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Implementing the National Standard in the Canadian Health Sector

A Cross-Case Analysis

Commissioned by HealthCare*CAN* and the Mental Health Commission of Canada

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Executive Summary

This cross-case analysis examines progress in implementation of the National Standard for Psychological Health and Safety in the Workplace (the Standard) by healthcare sector organizations, compared to a case control group of non-healthcare organizations. It is based upon data from the Case Study Research Project, a three-year formative evaluation of 41 Canadian organizations implementing the Standard. The largest number of participating organizations fall within the healthcare sector. This analysis is informed by qualitative data from the HealthCare*CAN*/Mental Health Commission of Canada Roundtable, which brought together national healthcare leaders in a conversation about implementing the Standard. Two primary questions are addressed: (i) whether there are unique features of healthcare sector organizations in regard to implementation of the Standard; (ii) whether interim project results support the development of implementation tools or resources customized for the healthcare sector ("by health, for health").

Key findings

- Healthcare organizations demonstrate more progress than non-health organizations in implementing the Standard, motivated by the importance of building an engaged and productive workforce.
- The healthcare sector manifests a number of unique strengths and challenges in implementation which distinguish it from the non-health sector.
- Healthcare organizations vary considerably in implementation progress and strategy (e.g. staged vs full roll-out), likely reflecting different levels of organizational readiness for the change.
- Healthcare organizations show notably low levels of employee knowledge and confidence regarding organizational programs and policies related to Standard implementation.
- Healthcare organizations, like non-health organizations, have limited access to indicators specifically reflective of psychological health and safety issues.

Key recommendations

1. A resource should be developed that supports implementation of the Standard and is customized to the healthcare sector.
2. Implementation of the Standard by healthcare organizations should include evaluation of organizational readiness for this change by use of a tool or resource appropriate to the healthcare context.
3. Healthcare organizations should measure employee knowledge and confidence regarding organizational policies related to implementation of the Standard, again using a tool or resource appropriate to the healthcare context.
4. HealthCare*CAN* and the Mental Health Commission of Canada should consider initiating a collaborative task force to identify best practices in accessing and utilizing indicators of psychological health and safety, drawing upon knowledge gained through the Case Study Research Project.

5. Healthcare organizations that have achieved substantial progress in implementing the Standard should be engaged as exemplars and mentors for healthcare organizations across the country.

Background

The delivery of efficient, effective healthcare to all Canadians depends on many factors, particularly the availability of an engaged and skilled workforce. This is, in turn, dependent on a healthy and safe workplace with the leadership and support needed to successfully deliver services.[1] Ensuring adequate healthcare human resources is increasingly challenging given shifting population health needs and ensuring the availability of appropriately skilled and experienced healthcare providers.[2] Progress has been made in addressing the *physical* health and safety of healthcare workers and workplaces, however there is also a need for attention to their *psychological* health and safety. Psychological health disorders amongst Canadian workers are common[3], contribute to workplace absenteeism[4] and disability[5], and constitute a large economic burden[6]. The healthcare sector is not exempt from these challenges.[7] [8]

> The nature of healthcare work requires close contact with a wide variety of people including co-workers, clients, families, and visitors. Health issues are often stressful, and it is not uncommon to see many different responses to stress from clients, residents, patients, families, and healthcare workers (HCWs). Societal issues may also predispose individuals to conditions or behaviours that may cause psychological effects to HCWs. Work organizational factors, health factors, and environmental factors have significant impacts on the psychological health of workers.[9]

Over the last year, HealthCare*CAN* has collaborated with the Mental Health Commission of Canada (MHCC) to conduct roundtables with healthcare leaders across the country in order to facilitate advancement of workplace psychological health and safety. As noted in the roundtable summary, "Simply put, good psychological health is integral to being an effective healthcare worker and protecting the psychological health of healthcare workers may contribute to fewer medical errors and patient-safety incidents"[1].

The roundtables identified three key questions to inform planning and identify next steps to further support implementation of the Standard in healthcare settings.

1. What are the unique characteristics of the healthcare work setting in relation to workplace mental health?
2. What kind of new support/resource could be developed that would address these unique characteristics?
3. What might a "by health, for health" resource look like?

The results of these roundtable discussions identified unique aspects of such settings and suggested enablers and challenges to progress in this area[10]. Of particular relevance to these discussions is the voluntary *National Standard of Canada for Psychological Health and Safety in the Workplace (*the Standard*)* championed by MHCC and released in 2013[11]. The goal of the Standard is to make it easier for employers and employees to take steps to prevent mental injury, reduce psychological risk and promote a psychologically healthier workplace. Adoption of the Standard involves the creation and application of a Psychological Health and Safety Management System (PHSMS) incorporating five key integrated elements: Commitment & Policy; Planning; Implementation; Evaluation and Corrective Action; and Management Review.

[1] P 2, Advancing Workplace Mental Health in Healthcare Settings. The Mental Health Commission of Canada and HealthCare*CAN,* December 2015

While healthcare organizations differ from one another in many ways, there are several distinctive and shared characteristics of such organizations that impact the nature and success of efforts to implement the Standard and improve workplace psychological health and safety. Such unique healthcare sector features may help explain the different rates/speed and breadth of Standard implementation among healthcare organizations and between the health sector and other sectors.

