Mentally Healthy Work in Aotearoa New Zealand

Short essays on important topics

WORKSAFE
Mahi Haumaru Aotearoa

Te Kāwanatanga o Aotearoa
New Zealand Government

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Mentally Healthy Work in Aotearoa New Zealand: Short essays on important topics

John Fitzgerald

Good work has always been good for workers, and engaged, happy workers have always been good for business and good for the community. However, it is only recently that these truisms have been widely accepted and have started to drive health and safety systems and practices in the workplace.

Health and safety at work is no longer limited to keeping workers alive and on the job. There is a greater recognition that healthy workers are more productive, more likely to stay around, better advocates for their employer, actively engaged and contributing to the production process, better work colleagues, and so on. What may not be seen directly by a business is that healthy workers also reap benefits outside of work and contribute to wider community welfare.

A new focus on worker wellbeing, supported by good work design, has never been more important than in recent years when we have all been living in the shadow of a global pandemic. While there are many challenges to addressing the mental wellbeing of workers, three stand out in particular.

1. **Wellbeing is dynamic and personal** – Wellbeing is not a binary concept, that is, a person does not either have wellbeing or not. Rather it is a continuum along which a person can move from moment to moment. It is dynamic and a person's state of wellbeing is constantly changing. Events, interactions, even thoughts and recollections can change a person's wellbeing. This makes monitoring wellbeing difficult because it relies heavily on the level of engagement between a worker and the employer, usually via a line manager, which is dependent on the nature of the relationship between these people, that is, the level of trust, confidence, openness, relationship history, reliability, etc.
2. **Wellbeing is subjective** – How do we know this? Consider how difficult it is to describe an experience such as pain or the experience of receiving an inoculation. The practitioner administering the inoculation will describe what is about to happen as 'slight pressure', but this might be quite different from the experience of the person on the receiving end of the needle. Perspective matters. Personal wellbeing is susceptible to the same subjective evaluations, and this is why a one-size-fits-all approach will never work — people are different, have different needs, and are changeable.

3. **Challenges to mental health at work are ubiquitous** – which means there is the potential for every worker in every workplace across New Zealand to be exposed to risks to their mental health and wellbeing. Workers within even the most supportive businesses in New Zealand will experience challenges to their mental wellbeing. This is just a fact of life. Many of these can be short-lived and/or easily managed. What a business needs to do is work to identify and mitigate the challenges that may impact on a worker's health and safety at work, and certainly not exacerbate these challenges by heaping work-related challenges on top of the usual challenges of life.

So, all workers are exposed to psychosocial risks. They build up over time and workers respond differently to these risks, and our attempts to mitigate the risks. These considerations are what makes this a complex but rewarding area of work.

About this book

Our aim when planning this book was to invite a range of experts, practitioners, thought leaders and interested parties to share their knowledge and insights on the range of topics associated with mentally healthy work in Aotearoa New Zealand. We are grateful to the authors who accepted this challenge. As if this were not enough, we placed some additional restrictions on them.

We asked authors to keep their comments as grounded as possible, providing the reader with ideas, examples that can be used in practice. Because of this, we have some chapters which are more academic/research oriented because this is the experience and area of expertise of the writers, while others are built on practice. We hope the range of approaches and differing styles will mean there is something here for everyone.

I believe we have collected a great range of essays on disparate topics within the field of mentally healthy work. It is a book that has been produced by local scholars and practitioners for Aotearoa New Zealand. We hope you find it useful. Our thanks to all those who have worked so hard to bring this book to completion.

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Mentally Healthy Work in Aotearoa New Zealand

Janice Riegen & Hugh Norriss

Having a healthy workplace has been described as "the right thing to do, the legal thing to do and the smart thing to do" (World Health Organization, 2010). This includes mental health, and interest in psychosocial health within workplaces has been growing rapidly in recent years.

This chapter explores how health and safety practice, legislation, research policy, and cultural developments are changing our understanding and practice of mental health at work in Aotearoa New Zealand.

We see that there are three main drivers leading towards more proactive approaches to mentally healthy work in Aotearoa New Zealand. These are:

1. Shifting expectations, trends and attitudes towards mental health in wider society
2. Changes in New Zealand's Health and Safety legislation, policy, practice and attitudes
3. International influences

Shifting expectations, trends and attitudes towards mental health in wider society

Mental health at work is affected by the overall mental health of a worker interacting with what happens at work. This might result in mental states of flourishing with high wellbeing, being stressed, burnt out, anxious or depressed, or anywhere in between.

Mental health at work cannot be considered in isolation from the trends relating to psychological health in wider society. While workplaces may have some influence on worker mental health, potentially the greater effect will come from broader social and environmental factors. Therefore, workplace mental health strategies that ignore these may be in for challenging times when aiming to support their employees' mental health in the most effective way. The New Zealand Health Survey 2019/20 (Ministry of Health, 2020) reports steadily increasing levels of psychological distress in the population, reflecting a largely physically safer but psychologically more challenging world.

Data shows increasing psychological distress, anxiety and depression, particularly among young people and especially young women where psychological distress more than doubled in the 10 years prior to 2019 (Ministry of Health, 2020). While workplaces are currently focusing on what they need to do to create mentally healthy workplaces, they will also need strategies for how to cope with heightened anxiety and depression being generally experienced by employees, and how they overlap with workplace experiences. Therefore, explicit discussion and understanding of societal trends, and drivers of population mental health should be considered as part of any overview of workplace wellbeing.

Another important trend has been greater acceptance of talking about mental distress and mental illness, seeking help, and reduction in stigma. This is associated with increased public expectation of substantially expanded and improved mental health service systems to respond to changing ideas about mental health.

International mental health policy, including in Aotearoa New Zealand, has been moving towards the three imperatives; mental health promotion (staying well and resilient), mental health prevention (intervening early), and improvements in treatment in line with human rights and dignity.

In spite of cultural and policy changes to mental health, many workplaces are ill-prepared to have even basic mental health conversations, let alone a comprehensive strategy that can provide mental health protection, support and promotion.

