomes of a pilot trial to improve mental health and wellbeing in the workplace with the promoting adult resilience (PAR) program. Behaviour Change, 25(4), 215-228.

Mimura, C., & Griffiths, P. (2003). The effectiveness of current approaches to workplace stress management in the nursing profession: An evidence based literature review. Occupational and Environmental Medicine, 60(1), 10-15.

Mino, Y., Babazono, A., Tsuda, T., & Yasuda, N. (2006). Can Stress Management at the Workplace Prevent Depression? a randomized controlled trial. Psychotherapy and Psychosomatics, 75(3), 177-182.

Morrison, D. L., & Payne, R. L. (2003). Multilevel approaches to stress management. Australian Psychologist, 38(2), 128-137.

Munz, D. C., Kohler, J. M., & Greenberg, C. I. (2001). Effectiveness of a Comprehensive Worksite Stress Management Program: Combining Organizational and Individual Interventions. International Journal of Stress Management, 8, 49-62.

Murta, S. G., Sanderson, K., & Oldenburg, B. (2007). Process evaluation in occupational stress management programs: a systematic review. American Journal of Health Promotion, 21(4), 248-54.

Myette, T. L. (2008). Integrated management of depression: Improving system quality and creating effective interfaces. Journal of Occupational and Environmental Medicine, 50(4), 482-491.

Mynors-Wallis, L., Davies, I., Gray, A., Barbour, F., & Gath, D. (1997). A randomised controlled trial and cost analysis of problem-solving treatment for emotional disorders given by community nurses in primary care. British Journal of Psychiatry, 170, 113-119.

National Institute for Clinical Excellence. (2009). Promoting mental well-being through productive and healthy working conditions: Guidance for Employers. Retrieved from http://www.mindfulemployer.net/NICE%20Guidance%20-%20promoting%20mental%20wellbeing%20-%20guidance%20for%20employers.pdf

Nytro, K., Saksvik, P. Ø., Mikkelsen, A., Bohle, P., & Quinlan, M. (2000). An appraisal of key factors in the implementation of occupational stress interventions. Work & Stress, 14, 213–225.

Olsheski, J. A., Rosenthal, D. A., & Hamilton, M. (2002). Disability management and psychosocial rehabilitation: Considerations for integration. Work, 19(1), 63-70.

Osilla, K. C., Zellmer, S. P., Larimer, M. E., Neighbors, C., & Marlatt, G. A. (2008). A brief intervention for at-risk drinking in an employee assistance program. Journal of Studies on Alcohol and Drugs, 69(1), 14-20.

Patterson, C. R., Bennett, J. B., & Wiitala, W. L. (2005). Healthy and unhealthy stress unwinding: Promoting health in small businesses. Journal of Business and Psychology, 20(2), 221-247.

PRIMA: Psychosocial Risk Management, Excellence framework. Retrieved from www.prima-ef.org

PRIMA Psychosocial Risk Management, Excellence framework: Inventory of best practice. Retrieved from www.prima-ef.org/inventory.aspx

PRIMA: Psychosocial Risk Management, Excellence framework: PRIMA-EF guidance on the European Framework for Psychosocial Risk Management – A resource for employers and worker representatives. Retrieved from http://prima-ef.org/guide.aspx

PRIMA Psychosocial Risk Management, Excellence framework: Psychosocial risk management – Vocational education and training (PRIMAeT). Retrieved from www.prima-ef.org/primaet.aspx

Putnam, K., & McKibbin, L. (2004). Managing workplace depression: An untapped opportunity for occupational health professionals. AAOHN Journal: Official Journal of the American Association of Occupational Health Nurses, 52(3), 122-129.

Rahe, R. H., Taylor, C. B., Tolles, R. L., Newhall, L. M., Veach, T. L., & Bryson, S. (2002). A novel stress and coping workplace program reduces illness and healthcare utilization. Psychosomatic Medicine, 64(2), 278-286.

Randall, R., Griffiths, A., & Cox, T. (2005). Evaluating organizational stress-management interventions using adapted study designs. European Journal of Work and Organizational Psychology, 14(1), 23-41.

Randall, R., Nielsen, K., & Tvedt, S. D. (2009). The development of five scales to measure employees' appraisals of organizational-level stress management interventions. Work & Stress, 23(1), 1-23.

Reynolds, S. (1997). Psychological well-being at work: is prevention better than cure? Journal of Psychosomatic Research, 43(1), 93-102.

Richardson, K. M., & Rothstein, H. R. (2008). Effects of occupational stress management intervention programs: A meta-analysis. Journal of Occupational Health Psychology, 13(1), 69-93.

Richmond, R., Kehoe, L., Heather, N., & Wodak, A. (2000). Evaluation of a workplace brief intervention for excessive alcohol consumption: The workscreen project. Preventive Medicine, 30(1), 51-63.

Rutter, M. (1985). Resilience in the face of adversity. Protective factors and resistance to psychiatric disorder. British Journal of Psychiatry, 147, 598-611.

Saksvik, P. Ø., Nytrø, K., Dahl-Jørgensen, C., & Mikkelsen, A. (2002). A process evaluation of individual and organizational occupational stress and health interventions. Work & Stress, 16(1), 37-57.