These can be summarized as follows:

- Commitment to health. The core mandate of all healthcare sector organizations is the provision of evidence-based care for all Canadians. This generates a sophisticated awareness of the importance, nature and treatment of physical and mental health issues, making adoption of the Standard a natural extension of the healthcare mandate. At the same time, the challenges of providing care to patient populations with complex needs can lead to burnout, compassion fatigue and stigma.
- Professionally diverse workforce. Healthcare sector organizations are characterized by cross-disciplinary work teams consisting of highly trained staff from differing professions. This provides a natural forum for multiple perspectives and input into the nature of the work environment. At the same time, this can impede consensus and progress amongst employee groups with differing issues, work agreements and responsibilities.
- Public Accountability: Healthcare sector organizations are primarily publically funded and thus accountable to provincial and federal governing bodies. This responsibility facilitates early adoption of relevant organizational regulations, policies and practices, such as the Standard. However, this relationship also means that healthcare sector organizations are subject to changes in government priorities, resources and organizational/governance models which differ from province to province.

In order to better understand the experiences of organizations implementing the Standard, the MHCC instigated the Case Study Research Project (CSRP). The CSRP is a research project investigating the process of voluntary implementation of the Standard by participating Canadian organizations, varying in size, structure and sector. Some of these organizations implemented the Standard with their entire organization; others focused on one department or area, with the intention of gradually phasing in implementation over an extended time. The CSRP is an iterative process evaluation, collecting qualitative and quantitative data from participating organizations, and delivering feedback along the way to foster continual improvement. The specific measures are described below. These data are analyzed to gain an understanding of organisations' approaches to implementation and to identify promising tools and practices that would support broader adoption of the Standard. A report on the interim findings of this project is available at: www.mentalhealthcommission.ca/English/document/77355/case-study-research-project-early-findings-interim-report.

Of the 41 CSRP organizations now involved, 19 fall within the healthcare sector (Appendix A). These healthcare organizations, spread across the country, represent the largest sector in the CSRP. This may reflect a greater awareness of the importance of addressing workplace psychological health and safety by such organizations. This sets the stage for a request by HealthCare*CAN* and MHCC for a more detailed analysis of the interim implementation results from the participating healthcare organizations. In response to this, the Centre for Applied Research in Mental Health and Addiction (CARMHA) carried out a Healthcare Sector Analysis (HSA), focusing upon organizations in the CSRP falling within the healthcare sector and comparing them to the other organizations. This a *cross case analysis*, that is, "comparison of commonalities and differences in the events, activities, and processes that are the units of analyses in case studies".[12] The aim of the HSA is to learn more about how to accelerate successful adoption of the Standard by the Canadian healthcare sector: providing a tailored approach to the results of CSRP, with a specific focus on findings within the healthcare sector and identification of unique strategies for such settings.

HSA Methodology

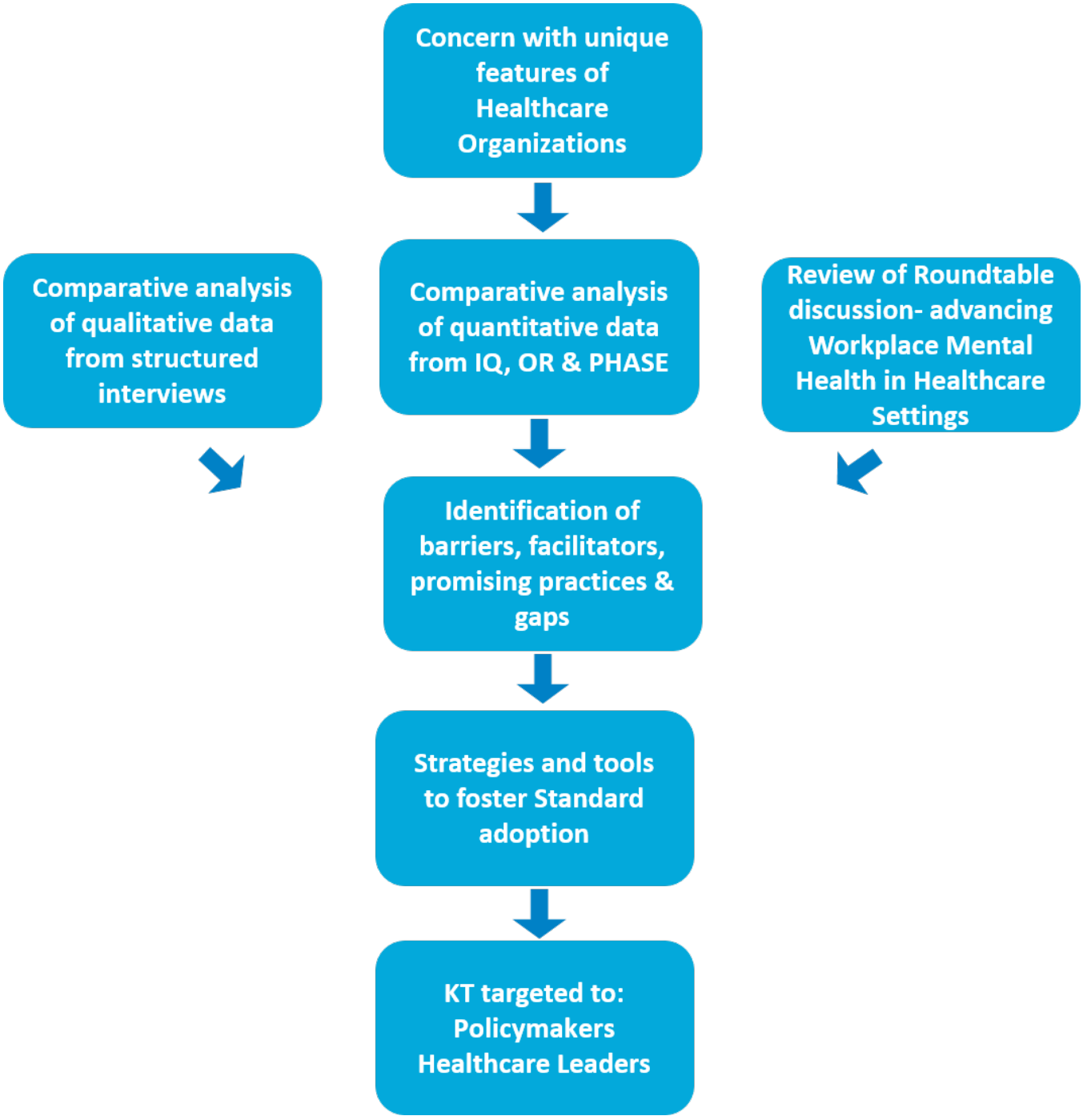
First, quantitative data from the Interim phase of the CSRP were analyzed, comparing findings within the healthcare sector and between healthcare and non-healthcare organizations. We relied upon the following measures that were completed by key informants or employees within each organization.