Changes in New Zealand health and safety legislation, policy, practice and attitudes

In recent years there has been a recognition that workplaces need a culture shift towards "putting the health back into health and safety" (Laird, 2017). This supports previous Occupational Health (OH) approaches where OH practitioners used to be part of many larger workplaces, ensuring a holistic approach with an in-depth knowledge of the industry. There are benefits of this more holistic focus with identifying a need to look at the effect of work on health and health on work. Treating people not just as liabilities for accidents but as individuals with rich inner and social lives, and having many strengths to offer, opens the way to a more accepting workplace environment.

From a legislative perspective, the introduction of the Health and Safety in Employment Act (1992) saw an increased focus on workplace safety and employer responsibilities, including mental health. Resulting case law informed legal and medical obligations, placing increased responsibilities on employers to provide a work environment and management practices that did not put unreasonable stress on employees (see Scott-Howman & Walls, 2003). The Health and Safety Employment Amendment Act (2002) redefined hazards and harm, ensuring the management of risk of mental harm through physical and mental fatigue were identified as an employer's responsibilities.

The 2010 Pike River mining disaster led to legislative changes and the creation of the Health and Safety at Work Act (HSWA) 2015, revised in 2020. This Act doesn't specifically identify wellbeing or psychosocial risks, but it does specify that health refers to both physical and mental health. As workplace health-related challenges shift, and with mental illness and cardiovascular disease rising, "… addressing the more complex relationships between work and health becomes an urgent task for the future of New Zealand labour law" (Duncan, 2018).

In recent years, a number of key documents and projects have been influential in highlighting the importance of mental health in workplaces.

Government

- The *New Zealand Government's Health and Safety at Work Strategy (2018–2028)* was developed jointly by the Ministry of Business, Innovation and Employment (MBIE), WorkSafe New Zealand, and a range of relevant stakeholders. The document is built on a vision of improving the wellbeing of all New Zealanders through making workplaces healthier and safer, and reinforcing the need for workers to be at the heart of the strategy. In the strategy, the government calls for a broader view of work-related health risks, including mental health, and the development of work cultures that support healthy work.
- *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addictions* (New Zealand Government, 2018) identified a need for a whole-of-government approach to mental wellbeing. This included more responsive services and influencing the social determinants of health through adopting a prevention focus and acknowledges that workplaces have a part to play. The Mental Health and Wellbeing Commission (MHWC), now called Te Hiringa Mahara, was established to provide monitoring and advocacy over the work. Their report, *Te Rau Tira, Wellbeing Outcomes Report 2021* identifies a vision of "Tū tangata mauri ora, flourishing together" for wellbeing in Aotearoa (MHWC, 2021, p.2). From a shared perspective, they identify a need for "people feel safe, secure and free from harm and trauma" wherever they live, learn and work (p.9).
- Within New Zealand there is growing recognition of our bi-cultural environment and our commitment to Te Tiriti o Waitangi. The principles fit well with supporting workers through partnership, participation and protection. Many workplaces have an increasing awareness of hauora (health and wellbeing) of their workers, with some even using Māori models of wellbeing such as Te Whare Tapa Whā (Durie, 1984). These ensure a holistic perspective that is inclusive of mental health.

- The *New Zealand Treasury Living Standards Framework (LSF)* outlines four domains needed for wellbeing. These domains consist of natural, financial and physical, social, and human capital. There are synergies across these four areas of capital, and culture is woven throughout (The Treasury, 2021). Under human capital, employment is mentioned. It is intended that, in time, organisations and government will be reporting on how they are integrating this framework. New Zealand saw its first Wellbeing Budget in 2019 guided by the LSF. Arguably good work and healthy workplaces play a critical role in the government's commitment to improving the living standards and health and wellbeing of all New Zealanders.
- Accident Compensation Corporation New Zealand – As context for their Workplace Injury Prevention Grants in 2021, the Accident Compensation Corporation (ACC) stated that COVID-19 has pushed wellbeing to the forefront and shown the importance of reciprocal social support in the workplace. This attention to wellbeing, in addition to physical harm/safety, is generally new terrain for ACC. It is a further indication that the wider workplace health and safety conversation is moving beyond solely physical risks, to include psychosocial protection.
- The Government Health and Safety Lead (GHSL) is a service which provides practical support for government agencies. The *Creating Mentally Health Work and Workplaces* guide (GHSL, 2021) showcases the link to evidence of how modern work practices and psychosocial risks are harming workers.

Regulator

- *Healthy Work: WorkSafe's Strategic Plan for Work-Related Health 2016–2026* recognises that the health and safety system has generally failed to adequately address work-related health risks and the harm associated with them even though health-related harm far exceeds acute work injuries. It requires five categories of risks to be managed: physical, ergonomic, chemical, biological, and psychosocial. It also highlights employers' responsibilities and the need to work with social partners and stakeholders collaboratively. This includes the Ministry of Health (MoH) given that the *New Zealand Health Strategy: Future Directions* (MoH, 2016) promotes a whole-of-life approach inclusive of employment.

- A precursor to the current WorkSafe focus on psychosocial risks was the report *Healthy Work: Managing Stress and Fatigue in the Workplace* (Department of Labour, 2003). This identified the need to adopt a hierarchy of control for workplace stressors. This approach was not comprehensively implemented. A focus on psychosocial harm has been highlighted more recently by the WorkSafe report *Psychosocial Hazards in Work Environments and Effective Approaches for Managing Them* (WorkSafe, 2019).

- Ross Wilson, WorkSafe Board Chair, said at the 2020 Health and Safety Association of New Zealand (HASANZ) AGM discussion forum, that we are not appropriately dealing with health and psychosocial stressors, and it was time to adapt and change, to work differently and create better workplaces with mentally healthy workers. He identified the need to move away from traditional risk management, shifting from a liability mentality to social purpose, and people being seen as the problem to people as the solution, and deficient to resilient workers.

- *How Healthy is your Workplace?* (WorkSafe, 2021) encourages business leaders to improve safety practice by proactively managing health-related risks. The Deloitte (2017) Health and Leadership survey identified that only 18% of leaders made worker health a priority. It also found that there is a need to think beyond safety concerns and consider the impact work has on worker health.

