# Building Healthy Workplaces: Where We Need to Be

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Developing healthy workplaces has received increased attention by the media and researchers, and it has become an important goal for many organizations. However, many organizations are struggling not only to define a "healthy" workplace, but also to assess both the "healthy" and "unhealthy" aspects of their own environment, and to implement initiatives to improve the quality of their work and workplace.

## What Do We know?

In our quest for healthy workplaces, we must be careful to ensure that we incorporate a holistic approach to health. That is, a healthy workplace must encompass the physical, psychological, and social contributing factors. Moreover, we must assess the effectiveness of healthy workplaces using multiple indices of individual health (i.e., psychological, physical, and behavioural), multiple indices of organizational health (e.g., productivity, turnover, customer perceptions), and multiple societal indices.

As the articles in this Special Issue attest, several conclusions regarding the linkages between work and both mental and physical health are justified. First, there is a huge body of literature documenting the direct and indirect costs of work stress (e.g., unsafe work environments). Paradoxically, the pervasiveness of the "stress" effect, as well as the myriad of pathways through which occupational stress can affect economic and social outcomes, makes it almost impossible to derive a precise accounting of these effects. What is clear, however, is that the costs of unsafe, stressful, and unhealthy workplaces are horrific in personal, economic, and social terms.

Second, research conducted primarily since the 1960s has identified the principal characteristics of jobs that affect well-being. Although debate about individual mechanisms (e.g., the interaction of demand and control) continues and new empirical findings continue to emerge, it is possible to articulate the principal features of "good" work as defined in terms of health (see for example Parker, Turner, & Griffin, 2003; Warr, 1987). Failure to design healthy work and workplaces can no longer be blamed on a matter of lack of knowledge about the factors influencing the development of a healthy workplace; it has more to do with a lack of communication of this knowledge to the change agents, a lack of skills in how to produce change, and a lack of will to change.

Third, there is a clear parallel between the literature addressing job design as a means of increasing motivation and organizational effectiveness (e.g., Hackman & Oldham, 1980; Parker & Wall, 1998) and job design as a means of improving individual well-being. The job features identified in both cases are virtually identical. Jobs that challenge individuals to use their abilities, that allow individuals to develop and use their skills, that allow individuals decision-making authority or autonomy, and that allow the use of a variety of skills result in increased motivation, increased performance (Fried & Ferris, 1987), and enhanced mental health outcomes (Warr, 1987).

## Towards a National Strategy

These observations and the supporting literature suggest three principal foundation blocks for a national strategy to address issues of work and mental health, in terms of assessment, primary interventions, and education and training. First, assessing solely disease (either mental or physical) and organizational outcomes (e.g., absenteeism, productivity) is, by definition, focusing solely on the *lagging* indicators (i.e., outcomes of individual and organizational well-being). In contrast to such a focus, we advocate a focus on the assessment of *leading* indicators (i.e., predictors or causes) of mental and physical health in the workplace. Second, discussions of job stress are frequently limited to "stress management" interventions and to the role of counseling services through employee assistance programs. In contrast, the organizational research would suggest a dual focus, not only on these types of stress management interven-

tions (i.e., tertiary care), but also on changing the job stressors through activities such as job design and leadership training (i.e., preventative or primary care). Third, implementation of these first two points requires education and training at two levels: (1) in the workplace so that managers see the value of properly designed jobs; and (2) among mental-health professionals, who may be poorly not be equipped to deal with specific issues of mental health in the workplace.

*(1) Assessment*

In articulating their National Strategy for the Prevention of Stress Related Disorders, the researchers at National Institute for Occupational Health and Safety (NIOSH) advocated a national program of assessment and monitoring work conditions (Sauter, Murphy, & Hurrell, 1990). In Canada, sporadic and pro forma attempts to measure work conditions have been made through the *National Population Health Survey*, the *General Social Survey*, and, most recently, the *Workplace and Employee Survey*. However, several problems have been associated with many stress surveys. First, only rarely do these surveys measure job characteristics in sufficient detail to allow in-depth analysis. Moreover, those surveys that include valid measurements of job characteristics often fail to include either physical- or mental-health outcomes. Finally, inclusion of measures has also been based on a limited consideration of job characteristics – most often tied to a particular theoretical model (e.g., the Job Characteristics Scale associated with the Demand-Control model), without regard for other characteristics or models.

Therefore, as identified in the Healthy Workplace model in the introductory article, more useful data could be derived from a comprehensive assessment of job characteristics, role stressors, and both mental and physical health in the Canadian workforce. Such an assessment should be based on longitudinal design to allow the precise specification and testing of rival theories, and most importantly, the assessment of changes in the workplace.

Implementation of such an assessment strategy will provide the data that will allow organizations to come to grips with issues of workplace stress and workplace health. In particular, such data will provide a normative basis for comparison and allow organizations to make informed judgments about what is working and what is not working in their specific workplace. In the absence of "real" data and "real" benchmarks with which to provide such a comparison, calls for organizations to deal with issues of workplace stress will continue to fall on deaf ears.

The need for ongoing assessment of working conditions and their relationships to well-being is exacerbated given the rapid changes experienced in today's workforce (NIOSH, 2002). Our ability to understand and deal with the effects of change has been far outstripped by the extent and speed of change in the workplace.

