An Environmental Scan on the Experience of Canadian Employers to Introduce and Implement CAN/CSA Standard Z1003-13/BNQ 9700-803/2013 – Psychological Health and Safety in the Workplace

Prepared for WorkplaceNL by the SafetyNet Centre for Occupational Health and Safety Research at Memorial University

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Submitted: October 31, 2018
Updated: January 3, 2019

MEMORIAL UNIVERSITY SafetyNet Centre for Occupational Health & Safety Research

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ABOUT THIS REPORT

This report summarizes the findings of an environmental scan undertaken to examine the experience of employers in Canada to introduce and implement CAN/CSA Standard Z1003-13/BNQ 9700-803/2013 – Psychological Health and Safety in the Workplace. In addition to a review of the Canadian standard, the project entailed a high-level environmental scan of the internet to identify similar standards in other jurisdictions, to determine whether industry best practices exist for psychological health and safety, and to compile information on the range of strategies currently being applied for the prevention of psychological injury and illness.

A companion report was prepared by the Institute for Work and Health, which summarizes the findings from a rapid review of the peer-reviewed literature to answer the question, "*What are effective workplace strategies used by employers to positively impact employee mental health*?" The review focuses on research about workplaces that have adopted psychological health and safety programs and/or CAN/CSA Standard Z1003-13/BNQ 9700-803/2013.

LIST OF ABBREVIATIONS USED IN THIS REPORT

BNQ	Bureau de Normalisation du Québec
BSI	British Standards Institution
CSA	Canadian Standards Association
EI	Exit Interview (assessment tool)
EU	European Union
HSE	Health and Safety Executive
II	Implementation Interview (assessment tool)
IQ	Implementation Questionnaire
ISO	International Organization for Standardization
OCQ	Organizational Champion Questionnaire
OHS	occupational health and safety
OHSMS	occupational health and safety management system
OR	Organizational Review (assessment tool)
PHASE	Psychological Health Awareness Survey for Employees
PHS	psychological health and safety
PHSMS	psychological health and safety management system
PTSD	post-traumatic stress disorder

EXECUTIVE SUMMARY

Purpose of the project

This report summarizes the findings of a comprehensive environmental scan undertaken to examine the experience of employers in Canada to introduce and implement CAN/CSA Standard Z1003-13/BNQ 9700-803/2013 – Psychological Health and Safety in the Workplace (the "National Standard"). Information generated by this scan and by the companion report prepared by the Institute for Work and Health will inform WorkplaceNL's strategic approach to addressing psychological health and safety, one of its top eight injury and illness priorities (2).

Scope and methodology

Scope of the scan

The scope of the scan was delineated by five questions posed by WorkplaceNL:

1. Is there research or other documentation related to the implementation of CAN/CSA Z1003-13/BNQ 9700-803/2013 in Canadian workplaces and the outcomes or impacts of this implementation? Similarly, is there research or other documentation related to the implementation of similar standards in other jurisdictions?
2. Are there industry best practices for psychological health and safety in Canada?
3. What prevention strategies do sample employer representatives think should be utilized to prevent psychological injury and illness?
4. Do workers and employers have a common understanding of a psychologically safe workplace?
5. Are there performance indicators and evaluation methods that could be adopted regarding the implementation of psychological health and safety programs in the workplace?

This report focusses primarily on answering questions about the documentation that exists regarding the implementation of the Standard, industry best practices, performance indicators and evaluation methods that have been adopted by organizations that have implemented the Standard. Questions regarding research evidence of the effectiveness of workplace mental health interventions are addressed in the companion report prepared by the Institute for Work and Health entitled "*What are effective workplace strategies used by employers to positively impact employee mental health?*"

Data collection methodology

Information for this project was collected primarily from online sources. Standards governing psychological health and safety in the workplace, as well as tools and resources designed to facilitate implementation, were identified and retrieved by searching: official standards organizations in Canada and abroad; official government websites on mental health in the workplace; and other websites and online portals that gather information on psychological

health and safety or mental health in the workplace[1]. Sites were bookmarked and any relevant documents were downloaded (when they were available in a downloadable format). Details of the search/scan strategy are provided in Appendix 1.

The primary focus of the project was CAN/CSA Standard Z1003-13/BNQ 9700-803/2013. At the request of WorkplaceNL, the scan included similar standards in other jurisdictions to determine if any relevant lessons could be learned from their implementation. Emphasis was placed on standards in Europe and Australia as these jurisdictions are most similar to Canada in their approach to OHS. For this part of the scan, the starting point was the official website of the organization with jurisdictional responsibility for preventing workplace injury and disease, followed by official websites of organizations responsible for creating national or international standards. Using the hyperlinks and search engines located on those sites, relevant documents were downloaded, and webpages pertaining to psychological health and safety and to the prevention of psychological injury and illness were downloaded and/or bookmarked.

Information synthesis and generation of the final report

Information on the National Standard was primarily collected from the Canadian Standards Association (CSA), the Bureau de Normalisation du Québec (BNQ), and the Mental Health Commission of Canada (MHCC). An up-to-date copy of the National Standard was downloaded for free from the CSA website, along with copies of the Healthy Enterprise Standard and a recently introduced CSA standard on psychological health and safety in paramedic organizations. All of these standards were carefully reviewed and their requirements were descriptively summarized in Part 3 of the report. This part of the report also provides brief descriptions of voluntary guidelines and/or management standards from other jurisdictions (specifically, the European Union, the United Kingdom, and Australia). To be included in the report, these guidelines and/or standards had to have a focus on psychological health and safety in the workplace and/or work-related psychosocial risk factors.

Information on the experience of Canadian employers who have adopted and implemented the Standard was entirely collected from published research reports and articles in the peer-reviewed and grey literature on workplace policy and organizational management as it pertains to occupational health and safety. Although our original intention was to conduct key informant interviews, we elected to focus on these sources for the following reasons: the research reports and published articles provided information on a larger and more diverse range of employers than we would have been able to survey in the time available; the data summarized in the literature and in the research reports had been collected with reliable survey instruments; and the publications painted a relatively complete picture of the implementation journey experienced by participating organizations over the 3- to 4-year period immediately following the launch of the National Standard. The findings of these qualitative case studies have been synthesized and summarized in Part 4 of the report.

[1] The three principal sites used were the Mental Health Commission of Canada (MHCC), Workplace Strategies for Mental Health, and Workplace Safety and Prevention Services.

Key findings

National and international standards on psychological health and safety

Canada was the first country in the world to introduce a voluntary standard on psychological health and safety in the workplace. At present, there are three Canadian standards that explicitly address this topic: Québec's Healthy Enterprise standard, which was introduced in 2008; the National Standard, which was introduced in 2013 and which is aimed at all workplaces in Canada; and a workplace-specific standard, which was introduced in 2018 and is aimed at organizations employing paramedics. Similar voluntary guidelines for addressing stress and mental health in the workplace exist in other countries (e.g., the United Kingdom, the European Union, and Australia). To date, none of these countries have adopted or enacted these voluntary guidelines as "national standards". An international voluntary standard on psychological health and safety, based on the Canadian standard, is currently in the early stages of development by the International Organization for Standardization (ISO).

The purpose of Canada's National Standard is to enable organizations to create a psychologically healthy and safe workplace as part of an ongoing process of continual improvement. The prevention framework that underlies the requirements set out in the National Standard is the "Plan–Do–Check–Act" cycle, which is at the core of an occupational health and safety management system (OHSMS). The National Standard was designed to align with other relevant Canadian standards and with recognized management system standards that incorporate the following five elements: policy, commitment and engagement; planning; implementation; evaluation and corrective action; management review and continual improvement.

In a recently published systematic review and comparison of 20 international guidelines on workplace mental health, the Canadian National Standard was the only voluntary guideline to receive a score of 100% for its comprehensive approach to psychological health and safety (3). In that same review, the Canadian National Standard also received a quality score of 91% (3).

Canadian employers' experience of implementing the National Standard

Several reports and peer-reviewed article have been published that discuss or describe the experience of Canadian employers in implementing the National Standard (1, 4-9). The most comprehensive examination of employer experience with the National Standard was undertaken by the Centre for Applied Research in Mental Health and Addiction (CARMHA) in the 3-year period immediately following the launch of the National Standard (1, 4). In addition to this large case study, two smaller qualitative studies have been carried out in Ontario and Québec to examine employers' perceptions about and response to the National Standard (7, 9). The Mental Health Commission of Canada (MHCC) recently reported findings of a 1-year follow-up study to examine how well employers who participated in the CARMHA study are doing at sustaining their commitment to implementing the National Standard (5). With the findings of the various studies it has commissioned, the MHCC has generated a list of promising practices

and developed tools and resources to enhance adoption of the National Standard across Canada. These are available on their website and are listed in Appendix 2 of this report.

Key findings from the MHCC-sponsored research on employers' experience of implementing the National Standard are summarized below. The findings of the MHCC's case study are supported and echoed by the two articles mentioned above. Where findings of the case study were also replicated in the other smaller studies, a note to that effect is included in the relevant bullet point.

Key findings from published research on implementation of the National Standard

- Organizations demonstrated differing levels of organizational readiness for the change and their progress in implementing the Standard over the 3-year time period varied across all organizations and within sectors.
- All organizations had limited access to indicators that are specifically reflective of outcomes measuring psychological health and safety in the workplace. The most commonly reported sources of data were: employee and family assistance program (EFAP) utilization rates, return-to-work and accommodation data, and long-/short-term disability rates.
- Organizations reported that over the 3-year period, they significantly increased their use of other data sources (e.g., incident reports, psychological health risk assessments, disability relapse rates.
- The **top actions** undertaken to address psychological health and safety and to implement the National Standard included: enacting a respectful workplace policy and implementing educational initiatives; providing early intervention through EFAPs tailored towards promoting mental health; raising awareness and enhancing mental health knowledge in the workplace; building employee resilience; supporting stay-at-work and sustainable return-to-work programs for employees with psychological health issues; and training managers about mental health to give them the skills and knowledge they need to appropriately respond to psychological hazards in the workplace.
- The **most important internal and external facilitators of success** were: leadership support and involvement; adequate structure and resources; size of the organization; awareness of psychological health; the presence of pre-existing processes, policies and programs to support workplace psychological health and safety; previous experience with implementing standards and other similar management systems; and connection to other individuals or organizations with experience in psychological health and safety (for example, through strategic partnerships or communities of practice). Similar findings were observed in the two qualitative studies (7, 9). In these studies, the following emerged as facilitators of success: leadership throughout the organization; appropriate levels of resourcing; clear articulation of the added value and benefits of complying with the National Standard (i.e., making the business case); simplifying the language of the National Standard into a step-by-step guide; planning and implementing the Standard in stages rather than having full roll-out; aligning implementation with existing management strategies and organizational structures or incorporating elements into other existing certification programs.

- The **most important barriers to implementation** were: limited access to psychological health data; inconsistent leadership support; significant organizational change unrelated to the implementation of the Standard (for example, a merger or an organizational redesign); the lack of a mechanism to track and measure evidence of employee knowledge about psychological health and safety; inconsistent approaches across departments within organizations for collecting data; inadequate allocation of the necessary financial and human resources required for implementation; uncertainty and a lack of consensus about how to define and report certain terms related to psychological health and safety (e.g., "excessive stress" and "critical events"). Similar findings were observed in the two qualitative studies (7, 9). In these studies, the following emerged as challenges and barriers to implementation: stigma; lack of knowledge; under-utilization of existing resources (such as employee assistance programs); lack of mechanisms to support leadership and to develop awareness/understanding; how work is organized (e.g., remote sites, shiftwork, management hierarchy); atypical working environments; organizational size; competing workplace priorities; absence of leadership commitment; and perceptions that workers may take advantage of the system.
- The **most promising practices** identified by employers who had implemented the National Standard included: develop a solid business case that not only justifies investing the necessary resources but also accounts for the opportunity cost of projects that won't be undertaken because of reallocated resources; ensure commitment throughout the organization, including *active and visible* involvement of both management and worker representatives; maintain ongoing bi-directional communication (i.e., top-down *and* bottom-up) about why and what the organization is doing; take action to embed psychological health and safety in the overall organizational culture; ensure adequate human and financial resources are allocated to implementation; focus on selecting a risk management strategy that is the most suitable to the organization's context; determine readiness for change *before* beginning the implementation process; and, develop and utilize a targeted evaluation strategy to measure the impact of implementing the National Standard.

<u>Employer experience of implementing workplace mental health guidelines in other jurisdictions</u>

Information is scarce on the implementation of workplace mental health guidelines in other jurisdictions. The lack of information regarding the implementation and the effectiveness of these guidelines has been flagged as an information gap and a research need by authors of four recent publications (10-13). The scan identified one article that examined the implementation of the Management Standards on work-related stress in the United Kingdom (14).

The findings of this study echoed the experience of Canadian employers and identified similar barriers and facilitators.

- The **main factors supporting the implementation of the United Kingdom's Management Standards for work-related stress** included: active and visible support from organizational leadership (which included senior management, human resource departments, and line managers); regular communication; sufficient organizational capacity (in terms of both

expertise, human and financial resources); phased *vs*. full roll-out (i.e., assessment by departments and teams *vs*. corporate wide assessment); and, involvement of key stakeholders.
- The **main barriers and impediments to implementation** included: major or on-going change at the organizational level; lack of organizational capacity; and, resource-intensive data collection requirements.

Summary of the findings of the environmental scan

Standards on psychological health and safety in the workplace

The scan identified three Canadian standards and six international standards/guidelines that explicitly address the topic of psychological health and safety in the workplace. To date, the Canadian standard is the only one that has been adopted or enacted as a "national standard". An international voluntary standard, based on the Canadian standard, is currently in the early stages of development by the International Organization for Standardization (ISO). The National Standard is reportedly also undergoing review and being updated.

In 2018, the CSA Group launched a second psychological health and safety standard – specifically for paramedic organizations – that builds on the National Standard. In addition to the inclusion of paramedic-specific requirements that go beyond the core requirements of the National Standard, one of the key areas of difference in the new standard is that it provides much more comprehensive introductory and explanatory sections. The other key difference is the inclusion of two new factors in the list of workplace factors – namely, "other chronic stressors as identified by workers" and "cumulative exposure to critical or stressful events". The inclusion of the wording "as identified by workers" is a notable difference between the new standard and the National Standard and suggests that, in developing the new standard, the CSA Group was being responsive to the concerns of workers.

Employer experience of implementing the National Standard

The scan identified a number of research reports published online, as well as articles published in the peer-reviewed literature, that examined the experience of Canadian employers in implementing the National Standard. All of the studies conducted to date have focussed on the barriers and facilitators to implementation and all have relied on self-assessments and self-reports. No systematic evaluations have been undertaken to examine whether the Standard is effective at improving psychological health and safety outcomes or whether the self-reported assessments are valid and reliable. The lack of a tested audit tool for measuring conformance with the National Standard's requirements is problematic.

Information is scarce on the implementation of workplace mental health guidelines in other jurisdictions. The lack of information regarding implementation and the effectiveness of these guidelines has been flagged as an information and research gap.

PART 1 – INTRODUCTION AND OVERVIEW OF THE PROJECT

Introduction and purpose

The purpose of this project was to undertake an environmental scan to examine the experience of employers:

1. in Canada in introducing and implementing CAN/CSA Standard Z1003-13/BNQ 9700-803/2013 – Psychological Health and Safety in the Workplace (the "National Standard"), and
2. in other selected jurisdictions in introducing and implementing similar standards.

Information generated by this scan and by the companion report prepared by the Institute for Work and Health will inform WorkplaceNL's strategic approach to addressing psychological health and safety, identified as one of its top eight injury and illness priorities in its 2018–2022 workplace injury prevention strategy *Advancing a Strong Safety Culture in Newfoundland and Labrador* (2).

To achieve the project's objectives, the most recent version of the National Standard was reviewed, as were several other standards that informed its development[2]. An environmental scan of the internet was also undertaken to identify similar standards in other jurisdictions, to determine whether industry best practices exist in Canada and abroad for psychological health and safety, and to compile information on strategies available to employers (including available tools, courses and resources) for the prevention of psychological injury and illness in the workplace.

