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Employers' perceptions and attitudes toward the Canadian national standard on psychological health and safety in the workplace: A qualitative study

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ABSTRACT

The estimated societal and economic costs of mental illness and psychological injury in the workplace is staggering. Governments, employers and other stakeholders have been searching for policy solutions. This qualitative, exploratory study sought to uncover organizational receptivity to a voluntary comprehensive standard for dealing with psychological health and safety in the workplace. A series of five focus groups were conducted in a large Western Canadian city in November 2013. The seventeen participants were from the fields of healthcare, construction/utilities, manufacturing industries, business services, and finance. They worked in positions of management, consulting, human resources, health promotion, health and safety, mediation, and occupational health and represented organizations ranging in size from 20 to 100,000 employees. The findings confirm and illustrate the critical role that psychological health and safety plays across workplaces and occupations. This standard resonated across the represented organizations and fit with their values. This alignment posed challenges with articulating its added value. There appears to be a need for simplified engagement and implementation strategies of the standard that can be tailored to the nuanced differences between types and sizes of industries. It appears that organizations in the most need of improving psychological health and safety may be the least receptive.

1. Introduction

Are employers receptive to implementing standards for psychological health and safety in their workplaces? Mental health problems are prevalent in the working population (Blackmore et al., 2007; Broadhead, Blazer, George, & Tse, 1990; Wang et al., 2012b; Wang, Patten, Currie, Sareen, & Schmitz, 2012a). According to the 2003 Canadian national mental health survey data, the annual prevalence of mood and anxiety disorders in the working population is 5.3% and 4.8% respectively (Statistics Canada, 2010). Due to the nature of mental disorders, they can have significant impacts on workers' health and productivity. It has been estimated that mental health problems may cost the Canadian economy $15 billion to $33 billion each year (by absenteeism and presenteeism) with the related potential of lowering the competitiveness of the Canadian workforce (Statistics Canada, 2010). Workers with mental disorders report more work loss and work cutbacks (Broadhead et al., 1990; Kessler & Frank, 1997; Kessler et al., 2003; Kousiz & Eaton, 1994; Lerner et al., 2004; Lim, Sanderson, & Andrews, 2000) and a higher incidence of unemployment and significantly more job turnover (Lerner et al., 2004).

Maintaining a productive workforce while recruiting and retaining the most productive personnel are crucial endeavors for the corporate community yet this can be significantly affected by mental health problems (Wang et al., 2010). In Canada, employers have a duty to accommodate their employees with pre-existing mental illness to the point of undue hardship (Canadian Human Rights Commission, 2013). Furthermore, the protection of mental health in the workplace is considered to be a corporate responsibility with legal implications, and the provision of a psychologically safe workplace has become a governance and stewardship issue similar to the provision of a physically safe workplace (Shain, 2009, p.8).

Governments, employers and other stakeholders are extremely concerned about providing psychologically safe and healthy workplaces, and various groups have been working in search of solutions. One optimal approach is through reducing workplace risk factors at organizational levels through policies and other practices (Bambra et al., 2009). The benefits for employers of implementing mental health promoting and prevention policies include increased productivity, recruitment,

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Table 1
Description of the Thirteen Psychosocial Risk Factors.

1. **Organizational culture**, a mix of norms, values, beliefs, meanings and expectations that group members hold in common and that they use as behavioural and problem-solving cues.
2. **Psychological support** comprises all supportive social interactions available at work, either with co-workers or supervisors.
3. **Clear leadership and expectations**, when leadership is effective and provides sufficient support that helps workers know what they need to do, explain how their work contributes to the organization, and discusses the nature and expected outcomes of impending changes.
4. **Civility and respect**, when workers are respectful and considerate with one another, as well as with customers, clients and the public.
5. **Psychological demands** are documented and assessed in conjunction with the psychical demands of the job.
6. **Growth and development**, when workers receive encouragement and support in the development of interpersonal, emotional, and job skills.
7. **Recognition and reward**, when there is appropriate acknowledgement and appreciation of workers' efforts in a fair and timely manner.
8. **Involvement and influence**, when workers are included in discussions about how work is done, how decisions are made.
9. **Workload management**, when assigned tasks and responsibilities can be accomplished successfully with the time available.
10. **Engagement**, when workers enjoy and feel connected to their work and where they feel motivated to do their job well.
11. **Balance**, when there is acceptance of the need for a sense of harmony between the demands of work, family and personal life.
12. **Psychological protection**, when workers' psychological safety is ensured.
13. **Protection of physical safety**, when a worker's psychological, as well as physical safety, is protected from hazards and risks related to the worker's physical environment.