Sairanen, S., Matzanke, D., & Smeall, D. (2011) The Business Case: Collaborating to help employees maintain their mental well-being. Healthcare Papers. 11, 78-84.

Sanderson, K., Tilse, E., Nicholson, J., Oldenburg, B., & Graves, N. (2007). Which presenteeism measures are more sensitive to depression and anxiety? Journal of Affective Disorders, 101(1-3), 65-74.

Schene, A. H., Koeter, M. W., Kikkert, M. J., Swinkels, J. A., & McCrone, P. (2007). Adjuvant occupational therapy for work-related major depression works: Randomized trial including economic evaluation. Psychological Medicine, 37(3), 351-362.

Shain, M. (2004). The duty to prevent emotional harm at work: Arguments from science and law, Implications for policy and practice. Bulletin of Science, Technology & Society, 24(4), 305-315.

Shain, M. (2009). Stress, mental injury and the law in Canada: A discussion paper for the Mental Health Commission of Canada. Retrieved from www.mentalhealthcommission.ca

Sheldon, C. (1997). ISO 14001 and Beyond: Environmental Management Systems in the Real World, New York, NY: Prentice Hall.

Sherbourne, C. D., Wells, K. B., Duan, N., Miranda, J., Unutzer, J., Jaycox, L., Schoebaum, M., Meredith, L. S., & Rubenstein, L. V. (2001). Long-term effectiveness of disseminating quality improvement for depression in primary care. Archives of General Psychiatry, 58(7), 696-703.

Simon, G. E., Barber, C., Birnbaum, H. G., Frank, R. G., Greenberg, P. E., Rose, R. M., Wang, P. S., & Kessler, R.C. (2001). Depression and work productivity: The comparative costs of treatment versus nontreatment. Journal of Occupational & Environmental Medicine, 43(1), 2-9.

Smetanin, P., Stiff, D., Briante, C., Adair, C., Ahmad, S., & Khan, M. (2011) The list and economic impact of major mental illnesses in Canada: 2011 to 2041. RiskAnalytica, on behalf of the Mental Health Commission of Canada.

Spicer, R. S., & Miller, T. R. (2005). Impact of a workplace peer-focused substance abuse prevention and early intervention program. Alcoholism-Clinical and Experimental Research, 29(4), 609-611.

Stansfeld, S., & Candy, B. (2006). Psychosocial work environment and mental health: A meta-analytic review. Scandinavian Journal of Work, Environment and Health, 32(6), 443-462.

Stein, F. (2001). Occupational stress, relaxation therapies, exercise and biofeedback. Work, 17(3), 235-245.

Stevens, F. G., Plaut, V. C. & Sanchez-Burks, J. (2008). Unlocking the benefits of diversity: All-inclusive multiculturalism and positive organizational change. Journal of Applied Behavioral Science, 44, 116-133.

Tabanelli, M. C., Depolo, M., Cooke, R. M. T., Sarchielli, G., Bonfiglioli, R., Mattioli, S., & Violante, F. S. (2008). Available instruments for measurement of psychosocial factors in the work environment. International Archives of Occupational and Environmental Health, 82, 1-12.

Taris, T. W., & Schreurs, P. J. G. (2009). Well-being and organizational performance: An organizational-level test of the happy-productive worker hypothesis. Work & Stress, 23(2), 120-136.

The Standing Senate Committee on Social Affairs, Science and Technology. (2006). Out of the shadows at last: transforming mental health, mental illness and addiction services in Canada. Retrieved from www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02may06-e.htm

Van der Hek, H., & Plomp, H. N. (1997). Occupational stress management programmes: a practical overview of published effect studies. Occupational Medicine, 47, 133-141.

Wang, P. S., Simon, G. E., Avorn, J., Azocar, F., Ludman, E. J., McCulloch, J., & Petukhova, M. Z. (2007). Telephone screening, outreach and care management for depressed workers and impact on clinical and work productivity outcomes: a randomized controlled trial. Journal of the American Medical Association, 298(12), 1401-1411.

Wang, P. S., Simon, G. E., & Kessler, R. C. (2008). Making the business case for enhanced depression care: The National Institute of Mental Health-Harvard Work Outcomes Research and Cost-Effectiveness Study. Journal of Occupational and Environmental Medicine, 50(4), 468-475.

Wasiak, R., Young, A. E., Roessler, R. T., McPherson, K. M., Van Poppel, M., & Anema, J. R. (2007). Measuring return to work. Journal of Occupational Rehabilitation, 17(4,) 766-781.

World Health Organization. (2005). Mental health policies and programmes in the workplace: Mental health policy and service guidance package. Retrieved from http://www.who.int/mental_health/policy/services/13_policies%20programs%20in%20workplace_WEB_07.pdf

World Health Organization. (2010). WHO healthy workplace, framework and model, background and supporting literature and practices. Retrieved from http://www.who.int/occupational_health/publications/healthy_workplaces_model.pdf

Zechmeister, I., Kilian, R., McDaid, D., & MHEEN group. (2008). Is it worth investing in mental health promotion and prevention of mental illness? A systematic review of the evidence from economic evaluations. BMC Public Health, 8(1), 20.