Scope and methodology

<u>Scope of the scan</u>

The scope of the scan was delineated by five questions posed by WorkplaceNL:

1. Is there research or other documentation related to the implementation of CAN/CSA Standard Z1003-13/BNQ 9700-803/2013 in Canadian workplaces and the outcomes or impacts of this implementation? Similarly, is there research or other documentation related to the implementation of similar standards in other jurisdictions?
2. Are there industry best practices for psychological health and safety in Canada?
3. What prevention strategies do sample employer representatives think should be utilized to prevent psychological injury and illness?
4. Do workers and employers have a common understanding of a psychologically safe workplace?

[2] These included: BNQ 9700-800/2008 – Healthy Enterprise, CAN/CSA Z1000-06 – Occupational Health and Safety Management Systems (OHSMS), and CSA Standard Z1002 – Occupational health and safety - Hazard identification and elimination and risk assessment and control.

5. Are there performance indicators and evaluation methods that could be adopted regarding the implementation of psychological health and safety programs in the workplace?

This report focusses primarily on answering questions about the documentation that exists regarding the implementation of the National Standard, industry best practices, performance indicators and evaluation methods that have been adopted by organizations who have implemented the National Standard. Questions regarding research evidence are answered in the companion report prepared by the Institute for Work and Health entitled "*What are effective workplace strategies used by employers to positively impact employee mental health?*"

Data collection methodology

Information for this project was collected primarily from online sources. Standards governing psychological health and safety in the workplace, as well as tools and resources designed to facilitate implementation, were identified and retrieved by searching: official standards organizations in Canada and abroad; official government websites on mental health in the workplace; and other websites and online portals that gather information on psychological health and safety or mental health in the workplace[3]. Sites were bookmarked and any relevant documents were downloaded (when they were available in a downloadable format). Details of the search/scan strategy are provided in Appendix 1.

The primary focus of the project was CAN/CSA Standard Z1003-13/BNQ 9700-803/2013. At the request of WorkplaceNL, the scan included similar standards in other jurisdictions to determine if any relevant lessons could be learned from their implementation. Emphasis was placed on standards in Europe and Australia as these jurisdictions are most similar to Canada in their approach to OHS. For this part of the scan, the starting point was the official website of the organization with jurisdictional responsibility for preventing workplace injury and disease, followed by official websites of organizations responsible for creating national and international guidelines and standards. Using the hyperlinks and search engines located on those sites, relevant documents were downloaded, and webpages pertaining to psychological health and safety and to the prevention of psychological injury and illness were downloaded and/or bookmarked.

Information synthesis and generation of this report

Information on the National Standard was primarily collected from the Canadian Standards Association (CSA), the Bureau de Normalisation du Québec (BNQ), and the Mental Health Commission of Canada (MHCC). An up-to-date copy of the National Standard was downloaded from the CSA website, along with copies of the Healthy Enterprise Standard from the BNQ website, and a recently introduced CSA standard on psychological health and safety in paramedic organizations. All of these standards were carefully reviewed and their requirements

[3] The three principal sites used were the Mental Health Commission of Canada (MHCC), Workplace Strategies for Mental Health, and Workplace Safety and Prevention Services.

were descriptively summarized in Part 3 of the report. Part 3 of the report also provides brief descriptions of voluntary guidelines and/or management standards from other jurisdictions (specifically, the European Union, the United Kingdom, and Australia). To be included in the review and the report, these guidelines and/or standards had to have a focus on psychological health and safety in the workplace and/or work-related psychosocial risk factors.

Information on the experience of Canadian employers who have adopted and implemented the National Standard was collected from published research reports and articles in the literature on workplace policy and organizational management as it pertains to occupational health and safety. Although our original intention was to conduct key informant interviews, we elected to focus on these sources for the following reasons:

- The research reports and published articles provided information on a larger and more diverse range of employers than we would have been able to survey in the time available.
- The data summarized in the literature and in the research reports had been collected with reliable survey instruments.
- The publications painted a relatively complete picture of the implementation journey experienced by participating organizations over the 3- to 4-year period immediately following the launch of the National Standard.

The findings of these qualitative case studies have been synthesized and concisely summarized in Part 4 of the report.

Organization of the report

This report is organized as follows:

- **Part 1** introduces the project, summarizes the methodology used to undertake the environmental scan, and describes the structure of the report.
- **Part 2** presents background and context on some of the key concepts discussed in this report.
- **Part 3** presents information on national and international standards for psychological health and safety, with an emphasis on CAN/CSA Standard Z1003-13/BNQ 9700-803/2013 and CSA Standard Z1003.1-18.
- **Part 4** summarizes the findings of a multi-year study conducted by the Mental Health Commission of Canada on the experience of employers who have implemented the National Standard, as well as the findings of other qualitative studies published in the literature on workplace policy and organizational management as it pertains to occupational health and safety.
- **Part 5** summarizes the findings of the environmental scan.

The report concludes with three appendices:

- **Appendix 1** presents details of the search/scan strategy.
- **Appendix 2** provides a list of resources and best practices that were identified in the scan.
- **Appendix 3** lists the standards and other references cited in the body of the report.

PART 2 – BACKGROUND AND CONTEXT

Background: a brief history on the creation of the National Standard

In January 2013, Canada became the first country in the world to launch a voluntary National Standard intended to safeguard psychological health and safety in the workplace. A second voluntary standard, which builds on the National Standard and focusses specifically on the psychological health and safety of paramedics, was introduced in 2018. The creation of both of these standards was the culmination of nearly 20 years of concurrent and inter-related activity across several segments of Canadian society – including government, business, and academia (15, 16). Key milestones in the evolution of workplace mental health in Canada over the past two decades are presented below[4].

Table 1: Key milestones in the evolution of workplace mental health in Canada

1998 – 2002	
1998	Launch of the Global Business and Economic Roundtable on Mental Health and Addiction.
2001	Canadian Mental Health Association establishes Mental Health Works.
2003 – 2007	
2004	Québec introduces its OHS legislation to include deterrent for workplace bullying.
2005	Ontario enacts legislation removing discriminatory workplace barriers for people with disabilities.
2006	Standing Senate Committee on Social Affairs, Science and Technology releases report on first national study of mental health, mental illness and addiction.
2007	Mental Health Commission of Canada and Great-West Centre for Mental Health in the Workplace established. White paper on mental health in the labour force released.
2008 – 2012	
2008	Québec introduces BNQ 9700-800 (the "Healthy Enterprise" Standard), first workplace health standard in Canada.
2009	Launch of "Guarding Minds @ Work", first comprehensive framework in Canada for assessing and addressing workplace psychological health & safety. Release of the first of a series of discussion papers authored by Dr Martin Shain on employer responsibility for creating a psychologically safe workplace. Consensus Conference on a National Standard for PHS in the Workplace takes place.
2010	Ontario amends its OHS Act to require employers develop policies and practices to prevent and respond to workplace violence.
2011	Start of Bell Canada's Let's Talk campaign.
2012	Alberta amends its Workers Compensation Act to include PTSD presumption for first responders.
2013 – 2018	
2013	Launch of CAN/CSA Standard Z1003-13/BNQ 9700-803/2013.
2014	British Columbia amends its Workers Compensation Act to address bullying and harassment.
2015	Manitoba amends its Workers Compensation Act to include PTSD presumption for all workers.
2016	New Brunswick and Ontario establish PTSD presumption for members of certain occupations. Saskatchewan establishes presumption for all workers covered by Workers Compensation Act.
2017	Nova Scotia establishes presumption for front-line and emergency response workers. Yukon establishes PTSD presumption for first responders.
2018	Prince Edward Island, British Columbia and Newfoundland amend legislation to establish PTSD presumption. Ontario and Alberta expand coverage of their PTSD presumptions. Launch of CSA Standard Z1003.1-18 on psychological health and safety in paramedic organizations.

[4] For more detail, the reader is referred to two recent publications of the Great-West Life Centre for Mental Health in the Workplace (Dr. Johti Samra's research report, as well as the book by Mary Ann Baynton and Leanne Fournier). Both are listed in Appendix 3.

Context: key concepts to help foster understanding of the National Standard's requirements

The prevention framework that underpins the requirements set out in the National Standard, as well as the newly launched Standard for paramedic organizations, is an occupational health and safety management system (OHSMS). There are a number of national and international standards that set out requirements for developing and implementing OHSMS. The most commonly cited international standards are those published by the International Labour Organization (ILO), the International Organization for Standardization (ISO), and the Occupational Health and Safety Assessment Series (OHSAS). Many national standards are derived from these international standards. In Canada, the relevant national standard is CSA Z1000-14 – Occupational Health and Safety Management, which was first published by the CSA in 2006 and then updated in 2014.

This section of the report defines some important terms and provides context on key conceptual features of an OHSMS that are common to the psychological health and safety standards. This information may be useful to WorkplaceNL as they weigh the factors that have been reported to influence employer uptake and their capacity to implement the National Standard.

Definitions of important terms

Occupational health and safety management system: The definition of an occupational health and safety management system (OHSMS) varies depending slightly on the source. The International Organization for Standardization (ISO) defines an OHSMS as a "management system or part of a management system used to achieve the OH&S policy" (17). A management system is, in turn, defined as a "set of interrelated or interacting elements of an organization to establish policies and objectives and processes to achieve those objectives" and an OH&S policy is defined as a "policy to prevent work-related injury and ill health to workers and to provide safe and healthy workplaces" (17). The Canadian Standards Association (CSA) adopts a similar definition of OHSMS in CAN/CSA-Z1000-14 – Occupational Health and Safety Management, but expands the definition of occupational health and safety as follows: "the promotion in the workplace of the physical, *mental, and social wellbeing* of workers and the protection of workers from, and the prevention of, workplace conditions and factors adverse to their health and safety" *[emphasis added]* (18).

Psychological health and safety management system: Although the requirements set out in the National Standard are for a psychological health and safety management system (PHSMS), it does not explicitly define the term PHSMS. The implementation guide that accompanies the National Standard, entitled "Assembling the Pieces", explains that a PHSMS is a tool that "helps an organization identify hazards that can contribute to psychological harm to the worker. It is a preventive approach that assesses your workplace's practices and identifies those areas of concern" (19). The guide notes that "a PHSMS is similar to other management systems and should be integrated with existing policies and processes".

In its recently launched Standard for psychological health and safety in paramedic organizations, the CSA Group defines what it means by a PHSMS as follows (20):

> A psychological health and safety management system (PHSMS) helps an organization to identify and mitigate hazards that can contribute to psychological harm to the worker. It is a preventive approach that assesses a workplace's practices and identifies areas of concern. When concerns are noted, the organization implements strategies for preventive measures that are designed to reduce potential harm and mitigate or eliminate hazards. It is recognized that there are hazards that cannot be eliminated from the work; however, the PHSMS can be focused on minimizing risk, addressing early awareness, and ensuring evidence-informed intervention practices and appropriate support. This management system approach is the basic framework of this Standard (see Figure 1) and guides an organization to develop a PHSMS system that is unique to their requirements and workplace issues.
>
> Clause 0.3, CSA Standard Z1003.1-18

Continual improvement as it pertains to OHSMS and PHSMS

The common (and core) feature of OHSMS approaches is that they incorporate the concept of continual improvement and all are built around the principles of the "Plan–Do–Check–Act" (PDCA) cycle. PDCA is an ongoing and iterative process designed to help organizations monitor performance, make decisions and achieve improvement on a continual basis[5].

In general, the PDCA cycle involves the following four steps:

Plan:	Identify goals, outputs, and expected outcomes. Identify how they are to be achieved.
Do:	Implement the plan's objectives. Collect data to measure active and reactive performance.
Check:	Compare "actuals" with targets. Analyze differences to determine root cause of deviation.
Act:	Review performance. Take corrective action. Revisit plans and update/improve as necessary.

Figure 1 illustrates the PDCA cycle. This figure appears in CAN/CSA-Z1000-14 (Occupational Health and Safety Management), CSA Standard Z1003.1-18 (Psychological Health and Safety in Paramedic Organizations) and the National Standard's implementation guide. It does not appear in the National Standard on psychological health and safety in the workplace.

[5] In some versions of the PDCA cycle, an alternative version of the "A" is "adjust". Typically, this would take place after the process has been monitored multiple times, allowing for adjustments to be made and for evaluation of their impact, thereby ensuring that the cycle truly is one of continuous improvement. [Source: Wikipedia - PDCA cycle]

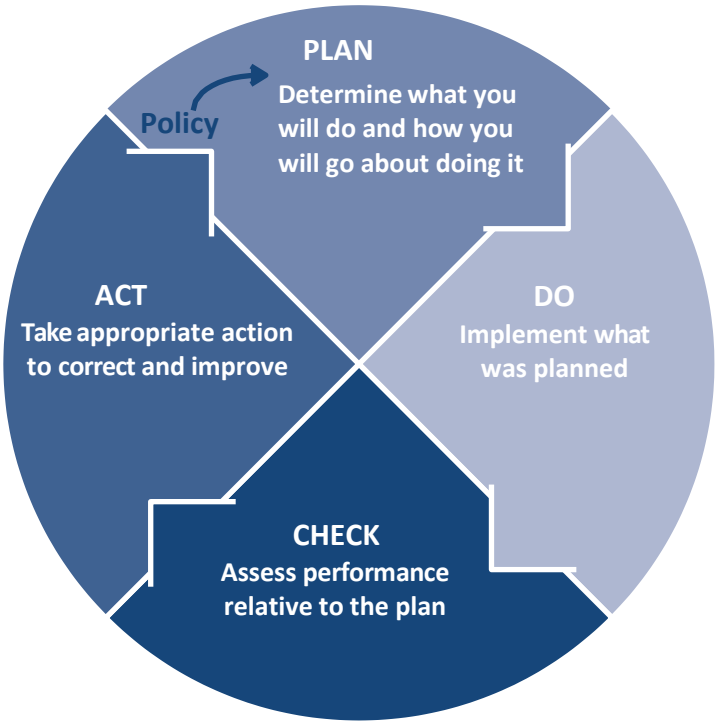

Figure 1: Management system framework (Source: CSA Z1003.1-18)

How conformance with management standards is determined

To demonstrate conformance with a given management standard, organizations must undergo an audit[6] in which they are awarded a certain number of points for meeting or exceeding the standard's mandatory requirements. Certification is awarded based on meeting or exceeding a minimum threshold of points. A number of organizations[7] have published guidelines on how to manage and conduct effective internal or external audits of management systems. These audit standards, which are also built around the core tenets of the PDCA cycle, provide guidelines on how to manage an effective audit program, how to conduct management system audits, and how to evaluate the competence of audit program managers, auditors and audit teams. While none of these standards or guidelines are specific to OHSMS, the ISO recently published a technical specification that sets out the required skills and knowledge of individuals or bodies who provide auditing services to organizations that have implemented ISO 45001, its new international standard on OHSMS. The purpose of the technical specification is to guarantee that a harmonized auditing approach is used and that auditors have the necessary competence to both perform the audits and to make the decisions regarding accreditation and certification[8].

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[6] Most OHSMS standards require that the audit be external for large organizations. However, allowance is made for small employers to conduct the audit internally.

[7] The ISO, the ILO, the Health and Safety Executive in the United Kingdom and the Health and Safety Authority in Ireland.

[8] For more information on ISO/IEC TS 17021-10, Conformity assessment – Requirements for bodies providing audit and certification of management systems – Part 10: Competence requirements for auditing and certification of occupational health and safety management systems), see https://www.iso.org/obp/ui/ - iso:std:iso-iec:ts:17021:-10:ed-1:v1:en

PART 3 – STANDARDS ON PSYCHOLOGICAL HEALTH AND SAFETY IN THE WORKPLACE

This part of the report describes Canadian and international standards on psychological health and safety. It is divided into two sections. The first section presents three Canadian standards: Québec's "Healthy Enterprise" Standard (BNQ 9700-800/2008), Canada's National Standard on psychological health and safety in the workplace (CAN/CSA-Z1003-13/BNQ 9700-803/2013), and a newly introduced standard on psychological health and safety in paramedic service organizations (CSA-Z1003.1-18/2018). The second section describes voluntary standards that have been developed internationally.