*Source: Standards Council of Canada (2013). *Psychological health and safety in the workplace— prevention, promotion, and guidance to staged implementation.*

retention, and operational success along with decreased conflict and costs of disability and absenteeism (Standards Council of Canada, 2013). There are also promises of increased worker job satisfaction, self-esteem, and job fulfillment when these policies are implemented (Standards Council of Canada, 2013).

In Canada, a recent policy advance in this regard is the newly released National Workplace Psychological Health & Safety Standard (the Standard), commissioned by the Mental Health Commission of Canada and released in January 2013. With this approach, consideration is given to thirteen organizational factors including: organizational culture; psychological support; 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, and; protection from physical harm (Standards Council of Canada, 2013). This voluntary standard provides employers with a framework and also a guide to a documented and systematic approach for developing and sustaining a psychological healthy and safety workplace. (See Table 1.)

The release of the Standard marks a significant forward from the policy intervention perspective. However, the level of awareness among Canadian employers is unknown. Furthermore, employers' reactions to the standard have not been captured in a meaningful or objective way, making it difficult if not impossible to determine its strengths, weaknesses and challenges. It is critical to uncover employer receptivity to the Standard for the purposes of informing and guiding meaningful approaches to support its implementation. Such information is also useful for implementing similar standards and policies in other regions. Therefore, the purpose of this qualitative, exploratory study was to uncover Canadian employer's receptivity to the implementation of the Standard in their workplace.

Table 2
Interview Schedule.

1. After listening to a brief description of the Standard, what is your initial reaction to it?
2. What issues are you currently dealing with?
3. How do you track these issues / indicators?
4. How satisfied are you with your current processes for preventing / managing these issues?
5. Based on the factors included in the Standard, what do you think are your top priorities / areas of concern in regards to the psychological health and safety of your employees?
6. What are some potential barriers to implementation?
7. What are some specific challenges for your sector?
8. What are some of the potential 'wins' to implementing the Standard?
9. What are some potential 'wins' specific to your sector?
10. What would help to facilitate the process?

2. Methods and design of the study

2.1. Study Purpose

The purpose of this study was to understand employers' receptivity to implementing the Standard, and there were four main research questions. These included:

(i) Are psychological health and safety issues a current concern in the workplace?
(ii) Are employers and organizations receptive to implementing a national standard for a psychologically safe and healthy workplace?
(iii) What are perceived barriers and benefits to implementing this Standard? And
(iv) What would facilitate the process of implementing the Standard?

For the purposes of this study, a psychologically health workplace was defined as one where every reasonable effort is made to promote mental health through awareness, resources and education. A psychologically safe workplace was considered to be one where every reasonable effort is made to prevent harm to mental health through negligent, reckless or deliberate mentally injurious conduct (Standards Council of Canada, 2013).

2.2. Participants and Setting

A descriptive-exploratory design was selected for this study given the appropriateness of this approach for exploring meanings, complex situations and interpretations of experiences (Parse, 2001; Richards & Morse, 2006). The study was conducted in a large Western Canadian city as its vibrant economy and low unemployment rate suggested that recruitment and retention of employees would a priority for employers. In collaboration with the local Chamber of Commerce, recruitment of participants was accomplished through purposive sampling, a process that involves selecting participants with knowledge of issues of central importance to the research questions (Lincoln & Guba, 1985). This sampling approach allowed for selection of participants familiar with psychological health and safety issues in the workplace that were in diverse positions of management, consulting, human resources, health promotion, health and safety, mediation, and occupational health. Amongst the seventeen participants, six were in the field of healthcare, five identified the focus of their organizations were construction/utilities, three came from manufacturing industries, two were with business services, and one was in the field of finance. These five selected fields had been selected to give a good representation of office and operational settings and industries, as well as for providing heterogeneity of the sample. Half of the participants were aware of the Standard prior to study participation. There was a broad representation in terms of the range in size of the organizations: one had only twenty employees while the largest had about 100,000. Out of the twelve organizations that were represented, ten had an Employee Assistance Program and four had mental health programs in their workplace.