- Implementation Questionnaire (IQ)*:* a weighted checklist based on the Standard Audit Tool and completed by key informants, the IQ generates five weighted scores (Commitment & Policy, Planning, Implementation, Evaluation, Management Review), reflecting the five Elements of the Standard, and is the primary measure of implementation progress;
- Organizational Review (OR): an organizational self-assessment measure completed by key informants, with input from relevant colleagues, meant to identify potential barriers and facilitators, psychosocial risk factors, and relevant existing programs, policies and indicators;
- Psychological Health Awareness Survey for Employees (PHASE): a survey to determine workers' knowledge about and confidence in their organization's policies, programs and practices for improving psychological health and safety. Survey items were derived from the Standard's specification of the kinds of knowledge that employees should possess.

Second, qualitative data from the IQ and OR as well as a structured interview with key informants within each organization w analyzed with a focus upon organizational indicators, policies and programs comparing practices among healthcare organizations and contrasting healthcare with other sectors.

HSA data were then enhanced by the HealthCare*CAN*/MHCC roundtable process: the roundtable findings informed and enriched interpretation of healthcare sector data. The HSA was used to identify barriers and facilitators, describe promising practices specific to the healthcare sector and highlight gaps and suggest strategies or tools likely to be helpful in fostering adoption of the Standard in other Canadian healthcare settings. The logic model for this approach is as follows:

Healthcare Sector Analysis Logic Model



Findings

Reasons for implementing the Standard

The motivations of organizations for participation were investigated by asking in the Baseline IQ, *"why is your organization interested in adopting the Standard?"*

Common reasons for implementing the Standard, across healthcare and non-healthcare organizations, were: *Protecting the psychological health of employees; Do the right thing;* and *Enhance reputation*. A surprisingly small number of organizations, across healthcare and non-healthcare, endorsed *Managing costs* as a reason for implementing the Standard. Given the widespread concern with establishing a business case, the prominence of the practical and ethical rationale is noteworthy.

Healthcare sector organizations placed a high priority upon *Employee Engagement*, emphasizing it more than do non-healthcare organizations. This is consistent with HealthCare*CAN*/MHCC Roundtable discussions highlighting "commitment to improving the work environment through staff engagement and empowerment – genuinely engaging staff in improving the environment they work in creates buy-in and impacts employee satisfaction".[13]

It is notable that healthcare organizations are more likely than non-healthcare organizations to endorse *Reducing liability* as a reason for implementing the Standard, a finding that may reflect a strong emphasis upon enacting policies to ensure safety of patients and staff. As stated in the Roundtable discussions, healthcare sector leadership "is focused on a culture of safety."

FINDING: Healthcare organizations consistently report that addressing psychological health and safety is the right thing to do, seeking to support staff and ensure their engagement