Canadian standards

BNQ 9700-800/2008

Although technically not a standard on psychological health and safety in the workplace, Québec's Standard "BNQ 9700-800 Prevention, Promotion, and Organizational Practices Contributing to Health in the Workplace (Prévention, promotion et pratiques organisationnelles favorables à la santé en milieu de travail)" has been included in this environmental scan because it is considered to be one of the milestones in the evolution of workplace mental health in Canada (16) and because it sets out a framework for voluntary certification of organizational practice interventions that contribute to making workplaces physically and psychologically healthier (21). This standard, which is also known as the "Healthy Enterprise Standard", certifies organizations on the degree to which they comply with the requirements of the standard across five domains:

1. commitment by senior management
2. health and wellness committee
3. data collection
4. implementation plan
5. evaluation

Two levels of certification are available.

1. **"Healthy Enterprise" (HE)**: To achieve this level, an organization must demonstrate compliance with all requirements designated HE in the standard. An organization at this level is defined as clearly showing "its commitment to its employees' health and wellness. It aims at structured and planned prevention, promotion and implementation of supportive organizational practices for health and wellness in the workplace, based on the employees' health problems and needs revealed by data collection and based on the enterprise's priorities".
2. **"Elite Healthy Enterprise" (EHE)**: To achieve this level, an organization must demonstrate compliance with all the requirements of both the Healthy Enterprise and Elite Healthy Enterprise levels. An organization at this level is defined as going "further in the intensity and integration of its efforts for its employees' health and wellness. The intervention and spheres of activity affected are more numerous. Health and wellness

are better integrated into the corporate culture and management processes, which is even more supportive of employee wellness and work/life balance".

CAN/CSA Standard Z1003-13/BNQ 9700-803/2013

Background

The creation and development of CAN/CSA Z1003-13/BNQ 9700-803/2013 (Psychological health and safety in the workplace – prevention, promotion, guidance to staged implementation) was commissioned by the Mental Health Commission of Canada and was supported through funding from the Government of Canada[9], Bell Canada and the Great-West Life Centre for Mental Health in the Workplace. First published in January 2013 by the CSA Group and the Bureau de Normalisation du Québec (BNQ) and subsequently reaffirmed in 2018, it has been approved as a National Standard of Canada by the Standards Council of Canada.

The purpose of the National Standard is to enable organizations to create a psychologically healthy and safe workplace as part of an ongoing process of continual improvement (22). The National Standard defines such a workplace as "one that promotes workers' psychological well-being and actively works to prevent harm to worker psychological health including in negligent, reckless or intentional ways" and sets out voluntary requirements for a documented and systematic approach to develop, implement and maintain a psychological health and safety management system (PHSMS).

The National Standard was designed to align with other relevant Canadian standards[10] and with recognized management system standards[11] that incorporate the following five elements:

1. policy, commitment and engagement
2. planning
3. implementation
4. evaluation and corrective action
5. management review and continual improvement.

As noted in Part 2 of this report, the CSA's approach to PHSMS is built around the "Plan–Do–Check–Act" cycle and is consistent with its approach to occupational health and safety management systems (OHSMS) more generally.

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[9] Funding was provided by: Human Resources and Skills Development Canada, Health Canada, Public Health Agency of Canada.

[10] Specifically, BNQ 9700-800/2008 (Prevention, Promotion and Organizational Practices Contributing to Health in the Workplace) , CAN/CSA-Z1000 (Occupational health and safety management), and CSA Z1002 (Occupational health and safety - Hazard identification and elimination and risk assessment and control).

[11] Examples of these standards include those published by the International Organization for Standardization (ISO 45001:2018 Occupational health and safety management systems – requirements with guidance for use) and by the British Standards Institution (OHSAS 18001 Occupational Health and Safety Management, which the BSI will phase out over the next three years and replace with ISO 45001).

Strategic pillars on which the National Standard is based

The introductory preamble to the National Standard highlights the three strategic pillars of a psychological health and safety (PHS) system (namely, prevention of harm, promotion of psychological health, and resolution of incidents or concerns) and emphasizes the importance of organizations taking the time to assess needs and address gaps in psychological safety *before* embarking on health promotion activities (22). The National Standard goes on to set out a framework to address factors within the control, responsibility or influence of the workplace. These include: identifying and eliminating hazards in the workplace that pose a risk of psychological harm to a worker; assessing and controlling the risks in the workplace associated with hazards that cannot be eliminated (e.g., stressors due to organizational change or reasonable job demands); implementing structures and practices that support and promote psychological health and safety in the workplace; and, fostering a culture that promotes psychological health and safety in the workplace.

Annex A.4 of the National Standard lays out a model of a planned approach for addressing the 13 workplace factors[12] that affect psychological health and safety. As noted in the Annex, these factors are "organizational or systemic in nature and therefore within the influence of the workplace" (22). The 13 factors are:

1	organizational culture	8	involvement and influence
2	psychological and social support	9	workload management
3	clear leadership and expectations	10	engagement
4	civility and respect	11	balance
5	psychological demands	12	psychological protection
6	growth and development	13	protection of physical safety
7	recognition and reward		

A copy of the model (which was updated and expanded to 15 factors in 2018) is shown in Figure 2, in the next section. The two new factors added are "other chronic stressors as identified by workers" and "cumulative exposure to critical or stressful events".

Application of the National Standard

The National Standard applies to any workplace; however, its application is voluntary unless legally or contractually required. The National Standard, which can be used for conformity assessments, distinguishes between three types of requirements:

1. those that a user must satisfy in order to comply with the National Standard (denoted by the use of the word "shall")
2. those that a user is advised (but is not required) to satisfy in order to comply with the National Standard (denoted by the use of the word "should")
3. those that are permissible within the limits of the National Standard, but do not

[12] Twelve of these factors were adapted from GuardingMinds@Work. The thirteenth (protection of physical safety) was added for the purposes of the National Standard.

determine compliance with the National Standard (denoted by the word “may”).

Seven appendices (referred to as “Annexes”) accompany the National Standard. They provide complementary information intended to provide context about the National Standard, to support its interpretation and to facilitate its implementation. A high-level summary of the mandatory and recommended elements of a PHSMS, as set out in the National Standard, is provided in Table 2.

Table 2: Mandatory vs. recommended elements of a PHSMS, as per CAN/CSA Z1003-13/BNQ 9700-803/2013

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
4.1 General	Organization **shall** establish, document, implement and maintain PHSMS in the workplace and continually improve its effectiveness in accordance with the requirements of this standard	PHSMS **should be** integrated into, or compatible with, governance practices and other systems in the organization	PHSMS includes following elements: a) commitment, leadership, participation b) planning c) implementation d) evaluation and corrective action e) management review
4.2 Commitment, leadership and participation			
4.2.1 General	Management **shall** ensure that the responsibilities and authorities related to the PHSMS are defined and communicated throughout the organization.		Standard notes that: ▪ commitment, leadership and effective participation are crucial to the success of PHSMS ▪ all stakeholders share an interest and responsibility to ensure PHS in the workplace
4.2.2 Commitment	Organization **shall** have or incorporate into existing policies a current policy statement that outlines their commitment to the development of a systematic approach for managing psychological health and safety in the workplace. Policy **shall** be based on organizational commitment to: establish, promote and maintain a PHSMS in accordance with standard; align with the ethics and stated values of the organization; establish and implement a process to evaluate system effectiveness and implement changes as necessary; delegate necessary authority to implement effective system; ensure that workers and representatives, as		Clause indicates that policy statement to be approved by senior management and Board of Directors where applicable.

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
	required, participate in developing, implementing, and continually improving the system; provide required resources to develop, implement and maintain PHSMS; evaluate and review system at planned intervals for purpose of continual improvement; recognize it is in everyone's common interest to promote and enhance a working relationship consistent with the principles of mutual respect, confidentiality and cooperation		
4.2.3 Leadership	People in leadership roles **shall**: reinforce the development and sustainability of a psychologically healthy and safe workplace; support and reinforce all line management in implementation of PHSMS; establish key objectives toward continual improvement of PHS in the workplace; lead and influence organizational culture in a positive way; ensure that PHS is part of organizational decision-making processes; engage workers and, where required, their representatives to be aware of the importance of PHS and of the implications of tolerating PHS hazards, to provide feedback to help organization determine effectiveness of PHSMS and, identify workplace needs regarding PHS.		Clause pertains to those who have key responsibility for the organization's performance.
4.2.4 Participation	Organization **shall**: engage stakeholders in active regular dialogue that facilitates understanding of their needs and goals; engage workers and, where required, their representatives in policy		Standard notes that: ▪ active, meaningful, and effective participation of stakeholders is a key factor in psychological health ▪ participation is a requirement for

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
	development, data gathering and planning process to better understand their needs with respect to PHS in the workplace; encourage workers and, where required, their representatives to participate in programs implemented to meet identified needs; actively involve workers and, where required, their representatives in the evaluation process through use of recognized instruments (e.g., focus groups, surveys, audits); ensure that the evaluation results and the follow-up plans of action are effectively communicated with all management, workers and their representatives (where applicable) Organization **shall** engage the OHS committee or HS representatives, where required, to define their involvement in the PHSMS. Where discussion of psychological hazards in the workplace takes place at the OHS committee, confidentiality of all persons **shall** be respected and identifying markers removed from documents used. Organization **shall**: provide workers and worker representatives with time and resources to participate effectively in the development of the PHS policy and in the process of PHSMS planning, implementation, training, evaluation, and corrective action; encourage worker participation by providing mechanisms that support participation, establish workplace HS committees and ensure		successful policy development, planning, implementation, and operation of specific programs, and evaluation of the system and its impacts ▪ worker participation is an essential aspect of an organization's PHSMS ▪ consultation with workers and their representatives does not require the organization to obtain worker approval or permission. Worker and worker representative participation should not interfere with business needs or operations. **Permissible within limits of the standard:** Organization may consider the implementation of a specific committee or sub-committee for PHS in the workplace in order to further encourage participation and engagement.

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
	that workers and worker representatives are trained in, and consulted on, all aspects of PHSMS associated with their role within this system.		
4.2.5 Confidentiality	Organization **shall** establish and sustain processes that ensure confidentiality and privacy rights are respected and protected.		Clause is explicitly referenced in Clause 4.2.4.
4.3 Planning			
4.3.2 Planning process	Planning process **shall** include planning for management of PHS in the workplace, including assessment of worker health impact, financial impact, organization policy and processes that promote good psychological health; developing a collective vision of a psychologically healthy workplace, specific goals for reaching the vision, and a plan for ongoing process monitoring for continual improvement; assessing the strengths of the existing PHS strategy; and recognizing and identifying current practices that are already protecting and promoting psychological health and safety		A general introductory clause (Clause 4.3.1) sets out that planning enables an organization to identify and prioritize work-related PHS hazards, risks, legal requirements, management system gaps, and opportunities for improvement. This clause further notes that planning is necessary to establish: appropriate objectives and targets; plans to achieve compliance with legal requirements, relevant regulations, organizational requirements, and a commitment to continual improvement. Cross-references **Annex B** (which provides resources)
4.3.3 Review	Organization **shall** review its approach to managing and promoting PHS in the workplace, to assess conformance with the requirements and recommendations in the standard. If no such system exists, the organization **shall** establish a system in conformance with the standard.		

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
4.3.4 Identification, assessment, and control	Organization **shall** develop, implement and maintain a documented risk mitigation process that includes: hazard identification, elimination of those hazards that can be eliminated, assessment for level of risk for hazards that cannot be eliminated, preventive and protective measures used to eliminate identified hazards and control risk, and a priority process reflecting the size, nature and complexity of the hazard and risk and, where possible, respecting the traditional hierarchy of risk control	Factors to assess **should** include, but are not limited to: psychological support, organizational culture, clear leadership and expectations, civility and respect, psychological job demands, growth and development, recognition and reward, involvement and influence, workload management, engagement, work/life balance, psychological protection from violence, bullying, and harassment, protection of physical safety, and other chronic stressors as identified by workers In addition to assessing risks, the organization **should** identify and assess opportunities for promoting psychological health	Clause includes a note that the hierarchy of risk control can involve: eliminating the hazard, controlling the risk or access to the hazard, substituting the hazard with something less hazardous, making changes to how the work is organized and done, modifying procedures and practices, training, use of personal protective equipment, and emergency response plans. Also noted is that the documentation can be scaled to the size, nature and the complexity of the organization. Cross-references **Annex A** (specifically, Clause A.3 which provides a description of the 14 factors that should be assessed)
4.3.5 Data Collection	Organization **shall** establish a data gathering process using qualitative, quantitative, or mixed methods. Any collection of data **shall** comply with all privacy requirements, legislation, collective agreements and policies. Organization **shall** keep a record of the data collected and of the methods used in data collection. Where required by regulation, the organization **shall** share the data collected and related reports with the OHS committee. Where data is shared, confidentiality of all persons **shall** be respected and identifying markers removed from documents in accordance with Clause 4.2.5.		Clause notes that the degree of detail required will depend on the complexity of the workplace, the goals of the PHSMS, the reasonable accessibility of reliable data, and the decision-making needs of the organization. **<u>Permissible within limits of the standard</u>:** Data sources and reference documents may include: existing organizational policies and plans pertinent to PHS in the workplace; job descriptions/job demands analysis; aggregated administrative data (e.g., rates of absenteeism, return to work and accommodation data, etc.); laws and regulations (e.g., human rights, OHS acts, labour laws, etc.); standards, codes, and guidelines; worker

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
			engagement indicators and worker feedback (e.g., surveys, participation rates); reports from unions or worker groups regarding exposure/risk information; diverse perspectives (e.g.,, mental illness, cultural differences) including those with personal experiences of mental health issues, etc.; results of organizational audit; industry or association established best practices; and, research.
4.3.6 Diversity	Organization **shall** consider the unique needs of diverse populations and groups and solicit input when these needs are relevant to complying with the requirements of the standard. Organization **shall** consider workplace factors that can impact the ability of these workers to stay at work or return to work. Organization **shall** take steps to link workers in need to internal resources.	Organization **should** support individual workers to seek assistance internally or externally when needed. Organization **should** also take steps to link workers to community or other resources.	Standard prefaces this clause by noting that organizations comprise diverse populations and groups. In framing the first "should" sub-clause, the Standard acknowledges that workplace PHS is a shared responsibility.
4.3.7 Objectives and targets	Organization **shall** document the PHS objectives and targets for relevant functions and levels within the organization. Organization **shall** establish and maintain a plan for achieving its objectives and targets. Plan **shall** include: designated responsibility for achieving objectives and targets; identification of means and time frame within which the objectives and targets are to be achieved.	Objectives and targets **should be**: measurable; consistent with the PHS policy and commitment to the PHSMS, compliance with legal and other requirements, and commitment to continual improvement; based on past reviews, including past performance measures and any PHS hazards, risk, the results of the data collection and identification and assessment of psychological workplace factors, management system deficiencies, and	

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
		opportunities for improvement that have been identified; determined after consultation with workers and with consideration of technological options and the organizations operational and business requirements; and reviewed and modified according to changing information and conditions as appropriate. Organization **should** consider objectives and targets that reinforce existing strengths and promote new opportunities for improving PHS.	
4.3.8 Managing change	Organization **shall** establish, implement, and maintain a system to manage changes that can affect PSH. System **shall** address changes that include: new produces, process or services at the design stage; significant changes to work procedures equipment, organizational structure, staffing, products, services, or suppliers; changes to PHS strategies and practices; changes to PHS legal and other requirements; and changes to work arrangements.	Such a system **should** include: communication between stakeholders about the change; information sessions and training for workers and worker representatives; and support as necessary to assist workers in adapting to changes	
4.4 Implementation			
4.4.1 Infrastructure and resources	Organization **shall** provide and sustain infrastructure and resources needed to achieve conformity with Standard.	Following **should be** taken into consideration: workplace parties **should** possess sufficient authority and resources to fulfill their duties related to the standard; workplace parties **should** possess the knowledge, authority, and abilities to integrate PHS into	Standard notes that internal or external resources might be able to provide substantial expertise, proven programs, or assistance in implementing PHS programs in the workplace.