*(2) Primary and Tertiary Intervention*

Few would debate the necessity for effective treatment of mental disorders and mental diseases. To do so would be simply irresponsible because there always will be an ongoing need in organizations for the services of employee assistance programs, stress management programs, lifestyle programs, and the full range of interventions designed to enhance individual well-being. A sole focus on treatment, however, will limit us to continually "healing the wounded." A complementary initiative should focus on primary intervention, in which organizations focus on reducing workplace stressors.

As indicated in the Healthy Workplace model presented in the introductory article, there are several factors leading to the development of healthy workplaces. Many (and we may argue *all*) of these factors are amenable to primary intervention. In the context of workplace stress, two primary interventions that may influence these factors are readily apparent: job design and leadership training First, it is clear that job redesign (e.g., to enhance skill variety, autonomy, skill use) is an effective means of improving mental-health outcomes. Moreover, job redesign has clear benefits in terms of motivation, performance, productivity, and absenteeism (for a review, see Parker & Wall, 1998). The national program of assessment and monitoring mentioned above would provide workplaces with the data and tools necessary to redesign jobs for optimum health and business efficiency. Harter, Schmidt, and Hayes (2002) found that employee attitudes were closely linked to organizational profitability and productivity. These results clearly show that individual health and business efficiency objectives are not mutually exclusive, and in fact, are complementary.

Second, as reviewed earlier, organizational leaders are potent influences on the well-being of their subordinates (Kelloway, Sivanathan, Francis, & Barling, 2005). Sivanathan, Barling, Loughlin, and Kelloway (2003) reported that perceptions of leaders' transformational leadership style were linked to increased trust in management and increased self-efficacy. In turn, trust and self-efficacy were linked to well-being. Interestingly, Sivanathan et al.'s (2003) findings emerged in the context of relatively low levels of

organizational stressors, suggesting that being exposed to transformational leadership had a generally beneficial effect on employee well-being, regardless of the degree of exposure to stressors.

Sivanathan et al.'s (2003) results are important for two reasons. First, the notion that transformational leadership exerts indirect effects on well-being is consistent with findings relating transformational leadership to other important outcomes (Howell & Avolio, 1993), including organizational performance (Barling, Weber, & Kelloway, 1996). Second, some implications for primary prevention of employee well-being ensue from these results. Specifically, interventions that attempt to achieve high-quality leadership in the workplace might plausibly be associated not only with enhanced work performance, but also with enhanced psychological well-being.

*(3) Education and Training*

Finally, not only is this type of leadership training important within organizations, there is a need for greater education and training on these issues external to organizations. Mental-health professionals and organizational scholars may be poorly suited to dealing with issues that span the domains of both organizational and individual functioning. Recognizing these limits, the U.S.-based NIOSH joined with the American Psychological Association (APA) to promote a new subdiscipline, "occupational health psychology," as being concerned with "the application of psychology to improving the quality of worklife, and to protecting and promoting the safety, health and well-being of workers" (Sauter & Hurrell, 1999, p. 120). This APA-NIOSH partnership resulted in several initiatives, including the sponsorship of five international conferences dealing with work, stress, and health. A new APA journal, *The Journal of Occupational Health Psychology*, was launched, and programs to fund graduate and postgraduate training in occupational health psychology were initiated and are ongoing (for a review of these early efforts see Schneider, Camara, Tetrick, & Stenberg, 1999).

These activities also were reflected in the European community. A journal specifically devoted to issues of workplace health, *Work & Stress*, was launched and the European Academy of Occupational Health Psychology (http://www.ea-ohp.org) was formed and hosts regular conferences. In addition to the programs in the United States, graduate training programs in occupational health psychology have been launched in various countries, including England, the Netherlands, and Sweden (Sauter & Hurrell, 1999).

In Canada, the field of occupational health psychology is flourishing, although to date, there have been few formal efforts to develop the field as an entity apart from, or within, Industrial/Organizational Psychology. Graduate training in occupational health psychology is either nonexistent or hidden in existing graduate I/O or management programs (i.e., courses in organizational psychology or organizational behaviour typically include some consideration of stress, health, and/or safety). There would appear to be an opportunity here to address an important issue in public health through education and training in occupational health psychology.

## Conclusion: Where We Need to Be

The model we presented in the introductory article of this Special Issue was predicated on the job stress model. Although it was not meant to be all-encompassing, it provides a succinct summary of the literature on the multiple antecedents and consequences of healthy workplaces. As demonstrated by the literature reviews (and by the research itself) in all of the articles in this Special Issue, we have a solid understanding of many of these factors. However, in order to move this research into practice, and develop healthy workplaces, we need to communicate these findings to organizational change agents, explicitly making the link between healthy workplaces and organizational efficiency and effectiveness in terms of their bottom line. This transfer of knowledge must also be accompanied by skills training for key organizational individuals, to ensure organizations have the capability to change. Most importantly, the three foundations of assessment, primary prevention, and education/training provide the basis for effecting this real change in Canadian workplaces: change that will improve both individual well-being and organizational functioning, and change that will lead to the creation of truly healthy organizations.

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