- WorkSafe has an increasing focus on 'Better Work' (where more things go right) with three strategic outcomes: healthy work, safe work, and equitable outcomes. In relation to this, WorkSafe commissioned a literature review entitled, *Workplace Health and Safety and the Future of Work in New Zealand*, examining the impact of mental health and chronic health conditions and their relatedness to work. The authors suggested that health and safety at work is about more than the absence of injury, and that work-related illness and psychosocial risks are important considerations (Hennecke, Meehan, & Pacheco, 2021).

Non-government organisations

- The Mental Health Foundation (MHF) of New Zealand was an early leader in workplace wellbeing with its *Working Well* programme and resources being established in the 1990s. *Working Well – A practical guide to building mentally healthy workplaces* (latest version MHF, 2016) provided early guidance for businesses, much of which is still relevant today. Since then, a wide range of private and not-for-profit entities have set up training, websites and resources for workplace mental health covering topics such as stress, generic mental health, wellbeing, resilience, bullying and harassment, suicide prevention, and managing issues like fatigue, substance misuse, and the COVID-19 pandemic.
- The Health and Safety Association of New Zealand (HASANZ) was established in 2014, as a representative body of health and safety professionals. This stemmed from the government's Taskforce on Workplace Health and Safety (2012) and the Working Safer package of reforms (2013). A predecessor of this group was the voluntary Occupational Health and Safety Group (OHSIG). Such collaborative approaches are helping shift the culture away from silo working, building the capacity and capability of professions, through sharing data and promoting the importance of mentally healthy workplaces.
- Business Leaders' Health and Safety Forum (the 'Forum') comprises CEOs and other senior business leaders who run businesses in New Zealand and who are committed to developing their leadership of health and safety. In 2021 the Forum published a revised version of their *CEO Guide to Mental Health and Wellbeing at Work*. In it they note that there are moral, legal and business drivers to creating mentally healthy work through a framework of protecting, supporting, reclaiming and fostering their workers. Also, in 2021 the Forum released *Protecting Mental Wellbeing at Work: A Guide for CEOs and their Organisations*, which suggests that mental wellbeing is not a matter of luck but a matter of design. That is, achieving worker wellbeing requires a deliberate effort to control psychosocial risks and build in the protective factors associated with good work.

- New Zealand Workplace Barometer studies (2018–21). This ongoing research is conducted by Massey University's Healthy Work Group and was developed in collaboration with the Asia-Pacific Centre for Work, Safety and Health (Tappin et al., 2019; Forsyth et al., 2020). It uses a Psychosocial Safety Climate (PSC) lens to assess the prevalence, nature and impact of psychosocial risk factors on workers and businesses in New Zealand.
- Another healthy work policy initiative that further demonstrates growing multi-sector policy alignments around mental wellbeing is from the Australasian Faculty of Occupational and Environmental Medicine (AFOEM) and the Royal Australasian College of Physicians (RACP). Their *Consensus Statement on the Health Benefits of Good Work* (2017) emphasises the benefits of good work on health and wellbeing and the negative impact of unemployment. It supports several policy documents on the health benefits of work, and what is considered good work. It defines good work as, "...engaging, fair, respectful and balances job demands, autonomy and job security".
- With five editions between 2013–2021 the Southern Cross and BusinessNZ Workplace Wellness Survey is playing an important part in prompting ongoing improvement in New Zealand's health and safety landscape. The 2019 survey provided data on how businesses are understanding their workforce more holistically (physically and mentally). Factors contributing to workplace stress were highlighted, with a 23.5% increase in stress and anxiety and a rise in absenteeism and associated costs.

  The 2021 survey found an increased interest in workplace health and wellbeing due to COVID-19 and related public policy. Adaptability and flexibility, including increased working from home, were seen as key challenges. Workload remained the biggest cause of work-related stress/anxiety for business, with 66% reporting increased stress levels, with 91% citing COVID-19 as a partial reason why. Other concerns were change and uncertainty, fear of getting sick, and relationships at work. Time lost to absence averaged 4.2 days per employee, a cost of around $1.85 billion for the total economy. The report noted an increase in approaches to wellbeing in the workplace such as pandemic preparedness, increased provision of flexible working, and some generic and mental wellbeing education. There is a continuing high reliance on Employee Assistance Programs (EAP).

Small businesses

- Small and micro businesses (<20 employees) make up 97% of New Zealand's businesses (Ministry of Business, Innovation and Employment, 2021). A 2019 survey found that 31% have experienced poor mental health since starting or taking over their business (NZ Entrepreneur, 2019). The *Small Business Wellbeing Report* by Xero and the Mental Health Foundation (2019) found that many small business leaders lacked a holistic understanding of the importance of wellbeing and the impact this has on their business, and only a third thought their staff would benefit from improved wellbeing.

The New Zealand examples of recent or current policy and research (above) illustrate the extent of increase in knowledge and intent for improvement of mental health in workplaces. This now needs to translate into more practical applications. As data continues to show increasing stress at work, little if any reduction in injuries, and increasing distress and mental illness across the total adult population, there is a risk the many workplace wellbeing policy initiatives, statements and plans could become just encouraging but ineffective words. Despite this, there is some evidence of businesses leading with positive and outcomes focused approach to health and wellbeing.

One example of an industry where a mental wellbeing approach is becoming embedded effectively into workplace culture is farming. "An estimated 15,000 farmers and farm workers have attributed improvement in their wellbeing to Farmstrong, and research shows this is linked to a decrease in physical injuries (Wyllie, 2021). The Farmstrong programme draws on the expertise of farmers themselves and facilitates positive and practical information-sharing about health and wellbeing among peers. This may be the key to the programme's success. It contrasts with many current health and wellbeing approaches which have a top-down approach from experts not embedded in the reality and identity of the workforce. Another example of a comprehensive and social approach that includes education and resources, screening, early intervention, and peer-sharing is the New Zealand Defence Force Health Hub.