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
		management systems, operations, processes, procedures, and practices; and, persons with roles as specified by the standard **should** possess the knowledge, skills and abilities to carry out their roles (e.g., auditing, training, assessment, analysis)	
4.4.2 Preventive and protective measures	Organization **shall** establish and sustain processes to implement preventive and protective measures to address the identified work-related hazards and risks.	Preventive and protective measures **should be** implemented according to the following priority: eliminate the hazard; implement controls to reduce the risks related to hazards that cannot be eliminated; implement use of personal protective equipment in applicable circumstances; implement processes to respond to issues that can impact PHS of workers; and, offer resources to workers who are experiencing mental health difficulties	Standard notes that ▪ the key (with regards to personal protective equipment) is to recognize and consider the requirements in the context of both physical and psychological safety ▪ resources offered to workers experiencing mental health difficulties may be found within the organization, in the public domain, online, or in the community
4.4.3 Education, awareness, and communication	Organization **shall** establish and sustain processes to: provide information about factors in the workplace that contribute to PHS and specifically how to reduce hazards and risk that potentially cause psychological harm and how to enhance factors that promote psychological health; ensure stakeholder education, awareness and understanding in regards to the nature and dynamics of stigma, psychological illness, safety and health; communicate to stakeholders: existing policies and available supports; processes available when issues can impact PHS; information about the PHS system and		

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
	related plans and processes; include stakeholder ideas, concerns and input for consideration; and, ensure communication throughout the monitoring and review process to all workplace parties		
4.4.4 Sponsorship, engagement, and change management	Organization **shall** establish processes that support effective and sustained implementation, including: sponsorship by senior leadership and leadership at all levels of the organization; engagement on the part of the stakeholders; assessment and application of change management principles throughout planning and implementation		
4.4.5 Implementation governance	Organization **shall** establish: clear responsibilities and accountabilities for effective implementation; governance processes that support effective implementation and communication plans; and documentation requirements		
4.4.6 Competence and training	Organization **shall** establish and sustain processes to: determine expectations and minimum requirement of workers and, in particular, those in leadership roles (e.g., supervisors, managers, worker representatives, union leadership) to prevent psychological harm, promote psychological health of workers, and address problems related to PHS; and, provide orientation and training	Organization **should** establish and sustain processes to: provide accessible coaching and supports as required; and, assess and address competence of those in leadership roles	Standard recognizes the potential complexities of PHS situations, the unique needs of the individuals affected, and the skills needed are factors to be considered in the provision of accessible coaching and supports.
4.4.7 Critical event preparedness	Organization **shall** establish and sustain processes to: identify potential critical		Standard notes that the purpose of this clause is to help workers who might be

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
(individual)	events where psychological suffering, illness or injury is involved or likely to occur; provide response and support; provide related training for key personnel involved in critical event response; and ensure there are opportunities for debriefing and for revising guidelines for critical events as applicable		dealing with incidents within or external to the workplace (such as bullying, harassment, death in the family)
4.4.8 Critical event preparedness (organization)	Organization **shall** establish and sustain processes to: ensure PHS risks and impacts of critical events are assessed; manage critical events in a manner that reduces psychological risks to the extent possible and supports ongoing psychological safety; incorporate learning from critical events into established plans related to PHSMS; and, ensure there are opportunities for reviewing and revising guidelines for critical events as applicable		Standard notes that organizations might undertake or experience events that pose particular risks or are likely to have particular impacts on PHS.
4.4.9 Reporting and investigations	Organization **shall** establish and maintain procedures for reporting and investigating work-related PHS incidents Procedures **shall** include: establishment of roles and responsibilities of all parties participating in investigation process; practices that foster a psychologically safe environment; commitment to appropriate accountability; actions to mitigate any consequences of work-related psychological injuries, illnesses, acute traumatic events, chronic stressors, fatalities (including suicides), attempted suicides, and PHS incidents; identification of immediate and underlying cause(s) of	Such investigations **should be** carried out by persons who are experienced in psychological injury and incident investigations and who are impartial (and are perceived to be impartial by all parties), and **should be** carried out with the participation of appropriate workplace parties, respecting the privacy and confidentiality of involved parties and relevant legislation Investigation results and recommendations **should be** used for continual improvement of the PHSMS	Clause lists examples of work-related PHS incidents, including: psychological injuries, illness, acute traumatic events, fatalities, suicides, and attempted suicides.

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
	such incidents and the implementation of recommended corrective and preventive actions; and assessment of effectiveness of any preventive and corrective actions taken Investigation of cause(s) of work-related PHS incidents **shall** include the identification of any failures in the PHSMS and **shall** be documented Recommendations **shall** be developed and communicated to workplace parties along with the investigation results. Recommendations **shall** form the basis of corrective action and **shall** be included in the management review.		
4.4.10 External parties	Organization **shall** establish and sustain processes to: make external parties and their personnel aware of the organization policies and expectations related to protecting the PHS of the organization's workers; and, address any issues or concerns identified		Standard introduces this clause by noting that organizations often engage external providers and suppliers whose personnel interact with those of the organization.
4.5 Evaluation and corrective action			
4.5.1 Introduction	Organization **shall** establish and maintain procedures to monitor, measure and record PHS system conformance and the effectiveness of PHSMS, respecting the confidentiality and privacy of all individuals		Clause cross-references **Clause 4.2.5** (Confidentiality). It further notes that the purpose of monitoring and measurement is to obtain qualitative and quantitative measurements of the PHS of the organization (including promotion, prevention, and intervention efforts) and organizational conformance to the Standard (including process evaluation). A notation under this clause emphasizes

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
			that evaluation is best planned before implementation so that appropriate data requirements can be identified and subsequently included in the evaluation results.
4.5.2 Monitoring and measurement	Performance monitoring and measurement **shall**: determine the extent to which the PHSMS policy, objectives and targets are being met: provide data on PHSMS performance and results; determine whether the day-to-day arrangements for hazard and risk identification, assessment, minimization, and elimination or control are in place and operating effectively; and, provide the basis for decisions about improvements to PHS of the workplace and the PHSMS Both appropriate qualitative and quantitative measures **shall** be developed in consultation with workers and where applicable their representatives. Such assessments **shall** be carried out by competent persons. Monitoring and measurement activities **shall** be recorded. Monitoring and measurement **shall** include requirements of the PHSMS and the results of the following as applicable: leadership engagement with the PHSMS; baseline assessment of the other workplace determinants of psychological health; psychological injury and illness statistics; return-to-work programs;		Clause cross-references **Clause 4.3.5** (Data Collection). Standard notes that the measures to be developed are appropriate to the needs, size and nature of the organization.

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
	aggregated data from health risk assessments; and aggregated analysis of the results of investigations or events		
4.5.3 Internal audits	Organization **shall** establish and maintain an internal audit program to conduct audits at planned intervals to determine whether the PHSMS: conforms to the requirements of the standard and to the PHS system requirements established by the organization; and is effectively implemented and maintained. Audit results, conclusions and any correction action plans **shall** be documented and communicated to affected workplace parties and those responsible for corrective action Organization **shall** consult with workers and where applicable their representatives on auditor selection, the audit process, and the analysis of results Management responsible for activity being audited **shall** ensure that corrective actions are taken to address any non-conformance with the organization PHSMS or the standard identified during the audit	Internal audit program **should** include criteria for auditor competency, audit scope, frequency of audits, audit methodology; and reporting	Clause notes that the audit can be scalable to the size, nature and complexity of the organization. Cross-references **Annex E** (which provides a sample audit tool) and **CAN/CSA-ISO 19011** (which provides guidelines on managing OHSMS).
4.5.4 Preventive and corrective action	Organization **shall** establish and maintain preventive and corrective action procedures to: address PHSMS non-conformance and inadequately controlled hazards and their related risks; identify any newly created hazards resulting from preventive and corrective actions; expedite action on new or inadequately		

Clause of the Standard	Mandatory Requirement	Recommended Requirement	Notes
	controlled hazards and risks; traction actions taken to ensure their effective implementation; and implement initiatives to prevent recurrence of hazards Organization **shall** take into account input from PHSMS performance monitoring and measurement, recommendations from workers and worker representatives, PHSMS audits, management reviews when determining preventive and corrective actions		
5.0 Management review			
5.1 Review process	Organization **shall** establish and maintain a process to conduct scheduled management reviews of PHSMS Review process **shall** include: review an analysis of key outcome data; assessment of the level of conformance of PHSMS to the standard; detailed review of findings that are considered significant; and organizational and other reporting requirements	Review process **should** address degree to which the goals of a psychologically healthy and safe workplace are bring achieved.	
5.2 Outcome of the review process	Outcome of the review process **shall** include: opportunities for improvement and corrective actions to be implemented; review an update of the organizational policies and procedures specific to or related to PHSMS; review and update of objectives, targets, and action plans; and communication opportunities to enhance understanding and application of results		

CSA Standard Z1003.1-18

In March 2018, the CSA Group published CSA Standard Z1003.1-18 (Psychological health and safety in the paramedic service organization). Creation of this voluntary standard, which builds on the National Standard, was commissioned by the Paramedic Association of Canada and was funded by the Ontario Ministry of Labour's Occupational Health and Safety Prevention and Innovation Program (OHSPIP). According to the Standard's preface, it is an "evidence-informed document that encompasses existing CSA Standards, government policy documents, peer-reviewed research articles, and non-peer-reviewed materials" (20). The Standard indicates that its source materials are primarily Canadian (although a few international sources have been included) and that it does not include in-text citations as would an academic publication[13].

Background

Like the National Standard, this Standard provides requirements, recommendations, and guidance for developing, implementing, and monitoring a systematic approach to PHS. It differs from the National Standard in that it is specifically targeted towards paramedic service organizations and other key stakeholders, providing them with guidance on good practice for identifying and assessing psychological hazards (i.e., potential areas and activities that give rise to occupational stressors), managing risk and promoting improved PHS through the implementation of measures before harm can occur.

Although this Standard focusses on the specific needs of paramedic service organizations, it was written to align with other relevant guidance, specifications and standards used by organizations to manage PHS, OHS and quality. It is also built around the "Plan–Do–Check–Act" cycle and incorporates the same five elements as the National Standard (i.e., policy, commitment and engagement; planning; implementation; evaluation and corrective action; management review and continual improvement) and provides clause by clause text of Clauses 4 and 5 from the National Standard. To distinguish the additional paramedic sector-specific requirements and guidance from the text of the National Standard, the symbol P appears in the Standard's margin.

Application of the Standard

The Standard applies to "any paramedic service organization that seeks to establish a program to eliminate and/or minimize workplace PHS risks to paramedics and other workers of the organization; enhance psychological well-being; implement, maintain, and continually improve a program for PHS; assure itself of its conformity with its stated PHS policy; and demonstrate conformity with this Standard". Clause 0.5 indicates that the Standard's requirements can be implemented on their own or that they can be incorporated into other management systems (i.e., OHS, PHS, or other quality management systems). The following factors will influence the extent to which the Standard applies in a given organization: OHS/PHS policies of the

[13]The preface of the Standard refers the user to Annex J for the complete list of resources used.

organization, nature of its activities, complexity of its operations, hazards and related risks. Clause 0.5 also notes that an organization may apply the Standard to other workers who could be exposed to PHS hazards as a result of their roles or activities (for example, 911 call-takers and dispatchers, fleet and administrative staff.

Clause 1.2 of the Standard emphasizes that it is intended to provide guidance at an organizational level to the paramedic service organization (i.e., the *employer*). The guidance provided is not intended to aid in the diagnosis or treatment of an employee's workplace-related mental health problems nor is it intended to be used by other first responder organizations (e.g., firefighters or police officers). Other areas also outside the scope of the Standard include requirements for: equipment and vehicle design, equipment standards, workplace ergonomics, personal protective equipment, or emergency management programs.

Like the National Standard, this Standard can be used for conformity assessments (either by the organization itself or by others external to the organization) and allows for an organization to make a self-declaration that it is in conformance. An external conformity assessment may be used to verify the validity of this self-declaration. CSA Z1003.1-18 uses the same terminology as the National Standard to distinguish between three types of requirements:

1. those that a user must satisfy in order to comply with the Standard (denoted by the use of the word "shall")
2. those that a user is advised (but is not required) to satisfy in order to comply with the Standard (denoted by the use of the word "should")
3. those that are permissible within the limits of the Standard, but do not determine compliance with the Standard (denoted by the word "may").

Ten appendices (referred to as "Annexes") accompany the Standard. All of the Annexes are informative and, as such, they are intended to provide context about, to support interpretation and facilitate implementation of the Standard. None of them contain requirements that must be satisfied in order to comply with the Standard.

Key areas of difference between the National Standard and the paramedic standard

In addition to the inclusion of paramedic-specific requirements that go beyond the core requirements of the National Standard, one of the key areas of difference in the new standard is that it provides much more comprehensive introductory and explanatory sections. Included in these sections are: a definition of PHSMS (provided in Part 2 of this report); a figure illustrating the "Plan–Do–Check–Act" cycle (also provided in Part 2 of this report); and a figure illustrating the model of a planned approach to address 15 factors (*vs*. 13 in the National Standard) known to impact psychological health in the workplace[14] (included as Figure 2 in this report).

Section 0 (Introduction) of the Standard lays out a model of a planned approach for addressing

[14]As noted above, this model appears in Annex A.4 of the National Standard.

the 15 workplace factors listed in Annex B.2 that could contribute to psychological harm (see Figure 2). In addition to stating that these factors are "organizational or systemic in nature and therefore within the influence of the workplace", the Annex goes on to note that "*While psychological health and psychological safety are deserving of equal protection, it is important to note that, from a strategic perspective, ensuring safety (in the sense of preventing psychological harm) is a prerequisite to the promotion of health." [emphasis original]* (20).

The other key difference is the inclusion of two new factors in the list of workplace factors known to impact psychological health in the workplace – namely, "other chronic stressors as identified by workers" and "cumulative exposure to critical or stressful events". The inclusion of the wording "as identified by workers" is a notable difference between the new standard and the National Standard and suggests that, in developing the new standard, the CSA Group was responsive to the concerns of workers. These concerns were voiced on the Canadian Labour Congress' website in their explanation of what psychological risk factors were:

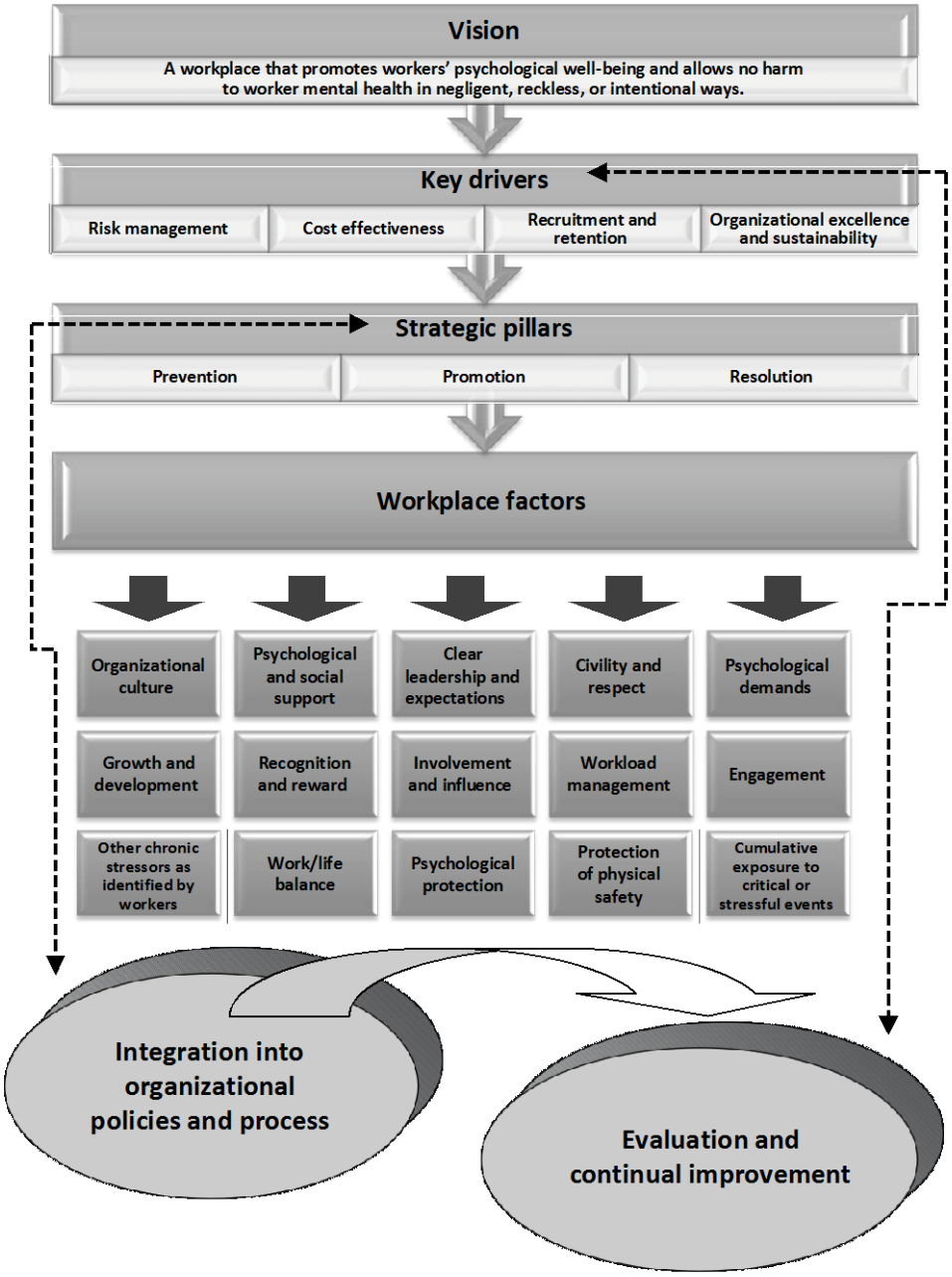
> *There are 14 workplace psychosocial factors known to positively impact an employee's mental health, psychological safety, participation, and productivity. If these factors effectively exist in the workplace, they have the potential to prevent psychological harm. The first 13 of these workplace factors were adapted from Guarding Minds @ Work and used for the purposes of the National Standard of Canada for Psychological Health and Safety in the Workplace. The 14th factor is particularly important to unions in assessing psychological health and safety in the workplace.*
>
> Source: Canadian Labour Congress