2.3. Data Collection and Analysis

The primary data collection strategy was composed of face-to-face group interviews. Group interviews are an appropriate approach for generating impressions of new programs, diagnosing the potential for problems with the new programs, and for learning how respondents talk about the phenomena of interest (Stewart & Shamdasani, 1990). In November 2013, five interviews were held; these had a range of two to six participants within each group ($n = 17$). As group interviews are an appropriate approach for eliciting information when genuine discussion occurs, attempts were made to ensure a degree of homogeneity within sector of employment among members for each interview grouping (Stewart & Shamdasani, 1990).

The interviews were hosted in a neutral setting. One experienced moderator facilitated all of the interviews, each of which lasted approximately two hours. As the aim of this research was clear and focused, a relatively structured approach was used to ensure that all of the groups discussed the same issues (Morgan, 1997), and the interviews followed a semi-structured interview guide that included provision of information about the Standard (Table 2). After responses to each question, the moderator probed for different experiences, perceptions, and opinions amongst participants, and this allowed capture of a broad range of perspectives; one of the strengths of this methodology (Stewart & Shamdasani, 1990).

The group interviews were audio-recorded, transcribed verbatim, and checked for accuracy. Analysis followed an iterative process of coding, categorizing, and abstraction. Using procedures consistent with content analysis (Patton, 2002), several members of the research team reviewed the interview transcripts. Each transcript was read several times, and then coded line by line. Words or sentences that captured the critical issues and thoughts identified by the participants were highlighted. These were considered to be primary level codes and entered into NVIVO 10 software for assistance with data management and analysis. The primary level codes were then examined for patterns, connections and silences. These were subsequently sorted and collated to form categories in which similar codes or excerpts of data were grouped and labelled.

2.4. Rigor and Trustworthiness

To ensure that the study was based in rigor/trustworthiness, a number of steps were undertaken in this project. A substantial amount of time was taken with documentation, journaling, maintenance of an audit trail, and reflexivity (Mayan, 2009). For example, the moderator and research assistant documented their reflections following the group interviews. Furthermore, the primary investigator maintained a reflexive journal to track the analysis and interpretation of the data, and also maintained an audit trail of decisions.

2.5. Ethical Considerations

In keeping with the formal ethical approval from the University of Calgary, REB13-0286, informed consent was obtained prior to the group interviews with the understanding that participation was voluntary and could be withdrawn at any time. Eliminating names and other identifiers as well as removing distinguishing features from the records and discourse preserved the anonymity of participants. The project materials were stored appropriately to preserve confidentiality. In recognition of their valuable contributions, a gift certificate worth approximately twenty dollars was provided to participants.

3. Results

Four key themes emerged from the analysis. These include: 1) Factors Influencing Workplace Mental Health, 2) Reaction to the Standard, 3) Benefits and Barriers to Standard Implementation, and 4) Facilitators and Suggestions for Implementation. These findings included observations regarding the disjuncture of discourses within and between themes. In summary, as befitting an exploratory study, the findings report on a range of characteristics within each of these themes.

3.1. Factors Influencing Workplace Mental Health

In all of the groups, psychological health and safety was described as the *underlying issue* in the workplace, exceeding all other workplace health issues and "a larger problem than anyone is aware of". One participant wryly noted that the costs in their organization that were associated with short- and long-term disability related to mental illness were over three times those for musculoskeletal injuries. When describing its seriousness, one interview group shared that a number of suicides amongst employees within their organization were generally believed to have resulted from psychological injury in the workplace. Unless the promotion of mental health and prevention of psychological injury is addressed in a meaningful way, it was concluded that there would not be any substantive reduction of mental illness and addiction amongst employees. It was also observed that psychological health and safety is an important consideration for the next generation of workers. One participant from healthcare worried about the scope of the problem even amongst post-secondary students and that "we are stressing out our future workers before they get to the workplace", and was concerned about the long-term implications.