In recent decades there has been growing response to the psychological effects on people of witnessing and experiencing disasters. New Zealand's population-wide initiative *All Right?* (www.allright.org.nz) set up to support people psychologically following the Christchurch Earthquakes, has been extended and re-purposed for disasters such as the Kaikoura Earthquakes and the COVID-19 pandemic. A subset of this work directly supports workplaces as they adjust to these events. This has brought a more social dimension to workplace mental health prevention and promotion. It complements and extends more traditional health promotion approaches focused on individual behaviour change.

International influences

There is international evidence that investing in the health and wellbeing of workers provides a substantial return on investment (ROI) (Price Waterhouse Cooper, 2008, 2010). The OECD (2018) estimated that poor mental health cost the New Zealand economy some 4–5% GDP every year through lost labour productivity, increased healthcare expenditure, and social spending. Belcher and Dollard (2016) looked directly at the links to productivity and identified that there was strong financial argument for businesses to mitigate psychosocial hazards by establishing and maintaining a good Psychosocial Safety Climate (PSC).

A Deloitte (2019) study revealed that it is critical to have a comprehensive strategy that promotes positive mental health and wellbeing, as well as supporting those with poor mental health, in work, at home, and on return to work. A focus on leadership commitment and training is crucial at all levels.

There is a need to take this global evidence and make it applicable to the New Zealand environment, and relevant to Māori and in alignment with Te Tiriti o Waitangi obligations.

Some examples of relevant, influential international approaches and developments are outlined below.

Australia

New Zealand's health and safety frameworks and practices are largely based on the Australian work health and safety law but with changes to reflect the differences between the New Zealand and Australian working environments. Psychological health entered Australian legislation via the Work Health and Safety Act 2011, stating that health was both physical and psychological.

The Australian government's Productivity Commission (2020) report on mental health in Australia identifies the critical role that workplaces play in prevention of harm and support of those with mental health problems. The report recommends improving psychological safety through better risk management to improve both mental health outcomes and productivity.

SafeWork Australia data shows that AUD$543 million is paid in worker compensation for work-related mental health conditions. Their 2019 *Work-Related Psychological Health and Safety* guidance recommended developing and sustaining a psychologically healthy and safe workplace that focuses on preventing harm, intervening early and supporting recovery.

The Australian Government's *Blueprint for Mentally Healthy Workplaces* (National Mental Health Commission, 2021) is aimed at creating a consistent approach to mentally healthy workplaces. It states that healthy environments, cultures and practices are essential to support life's challenges and enable development. They outline a model of three intersecting foundational pillars: protect, respond and promote.

There is also a focus on psychosocial risk management at the state level. The SafeWork NSW *Code of Practice Managing Psychosocial Hazards at Work* (NSW Government, 2021) outlines legal responsibilities and effective ways of managing these risks. WorkSafe Victoria (2021) have released their first *Mental Health Strategy 2021–2024*. It notes the growing mental health challenges in the community and suggests workplaces can play a key role in addressing these. WorkSafe Victoria have produced comprehensive guides for employers that support the creation of mentally healthy workplaces through psychosocial risk management. Their *WorkWell* model is aimed at promoting mentally healthy work and workplaces through resources, funding, and networking to prevent harm.

In 2021 SuperFriend, backed by the Australian insurance industry, published their *Indicators of a Thriving Workplace* survey of 10,000 workers. This national report looks at the benefits for thriving workplaces (for both the individual and organisation). It identifies connectedness, culture, capability, leadership, and policy as key areas of focus.

Canada

The *Canadian Psychological Health and Safety Standards* (CSA, 2013) provides a comprehensive voluntary framework for organisations to promote mental health and prevent psychological harm. The Standards framework includes guidelines, tools and resources to identify and reduce risks related to mental health and promote productivity and engagement, and reduce costs related to employee mental illness.

United Kingdom

Recognition of the importance of good work on population health and wellbeing has led to an increased focus on mentally healthy workplaces through the Health and Safety Executive (HSE), Public Health, The National Health Service, industry, research institutions, and not-for-profit advocacy. More recently there has been a notable increase of a whole-of-government approach in the recognition of good work on population health and wellbeing. Examples of this include *Improving Lives: The Future of Work, Health and Disability (2017); Thriving at work. The Stevenson/Farmer review of mental health and employers (2017); Good Work: The Taylor Review of Modern Working Practices; Living and working well (2018); Better health care for all. A 10-point plan for the 2020s; The Lord Darzi Review of Health and Care (2018); Good Work: A response to the Taylor Review of Modern Working Practices (2018).*

Organization for Economic Co-operation and Development

The OECD's recent report *A New Benchmark for Mental Health Systems: Tackling the Social and Economic Costs of Mental Health* (2021) highlights the importance of the burden of mental ill health. It identifies six principles to address rising mental health challenges, with an integrated approach across sectors and government departments essential. The report notes that the approach must include many actors, including workplaces, especially line managers.

Other global perspectives and influence

In 1986 the World Health Organisation (WHO)/International Labour Organization (ILO) committee on occupational health recognised the decades of research showing the association between workplace psychosocial factors and a wide range of health disorders. The 1989 the European Economic Community (EEC) directed a focus on psychosocial factors, which led to the formation of Psychosocial Risk Management Excellence Framework (PRIMA-EF). The European Agency for Safety and Health at Work observes that psychosocial risks and work-related stress are among the most challenging issues in occupational safety and health, and predicts a significant impact on the health of individuals and organisation, and on national economies.

In 2010, WHO published *Healthy workplaces. A model for action – for employers, workers, policymakers and practitioners*. It recommends workers and managers collaborate to use a continual improvement process to protect and promote the health, safety and wellbeing of all workers and the sustainability of the workplace.

The International Organisation for Standardisation (ISO) recently released their *Guideline for managing psychosocial risks – ISO 45003 (2021)*, which is helping further define psychosocial risks. It is intended to support the *Occupational Health and Safety Management System ISO 45001.* According to Crush (2021) ,the goal of ISO 45003 is to make good mental wellbeing part and parcel of business culture.

Globally, social and economic policymakers, governments, and many large organisations are acknowledging the importance of the social determinants of health, and the United Nations Sustainable Development Goals (SDGs). Good, decent and meaningful work is recognised as being critical to improving the health and wellbeing of populations. New Zealand's update on the progress of the 17 SDGs identifies a desire for an inclusive economy to deliver higher wellbeing and living standards and also a focus on improving mental health in the population. (New Zealand Ministry of Foreign Affairs, 2019).