The 15 factors listed in Annex B.2 of CSA Z1003.1-18 are:

1	psychological and social support	9	workload management
2	organizational culture	10	engagement
3	clear leadership and expectations	11	work/life balance
4	civility and respect	12	psychological protection
5	psychological demands	13	protection of physical safety
6	growth and development	14	other chronic stressors as identified by workers
7	recognition and reward	15	cumulative exposure to critical or stressful events
8	involvement and influence		

Figure 2: Model of a planned approach to address psychological hazards in the workplace

(Source: CSA Z1003.1-18)



International standards

An international voluntary standard, based on the Canadian standard, is currently in the early stages of development by the International Organization for Standardization (ISO). In addition, a number of voluntary guidelines and frameworks for addressing stress and mental health in the workplace have been published in other jurisdictions (e.g., European Union, the United Kingdom, and Australia). Few of these guidelines and frameworks would be considered "standards" (i.e., they are not formal documents that establish or set out uniform criteria, methods, processes and practices or requirements by which conformance can be measured). Rather, they tend to be documents created by organizations with an interest in mental health in the workplace to provide guidance to employers on steps they can take to create a psychologically healthy and safe workplace. None of these guidelines has been adopted or enacted as a "national standard".

International Organization for Standardization

An international standard on psychological health and safety in the workplace, based on the Canadian standard, is currently under development by the International Organization for Standardization (ISO). According to the ISO website, the draft standard, which is entitled "ISO/AWI 45003 Occupational health and safety management -- Psychological Health and Safety in the Workplace – Guidelines", is currently in Stage 20 (the Preparatory Stage). What this means is that the project has been approved as a work item[15] and that it has been registered in the work program of the Technical Committee responsible for drafting the standard[16]. According to the ISO's website, the project was registered in Stage 20 in June 2018. There is no information on the website about the timeline for the Committee's work.

United Kingdom

The scan identified two published documents from the United Kingdom addressing mental health in the workplace that could be considered "standards", along with several other guidance documents. The first is a Publicly Available Specification (PAS) and the second is a Management Standard of the Health and Safety Executive.

PAS 2010: 2011 – Guidance on the management of psychosocial risks in the workplace

The University of Nottingham (Institute of Work Health and Organizations) sponsored the creation of PAS 1010:2011 – Guidance on the management of psychosocial risks in the workplace. Its development was facilitated by the British Standards Institution and involved the participation of a number of organizations across the European Union. Information on the development of the PAS is provided in a 2011 article by Leka *et al*. published in Safety Science (10).

[15]The AWI in the draft standard's title denotes that it is an "approved work item".

[16]The responsible technical committee is ISO/TC 283. Information on the committee's work, along with workplans, business plans, publicly viewable drafts, etc. can be viewed at https://www.iso.org/committee/4857129.html.

The overall aim of PAS 1010:2011 is to "support and promote good psychosocial risk management practices" (23). In the introductory section, PAS 1010:2011 notes that it "takes the form of guidance and recommendations" and "should not be quoted as if it were a specification". As such, it is technically not a legal document. However, it goes on to stipulate that "any user claiming compliance … is expected to be able to justify any course of action that deviates from its recommendations" (23). This suggests that like the National Standard, it can be used to perform a conformity assessment of employers who adopt the specification.

Like other standards described above, it adopts the PDCA framework and aligns its requirements with other occupational health and safety management systems, such as that of the International Labour Organization, the British Standards Institution (OHSAS), and the American National Standards Institute (ANSI). However, the PAS expands on these OHSMS by laying out a framework specifically designed for managing work-related psychosocial risks. It is intended to apply to organizations of any size and to provide guidance and recommendations to employers for developing, implementing and evaluating a PHS strategy.

Health and Safety Executive Management Standards

The Health and Safety Executive's (HSE) Management Standards are aspirational (i.e., voluntary) standards that provide practical guidance to employers that can help them allocate resources to manage six psychosocial risk factors related to the organization of work – namely, demands, control, support, relationships, role and change (24). For each of the six risk factors, the Management Standards provide a clear statement of the standard[17], followed by concise explanations of what should be happening in the organization to meet that standard (e.g., one of the items listed in the Demands standard is "people's skills and abilities are matched to the job demands") and a series of practical steps that the employer can take to achieve the standard (e.g., "develop personal work plans to ensure staff know what their job involves") (24).

In 2017, the HSE published a workbook entitled "Tackling work-related stress using the Management Standards approach" that provides step-by-step advice to employers on how to prepare for and how to conduct a risk assessment of the six risk factors, as well as how to come up with a plan once they have their results. The workbook also includes information for senior management on how to build a business case for addressing mental health in the workplace and provides a sample policy on workplace stress, as well as a template for calculating the costs associated with work-related stress, anxiety or depression. A link to this resource is also provided in Appendix 2.

European Union

The scan identified one framework focussed on addressing psychosocial risk factors in the workplace. The Psychosocial Risk Management Excellence Framework (PRIMA-EF) is part of the

[17] For example, the Management Standard for Demands is: "Employees indicate that they are able to cope with the demands of their jobs."

World Health Organization's Healthy Workplaces Framework and is led by the University of Nottingham's Institute of Work, Health and Organization (the sponsor of *PAS 2010:2011* described above). The purpose of PRIMA-EF is to provide stakeholders (workers, employers, trade unions) and other decision makers with a comprehensive best practices framework for managing psychosocial risks in the workplace (25). A number of organizations across the European Union[18] participate in PRIMA-EF activities and initiatives. The PRIMA-EF consortium has published reviews of European best practices in workplace mental health, in addition to producing a number of practical tools (e.g., guides, guidance documents, and inventories of best practice in psychosocial risk management). These tools and resources are listed in Appendix 2.

Australia

The scan identified two published documents from Australia addressing mental health in the workplace that could be considered "standards", along with six other guidance documents. A seventh document, entitled *Mad workplaces: a common sense guide for workplaces about working alongside people with 'mental illness'*, was identified in an article published in the journal Preventive Medicine (3).

The first "standard" was published by Safe Work Australia and lays out a systematic approach for employers to manage PSH in the workplace (26). The second was published by the Melbourne School of Population and Global Health (27) and sets out a series of guidelines developed using the Delphi method (28). Links to some of the guidance documents are included in Appendix 2.

Safe Work Australia National Guidance Material

This document sets out a systematic and practical approach for managing psychological health and safety in the workplace. While its core principles align with the five elements of an occupational health and safety management system, it does not explicitly reference the PDCA cycle. Rather, it uses a framework that incorporates the following three elements: preventing harm, intervening early, and supporting recovery. The purpose of the document is to provide employers with greater clarity about what they must or should do to create a psychologically healthy and safe workplace. The document describes how to: identify psychosocial hazards; assess and control risks; review control measures; support early intervention; support recovery and return to work; achieve timely, durable and safe recovery and return to work; and, overcome barriers to successful recovery. For each of these steps, the document distinguishes between legal requirements, recommended actions, optional actions, and best practices[19]. Many of the elements laid out in this document align with legislative or regulatory

[18]Organizations involved in activities related to the Framework include: the World Health Organization, the International Labour Organization, the European Commission, the European Occupational Safety and Health Agency, and others.

[19]Legal requirements are denoted by "must", "requires", or "mandatory". Recommended and optional actions are denoted by "should" and "may", respectively. Where best practices are identified, they are noted by accordingly.

requirements[20] in all Australian jurisdictions and as such, this guidance document is the closest to a "national standard" of all the international standards identified in this project.

In addition to the guidance material described above, Safe Work Australia has also published a Fact Sheet entitled "Preventing psychological injury under work health and safety laws" (29). This document provides a concise overview of why work-related PHS is important, who has primary responsibility to manage risks and prevent harm, and what is involved in a psychological risk management program. The Fact Sheet guides the employer[21] through the stages of identifying, assessing, and controlling the risks and references a series of Codes of Practice[22] that provide more detail on what they are legally required to do under the *Work Health and Safety Act*.

Melbourne School of Population and Global Health guidelines

This document, entitled Workplace Prevention of Mental Health Problems, is a concise set of guidelines that set out a series of actions that employers can take to prevent work-related psychological injury. They were developed through a Delphi expert consensus research study that involved a systematic review, the development of a 363-item survey, and consultation with experts in the employer, health professional and worker communities (28). The guidelines[23], which are intended to complement existing legislative frameworks, provide information on how to: create and implement a mental health and wellbeing strategy; develop a positive work environment; reduce job strain by balancing job demands with job control; reward employee efforts and provide feedback on performance; foster a climate of workplace fairness; provide appropriate workplace supports; implement supportive change management processes during times of organizational or individual role change; develop leadership and management skills; provide workplace mental health education and training to workers, managers and supervisors; and communicate employee responsibilities for promoting their own mental health (27).

[20]Workers' compensation law and work health and safety laws apply. Under Australia's *Work Health and Safety Act*, health is defined to include both physical and psychological health.

[21]Defined as a "person conducting a business or undertaking (PBCU)" under the *Work Health and Safety Act*.

[22]Links to the complete list of Model Codes of Practice can be found at: https://www.safeworkaustralia.gov.au/resources-publications/model-codes-of-practice.

[23]The article by Reavley *et al*., which was published in Mental Health & Prevention, notes that a total of 314 strategies were endorsed as "essential or important by at least 80% of all three panels".

PART 4 – THE EXPERIENCE OF CANADIAN EMPLOYERS IN IMPLEMENTING THE NATIONAL STANDARD

Several reports and peer-reviewed article have been published that discuss or describe the experience of Canadian employers in implementing the National Standard (1, 4-9). The most comprehensive examination of employer experience with the National Standard was undertaken by the Centre for Applied Research in Mental Health and Addiction (CARMHA) in the 3-year period immediately following the launch of the National Standard (1, 4). In addition to this large case study, two smaller qualitative studies have been carried out by researchers in Ontario and Québec to examine employers' perceptions about and response to the National Standard (7, 9). The Mental Health Commission of Canada (MHCC) has also recently reported findings of a 1-year follow-up study to examine how well employers who participated in the 3-year study are doing at sustaining their commitment to implementing the National Standard (5). The MHCC has used the findings of the various studies it has commissioned to generate a list of promising practices; and, develop tools and resources to enhance adoption of the National Standard across Canada. These are available on their website and links to some are provided in Appendix 2.

Case study on the implementation of the National Standard

In 2014, following the introduction of the National Standard, the Mental Health Commission of Canada initiated a 3-year research project to gain a better understanding of the experience of workplaces across Canada in implementing the National Standard (1). Its goals were to:

- monitor the progress of participating organizations at implementing the National Standard
- identify the challenges and barriers to implementation, as well as the facilitators of success
- generate a list of promising practices, and
- develop tools and resources to enhance adoption of the National Standard across Canada.

The project was carried out by researchers at the Centre for Applied Research in Mental Health and Addiction at Simon Fraser University in British Columbia.

Background on the case study

The MHCC issued a Call for Interest in September 2013 to identify organizations and employers interested in participating in the project. Participating organizations were asked to complete an Affiliation Agreement to participate, in which they committed to:

- implement the National Standard, either fully or partially, by the end of the 3-year period
- nominate a champion within the organization and provide dedicated resources to assist him/her to carry out the implementation of the National Standard
- work collaboratively with the MHCC and the research team throughout the project
- share their data and experience of implementation.

Using a formative research methodology that focussed on the process of change rather than the outcome, the research team tracked participating organizations' experiences, progress and improvement across the five elements of the National Standard (commitment and policy,

planning, implementation, evaluation and corrective action, and management review). Data were collected at three stages of the project (baseline, interim and final) via a unique set of assessment qualitative and quantitative measures created specifically for the project (see Table 3). The measures were designed to allow for ongoing feedback, refinement and innovation.

The research team assessed participating organizations at the outset of the project to determine their baseline or "starting point". At this stage, participating organizations received the Organizational Review (OR), Implementation Questionnaire (IQ), and Implementation Interview (II) measurement tools. Results from these assessments were synthesized into a confidential feedback report and distributed to each organization, thereby providing them with a qualitative and quantitative description of their starting point in the project. At the interim assessment phase, the IQ and II were repeated and organizations were encouraged to complete the Psychological Health Awareness Survey for Employees (PHASE). Results of these assessments were again synthesized into a confidential feedback report and distributed to each organization.

Table 3: Assessment measures for the MHCC case study research project (1)

Instrument	Description	When completed
Implementation Questionnaire (IQ)	• quantitative and qualitative assessment of organizational perceptions of implementation • online survey, completed by Key Informant (KI) with input from other organizational personnel as needed	baseline, interim, final
Organizational Review (OR)	• planning tool used to identify and describe key organizational indicators, risk factors, policies, programs and practices related to workplace psychological health • completed by the KI with input from other organizational personnel as needed	baseline
Psychological Health Awareness Survey for Employees (PHASE)	• brief and confidential online employee survey to assess knowledge and perceptions of workplace PHS in organizations implementing the National Standard • participation was voluntary, but strongly encouraged	interim, final
Implementation Interview (II)	• structured telephone interview with the KI • questions designed to gain a detailed understanding of the organization's progress on implementation • questions customized for each phase of the project to reflect progress to date	baseline, interim, final
Organizational Champion Questionnaire (OCQ)	• confidential questionnaire specifically designed for the Organizational Champion (OC) of each participating organization • documents OC's perspective on progress made in adopting Standard and enhancing organization's PHS	final
Exit Interview (EI) (see Note 1)	• semi-structured phone interview • conducted with KI or OC from organizations who chose to discontinue participation in the project	interim, final

Notes

1. Some organizations chose to discontinue participation in the research project. The purpose of the EI was to gain an understanding of their reasons for doing so.

Participating organizations

Forty-three organizations responded to the MHCC's Call for Interest and completed the Affiliation Agreement. Organizations from 7 provinces[24] participated, with the largest proportion of participants coming from Ontario and Nova Scotia. None of the participating organizations were from Newfoundland and Labrador. Thirteen organizations had a national reach and some of these indicated their intent to implement the National Standard across multiple locations and jurisdictions.