Participants described frequent occurrences of psychological injury that they had observed in their workplace and noted that some of the ways in which it was expressed included absenteeism, turnover, bullying, harassment, anxiety, sleep issues, and conflict. One former occupational health nurse explained that,

> Psychological injuries are always the toughest to deal with, have the least recognition, and the least support. And nobody ever wants to deal with the issues until it comes down to the nitty gritty and even then an intervention has to be forced.

Participants were able to identify a number of factors that influence psychological health and safety in their workplaces. One that was described in the most depth across the interviews was *organizational culture* with differences noted in terms of organizational size and type of industry. Smaller and flatter organizations were described as being more cohesive and as having more effective communication ("its very easy to walk up and have five minutes to address concerns"). When employed in smaller organizations, workers were more able to see the outcomes of their work (i.e. "after you implement a program, you can see its benefits") and to feel more valued ("we are valued and are told that regularly"). Their relatively smaller numbers requires that workers must multi-task and that this can sometimes lead to a lack of job clarity and job confusion. In contrast, larger organizations were described as lacking in connectivity between people. One participant noted that their unit was created eight months ago and yet they had never met face-to-face. Furthermore, larger organizations have multiple layers of management and this creates challenges for "candid and clear communication" as well as for "getting things done". In large organizations, it was observed that senior leaders are less involved, and less likely to become involved with front-line workers and, as a result, not be as aware of their situations. Because of this, it was felt that senior managers in larger organizations are "more inclined to say no" to implementing strategies for psychological health and safety.

The culture of one industry, healthcare, was the particular focus of in-depth discussions. Healthcare was described as a "top down organization" whereby leaders make the decisions and those with knowledge or understanding have little, if any, input. Healthcare professionals are expected to "follow orders" and that this ingrained behaviour is difficult to break as it "goes right down to the root of their training". As one nurse lamented,

> Nurses eat their young. I have seen it over and over again. Comments like, "she needs to pay her dues" or "we did this, we had to suffer that". They are not even nice to each other. So some of the harassment and bullying is co-worker to co-worker.

It was frequently remarked upon that healthcare employees are experiencing "care fatigue", many are "disgruntled and disengaged", and that this is negatively affecting healthcare delivery. One participant recounted that people are "leaving with joy" or simply "staying for their pension". Another observed that,

> This negative work environment is fostering high turnover that, in turn, is having a big impact on their [the organization's] reputation. As their reputation keeps nose-diving, they are having trouble hiring.

While noting that there were some supportive managers and colleagues within healthcare, one participant further explained that even then it is hard to feel valued or supported for your work when the manager must say, "Yeah, we support you but you have no resources and no budget and you're not allowed to do this". Many participants spoke of a pervasive and overwhelming feeling of powerlessness throughout all levels of the organization and concern was expressed that there "really isn't anything in place to address this …… or to help employees get through this time a little bit easier". Ironically for an organization devoted to health "it is not okay to focus on staff health" and it was hypothesized that there would be little or no receptivity to implementing psychological health and safety strategies.

In these groups, there were also some unique attributes given to the construction industry. Construction was described as being marketplace driven and "fluctuating on a daily basis". This labile nature can be challenging in terms of job security for some workers. Civility and respect were described as not having been addressed historically and there continues to be "stereotypes that guys are rough and bullying is involved". There was mention of a culture of drug and alcohol use within the industry ("that's how we solve our problems, we break out the bottle of scotch at the end of the day off site") but changing with intervention now occurring if impairment occurs at the worksite. The demographics of their workers are also evolving with an increase of females in the trades and international workers filling local shortages. These pose unique organizational challenges. As one participant questioned,

> In terms of growth and development, how do you help somebody develop into a role that has come from a culture where you don't talk to your manager? It's the manager who decides when you are ready for promotion.

Despite these challenges, it was perceived that the "current process [for policy implementation] is very good". If a case could be made to make a psychological health and safety standard a priority, it was perceived that there would be receptivity from management along with the ability to implement quickly and successfully.