The way ahead

Change has become a constant in modern workplaces. Drivers of change within the workforce include demographic trends such as higher proportions of older people, skill shortages, changes in workplace expectations with new generations, and increasing incidence of long-term health conditions. These changes are taking place in an environment of accelerating technological changes, global political and economic volatility, changing social norms and increasing focus on the mental health challenges of nations and communities (Riegen, 2013, 2016, 2017).

We suggest a number of advanced-level 'people skills' need to be developed if we are to take the policy and practice initiatives outlined through to practical implementation.

1. **Effective, authentic leaders.** Business and people leaders who are compassionate and resolute play a crucial role in creating mentally healthy workplaces. The quality of leaders can make or break organisations and its people. UK Government Health and Safety Advisor Professor Dame Carol Black believes the most important area to improve the wellbeing of workers is developing leaders, especially line managers. They need to create positive environments, protect and prevent harm, respond to changing expectations and social norms among workers, and identify and support at-risk workers.
2. **Engagement with and valuing employees.** This includes listening to workers, acting on issues, and helping them build hope, meaning and purpose within a supportive workplace community.
3. **Best practice guides.** There are now many local and international good practice guides for organisations to follow. Specifically psychosocial risk management needs to be integrated into health and safety culture. There are opportunities to work collaboratively with industry-specific groups, developing resources and practices and evidence that are practical and adaptable to that industry.
4. **Inclusive practices and embracing diversity**. This includes support, policies and processes to respond to the increasing levels of psychological distress in the wider population and showing up in workplaces. It is also about providing psychological safety at work for people to be able to express their unique identities within the context of the work that needs to get done.

Growing healthy workplaces with good work practices is the right, legal and smart thing to do. It is good for mental health and wellbeing and vice versa. Workplaces that see mental health as a resource to be enhanced, not just a liability to be managed, will have reduced costs, higher productivity, and happier individuals and teams. They will also contribute to reducing a high mental health burden in wider society.

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Mentally Healthy Work context

Helen Lockett & Shunta Takino

This chapter places Aotearoa New Zealand policies and practices on mentally healthy work in an international context in relation to the OECD Council *Recommendation on Integrated Mental Health, Skills and Work Policy* (OECD, 2015). This legal instrument recommends, and provides the detail on, a set of policy guidelines to improve the labour force participation of people with mental health issues.

The chapter begins with an overview of the Council Recommendation, focusing on Part III – guidance for workplace policy. This is followed by a summary of the subsequent OECD review of Aotearoa New Zealand's polices on mental health and work, particularly workplace policies (OECD, 2018).

Next, the key findings of the latest OECD report on mental health and work, *Fitter Minds, Fitter Jobs*, which monitors the implementation of the Council Recommendation across all member countries (OECD, 2021a) are presented. A series of good practice policy and practice examples from other member countries that may be of relevance to Aotearoa New Zealand are also introduced to showcase how policies can incentivise employers to identify and respond early to employees experiencing mental ill-health and keep connected with employees who become sick. This section then provides examples of countries that have prioritised the role of integrated policy leadership and also the emerging policies across OECD countries responding to changes in the intersection of mental health and work during the COVID-19 global pandemic.

Recommendation of the Council on Integrated Mental Health, Skills and Work Policy

In December 2015, the OECD Council adopted the *Recommendation on Integrated Mental Health, Skills and Work Policy* (the Recommendation) (OECD, 2015), with all OECD countries, including Aotearoa New Zealand becoming Adherents.

The premise of the Recommendation is that to address the increasing numbers of working-age adults with mental health issues who are recently or long-term unemployed, an integrated, planned, and intentional national policy response is needed across health and welfare systems, in schools and in workplaces. The Recommendation calls for silos in mental health and work policies to be broken down and replaced by integrated policymaking and service delivery which take into account the linkages between mental health with employment, education, social, and health factors.

Of particular relevance to mentally healthy work is Part III of the Recommendation, which calls for member countries "to seek to develop and implement policies for workplace mental health promotion and return-to-work in close dialogue and co-operation with the social partners". The Recommendation has four key priorities for action that policymakers should consider to promote mental wellbeing in workplaces and retain workers who experience mental health issues (OECD, 2015) (see Text Box 1). The guidance covers:

1. How employers manage mental health risks and address concerns when mental health issues arise for workers
2. How public campaigns combat discrimination towards people with mental health issues and can raise awareness of mental health and its relationship with work
3. How workers with mental health issues are reintegrated into the labour market
4. How sickness leave policies help or hinder people with mental health issues

Text Box 1.

Extract from the Recommendation of the Council Part III. Improving mental health promotion and return-to-work

"III. Recommends that Adherents, in close dialogue and co-operation with the social partners, seek to develop and implement policies for workplace mental health promotion and return-to-work. To this effect, Adherents should, as appropriate:

a) promote and enforce psychosocial risk assessment and risk prevention in the workplace consistent with applicable privacy and non-discrimination laws, with the adequate support of occupational health services, to ensure that all companies have complied with their legal responsibilities;

b) develop a strategy for addressing stigma, discrimination and misconceptions faced by workers living with mental health conditions at their workplace, with a focus on strong leadership, improved competencies of managers and worker representatives to deal with mental health issues, peer worker training, and active promotion of workplace psychological health and safety;

c) promote greater awareness of the potential labour productivity losses due to mental health conditions by developing guidelines for line managers, human resource professionals and worker representatives to stimulate a better response to workers' mental health conditions, covering ways to best assist those workers, including recognition and intervention with co-workers and advice on when to seek professional support, with due regard to personal privacy;

d) foster the design of structured return-to-work policies and processes for workers on sick leave, and their (prospective or current) employers, notably by promoting a flexible and gradual return to work in line with the worker\s improving work capacity, with the necessary work and workplace adaptation and accommodations, and by using or experimenting with fit-for-work counselling services with a strong mental health component;

e) encourage employers to prevent and address overuse of sick leave by facilitating dialogue between employers, employees, and their representatives and treating doctors as well as other mental health practitioners on how an illness affects the work capacity and how adjusted working conditions can contribute to a solution, with due regard to medical confidentiality".