Of the 43 organizations participating at baseline:

- 10 were unionized, 19 were mixed, 14 were non-unionized
- 30 were public, 8 were for profit, 5 were not-for-profit
- 12 were small businesses (1-99 employees), 3 were medium-sized (100-500 employees) and 28 were large businesses (>500 employees)
- 12 were local/regional, 18 were provincial, and 13 were national

Of the 41 organizations still participating at the interim phase[25]:

- 19 were from the health sector
- 4 were from the government sector;
- 6 were from the finance and housing sectors (3 organizations from each sector)
- 8 were from the telecommunications, education, health promotion and support sectors (2 organizations from each sector)
- 4 from the oil and gas, transportation, immigration services and law sectors (1 organization from each sector)

Forty organizations[26], from 11 different sectors, participated in the project for its entire duration (see Table 4). They represented a diverse cross-section of jurisdictions, industries, sectors, size[27], and union presence. Of the 40 organizations that completed the project, the majority (n=34) had committed to full implementation of the National Standard and 6 had committed to partial implementation of the National Standard.

[24]Provinces represented in the project were: British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Québec and Nova Scotia.

[25]Forty-three organizations began the project. Two organizations dropped out by the interim phase – both were large, regional and part of the public sector with multi-union workforces. Analysis of the exit interview data revealed that both organizations were committed to addressing workplace PHS but faced internal and external impediments to participation (including, but not limited to, unexpected and imminent changes in provincial legislation, major labour action, lack of resources).

[26]One organization from the housing sector dropped out between the interim and final assessment phases.

[27]The smallest organization was a law firm with 11 potentially impacted employees. The largest was a provincial health services organization with over 100,000 potentially impacted employees.

Table 4: List of 40 organizations that remained in the MHCC case study until completion

Name of organization	Jurisdiction	Industry/Sector	Implementation	# of employees
AGS Rehab Solutions Inc.	Ontario	Health	Full	49
Alberta Health Services	Alberta	Health	Full	100,000
The Alberta New Home Warranty Program	Alberta	Housing	Full	50
Bernardi Law	Ontario	Law	Full	11
Bell Canada	Québec	Telecommunications	Partial	36,000
Belmont Health & Wealth	Nova Scotia	Finance	Full	30
Canadian Centre for Occupational Health and Safety	Ontario	Health	Full	84
Canadian Mental Health Association Toronto	Ontario	Health	Full	300
Canadian Security Intelligence Service	Ontario	Government	Full	3,400
Carleton University	Ontario	Education	Full	2,000
County of Frontenac	Ontario	Government	Full	400
Douglas Mental Health University Institute	Québec	Health	Full	1,158
Enbridge Gas Distribution	Ontario	Oil and gas	Full	2,300
Garden City Family Health Team	Ontario	Health	Full	53
Great-West Life	Manitoba	Finance	Full	11,000
Haliburton, Kawartha, Pine Ridge District Health Unit	Ontario	Health	Full	2,300
Health Association of Nova Scotia	Nova Scotia	Health	Full	100
Immigrant Services Association of Nova Scotia	Nova Scotia	Immigration services	Full	112
Lakeridge Health	Ontario	Health	Full	5,288
Manitoba Health, Healthy Living and Seniors	Manitoba	Health	Full	2,100
Manulife	Ontario	Finance	Partial	750
Mount Sinai Hospital	Ontario	Health	Full	4,500
Nova Scotia Health Authority – Cape Breton District Health Authority Pilot Site	Nova Scotia	Health	Full	60
Nova Scotia Health Authority – Capital District Health Authority Pilot Site	Nova Scotia	Health	Full	11,000
Nova Scotia Government and General Employees Union	Nova Scotia	Health promotion/support	Full	60

Name of organization	Jurisdiction	Industry/Sector	Implementation	# of employees
Ontario Shores Centre for Mental Health Sciences	Ontario	Health	Full	1,200
Pickering Public Library	Ontario	Education	Partial	64
Provincial Health Services Authority	British Columbia	Health	Partial	4,000
Province of Nova Scotia	Nova Scotia	Government	Full	11,000
RCMP – Division C	Québec	Government	Partial	1,300
Real Estate Board of Greater Vancouver	British Columbia	Housing	Full	75
Regional Municipality of York	Ontario	Government	Full	3,000
Region of Peel	Ontario	Government	Full	5,500
Regina Mental Health Clinic	Saskatchewan	Health	Full	60
Rogers Communication	Ontario	Telecommunications	Full	29,300
The Royal Ottawa HealthCare Group	Ontario	Health	Full	1,500
The Scarborough Hospital	Ontario	Health	Full	3,100
Toronto East General Hospital	Ontario	Health	Full	2,500
Unifor	Ontario	Health promotion/support	Full	500
Via Rail	Québec	Transportation	Partial	400

Key findings

In the final report on the project (1), the researchers grouped their key findings under four main themes: progress employers had made in implementing the National Standard over the 3-year period, their reasons for implementing the National Standard, the data sources they used to assess psychological health and measure compliance with the National Standard, and the top actions they had taken to address psychological health and safety. Results are presented below, along with figures copied from the MHCC final report.

1. **Progress made in implementing the National Standard.** Figure 3, below, shows aggregate achievement scores received by employers who participated in the study. Results are displayed for their overall achievement score and by each of the five individual elements of the National Standard at baseline, at the interim phase, and at project completion. What can be seen is that for each element and for all elements combined (i.e., the overall score), employers' conformance with the requirements of the National Standard tended to improve over the course of the project. Participants scored relatively high (63%, on average) at baseline in each of the first three elements (i.e., 60%, 61% and 68% compliance with the leadership, planning, and implementation requirements, respectively) and their scores

steadily improved over the duration of the project[28]. The two elements in which they scored consistently below 60% compliance were evaluation and corrective action, and management review – although improvement was seen over the 3-year duration of the project. As the figure illustrates, the average score on these two elements at baseline was 41%, increasing to 58.5% at project end. Overall compliance with the five elements of the National Standard at the end of the project was 75% *vs*. 55% compliance at baseline.

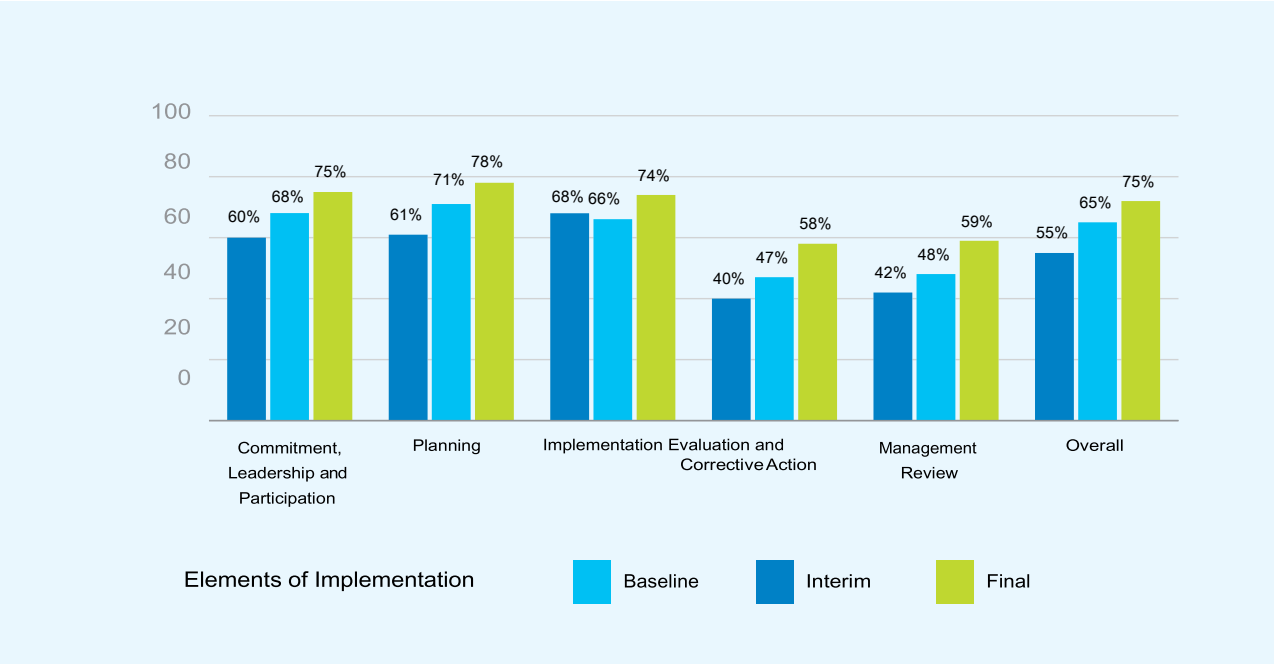


Figure 3: Aggregate achievement scores on the 5 elements of the National Standard [Source: MHCC (1)]

2. **Reasons employers reported for implementing the National Standard.** Figure 4, below, displays the various reasons employers gave for implementing the National Standard and shows the proportion of employers who selected a particular reason at baseline *vs*. at project completion. Options included: reduce liability, manage costs, enhance reputation, increase engagement, do the right thing, and protect health. As can be seen from the figure, the top two reasons given by participating organizations at completion were: "it was the right thing to do" (91%) and "to protect the psychological health of employees" (84%). As the researchers note in the report, minimizing financial and legal risks were not the primary motivations for organizations to implement the National Standard. Only 41% and 47% of participants at completion respectively cited "reducing liability" and "managing costs" as reasons to implement the National Standard. At baseline, 73% of the participants chose "enhance reputation"; but that dropped to 63% at completion. There was essentially no difference between baseline and completion for employers who said they wanted to increase engagement (73% *vs*. 72%). It is interesting to note that for options "do the right thing" and "protect health", only the former showed an increase over the course of the

[28]Compliance with the implementation requirements dipped at the interim phase to 66% but climbed to 74% by completion.

project. The proportion of employers who selected "protect health" as their motivation for implementing the National Standard dropped from 90% at baseline to 84% at completion. The researchers do not draw any conclusions about what might have motivated that change.

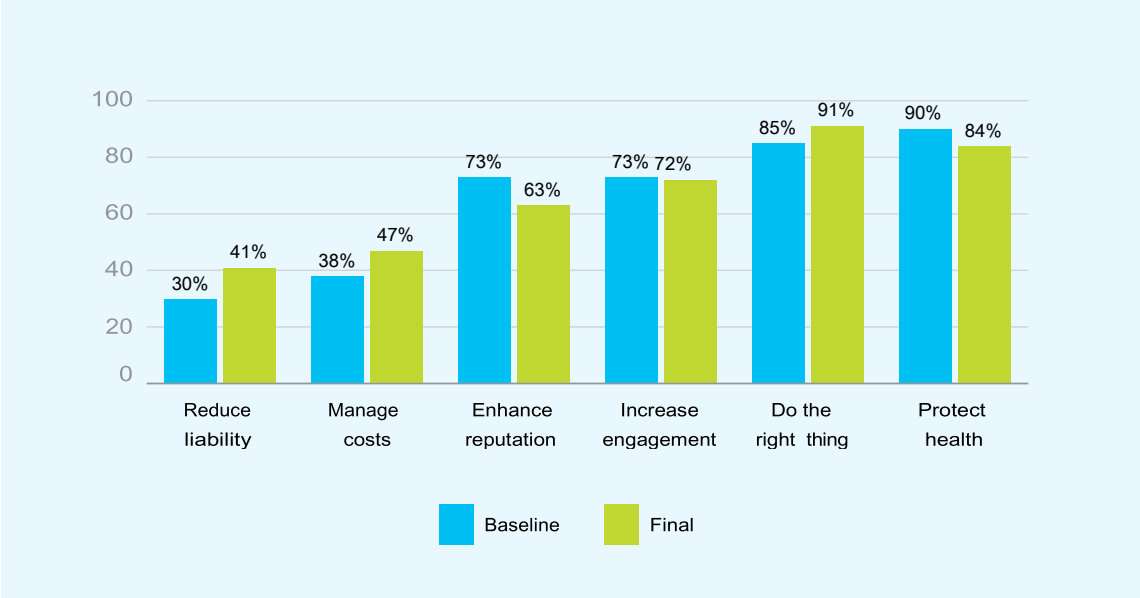


Figure 4: Reasons reported for implementing the standard [Source: MHCC (1)]

3. **Data sources used to assess psychological health and to measure compliance with the National Standard.** Figure 5 presents what the researchers found regarding participants' reported use of data to assess the psychological health of their employees and to inform their efforts to identify hazards, risks and root causes of worker concerns. As the figure indicates, participating organizations reported using the following sources of data: employee assistance program utilization rates[29] (73%), return-to-work and accommodation data[30] (68%), and long-/short-term disability rates[31] (66%). Organizations also reported a significant increase in the use of incident reports (54%); psychological health risk assessments, using tools like the GuardingMinds@Work Employee Survey (37%); and, disability relapse rates (29%). Note that these percentages are not shown in the figure.

[29] According to the Final Report, these data provide "information about levels of perceived need by workers regarding psychological health and safety issues and about employees' willingness to utilize available resources".

[30] As noted in the Final Report, these data include "indices such as frequency of return to work, types of accommodation measures provided, etc."

[31] The Final Report notes that these are "rich sources of information, particularly when broken down by psychological *vs*. physical cause (which is far more commonly accessible for LTD data than for STD data). Due to specificity in identifiable causation, LTD data give a clearer picture of the psychological health and safety within organizations."

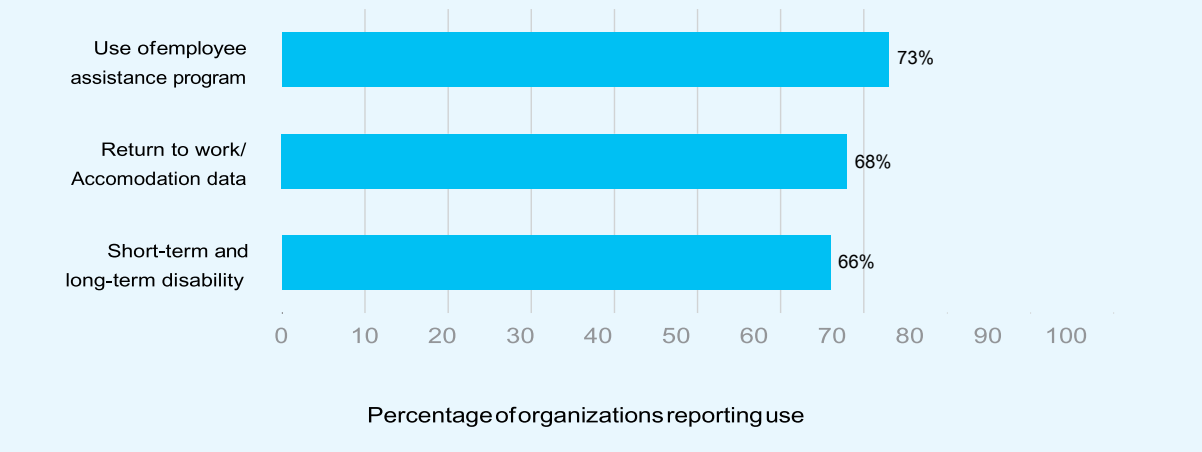


Figure 5: Most frequently used sources of data [Source: MHCC (1)]

4. **Top actions taken to address psychological health and safety.** Figure 6 illustrates the top six actions undertaken by participating organizations to address psychological health and safety and to implement the National Standard and the percentage of organizations who had undertaken them. The six actions were: enacting a respectful workplace policy and implementing educational initiatives (78% of participating organizations); providing early intervention through Employee and Family Assistance Programs (EFAP) tailored towards mental health promotion (70%); raising awareness and enhancing mental health knowledge in the workplace (66%); building employee resilience to cope effectively, to overcome adversity, and to thrive under ongoing pressure (61%); supporting stay-at-work and sustainable return-to-work programs for employees with psychological health issues (59%); and training managers about mental health to give them the skills and knowledge they need to appropriately respond to psychological hazards in the workplace (59%).