In terms of the manufacturing industry, it was explained that their dominant emphasis is on health and safety and that the absence of process is "what gets us through". One participant explained there is some resistance to developing policy and that the preferred methodology is to deal with individuals and their needs informally. The overall culture was described as being "intangible". Senior employees try to teach it but if newer employees do not learn it, they "will not survive". A further complication for manufacturing is that there are cultural differences between office staff and factory workers, with each having different methods of management, communication, and interactions. There may also be remote locations that are involved to add to this complexity. These raise challenges in terms of worker isolation from their families and management as well as barriers to disclosure of mental health issues due to lack of confidentiality. Somewhat similar to what was suggested in construction, there appeared to be confidence in their ability to implement the Standard when adopted.

Across the represented industries, it was agreed upon that psychological health and safety is challenging to address amongst the workforce. Stigma was raised in every interview as a major barrier to discussions about mental illness in the workplace ("you mean I have crazy people working for me?"). Stigma was also identified as a major barrier to recognizing the legitimacy of mental injury at times. One participant from Human Resources observed,

> When an employee has [a physical injury], people run to assist them and say "work from home" or "we'll help you out" but if the individual has a psychological injury then it's "oh, you're faking it" or "you're mooching off the system" or "it's not real".

Overall a *lack of action* related to psychological health and safety in the workplace across industries was described. It was agreed that it is not addressed to the same extent as physical health and safety and that the limited action that does occur remains more reactive rather than proactive. One of the explanations for this phenomenon was that high costs of prevention and promotion programs are seen to be prohibitive. Furthermore the resources that do exist, such as Employee Assistance Programs, are not well promoted, understood or utilized. It was also generally thought that a lack of knowledge, understanding, and skills are challenges to furthering action. In the words of one participant,

> You have an awareness that there is a right and a wrong way to have this conversation, and then you become a little afraid that you're going to say the wrong things and talk about the wrong issues and not in a psychologically safe way. So there is an awareness that you need to be politically correct. If a manager is worried that they are going to cross over that boundary, they won't ask the question.

A number of participants explained that although courses are available for management, these are more often viewed as a "nice thing to do" and could be put off "as I have this pile of things to do". It was also agreed upon that education alone is not enough. For example, when managers are "floundering", it is suggested that there needs to be other mechanisms for intervention such as leadership development and support.

3.2. Reaction to the Standard

The Standard was positively described as a resource that could provide direction, tools, and guidance to address psychosocial elements in the workplace. This kind of resource is needed as "the data indicates something needs to be done. Now even more than ever". One participant from the manufacturing sector wryly noted that, "I don't mean to be petty but it's [employing the Standard] what every job site should be doing already" and another from the construction sector said, "Everything on here [the Standard] is simply really good management practice".

In each of the interviews, there were discussions regarding the alignment of the Standard with the existing values and practices of their organizations. It was observed that the Standard ties into the values of "safety, respect and trust" and as being "ethically the right thing to do". As one participant validated,

> This [the Standard] is very aligned with what I do, what I want to do, and what I know about the workplace. I am very committed to seeing employers adopt this, extremely positive.

It was agreed that the 13 factors were already, or could well be, addressed in their workplaces. One participant stated that their organization already had "the tools to do that" with another observing that "every single one of these points could be incorporated in our existing systems". What the Standard added in these situations was a comprehensive approach, one that could help organizations to agree that "yes, we need to look at that" or that they could "align their work a little bit better".

Paradoxically this alignment posed challenges in terms of articulating its added value. For example one participant, previously unfamiliar with the Standard, noted that they were already implementing business excellence processes that have a mental health component,

> We've got those policies and we've got the values of respect and we've got the complaint process. I know that our company does not tolerate that [psychological injury] but do we want to call it now psychologically healthy? So what [added value] has it offered? I have no clue.

The terminology of "voluntary standard for psychological health and safety" became the focus of discussion within all of the group interviews. As one participant aptly observed "voluntary and standard are contradictory terms". Healthcare participants were particularly supportive of the term psychological with one expressing, "I don't want to say it is a softer term but psychological is less threatening than mental". Another thought that the term "psychological safety" was something that would resonate with employers as, "They have already been responsible for physical safety". There were others that described this terminology as being "scary", "legislative", and "ambiguous". One participant was left uncertain with "what this really means" and another questioned whether their international employees would understand. One went as far as to suggest, "Keep the title out of the discussion because it is overwhelming for CEO's". However, identifying that this was a Canadian Standards Association (CSA) Standard was seen to improve its receptivity, with one participant from manufacturing observing,

> CSA is a very respected organization in workplaces because all safety products goes through CSA certification so hard hats, boots, and other kinds of things. Then the CSA Z part sometimes deals with behaviours in the workplace. So CSA makes it [the Standard] more sellable.