OECD, 2015

Evaluating Aotearoa New Zealand's workplace mental health policies

In 2016, the Ministries of Health and Social Development requested an independent report from the OECD to evaluate Aotearoa New Zealand's approach to policy challenges in respect of the Recommendation and to support improvements in the labour market participation of people with mental health issues. The OECD review team worked alongside the Mental Health and Addiction Services Inquiry team and the resultant report, *Mental Health and Work: New Zealand* (OECD, 2018) was published at the same time as the report on the Inquiry findings, *He Ara Oranga*. This was to ensure a coordinated and complementary approach. In a Cabinet meeting in May 2019, the government accepted 18 out of 20 of the OECD's recommendations (Ministry of Health, 2019) alongside many of the recommendations in *He Ara Oranga*.

The OECD review acknowledged that Aotearoa New Zealand's current policies relating to mental health and work provide a good foundation on which to build, but that progress in this area has been slow. The report emphasised the importance of addressing systemic barriers, and the need for stronger cross-government leadership to enact change.

Specifically on workplace mental health policy, the OECD review highlighted that whilst Aotearoa New Zealand has developed a range of resources and tools to help build awareness, and support employers to manage mental health in the workplace, these are not enough and must be accompanied by relevant policies and legislation (OECD, 2018, p. 18). Based on these findings, the OECD suggested some actions, including the following:

- Enforce legislation through obligations for employers and sanction those employers that do not comply.
- Train WorkSafe New Zealand staff on psychosocial issues and strengthen its enforcement capacity.
- Share good practice across employers and employer networks.
- Widen access to Employee Assistance Programmes particularly to small and medium-sized businesses, and offer a single point of contact for guidance for employers on mental health matters.
- Increase the period of employer-paid sick leave to stimulate healthy workplaces and strengthen collection of data on sickness absence.

- Promote return to work strategies with mutual obligations for all actors. This should include existing employees, managers and new employees.
- Replicate the comprehensive ACC approach and process for cases of illness.

While an update on the implementation of these recommendations is beyond the scope of this chapter, there have been a number of developments in Aotearoa New Zealand since the 2018 review. The report's recommendation to extend the period of employer-paid sick leave was implemented, with the period of employer-paid sick leave doubled from five to 10 days in July 2021. This brings the duration of paid sick leave available to employees to levels comparable with OECD countries. Further efforts to collect data from employers on the incidence of sickness absence[1] and promote return-to-work strategies are, however, still needed.

The role of WorkSafe in relation to mentally healthy workplaces has also been strengthened since the 2018 review, and employer networks are also promoting and sharing good practice, most notably the Business Leaders' Health and Safety Forum (see Guidance on 'Protecting Mental Wellbeing at Work' and the CEO Guide Mental Health & Wellbeing (Business Leaders' Health and Safety Forum, 2021)). The Mental Health Foundation have developed a guide on creating mentally healthy workplace environments for Māori (Mental Health Foundation, 2022) and the Government Health and Safety Lead in May 2021 published *Creating mentally healthy work and workplaces: A guide for public sector health and safety leaders and practitioners*.

Whilst these policy developments are welcome, there remains room for Aotearoa New Zealand to make further progress in implementing policies to promote mentally healthy workplaces. This includes implementing legislation, enforcement and financial incentives that have been developed and used in other countries.

1 Existing data on incidence of sickness absence do not cover the entire workforce. For example, the Southern Cross Health Insurance – BusinessNZ Workplace Wellness Survey, which is the largest survey of employers (covering both public and private sector) on health and wellbeing in Aotearoa New Zealand, found that the average rate of absence was 4.2 days per employee. The 2021 Te Taunaki | Public Service Census meanwhile, found that public service employees took on average 8.1 days of sickness absence per year.

Learning from other countries' approaches to mentally healthy work

Through 2020 and 2021, the OECD assessed the implementation of the Recommendation on Integrated Mental Health, Skills, and Work Policy across member countries. The findings – which are based on country responses to a policy questionnaire and indicators on the labour market and social outcomes of people with mental health issues – were published in a report in November 2021 (OECD, 2021a). While the report does not make country-specific findings, it finds that successful implementation of integrated policy and delivery remains the exception rather than the norm. The most progress has been made in youth mental health policy, whereas progress in workplace policies has been mixed, with policies to support the return-to-work of employees on sick leave particularly lacking.

OECD countries have a variety of policies to promote mentally healthy work, which provide useful insights for Aotearoa New Zealand and these encompass the following areas:

1. Supporting employers to pick up and respond early and effectively to employees experiencing mental ill-health
2. Incentivising employers to maintain connection with employees who are off sick
3. Policy leadership and prioritisation of mentally healthy work
4. Adapting mentally healthy workplace policies in a new era of work

Picking up and responding early and effectively

Many governments have a commitment to workplace mental health promotion and supports for employers to pick up and respond early to employees experiencing mental health issues. This is reflected within legislation requiring employers to look after both the physical and mental health of their employees, and governments to disseminate best practices and guidelines for employers on promoting mentally healthy workplaces. Financial incentives and other supporting measures for employers to support workers with mental health issues and provide access timely mental health treatment are also used across OECD countries.

OECD countries, including Aotearoa New Zealand typically have guidelines for employers on how to promote the mental health of employees. Canada's *National Standard for Psychological Health and Safety in the Workplace*, which was established in 2013, was one of the first national-level guidelines on mentally healthy work. Recent efforts on the Standard have focused on raising awareness of the interlinkage of mental health and work, and some preliminary evidence suggests that implementation of the National Standard may be contributing to reduction in incidence of sickness absence (OECD, 2021a). In England (United Kingdom), the National Institute for Health and Care Excellence (NICE), a body dedicated to developing evidence-based guidelines on public health, has released guidance on the promotion of mental health in the workplace (NICE, 2022).