Figure 1. Reasons for implementation

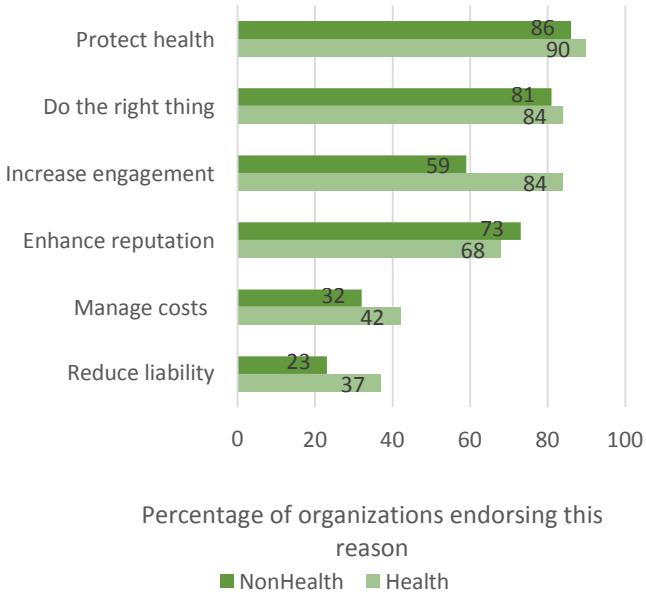
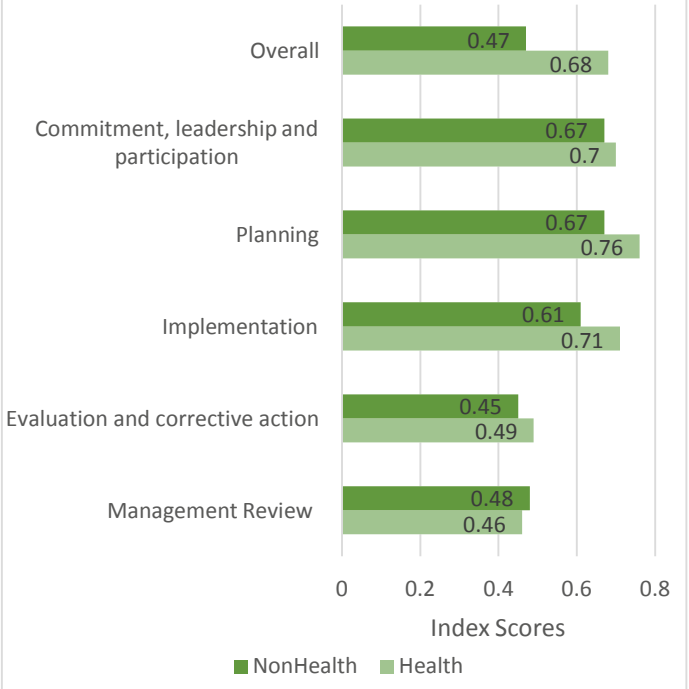


Figure 2. IQ Element scores



Progress in implementation

Analysis of IQ data (Figure 2) revealed that healthcare sector organizations as a group had achieved considerable progress by the Interim phase with regard to Overall Score and the 5 Element Scores (Commitment & Policy, Planning, Implementation, Evaluation, Management Review). The scores are expressed as an index between 0 and 1, where 1 is the highest score attainable. The mean Overall Score for healthcare organizations was .68 versus .47 for the non-healthcare organizations. Notable discrepancies were seen in Planning (.76 for health versus .67 for non-health) and Implementation (.71 for health organizations versus .61 for non-health).

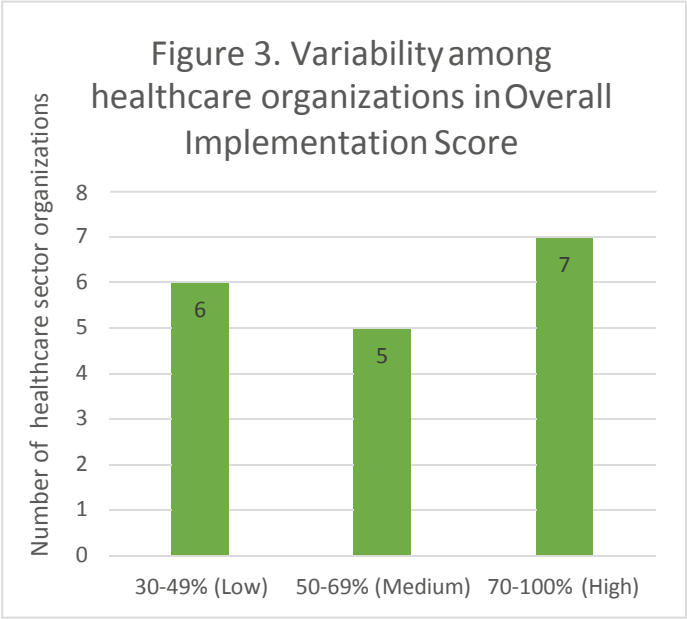
We statistically tested the differences between healthcare and non-healthcare organizations. The results of this analysis are shown in Table 1. Only one of the comparisons reached the level of statistical significance, that involving Implementation (T = 2.372, df = 37, P <.023). This suggests that healthcare sector organizations have made greater progress than other CSRP organizations in identifying and investing in specific initiatives designed to enhance psychological health and safety.

Table 1. Scores on the IQ Elements (Health minus Non-Health)

Element	t	df	Sig. (2-tailed)
Commitment	.520	37	.606
Planning	1.824	37	.076
Implementation	2.372	37	.023 (p<.05)
Evaluation	.682	37	.500
Management Review	-.167	37	.868
Overall	.909	37	.369

This is not to say that all healthcare sector organizations show the same degree of progress in implementing the Standard: there is significant variability in their degrees of progress. In Figure 3, we show that healthcare sector organizations can be divided into clusters based on their degree of implementation progress. The highest-progress organizations may be seen as champions, in a position to serve as models or guides for other organizations.

FINDING: ***None of the healthcare organizations started implementation of the Standard from scratch- all had a number of established programs, policies and data sources***



Organizational self-assessment of psychosocial risk factors

The OR included an organizational self-assessment of the thirteen psychosocial factors that impact workplace psychological health and safety as identified by the Standard. Figure 4 shows the results of this self-assessment. Note that in this graph a higher score represents a strength and a lower score represents a potential risk.

Overall, healthcare and non-healthcare organizations rated themselves fairly positively, suggesting relatively low levels of psychosocial risk and some notable strengths. This was most evident on *Engagement* (a work environment where employees enjoy and feel connected to their work) and *Physical Protection* (a work environment where management takes appropriate action to protect the physical safety of employees).