Being a voluntary standard was seen to be detrimental at this decreases its priority in the workplace and, therefore, justification would be required for its' implementation. If it were to become a mandatory standard, however, participants acknowledged that it would be accepted and the necessary resourcing would follow.

3.3. Benefits and Barriers to Implementation of the Standard

A broad range of potential benefits for employees, employers, and the workplace were identified for implementing the Standard. It was perceived that employees would feel more supported and safer to identify their challenges. Employers would experience benefits in terms of improved employee performance, corporate image, loyalty, recruitment and retention, approachability, and safety along with reduction in costs, conflict, and other issues. Furthermore, it was consistently noted that the Standard would result in a healthier and more productive workplace with increased awareness and dialogue about psychological health and safety. Ultimately, it was considered that the impact of mental illness on individuals, home, workplaces, and community would be reduced.

While acknowledging its value, descriptions of the Standard included comments such as, "it's quite cumbersome … and I don't know if it is 100% realistic". Its weightiness was also perceived as challenging to explain its' value ("less is always better") and with reducing the chances of its implementation to being "very, very slim". Its overwhelming nature reduced one participant to proclaim, "If this is voluntary, and I don't have to implement all of this, I am good". Another noted, "I see the value but anytime people are given a huge government document, they tune out". Participants felt that its size prohibited their ability to describe it in a meaningful and concise manner and that this would preclude their ability to advocate to their senior managers and other decision makers. Furthermore, participants continued to refer to the Standard as a "government document", demonstrating a lack of understanding about its etiology and developers.

There were other aspects considered to be barriers to implementation of the Standard. Remote sites, shift work, and multiple layers of management ("hierarchy can be crippling") could complicate its execution. Resistance to increased workload and tracking were seen as other possible barriers. There was some concern that implementing the Standard would "open up a can of worms" in terms of increasing the number of claims made by employees. One participant worried that, "by introducing this [Standard] and making it public to the employees, we're actually educating the scammers better, too". It was further explained that with a physical injury, "we can at least send them for an x-ray to see if it is legitimate" and was genuinely concerned that recognizing psychological injury in the workplace would simply add to their existing challenges.

3.4. Facilitators and Suggestions for Implementation

It was agreed that leadership from the highest level of the organization is critical for the Standard to be adopted well. As one participant emphasized,

> There cannot be enough emphasis on the importance of leadership. It is in the Standard but it is towards the end. I feel it should be at the forefront because in our experience in launching other initiatives, if we don't have the support of leadership, it doesn't move. They have to be in on it from the very beginning, throughout every decision-making process, and they need to uphold it, demonstrate it, publicly support it, and to allocate budgets and things like that. Leadership has to be a critical component of the process.

Leadership awareness of the Standard was not considered to be enough. Rather permission has to be obtained from the highest level of the organization ("a signed memorandum of agreement") for the necessary funding, staffing, planning, and implementation to follow. Furthermore, without the appropriate level of resourcing, it was believed that successful implementation of the Standard was "doomed".

To engage senior management, it was agreed that the added value and benefits of the Standard in addressing the needs of their organization needed to be clearly articulated. Demonstrating how the Standard would address the current challenges management is experiencing would also help to make the business case. One participant suggested,

> Well, you're having all this conflict and it's taking up all of your time. We could help you resolve this if we had these other pieces in place that would come from the Standard.

As employers are already responsible for physical *safety*, it was suggested emphasizing the psychological *safety* component to the Standard would be help receptivity. The work that has been done on stress at work, mental injury, and the law was also considered to be a convincing argument for administrators. As one participant explained,

> If you take Martin Shain, 2008 work and you explain to a CEO that one way or the other, you are going to pay. This [the Standard] is something that you [the CEO] can do to mitigate this risk.