Financial incentives and other supporting measures – including advice and counselling for employers – to promote employees' mental health are also used and often targeted at small- and medium-sized enterprises (SMEs). This is typically in recognition of the additional challenges faced by SMEs in promoting mental health in the workplace. In Japan, SMEs can apply for grants to implement mental health promotion plans and conduct so-called "stress checks". Since 2015, all employers with more than 50 employees have been required to conduct annual stress checks of their employees, which can be particularly challenging to implement for SMEs (OECD, 2021a). In Australia, the government launched a *Business Balance* initiative, which is providing funding to expand the availability of free training for small business owners and executives on mental health in the workplace (Australian Government, 2022). In the United Kingdom, a Wellbeing Premium trial was established in the West Midlands that provides grants to employers promoting wellbeing in the workplace, and the national government has since committed to testing a similar subsidy for SMEs (UK Government, 2021).

Maintaining connection with employees who are off sick due to mental health issues

A particular concern is the lack of support for employees on sick leave experiencing mental health issues. In many countries this appears to be the result of a lack of legal responsibility or incentives for employers to support return to work for their employees. As explained earlier, in Aotearoa New Zealand minimum sick leave entitlement was extended from five to 10 days per year in July 2021, although entitlements remain shorter than in some OECD countries such as Germany, the Netherlands and Switzerland. In Germany, sick pay continues for up to six weeks, while in the Netherlands, employers have to pay at least 70% of the previous salary for two years. Both the duration of employer-paid sick leave and the extent to which previous wages have to be covered affect the strength of the incentive for employers to remain in touch with their employees. In the United Kingdom, for example, while employers have to pay their employees on sick leave for up to 28 weeks, they are only required to pay the Statutory Sick Leave, while in France, employers contribute together with social security for sick pay, and thus only have to cover a minimum of 40% of the previous salary (Department of Work and Pensions, 2021).

A number of OECD countries, including Australia, Finland, Germany, the Netherlands, Norway and Sweden, also have policies that require employers to develop return-to-work plans for their employees on prolonged sick leave. For example, since July 2018, employers in Sweden have been required to prepare return-to-work plans within the first month of onset of sickness absence for employees who are not expected to return within two months. In the Netherlands, the well-established Gatekeeper protocol sets out that employers must agree to return-to-work plans with employees after eight weeks, and the employer has continued responsibility for monitoring the return-to-work process thereafter. In Australia, most states and territories require the use of return-to-work plans. Yet this alone does not translate to return-to-work plans being in place for all employees who are absent from work. In the 2021 National Return to Work Survey in Australia, only around two-thirds of workers absent from work reported having a return-to-work plan (67%), and the proportion was particularly low for individuals with a probable serious mental illness (55%) (Social Research Centre, 2022).

There are also examples of financial support available to employees on sick leave and employers to facilitate rehabilitation. Such incentives are often in place to reinforce or complement obligations placed on employers to promote early return-to-work. In the United Kingdom, employers can apply for an exemption of up to GBP 500 per employee from income tax for measures to support return-to-work after a period of injury or illness. In Sweden, employers can apply for grants from the Swedish Social Insurance Agency to subsidise the costs relating to providing workplace rehabilitation (OECD, 2021a). In other countries, competitive grants are provided. For example, in the state of Tasmania, Australia, organisations – including employers – can apply for a grant to implement innovative programmes to improve return-to-work outcomes (WorkSafe Tasmania, 2022).

Policies can also play an important role in facilitating phased return-to-work. Reforms such as those seen in Austria, Canada and Finland can help workers on sick leave due to mental health issues return to work in a flexible and gradual way. In Austria, for example, a new model to promote part-time return to work (WIETZ) was introduced in 2017, in which workers can work shorter hours while receiving financial protection. In Canada, since 2018, recipients of employment insurance such as mothers and individuals experiencing illness can continue to receive benefits as they gradually return to work (OECD, 2021a). In Germany, where phased return-to-work schemes have been in place for some time, evidence suggests that such schemes are particularly effective at reducing the duration of sickness absence for workers with mental health issues (Schneider et. al, 2016).

Policy leadership and prioritisation of mentally healthy work

A prerequisite for the implementation of policies to promote mentally healthy work is an overarching framework, strategy or plan that promotes an integrated approach to mental health, taking into account the interlinkages of workplace and mental health policy. Such emphasis can be seen in concrete targets set in national strategies in a number of OECD countries. In Czech Republic, the 2020 mental health plan includes a goal to reduce unemployment rates among individuals with mental health issues by 5% by 2024. In Japan, there is a target to ensure full coverage of mental health interventions and supports within workplace settings in the National Health Promotion Plan. Aotearoa New Zealand stands alongside a number of countries such as Germany and Italy with a specific emphasis on preventing work-related stress within its occupational health and safety strategy.

Policy leadership is also crucial to ensuring there is sufficient funding for policies to promote mentally healthy work. In a recent OECD survey, most countries reported not having dedicated mental health budgets for ministries other than the Ministry of Health (OECD, 2021b). Aotearoa New Zealand is one such country, with the country's first ever Wellbeing Budget in 2019 identifying mental health as one of the five key priority areas to improve the wellbeing of citizens. Whilst this resulted in significant funding to promote better mental health among young people including through investments in education and schools/mental health intersection, there appears to be less explicit recognition of the mental health and work intersection and mentally healthy workplaces.

The United Kingdom places a particularly strong emphasis on the intersection of mental health and work in its national strategies. The Work and Health Unit (WHU), a joint unit of the Department for Work and Pensions and Department of Health and Social Care, established in 2015, promotes a whole-of-systems approach to health, including mental health. Since the establishment of the unit, the two departments have jointly published two strategies on the intersection of health and work. This includes *Improving lives: The future of work, health and disability*, which sets out a 10-year strategy for the government for 2017–27 to improve the health and work outcomes for individuals with disabilities and health conditions (UK Government, 2017a). More recently, the two departments have jointly released *Health is Everyone's Business,* which focuses on how to support workers with health conditions, including mental health conditions, to remain in work and covers changes in the legal framework, sick pay arrangements and incentives to better support employers to stay in work. In 2017, the Prime Minister of the United Kingdom commissioned an independent review into the promotion of mental health in the workplace. The government accepted the recommendations from the review, which were published in *Thriving at Work: A review of mental health and employers* (UK Government, 2017b), including in the public sector, which resulted in the strengthening of mental health standards in the civil service.