In order to determine any differences between healthcare and non-healthcare organizations, we carried out a statistical analysis across the thirteen psychosocial factors. The items that significantly differ between healthcare and non-healthcare organizations are shown in Table 2. Healthcare organization are stronger than non-healthcare organizations on two psychosocial factors: Psychological Support (a work environment where there are appropriate supports for employees' psychological health concerns); and Clear Leadership and Expectations (leadership that effectively communicates to employees the nature and importance of their work and informs them of impending change). The recent Roundtable summary emphasized the importance of strong and visible commitment by senior leadership.

Figure 4. Self-assessed psychosocial factors

Table 2. Factors distinguishing Healthcare from Non-Healthcare organizations

Psychosocial Factor	t	df	Sig. (2-tailed)
Psychological Support	2.120	38	.042 (p<.05)
Clear Leadership & Expectations	2.316	38	.028 (p<.05)

FINDING: Healthcare organizations report a generally positive psychological risk profile with strengths in leadership and psychological support

Indicators

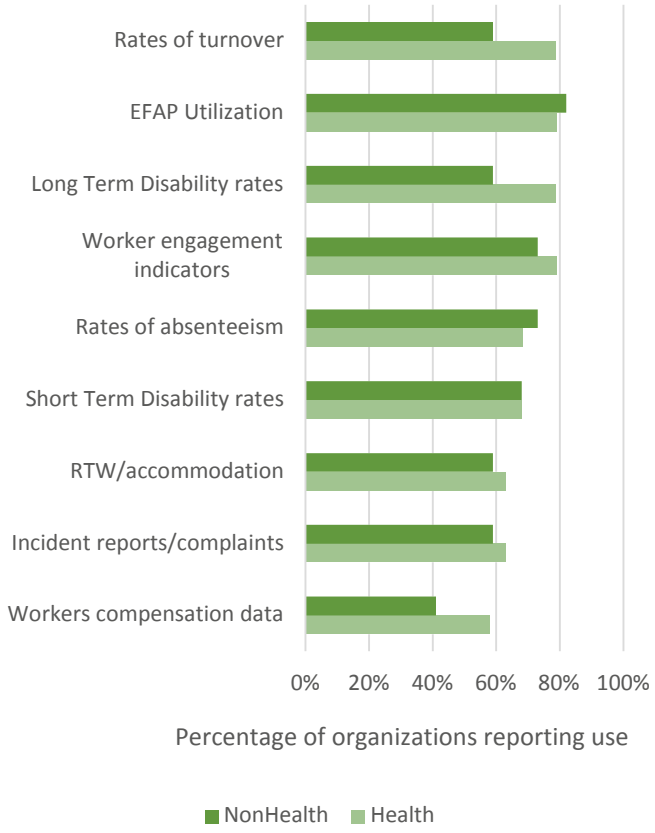
CSRP participants were asked to identify types of information used by the organization to identify psychological health and safety issues as well as to plan and evaluate actions. The use of relevant indicators has been demonstrated to facilitate healthcare sector decision making by key stakeholders and policy makers.[14]

It is evident from Figure 5 that healthcare sector organizations use a wide range of data sources. Health care sector organizations have more information on rates of turnover And workers' compensation claims than non-healthcare organizations. This may reflect a greater degree of concern with staff retention and concern with risk management.

Several data sources are used less frequently by healthcare sector organizations: industry best practices are cited as a data source by 42% of healthcare sector organizations; research evidence by 39%; and systematic surveys of psychological risk by 37%. Each of these represents an opportunity for enriched input of valuable information.

Although organizations may access a range of indicators to assist with planning, many of these indicators lack *specificity* with regard to psychological health and safety issues. For example, while rates of absenteeism are an important index of productivity and employee health, the reasons for employee absence are not typically available or monitored. It is not possible to determine if an increase in absenteeism rates is due to workplace stressors or a flu outbreak. Also, while an organization may collect a range of data, this may not be readily available to personnel charged with improving workplace psychological health and safety and/or may not actually be used as the basis for decision making or evaluation.

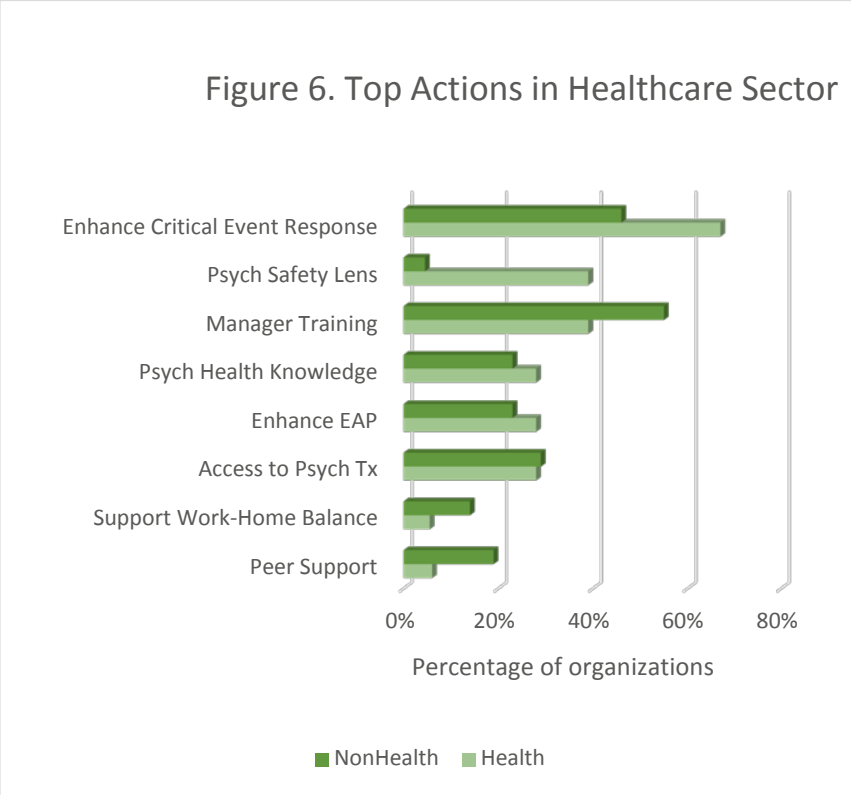
Figure 5. Top Data Sources in the Health Sector