For implementation to occur, the Standard was consistently described as having to be simplified (i.e. "into a step by step guide"), with the understanding that there will be modifications as every organization is different. Customization was frequently raised as for example, "the needs of a nurse working in ICU are different than an office worker". Having consultative support could help with developing the specific strategies and approaches required by unique, individual organizations. Another suggestion was to provide with a broad range of case studies and examples of best practice policies to learn from other organizations' experiences.

It was also considered easier for their organizations to break the Standard into smaller pieces and stage its implementation rather that to introduce all of its elements at once. It was suggested that management would resist if they are "hit with everything at once", and then there is the risk that nothing would be implemented. As one participant recommended,

> So take it in bite size manageable pieces because when you look at the entire thing, it's a lot and can be quite daunting, so where do I start? Even if you prioritize and identify that you focus on clear leadership and expectations, that's a huge piece. How do you create that amongst one leader, five or even a hundred? It's huge.

It was noted that organizations often have five-year business plans and that these are amenable for staging larger strategies such as the Standard. With planning, implementation can be targeted for less busy times in the work year.

To ease implementation, it was also proposed that the Standard could be aligned with existing strategies such as performance plans or incorporated with existing structures within the organization ("if we align it with the environmental health and safety group, we have a better chance of implementation"). One provincial level strategy, the Certificate of Recognition (COR) Health and Safety Audit, Alberta Association for Safety Partnerships, was suggested as a mechanism through which the Standard could be incorporated for a large number of organizations. Although it does not currently do so, the audit was described as having the ability to identify the presence of psychological health and safety concerns as well as to plan and evaluate interventions. There were a number of advantages identified to taking this approach as it can be customized to industries, has a long reach with over 2300 organizations currently participating, and would be sustainable.

4. Discussion

The findings in this study confirm and illustrate the critical role that psychological health and safety plays across a range of workplaces and industries, and the unique challenges and situations that organizational members anticipate with implementing the Standard into their particular sites. The scope of the themes emerging from this study, and the range within each of these, speaks to the complexity of these issues. As a number of organizational and work-related factors can impact the risk to psychological health and safety of workers, it is perhaps not surprising that there appear to be nuanced differences between types and sizes of industries in their discussions regarding implementing the Standard.

The arguments for situating a preventive approach to mental illness in the workplace continue to be compelling, practical, and economic. When describing the benefits of the Standard, the participants were able to identify how it would contribute to at least two dimensions of positive mental health for workers. These reinforce both the hedonic (subjective well-being and life satisfaction) and the eudaimonic (positive functioning, engagement, fulfilment and social well-being) components that have been identified in the literature (Barry, 2009). The data also confirmed previously identified benefits to implementation including increased productivity, recruitment, retention, and operational success along with decreased conflict and the costs of disability and absenteeism (Standards Council of Canada, 2013).

The Standard appears to strongly resonate with organizational values, beliefs and existing practices in the workplace such as programs addressing violence in the workplace, Employee Assistance Programs, and accommodation for disabilities. The 13 factors were either already, or could well be, addressed in the workplace according to the study participants. This speaks to the solid empirical and theoretical foundation of the Standard. The Standard agrees that a psychologically healthy and safe workplace requires commitment from both the employer and the employee, and that successful and continual improvement is determined by their active participation (Standards Council of Canada, 2013). To be effective, however, it appears that the Standard must be relevant and clear for employers regardless of the size, location, or sector of the workplace. The Standard also needs to be flexible enough to be customized to their unique situations.

The paradox is that this congruence with organizational values and practices raises the risk that the nuances and subtleties of the added value and the momentum for uptake of the Standard may be lost. In Canada, however, there is another "push" on governments, employers, and other stakeholders to create psychologically safe workplaces. Shain (2010) describes, "a rising tide of liability for employers in connection with failure to provide or maintain a psychologically safe workplace" and with it, "increasing insistence of judges, arbitrators and commissioners upon more civil and respective behaviour in the workplace and avoidance of conduct that a reasonable person should foresee as leading to mental injury (p. 24).