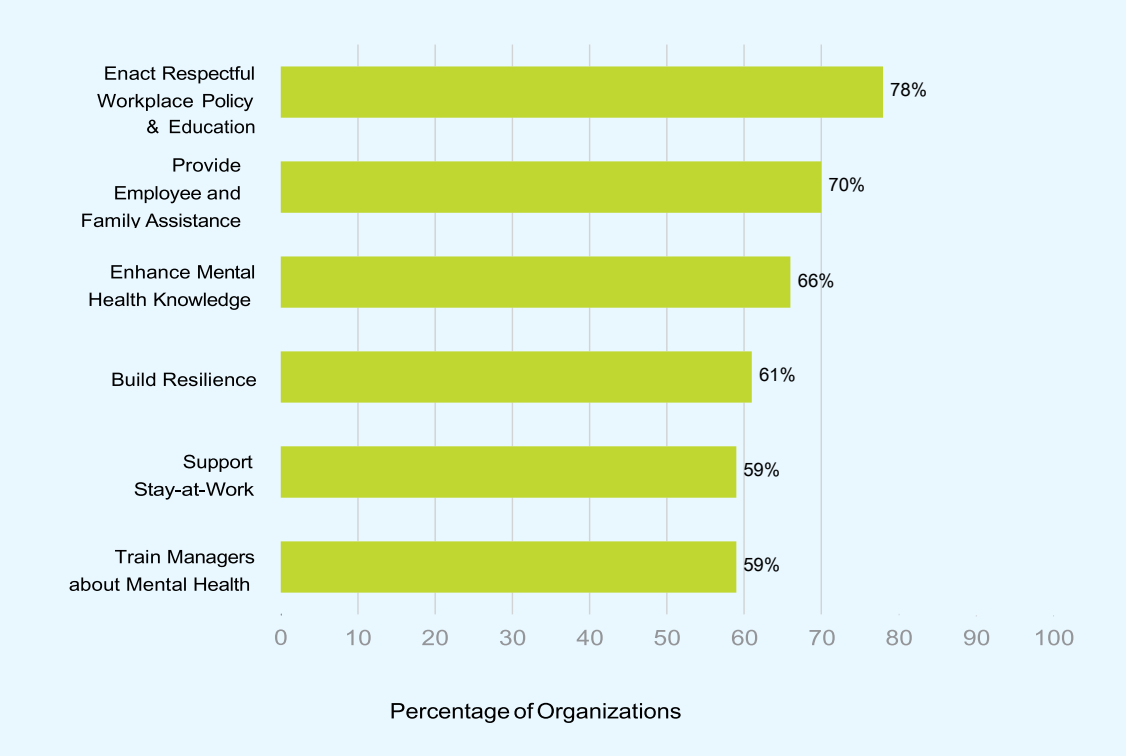


Figure 6: Top six actions taken to address psychological health and safety [Source: MHCC (1)]

Factors that facilitated an organization's ability to successfully implement the National Standard

The following factors emerged as the most important facilitators of success (1).

1. **Leadership support and involvement.** Successful implementation of the National Standard required transformational leadership and demonstrated alignment between workplace psychological health and safety and the organization's "fundamental purpose, goals, visions and values". The most successful organizations had actively involved champions.
2. **Adequate structure and resources.** Successful implementation of the National Standard required adequate financial and human support to those responsible for leading the initiative. This included: the capacity to use existing or to create new structures, delegated participants (who were able to commit the time to the project), and a flexible budget allocation (that factored in fluctuations in the intensity of activity and in the timing of expenditures).
3. **Size of the organization.** The size of the organization was identified as a factor that could either facilitate or impede success. Large organizations might be better resourced but could be more resistant to change and unwieldy to navigate. In contrast, while smaller organizations could be more connected and more nimble than their larger counterparts, they often lacked the human/financial/data resources required.

4. **Awareness of psychological health.** Many of the successful organizations were reported to have a relatively high level of literacy around workplace mental health[32] at both the organizational and individual level. The researchers note the importance that organizational awareness efforts be "authentic and recognize the value of a psychologically safe workplace".
5. **Existing processes, policies and programs to support PHS.** At baseline, all of the organizations had some organizational supports in place that demonstrated that workplace mental health was considered a priority. Examples included: an EFAP, enhanced disability management programs, or bullying/harassment protocols. However, the researchers noted that there is an important distinction between having a program and having a program *that demonstrably makes a difference*.
6. **Previous experience with implementing standards.** Previous and successful experience in implementing standards[33], recognition programs or other corporate initiatives[34] similar to the National Standard was a predictor of success in implementing the National Standard, as was experience with having to meet relevant legislation and regulations.
7. **Connection.** Successful implementation was also influenced by the extent to which organizations could connect with other organizations, establish communities of practice, or form strategic partnerships to share promising practices and discuss the barriers they had encountered during implementation.

Factors that impeded an organization's ability to successfully implement the National Standard

The following factors emerged as the most important barriers to implementation (1).

1. **Limited access to psychological health data.** Although organizations generally collected or had access to data (such as absenteeism and disability absence rates), the indicators often did not allow for a distinction to be made psychological and physical health outcomes. The researchers identified several possible reasons for the data challenges observed, including: the size of the organization, confidentiality concerns, and the possibility that psychological health information may not have been previously collected.
2. **Inconsistent leadership support.** Where there was limited (or no) leadership support or where it was hard to get uptake around the senior executive table, organizations found it hard to secure the necessary resources or to motivate action.
3. **Significant organizational change.** Any type of organizational change that has an impact on human or financial resource allocation and/or changes organizational priorities or organizational culture negatively impacts the success of implementation. Examples identified in the report included: mergers or an organizational redesign.
4. **Lack of evidence regarding employee knowledge about PHS.** The National Standard requires that efforts be made to raise employee awareness and improve literacy around

[32]The researchers noted that a reason for this may be that "their mandate is to provide mental health care or because their organization has made a public commitment to raising awareness and addressing mental health issues".

[33]For example, ISO 14000 and OHSAS 18000.

[34]For example, the Healthy Enterprise Standard in Québec, the American Psychological Association's Psychologically Healthy Workplace Awards and Canada's Mental Health at Work program.

mental health in the workplace. The lack of a mechanism to track employee knowledge was identified as a serious impediment to complying with this requirement.

5. **Inconsistent data collection.** The study found that a lack of standardization within "large and relatively complex organizations" in how they collect and code data created challenges for merging datasets or comparing data.
6. **Inadequate resources.** Some organizations found it challenging to dedicate adequate resources to all stages the project. Some of the reasons given included: lack of human and financial resources, redeployment of key participants, and issues with data or information access.
7. **Uncertainty in defining and reporting certain terms (e.g., "excessive stress", "critical events").** Some organizations experienced challenges with terminology and expressed concern over how to define terms like "excessive stress" and how to distinguish "critical incidents" from stressful situations that are just part of the job or work setting.

Promising practices that will enhance employers' ability to implement the National Standard

The following activities emerged as the most promising practices for the successful implementation of the National Standard (1).

1. **Define a business case.** The researchers concluded that an employer's decision to adopt the National Standard must be based on a solid business case that justifies investing the necessary resources and that accounts for the opportunity cost of projects or initiatives that won't be undertaken because resources are directed to the implementation of the National Standard.
2. **Ensure commitment throughout the organization.** Organizations demonstrating the greatest implementation success typically had: management and worker representatives[35] who were "actively and visibly involved" throughout implementation, as well as transformational leaders[36] whose behaviour demonstrated ongoing commitment to the project.
3. **Communicate widely and effectively.** Bi-directional (i.e., top-down[37] and bottom-up[38]) communication was found to be critical to the successful implementation of the National Standard. The communication strategy should be plain language and must ensure that everyone understands what the organization is doing and why. The report notes that "clear and ongoing communication … demonstrates leadership commitment and engagement".
4. **Build a culture of PHS in the workplace.** Organizations who successfully implemented the National Standard reported that their success depended on embedding psychological health and safety into the overall culture of the organization.
5. **Ensure adequate resources for implementation:** Successful implementation of the National Standard depends on adequate resourcing (i.e., time and funding) to support the key

[35] In unionized workplaces, this included involvement of informed labour representatives.

[36] The report notes that leadership came not only from senior management but was often demonstrated by other members of the organization, including middle managers, union officials or respected front-line staff.

[37] Communication from management to employees serves to increase knowledge utilization and demonstrates commitment.

[38] Communication from employees to management serves to provide feedback on particular programs and policies and to facilitate staff involvement.

personnel responsible. Participating organizations reported variations in the resources required over the project. Initial investments focussed on "preparation and education of key personnel", while later investments were directed toward "new programs, communication events or staff training".

6. **Select the best actions for organization.** The risk identification and mitigation framework laid out by the National Standard is not prescriptive. That is, it allows organizations to select and implement actions (i.e., programs, practices and policies) that are *suitable and relevant* to their context. The researchers concluded that "organizations will maximize the quality of their actions and achieve the best outcomes" through careful consideration and selection of suitable actions. Suggested approaches include: establishing clear protocols to identify and manage psychological risks; selecting programs, practices and policies based on identified needs and risks; incorporating "evidence derived from research and best practice reviews" into action plans; and, customizing actions and tailoring interventions to the "unique needs and characteristics of the workplace".
7. **Consider PHS in times of change.** Organizations can improve the likelihood of successful implementation by determining their readiness for change[39] *before starting the implementation process*. The study found that, over the 3-year project, most participants experienced organizational change and that, in many cases, PHS was not well integrated into organizational change processes. The report notes that in some cases, these changes were substantive (e.g., mergers, downsizing) and impeded implementation.
8. **Measure the impact of implementing the National Standard.** Developing and utilizing a "targeted evaluation strategy" will foster an organization's ability to evaluate conformance with the National Standard and to make any necessary adjustments. Many organizations participating in the project found it difficult measure change, despite understanding that this was a key requirement of the National Standard. The researchers recommended that organizations: determine *at the outset* what they are going to measure and how frequently they will collect data; identify indicators that are *specific to psychological health and safety*; be innovative and find ways to distinguish between psychological *vs*. physical health and safety indicators; appropriately match indicators with interventions (both upstream and downstream[40]); have dedicated capacity for analyzing indicator data[41]; adopt and implement a process of *ongoing* continual improvement.
9. **Sustain implementation efforts**. The researchers recommended that to sustain implementation efforts over the long term, organizations should: embed PHS into the "organizational fabric", ensure succession planning "when a champion leaves an

[39]The researchers suggest that organizations pose the following questions: "Is this the right time to initiate this change? Does the organization have the requisite knowledge and resources? Is this change consistent with the values and priorities of the organization?" Page 25 of the report sets out the four questions that one of the participating organizations developed to assess its own readiness for change.

[40]According to the report, "upstream indicators show a need for psychological health promotion and downstream indicators show a need for programs targeting employees experiencing psychological health challenges". The authors use resilience training as an example of an upstream initiative (which would require an "upstream indicator sensitive to change, such as demonstrating the ability to use resilient coping skills in a crisis"). The authors use a disability management program as an example of a downstream initiative and note that an indicator to examine its impact would be duration of lost time.

[41]Specifically, this includes personnel with the authority, capacity *and* knowledge.

organization or takes on a new role", form partnerships and create communities of practice, identify and collaborate with key stakeholders.

A cross-case analysis examining the experience of employers in the healthcare sector

The researchers who conducted the case study described above performed an additional analysis of the data to specifically determine the experience of employers in the healthcare sector, compared to a control group (also drawn from the case study) of non-healthcare employers (4). The two questions that the researchers sought to answer were whether healthcare organizations had any unique characteristics when it came to implementation and whether the findings supported the development of tools and resources specifically tailored to assist healthcare organizations with implementation.

Key findings

- Compared to non-healthcare organizations: the healthcare sector has unique strengths and faces unique challenges in implementation; healthcare organizations demonstrated better progress in implementing the National Standard;
- There was considerable variability across the sector in progress made and the strategy chosen (i.e., phased vs. full roll-out). The researchers conclude that this variability suggests "different levels of organizational readiness for the change"
- There were "notably low levels of employee knowledge and confidence" about "organizational programs and policies related to Standard implementation"
- Healthcare organizations are similar to non-healthcare organizations in that they also have limited access to psychological health and safety indicators

Based on their findings, the researchers made the following recommendations: customized resources (i.e., specific to the context of healthcare) should be developed to support implementation of the National Standard in the healthcare sector; any plan to implement the National Standard in the healthcare sector should incorporate an assessment of organizational readiness for change, using context-specific tools or resources; healthcare organizations should use context-specific tools or resources to measure employee knowledge and confidence; a collaborative task force should be initiated to identify best practices for accessing and utilizing PHS indicator data; and healthcare organizations that have successfully implemented the National Standard should be engaged to mentor other organizations across the country.

Follow-up study of organizations that had participated in the MHCC case study

The MHCC sponsored a 1-year follow-up study to examine how well organizations that had participated in the case study had sustained their implementation efforts with the support they received from the project team and MHCC over the 3-year research project. Between Spring 2016 and Spring 2017, twenty five of the forty participants who completed the original study were followed up to evaluate how sustainable their progress had been over the 1-year period, to identify organizational factors that promoted sustainable efforts, and to develop

recommendations for other organizations regarding the factors influencing successful and sustainable implementation of the National Standard (5).

Key findings

The key finding of the study was that participating organizations experienced variable success in implementation. According to the report, "21% of the organizations showed further progress, 33% regressed and 46% remained the same". All organizations reported "positive psychosocial safety climate", with organizational participation[42] being an important predictor of progress. The report notes: "Organizational participation captures a critical aspect of organizational culture that is important to address psychological health and safety in the workplace. In other words, the greater the degree of employee participation, the greater the likelihood that an organization will sustain or improve its implementation success. This reinforces the importance of ensuring that organizations continue to actively engage employees in the all aspects of the Psychological Health and Safety Management System outlined in the *Standard*."

Based on their findings, the researchers conclude "successful implementation of the *Standard* calls for organizational change and such change takes time". Recommendations arising from this study that are relevant to WorkplaceNL's strategic focus on psychological health and safety and specifically to the successful – and sustained – implementation of the National Standard in Newfoundland workplaces are reprinted verbatim below:

- Tools that measure and enhance employee awareness, trust and participation are particularly relevant to sustained implementation success.
- Organizational commitment to implementation of the Standard should be regularly reviewed and communicated to staff.
- Organizations should engage in succession planning to ensure that necessary resources, personnel and leadership are in place to sustain progress.
- Routinization of programs, policies and practices identified by the Standard will enhance sustainment.
- Careful evaluation of actions intended to address workplace psychological health and safety should be used to determine whether they are continued, modified or dropped.

Source: MHCC, October 2017

Other research on Canadian employers' experience implementing the National Standard

Sheikh *et al.* (2018)

A 2018 article published in the Canadian Journal of Psychiatry reported on a cross-sectional survey of Canadian employers undertaken to estimate the percentage who were aware of the National Standard, to determine the extent of implementation, and to identify and describe the

[42]Organizational participation is one of the factors of a psychosocial safety climate. In the report, it was defined as "inclusion of and consultation with employees, unions, and health and safety representatives in how workplace psychological health and safety is organized with attention paid to prevention and promotion of mental health at all levels of the organization".

impediments they perceived to implementation (30). Telephone interviews were conducted with representatives from a random sample of 1010 companies in which they were asked questions about their awareness of the National Standard, implementation, and what they perceived to be the impacts of the National Standard and the barriers to implementation.

Key findings

- 17.0% of the participants reported awareness of the National Standard
- 1.7% of the participants reported that their organizations had implemented the National Standard in its entirety *vs*. 20.3% who reported they had implemented parts of the National Standard
- 71.4% of participants believed their organizations would implement elements of the National Standard within the next year.
- Respondents reported: increased job satisfaction and employee retention as perceived benefits of implementation, while indicating that the belief that workplace psychological health and safety is irrelevant is the greatest barrier to implementation.
- The researchers concluded that while many Canadian employers are still unaware of the National Standard's existence, most are favourably inclined toward the National Standard because of its potential benefits.

Kunyk *et al.* (2016)

A qualitative study published in 2016 sought to determine whether employers in a range of industries were organizationally receptive to the National Standard (7). Five focus groups were carried out in November 2013 with seventeen individuals from the following sectors: healthcare, construction, utilities, manufacturing, business services and finance. Participants worked in a range of occupations (including management, human resources, health promotion, occupational health and safety) and for organizations ranging in size from 20 to 100,000 employees.