FINDING: Healthcare organizations collect a great deal of indicator data but this information may not be specifically relevant to psychological health or used to guide planning and evaluation

Organizational actions

CSRP organizations identified actions (programs, policies, training, etc.) that they were currently taking to improve workplace psychological health and safety. These were selected from an array of possible actions (most derived from the MHCC publication *Psychological Health & Safety: An Employer's Action Guide*[15]). It should be noted that all the organizations were engaged in some of these actions at the start of the CSRP and had enhanced existing, or initiated new, actions at the interim assessment point. Several other evidence-consistent actions were added to the list of possible actions, based on organizational feedback from project partners. Thus, the actions surveyed do not encompass all activities pursued by organizations, some of which are indirectly related to this area, but only those specific to psychological health and safety.



The most frequent action identified by healthcare sector organizations was to *enhance the response to critical incidents in the workplace*, and they were significantly more likely to do this than were non-healthcare organizations. The next most frequent was to *adopt a psychological safety lens* (i.e. consider the psychological impact on employees when hiring, allocating tasks, or making organizational changes), again with much greater frequency than non-healthcare organizations. The third most frequent action was to *provide relevant training to managers*, i.e. training related to psychological health and safety. This training typically involves educating managers to recognize psychological distress in staff and respond appropriately.[16] Although provision of training to managers was a relatively common action, it was notably less frequent than in non-healthcare organizations.

By contrast, healthcare sector organizations were much less likely to focus action on enhancement of the *provision of peer support for distressed colleagues*, initiatives to *foster balance between work and personal life*, or provision of *psychological self-care resources*. These represent areas of significant opportunity for enhanced management of psychological health and safety within the healthcare sector.

FINDING: Healthcare organizations are very likely to emphasize and response to critical incident, but less likely to focus on enhanced employee self-care or balancing demands of work and home

Employee awareness

A key indicator of the success of organizational efforts to address psychological health and safety is the extent to which staff are aware of, and confident in, such efforts. An appropriate indicator of staff awareness is the PHASE, a survey which was administered by 4 healthcare and 4 non-healthcare organizations in the interim phase of the CSRP.

Statistical comparison of employee awareness data between healthcare and non-healthcare organizations shows that healthcare sector organizations generally show employee awareness below that of non-healthcare organizations. On six of the twenty PHASE items concerning awareness of organizational initiatives, healthcare sector employees fall significantly below non-healthcare employees (Table 3). This is surprising in light of the previously noted commitment to, and organizational investment in, actions to enhance psychological health and safety in healthcare sector organizations. These results suggest that knowledge about such actions is not being effectively disseminated throughout the organization. Disseminating clear information to all staff is particularly important given the stigma associated with psychological disorder that can distort understanding and block effective action.

Table 3. Mean differences between Healthcare Sector and Non-Healthcare Sector

PHASE Items	t (Non-Health minus Health)	df	Sig. (2-tailed)
This organization informs workers about psychological health and safety programs (e.g. Employee Assistance Program).	2.545	526	.011 (p<.05)
This organization makes it clear how employees should report excessive job stress.	2.372	526	.018 (p<.05)
This organization has identified employees who are responsible for handling psychological health and safety issues (e.g. safety committee, union representative, etc.)	2.702	528	.007 (p<.05)
This organization encourages employees to participate in planning psychological health and safety improvements.	3.740	528	.000 (p<.05)
This organization makes efforts to reduce risks to the psychological health of workers.	2.029	524	.043 (p<.05)
This organization provides education about psychological health (e.g., stigma, stress, mental illness).	3.038	527	.003 (p<.05)

FINDING: **Healthcare employees tend to lack awareness of initiatives to enhance psychological health and safety, suggesting the need for a customized knowledge translation strategy**

Barriers to implementation

Key Informants within the CSRP organizations were asked to identify any barriers that they had encountered in their efforts to implement the Standard. Their responses were supported by the themes identified in the Charlottetown, Toronto and Vancouver HealthCare*CAN*/MHCC roundtables. Healthcare organizations showed a pattern of barriers similar to that seen outside of the healthcare sector. The four most common barriers were:

- *Lack of access to data specifically indicative of psychological risks*. Healthcare and non-healthcare organizations typically had access to health-related indicators but could not distinguish data related to psychological stressors or problems. Notably, healthcare organizations found this a much greater barrier than did non-healthcare organizations. This reduced their capacity to determine where to intervene so as to address psychological safety, select appropriate interventions or determine whether an intervention generated meaningful impact. The most frequent healthcare organization response was to implement procedures to specifically measure workplace psychosocial strengths and risks. This often involved administration of the Guarding Minds @ Work Employee Survey[17], which specifically assesses the thirteen psychosocial factors identified in the Standard.
- *Significant organizational change*. This usually took the form of a merger with another organization (redirecting leaders to new priorities) or redesign (reallocation of resources and job tasks). As noted above, it is ironic that attending to employee psychological safety might be deemphasized during organizational change, which itself represents a psychological risk.
- *Weakening of leadership support.* When there is ambivalent, absent or distracted leadership support, it is difficult to secure adequate resources or engage organizational capacity for implementation of the Standard. The usual response of organizations was to increase efforts to persuade leaders of the importance of psychological health and safety. It is critical that there be committed leadership across the organization, including representatives from middle management and labour representatives.
- *Lack of evidence regarding employee knowledge about organizational policies and programs in the domain of psychological health and safety.* A response to this barrier was to conduct the PHASE survey which provides detailed feedback about employees' knowledge of psychological safety as well as key practices like reporting critical incidents or bullying. An additional issue for healthcare organizations was difference in knowledge among groups of employees, e.g. direct vs. contracted staff.

FINDING: **Barriers to progress include competing organizational priorities, lack of demonstrated employee knowledge and limited access to specific psychological health and safety indicators**

Facilitators of implementation

Key Informants within the CSRP organizations were asked to identify features that enhanced their efforts to implement the Standard. Their responses were augmented by the facilitators identified in the Charlottetown, Toronto and Vancouver HealthCare*CAN*/MHCC roundtables. Healthcare organizations identified enablers that were similar to those seen outside the healthcare sector.

- *Strong leadership support*. The organizations making the most progress in implementation have Champions who are actively involved throughout the implementation process, participate in meetings, events and training programs and are able to inform and influence members of the senior team. Such transformational leaders have been demonstrated to exert a positive influence on employee mental health.[18]
- *Consistency with organizational mission*. Organizations which perceive their mandate as relevant to mental health healthcare are likely to have a stronger awareness of the importance of psychological safety to society and organizational productivity. In these organizations, there is a higher level of organizational mental health literacy.
- *Leverage of existing structures*. This may include Occupational Health and Safety or Wellness committees as well as targeted working groups with connection to other organizational areas (e.g. benefits) and employee representatives, particularly unions. The working group needs to include participants with the requisite time, commitment and access to information.

FINDING: Healthcare organizations embody a number of features that enhance implementation of the Standard

Conclusions

Healthcare sector organizations participating in the CSRP demonstrate a high degree of commitment to protecting employee psychological health and safety, recognizing that this is the 'right thing to do' and working to build an engaged and productive workforce. All of the participants had enacted a number of relevant programs and policies prior to adoption of the Standard and were taking additional actions on the basis of their planning process. Healthcare sector organizations surpassed non-healthcare organizations in their progress, particularly with regard to the Implementation element of the Standard. In this regard, healthcare organizations reported particular innovation such as development of a critical incident response protocol and utilization of a psychological safety lens in decision making. However, they lagged behind non-healthcare organizations in some areas such as training managers and supervisors, addressing work-home balance issues and developing peer support programs. It also should be noted that there is variability in progress amongst CSRP healthcare organizations, possibly reflecting differing levels of organizational readiness. Healthcare organizations that adopted the Standard benefited from: the commitment of senior leadership; dedication to improving psychological health for all Canadians; and the presence of appropriately-resourced committees with representation from labour and management. Challenges included: competing organizational priorities, particularly budgetary and structural; limited access to key indicators specifically relevant to psychological health and safety; and low employee awareness or confidence regarding organizational efforts to implement the Standard. The success and sustainability of psychological health and safety actions depends upon the utilization of comprehensive strategies to evaluate progress and make adjustments as needed. The findings from the HealthCare*CAN*/MHCC roundtables indicate that many healthcare organizations are highly committed to implementation of the Standard and thus to a culture of psychological health and safety. This will be accelerated and sustained by the creation, dissemination and application of tools and resources adapted to the healthcare sector.

Recommendations

1. Develop a guide to addressing psychological health and safety and implementing the Standard that is specifically tailored to the healthcare sector.
2. Given the differences in readiness to implement the Standard among healthcare sector organizations, it would be beneficial to evaluate readiness for this change as part of planning.[19]
3. Healthcare sector organizations should systematically survey employees with regard to their knowledge and confidence regarding organizational policies and programs focused on psychological health and safety. This will require practical and effective tools for determining and tracking this aspect of employee knowledge, preferably with the PHASE survey developed for this project, a measure of psychological safety culture. This would lead to a comprehensive organizational Knowledge Translation strategy, including targeted messaging to subgroups of the workforce, should be implemented to ensure that staff have the requisite knowledge of the Standard and related initiatives.[20]
4. Healthcare sector organizations should work to improve access to and use of indicators specific to the psychological health and safety domain. This would support planning and allow tracking of meaningful outcomes. It might involve initiation of a collaborative task force to identify best practices in access and utilization of indicators specific to psychological health and safety, within healthcare. Such a task force could be organized by HealthCare*CAN* and the Mental Health Commission of Canada and draw upon knowledge gained through the Case Study Research Project.
5. Healthcare sector organizations which have championed the Standard and achieved substantial progress should be engaged as exemplars and coaches for healthcare organizations across the country.
6. Organizational commitment should be broad-based, shared by multiple leaders rather than tied only to one champion. This can help to ensure that leadership commitment is resilient and able to survive change of leaders or competing priorities. This may take the form of working groups with appropriate authority and representation.
7. Healthcare sector organizations should enhance organizational action by increasing the implementation of evidence-based interventions. Any action designed to enhance organizational response to psychological health and safety issues should be evidence-based, solidly grounded in demonstrable effectiveness and feasibility, rather than off-the-shelf, i.e. chosen on the basis of convenience. Examples of evidence-based actions are:
    a. Increase the provision of effective manager training to raise awareness and skill in responding to psychological health and safety issues.
    b. Develop new mechanisms for peer support so that healthcare staff are better equipped to deliver appropriate support to colleagues.
    c. Augment policies and programs to better encourage a psychologically safe balance between work and personal life.
    d. Foster access to psychological self-care resources for staff.
8. Healthcare sector organization should develop comprehensive and accurate evaluation strategies to inform their response to psychological health and safety issues. Evaluation should integrate accurate risk assessment, appropriate selection of actions and meaningful determination of outcomes.