There were differences described by participants between the cultures of organizations, and the description of the culture within healthcare was particularly disturbing. It is perhaps not surprising that participants from the health sector had the language and ability to identify risks to psychological health and safety as they should have the education, training and experiences to identify that mental health, as an entity, is more than the absence of a mental disorder (Barry, 2009, p. 6). Research suggests that healthcare professionals have been disheartened with decreasing autonomy and job satisfaction, unacceptable rates of assault and injury, and emotionally draining experiences that include bullying, moral distress, compassion fatigue, and anger (Austin, Bergum, & Goldberg, 2003; Austin, Goble, Leier, & Byrne, 2009; Reknes et al., 2013; Shields & Wilkins, 2008; Thomas, 2009). Furthermore, healthcare does appear to have a history of slow adoption of healthcare standards (Moran & Scanlon, 2013). What this study does add is the perceived lack of receptivity by senior healthcare managers to implementing policies to protect and promote the mental health of their employees.

There is the also the suggestion from these findings that organizations most in need of implementing the Standard may be the least receptive. For example, in one large organization, there were a number of suicides that were generally believed to have resulted from psychological injury in the workplace. Despite this egregious possibility, positive change did not occur. There appears to be a tendency to view mental health as an attribute of the individual, to emphasize the importance of the most proximal psychological factors, and to underestimate the impact of the wider social and structural determinants (Barry, 2009, p. 9). In contemplating its role, Shain (2009) asserted that corporations need to move beyond thinking that mental distress in the workplace is a function of the individual and balance this with recognizing that "normal and typically resilient people can be brought to the brink of mental distress, and sometimes pushed over, by conditions of work over which employers have significant control while they as employees have very little (Shain, 2009, p. 47). As the greatest gains to be made for the mental health of employees are within those organizations that are the most psychologically hazardous, this finding suggests that there is an immediate and urgent need to determine strategies for improving receptivity to implementing the Standard in organizations that would most benefit.

There are several implications of the study findings. Mental illness and psychological injury have emotional and financial implications for employers, employees, families, and the broader society. There appears to be a need for tailored engagement and implementation strategies for different industries of type as well as for different sizes of organizations. Multiple sites, layers of management, types of employees, shifts, and cultures are just some examples of their challenges. Clearly, a complex issue like psychological health and safety in the workplace requires an equally nuanced and sensitive strategy for its intervention.

At the same time, there appears that there may be recognition for the benefit of the Standard as a resource that could provide direction, tools, and guidance, and it is suggested that a simplified description

and staged implementation has positive implications for policy implementation. Given the scope of 13 psychological factors and the 60-page document outlining the Standard, this is perhaps not surprising. The technical committee for the Standard itself recognizes that its implementation is not an event but rather a process (Standards Council of Canada, 2013, p. 1). Perhaps this is a message that needs more emphasis. What this study did uncover is the variability of receptivity to the language used in the Standard and the scope of the Standard.

5. Study Limitations

One limitation of this study is that some of the participants knew one another as well as the interview moderator. Although this is not uncommon in workplace settings and group interviews, and the moderator was not in a position of power or authority, it is possible this may have influenced their responses as a result of the social desirability of positive responses. To mitigate this effect, the moderator had invited participants to contact her with following the interviews. If this effect occurred, however, the negative reactions to the Standard as observed in this study could have been under stated. Due to process and structural constraints, the interviews occurred before data analysis precluding an iterative process that would have allowed for validation, exploration and further clarification of themes. The small number of participants may be considered a limitation particularly considering their heterogeneity, and there may be more to study in terms of variability and to draw conclusions (Thorne, 2008). Our analysis did, however, show thematic saturation based on the collected data. Another study limitation is that it was conducted in only one Canadian city, and does not give a very broad perspective of this topic. However, this was the first of a larger program of research employing the mixed methods approach of exploratory sequential design to explore the study findings across other settings and populations.

6. Conclusions

The findings of this exploratory study, in the context of the larger body of available knowledge, lead to some conclusions. Many employers recognize that psychological health and safety in the workplace is a critical issue that must be addressed, and are looking for direction in how to best respond. The Standard for psychological health and safety resonates with their organizational values and beliefs, and can provide direction, but its scope and complexity can pose challenges. For further receptivity, gains may be made through increased attention to the fit with different organizational cultures and sizes as well as a simplified process for implementation.

Conflict of Interest

The authors wish to declare that they do not have any actual or potential conflict of interest including financial, personal or other relationships with other people or organizations within three years of beginning the submitted work that could inappropriately influence, or be perceived to influence, their work.

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