Key findings

- Participants agreed that the National Standard was important and that unless psychological health and safety is addressed in a meaningful way, there would not be any substantive impact on mental health in the workplace.
- Overall, there was a positive response to the existence of the National Standard, which was described as a “resource that could provide direction, tools, and guidance to address psychosocial elements in the workplace”.
- Participants identified a number of factors that influence psychological health and safety in the workplace, including organizational culture, size of the organization, communication, leadership and commitment.
- Organizational challenges and barriers to implementation identified included the following: stigma, lack of knowledge, under-utilization of existing resources (such as employee assistance programs), lack of mechanisms to support leadership and to develop awareness/understanding, how work is organized (e.g., remote sites, shiftwork,

management hierarchy) the sheer volume of information in the National Standard, resistance to increased workload and the need for tracking of information.
- There was some confusion about the apparent contradiction between the terms "voluntary" and "standard" – and some participants noted that it being voluntary created a bit of a barrier to implementation (i.e., the necessary resourcing would be more likely made available if it were mandatory).
- Organizational facilitators of success identified included the following: leadership throughout the organization, appropriate levels of resourcing, clear articulation of the added value and benefits of complying with the National Standard (i.e., making the business case), simplifying the language of the National Standard into a step-by-step guide, planning and implementing the National Standard in stages rather than having full roll-out, aligning implementation with existing management strategies and organizational structures or incorporating elements into other existing certification programs (such as the Certificate of Recognition program).

Kalef *et al.* (2015)

A qualitative study published in 2015 interviewed 10 employers from large, medium and small workplaces in Montreal and Toronto to determine their perspectives on the National Standard (9). Participants were recruited by contacting organizations who had attended webinars offered by the Mental Health Commission of Canada and through word of mouth.

Key findings

- Participants reported limited awareness of the National Standard. For example, 5 of the 10 employers reported having limited information (n=3) or not being well-informed about the Standard (n=2).
- Participants recognized that the National Standard had the potential for positive impact and to create far-reaching benefits in the workplace (e.g., improved morale and work environment, increased work productivity, reduced stress and employee turnover, decreased prevalence of mental health issues).
- Participants shared the view that employers need assistance to implement the National Standard and that the Standard itself could act as a toolkit to guide initiatives on psychological health and safety in the workplace.
- Participants identified a number of initiatives already in place within their organizations that give them the foundation to build on for implementation (examples included: employee assistance programs, health benefits, wellness programs).
- Participants emphasized that the success of implementation hinges on leadership commitment and buy-in, empowerment, training, communication and tailoring the implementation to the conditions/environment/organizational needs of the individual workplace.
- Participants identified the following challenges and barriers to implementation: atypical working environments, organizational size, competing workplace priorities, absence of commitment from leadership, and perceptions that workers may take advantage of the system.

The experience of other jurisdictions

Information is scarce on the implementation of workplace mental health guidelines in other jurisdictions. The lack of information regarding implementation and the effectiveness of these guidelines has been flagged as an information gap and a research need by authors of four recent publications (10-13).

The scan identified one article published in 2011 that examined the implementation of the Management Standards on work-related stress in the United Kingdom. The findings echoed the experience of Canadian employers and identified similar barriers and facilitators. The main factors supporting the implementation of the Management Standards for work-related stress included: active and visible support from organizational leadership (which included senior management, human resource departments, and line managers); regular communication; sufficient organizational capacity (in terms of both expertise, human and financial resources); phased *vs*. full roll-out (i.e., assessment by departments and teams *vs*. corporate wide assessment); and, involvement of key stakeholders. The main barriers and impediments to implementation included: major or on-going change at the organizational level; lack of organizational capacity; and, resource-intensive data collection requirements. (14)

PART 5 – SUMMARY OF THE FINDINGS

Standards on psychological health and safety in the workplace

The scan identified three Canadian standards and six international standards/guidelines that explicitly address the topic of psychological health and safety in the workplace. To date, the Canadian standard is the only one that has been adopted or enacted as a national standard. An international voluntary standard, based on the Canadian standard, is currently in the early stages of development by the International Organization for Standardization (ISO). The National Standard is reportedly also undergoing review and being updated.

In 2018, the CSA Group launched a second psychological health and safety standard – specifically for paramedic organizations – that builds on the National Standard. In addition to the inclusion of paramedic-specific requirements that go beyond the core requirements of the National Standard, one of the key areas of difference in the new standard is that it provides much more comprehensive introductory and explanatory sections. The other key difference is the inclusion of two new factors in the list of workplace factors – namely, "other chronic stressors as identified by workers" and "cumulative exposure to critical or stressful events". The inclusion of the wording "as identified by workers" is a notable difference between the new standard and the National Standard and suggests that, in developing the new standard, the CSA Group was being responsive to the concerns of workers.

Employer experience of implementing the National Standard

The scan identified a number of research reports published online, as well as articles published in the peer-reviewed literature, that examined the experience of Canadian employers at implementing the National Standard. No organizations from Newfoundland and Labrador participated in the published research studies. All of the studies conducted to date have focussed on the barriers and facilitators to implementation and all have relied on self-assessments and self-reports. No systematic evaluations have been undertaken to examine whether the National Standard is effective at improving psychological health and safety outcomes or whether the self-reported assessments are valid and reliable. The lack of a tested audit tool for measuring conformance with the National Standard's requirements is problematic.

Information is scarce on the implementation of workplace mental health guidelines in other jurisdictions. As noted elsewhere in this report, the lack of information regarding implementation and the effectiveness of these guidelines has been flagged as an information gap and a research need by authors of four recent publications (10-13).

Brief responses to the five questions posed by WorkplaceNL

1. Is there research or other documentation related to the implementation of CAN/CSA Z1003-13/BNQ 9700-803/2013 in Canadian workplaces and the outcomes or impacts of this implementation? Similarly, is there research or other documentation related to the implementation of similar standards in other jurisdictions?

   Part 4 of the report provides an in-depth response to this question. In Canada, research has been done by the Mental Health Commission of Canada and others to explore the factors that influence whether or not an organization achieves success in implementing the National Standard. The findings of these research projects have been published in reports that are available online and in articles published in the peer-reviewed literature. To date, all of the studies have focussed on barriers and facilitators to implementation. None have examined whether the National Standard specifically – or psychological health and safety management systems more generally – are effective at improving psychological health and safety outcomes in the workplace. As noted in Part 4, little research has been done on the implementation of similar standards and guidelines in other jurisdictions. The scan identified one publication in the peer-reviewed literature that had examined the implementation of the Management Standards on work-related stress in the United Kingdom.

2. Are there industry best practices for psychological health and safety in Canada?

   Appendix 2 of the report provides a list of resources and best practices from Canada and other jurisdictions with similar standards. This list was compiled based on the findings of a systematic review of international guidelines published in 2017 which assessed the quality of existing guidelines and evaluated the comprehensiveness of the recommendations provided in these guidelines. Appendix 2 also provides a very high-level overview of how the systematic review was undertaken.

3. What prevention strategies do sample employer representatives think should be utilized to prevent psychological injury and illness?

   The scan did not seek to specifically answer this question. From the findings of the various research studies described in Part 4, it appears that many employers support the approach to prevention prescribed by the National Standard.

4. Do workers and employers have a common understanding of a psychologically safe workplace?

   Although some of the research reports and peer-reviewed publications consulted suggested that there is a lack of consensus on the meaning of certain terms (such as “critical incident”), the scan did not turn up any information that could readily answer

the question whether or not workers and employers have a common understanding of a psychologically safe workplace.

5. Are there performance indicators and evaluation methods that could be adopted regarding the implementation of psychological health and safety programs in the workplace?

   There are tools and resources available in Canada and internationally to support employers in creating a psychologically healthy and safe workplace (see Appendix 2). Included amongst them are tools to help employers do a baseline assessment of their programs and policies as part of the planning process. As noted in Part 2 of the report, an audit (either internal or external) is the most commonly used tool for assessing whether an organization has been successful in implementing a standard. The National Standard does include a sample audit form in the Annexes; however, it is very general and would likely not be very useful for quantifying the degree of conformance with the requirements of the National Standard. At present, there is no audit tool available for assessing compliance with the National Standard.

APPENDIX 1: SEARCH AND SCANNING STRATEGY

Step 1: Review CAN/CSA Z1003-13/BNQ 9700-803/2013, along with any relevant information on creation of the standard. This could include review of standards that informed the development of CAN/CSA Standard Z1003-13/BNQ 9700-803/2013, such as:

- BNQ 9700-800/2008 "Healthy Enterprise"
- CAN/CSA Z1000-06 Occupational Health and Safety Management Systems (OHSMS)
- Draft CSA Z1002 "OHS Hazards and Risks"

Step 2: High level internet scan to identify similar standards in other jurisdictions

- World Health Organization: Mental Health in the Workplace - Information Sheet
- European Union: Mental Health in the Workplace - Consensus Paper
- European Health and Safety Agency (in particular: prevention strategies for psychosocial risks and stress)
- Health and Safety Executive (UK) Management Standards
- Australia Human Rights Commission Mental Health in the Workplace

Step 3a: "Snowball" searches of the internet to identify industry best practices for psychological health and safety in Canada. This will include, but will not be limited to, review of the following sites:

- Workplace Strategies for Mental Health
- Workplace Safety and Prevention Services (including, for example, a review of the resources and links that came up by entering "psychological health and safety" into their search engine)
- The Mental Health Commission of Canada (MHCC): http://www.mentalhealthcommission.ca/, with specific emphasis on the following webpages, resources and documents:
    - Workplace
    - Case Study Research Project (a three-year national research project aimed at understanding how workplaces of all sizes and sectors across Canada were implementing the National Standard)
    - Case Study Research Project Final Report (a summary of promising practices and lessons learned from 40 participating organizations)
    - Implementation Resources
    - Advancing Psychological Health and Safety within Healthcare Settings
    - First Responders (overview and resources webpages)
    - Stress at Work: Mental Injury and the Law in Canada Discussion Paper (aka, The Shain Report)
    - Tracking the Perfect Legal Storm (an update to The Shain Report)
    - Improving Psychological Health and Safety in the Workplace: Critical Analysis and Pragmatic Options
    - Psychological Health and Safety: An Action Guide for Employers
    - The Road to Psychological Safety: Legal, scientific and social foundations for a national standard for psychological safety in the workplace
    - Assembling the Pieces: An Implementation Guide to the National Standard for Psychological Health and Safety in the Workplace
    - Implementing the National Standard in the Canadian Health Sector: A Cross -Case Analysis (published by Mental Health Commission of Canada and HealthCareCAN)
    - Issue Brief: Workplace Mental Health
    - A Leadership Framework for Advancing Workplace Mental Health

Step 3b: Internet searches to identify available tools, courses and resources, including but not limited to:

- Online Training in Psychological Health and Safety (courses offered by MHCC)
- Guarding Minds at Work

- Psychological Health and Safety Resources (online resources from "Workplace Strategies for Mental Health")
- BC Federation of Labour courses on building psychologically health workplaces (includes courses on: Bullying and Harassment, Stress in the Workplace, Psychological Health CSA Standard, Mental Health First Aid (New)
- PTSD Resource Toolkit (for First Responders) (PTSD Prevention Program Framework created by the Ontario Public Services Health and Safety Association)

Step 3c: Review of other sites that came up during initial internet searches of terms such as "psychological health and safety", "CSA standard Z1003", "workplace mental health"

- Canadian Labour Congress (The National Standard of Canada for Psychological Health and Safety in the Workplace)
- Federal Public Service Workplace Mental Health Strategy
- Centre of Expertise on Mental Health in the Workplace
- Roundtable on Traumatic Mental Stress: Ideas Generated (Ontario Ministry of Labour)
- Ontario Public Services Health and Safety Association
- Workers Health and Safety Centre (Ontario), including a review of pages generated by a search of "psychological health and safety"
- Occupational Health Clinics for Ontario Workers (OHCOW), including Mental Injury Toolkit
- Bullying in the Workplace
- Canada Safety Council resources, including Working with a bully and Mental Health and the Workplace

Step 3d: High-level scan of internet to collect baseline data on the level of awareness about psychological health and safety in Canadian workplaces

Step 4: Review of best practices reported in other jurisdictions, including but not limited to:

- Finland – The Well-being Guild of Entrepreneurs
- Germany - "Mental Health in the World of Work" project
- The Netherlands – SP@W: Stress Prevention at Work
- UK – Individual Placement and Support for Employment (IPS)
- Sweden - Organisational and social work environment (AFS 2015:4) provisions
- World Economic Forum: 7 Actions towards a Mentally Healthy Organization
- Health and Safety Executive (UK) Mental health at work and work-related stress
- Mental Health Toolkit for Employers (UK)
- Workplace Prevention of Mental Health Problems - Guidelines for Organizations (Australia)
- Global-Watch Network (international network providing best tools and practices in workplace health and well-being; aimed at employers)

Step 5: Key informant interviews

- Canada – a sample of employers from each province who have implemented the CSA standard; the list of possible key informants to be developed using the list of 40 organizations who participated in the MHCC case study (link provided in Step 3a, above)

Step 6: Prepare report for WPNL

- compile and summarize key findings and best practices

APPENDIX 2: RESOURCES & BEST PRACTICES

A recently published article systematically reviewed and compared 20 international guidelines on workplace mental health (3). Its objectives were to assess the quality of existing guidelines and to evaluate the comprehensiveness of the recommendations provided in these guidelines. In evaluating comprehensiveness, guidelines were scored on the basis of whether they included: recommendations for the individual and/or the organization; information on how to minimize risk factors or promote positive/protective factors; elements of primary, secondary or tertiary prevention. The scoring system also noted whether they: include recommendations and provide practical line of action; include recommendation, but do not provide practical line of action; or did not include recommendations or line of action.

Based on the review, four guidelines received comprehensiveness scores above 50%. As noted elsewhere in this report, the Canadian National Standard received 100%. Australia's Heads Up Program received 85.7%; the United Kingdom's Management Standards for work-related stress received 71.4%; and, the European Union's Psychosocial Risk Management Excellence Framework (PRIMA-EF) received 64.3%. Ten guidelines received quality scores greater than 50%. They included: Canada's National Standard (91%), the European Union's PRIMA-EF Consortium (89.7%), Australia's Heads Up (87.8%), United Kingdom's Management Standards approach for work-related stress (83.6%), Worksafe Victoria's (Australia) guidelines (83.5%), World Economic Forum (80.1%), World Health Organization (74.3%), National Institute for Health Care and Clinical Excellence (United Kingdom) guidance (71.5%), Superfriend Australia (69.5%), and the Human Rights Commission of Australia (67.3%)

Given the rigor of this review and the emphasis placed on evaluating quality and comprehensiveness, it is recommended that WorkplaceNL utilize resources and best practices associated with these guidelines and standards as it advances and moves forward with its strategy for addressing psychological health and safety in the workplace.

Resources to foster understanding about psychological health and safety in the workplace

- Canada: Mental Health Commission of Canada
- Australia: Heads Up Program
- United Kingdom: Management Standards on work-related stress
- European Union: Psychosocial Risk Management Excellence Framework

Resources to support employers' efforts to implement the National Standard

- Mental Health Commission of Canada: Implementing the Standard
- Workplace Strategies for Mental Health: Psychological Health & Safety Management System
- Guarding Minds at Work: A workplace guide to psychological health and safety
- CSA Group: Assembling the Pieces - Implementation Guide to the National Standard

Useful resources and best practices from other jurisdictions

- Australia: Strategies for healthy workplaces
- Australia: SafeWork Australia - Mental Health
- Australia: SuperFriend
- Australia Human Rights Commission: Workers with a mental illness - a practical guide for managers
- United Kingdom: Tackling work-related stress using the Management Standards (workbook)
- United Kingdom, National Institute for Health Care and Clinical Excellence: Promoting mental well-being through productive & healthy working conditions
- European Union: PRIMA-EF Inventory of Best Practices
- European Union: Prima-EF Guidance Sheets
- World Economic Forum: Seven Actions Towards a Mentally Healthy Organization
- World Health Organization: Healthy Workplaces - Global Model for Action

APPENDIX 3: STANDARDS AND OTHER REFERENCES CITED

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