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Appendix A:

Participating CSRP Organizations at Interim

1. AGS Rehab Solutions
2. Alberta Health Services
3. Canadian Mental Health Association – Toronto Branch
4. County of Frontenac
5. Garden City Family Health Team
6. Haliburton, Kawartha, Pine Ridge District Health Unit
7. Health Association of Nova Scotia
8. Lakeridge Health
9. Manitoba Health, Healthy Living and Seniors
10. Douglas Institute
11. Mount Sinai Hospital
12. Nova Scotia Health Authority - Cape Breton District Health Authority Pilot Site
13. Nova Scotia Health Authority - Capital District Health Authority Pilot Site
14. Ontario Shores Centre for Mental Health Sciences
15. Provincial Health Services Authority
16. Regina Mental Health Clinic
17. The Royal Ottawa HealthCare Group
18. The Scarborough Hospital
19. Toronto East General Hospital

Appendix B:

Case Study: A Healthcare Organization in Flux

Background

Goodhealth is a regional heath provider that provides range of services including acute care, outpatient, and public health programs. Goodhealth has 2500 unionized and non-unionized healthcare providers working with hospital and community physicians to serve a diverse, and primarily rural, population. As a healthcare organization, Goodhealth recognized that ensuring that their workforce was psychologically healthy and safe was critical to ensuring good patient care and fulfilling their obligations to the public. Recruitment and retention of staff was of particular importance given the reality of an aging workforce and increasing psychological health-related disability rates. For these reasons they decided to adopt the Standard and participate in the Case Study Research Project.

Challenges and Opportunities

Goodhealth is a relatively new organization, resulting from the amalgamation of three existing healthcare bodies. This was done in order to better coalesce services across the continuum of patient care and to seek efficiencies in non-patient care areas. This represented significant organizational change as it required the introduction of two new unions, integration of differing patient records and IT systems and a restructuring of the management team. Fortunately, the leader of the new entity had already begun implementing the Standard within her prior organization and thus was able to bring forward her knowledge, experience and commitment. In addition, the organization had a strong occupational health and safety committee with prior experience implementing a provincial program to meet new provincial regulations with respect to addressing 'bullying and harassment' in the workplace. This committee, with both management and union representation, enthusiastically embraced the challenge of implementing the Standard for the new organization.

Taking Action

In conjunction with the CEO and union leaders, Goodhealth created a policy expressing organizational commitment to ensuring a psychologically healthy and safety workplace. This was communicated to all employees via intranet and staff meetings. As the physician group were not always aware of organizational initiatives, special forums were held to inform them of these activities and their role in their success.

The OH&S working group began by conducting an organizational review to identify relevant existing policies, programs and sources of data. They also conducted an organizational self-assessment to identify risks and hazards and complemented this by administering the Guarding Minds @ Work Employee Survey across the organization.

These survey results were compared with the self-assessment. Interestingly, both datasets revealed concerns about 'Balance', while the management group were particularly concerned about 'Recognition and Reward' while the employee group noted strong concerns about 'Civility and Respect'. Both measures pointed to a high level of 'Engagement' suggesting that this could be a lever for success. These finding were shared with staff and the following actions were implemented:

- Creation of an organization-wide campaign called 'Balancing Work and Home' that informed staff of existing opportunities for job-sharing and extended benefits for family members.
- Roll-out of an enhanced recognition program whereby peers and managers distributed gift cards to employees, not only for a specific accomplishment but also in acknowledgement of personal events or challenges.

- An evidence-based training program, 'Civility, Respect, and Engagement at Work' was adopted and made available to all employees with the expectation that all management staff participate.

An evaluation strategy was created by the OH&S Committee was developed to determine the impact of these initiatives before they were launched. This incorporated information such as participation rates, on-line feedback forms and introduction of the PHASE to determine the extent of employee knowledge and confidence in the organizations efforts to implement the Standard. The results of this evaluation will be used to revise existing actions and develop new ones. In order to ensure sustainability of progress, the OH&S committee modified its terms of reference to explicitly include *psychological* health and safety.

Lessons learned

- Input and involvement by both line staff and management is critical in determining and addressing the psychological health and safety of an organization. Discrepancies in perspectives do not mean that one group is wrong, but rather may reflect access to information or awareness of issues that the other group may not have.
- Implementation of the Standard benefits from the use of existing organizational committees and prior implementation experiences in getting started and sustaining progress. This is particularly important when an organization is going through significant change
- Identifying relevant psychological health and safety indicators and using these to evaluate the impact of implementation actions is critical to successful adoption of the Standard. It is optimal if the evaluation strategy is developed in advance and used to revise specific actions.