Continuing to adapt and develop mentally healthy workplace policies in a new era of work

The COVID-19 global pandemic has had a significant impact on sickness absence, levels of labour market participation and mental health, as well as an impact on the way people work, and working arrangements. All these changes have implications for integrated policy on mental health, skills and work. Two trends are discussed in detail below: (1) The strengthening of employer-paid sick leave; and (2) Legislation to protect the mental health of employees working from home or remotely.

The COVID-19 pandemic has placed additional attention on the need to strengthen support for workers on sickness absence. While reforms were often already underway before the pandemic, it is notable that countries with inadequate paid sick-leave systems have strengthened employer responsibilities. In the Territory of British Columbia in Canada, the government introduced five days of employer-paid sick leave in January 2022, while in Ireland, the government announced in March 2022 that it would be phasing in employer-paid sick leave over a four-year period (Department of Enterprise, Trade and Employment, 2022). As outlined earlier, Aotearoa New Zealand also extended its duration of employer-paid sick leave from 5 to 10 days in July 2021. Given that mental health issues are among the most commonly cited reasons for sickness absence, such reforms could help to support employees with mental health issues to remain in work.

To limit the spread of the coronavirus, an unprecedented share of employees reverted to working remotely from home, aided by measures from governments and employers. While working from home may only truly be possible for one-third of jobs (OECD, 2020b), evidence suggests that employees have an increasing preference for a hybrid workplace, where they mix working from home with working in the office. This brings new complications for mental health, as working from home, while also bringing benefits, can increase risk of blurring of boundaries between work and the home, extended working hours, and detachment from the workplace.

To ensure that legislation keeps pace with the rise of remote work, many countries have introduced legislation to ensure workers have the right to disconnect outside working hours (OECD, 2021a). While such legislation existed in several countries before 2020, at least five OECD countries have introduced the right to disconnect since the onset of the pandemic at the national level (Greece, Ireland, Mexico, and Slovakia in 2021, Colombia in 2022), while it has also been introduced in Canada (in Ontario) at the sub-national level. The European Parliament has also called for the European Commission to propose legislation to introduce the right to disconnect, with mental health and work-life balance considerations a key driver (Eurofound, 2021). Implementing such legislation alone, however, may not be sufficient to ensure the right to disconnect. In one national survey of employees by a French trade union in 2021, where the right to disconnect was first introduced in 2016, a majority of employers (60%) did not have a system to ensure the right to disconnect (CGT, 2021). This is nonetheless a legislative change that the Aotearoa New Zealand Government may also find important, should the country also see a rise in the long-term prevalence of remote work and hybrid work.

Conclusion

Aotearoa New Zealand is well placed to build on and sustain the gains made from policies which support mentally healthy work. Most importantly this includes implementing legislation, financial incentives, and supporting measures particularly in relation to ensuring timely return-to-work of employees on sick leave. There are many good examples Aotearoa New Zealand can draw upon from other countries. In addition, the COVID-19 pandemic has, for all countries, exposed and shed light on existing gaps in workplace mental health policies. Notably, the lack of policies to minimise the mental health risks associated with remote work and changes to working patterns.

It is also crucial that Aotearoa New Zealand continues the implementation of integrated policy and delivery to address the interlinkages of mental health and work across workplaces, education, and the employment and health sector. The recently established Mental Health and Wellbeing Commission, now called Te Hiringa Mahara, may be able to provide the stewardship across government to support such an integrated approach. Now is certainly the time for concerted and collaborative action on mentally healthy work.

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Mentally Healthy Work: The drive to thrive

John Fitzgerald

What is mentally healthy work?

The word ‘mental’, as in ‘mental health’, appears twice in the Health and Safety at Work Act 2015 (HSWA), the primary health and safety at work legislation in Aotearoa New Zealand. The Act provides the statutory framework around which workplace health and safety practice must be built. While the Act does not specify how the health and safety of workers should be ensured, it does provide the legal imperative. Within this foundational statute, mental health hides in plain sight. While the word ‘mental’ is only used twice both occur within section 16, which provides a guide to the interpretation of terms used throughout the Act. The first definition relates to hazards, which include circumstances where a person’s behaviour has the potential to cause harm, “whether or not that behaviour results from physical or mental fatigue…”. While this is interesting because it recognises the importance of mental fatigue (e.g., cognitive exhaustion, mental overload), it is too specific for our general purposes.

The second occurrence is in the simple definition of ‘health’ where it states that, “health means both physical and mental health”. This brings to mind the words of Dr Brock Chisholm, the first Director-General of the World Health Organization, who famously stated that “without mental health there can be no true physical health”. Therefore, every time one reads the word *health* in the Act, it is necessary to also consider *mental health*. This includes, for example, the main purpose of the Act (section 3) which can be read as providing a balanced framework to secure the (mental) health and safety of workers and workplaces. Ensuring mental health and mentally healthy work are not new obligations, they are not an addendum to the Act, nor an additional responsibility for business owners, managers, and workers. It has always been there, hiding in plain sight.

Given the importance of the preservation of mental health under the Act, it is necessary to understand what we mean by 'mental health'. Unfortunately, the Act goes into no further detail than the interpretation that is given above. As WorkSafe New Zealand, the primary health (mental health) and safety regulator in New Zealand, has oversight of compliance with the Act, the way they interpret the term will be critical in its application. Although WorkSafe does not publish a formal definition of mental health, they do indicate that "When a business or organisation has committed to and is supporting Mentally Healthy Work, its people thrive". The use of the word 'thrive' is significant because it implies a view of mental health that is more than the simple absence of mental ill-health. In this regard we may assume WorkSafe is using a definition of mental health that is more closely aligned to the World Health Organization's definition, "Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community." (WHO, 2004). On this basis, supporting worker mental health is not limited to ensuring work does not contribute to mental health pathology, but also means that businesses have an obligation to support their workers to thrive and flourish.

In 2020 WorkSafe published their *Position Statement Supporting Mentally Healthy Work* (WorkSafe, 2020), which defines mental harm as, "the significant cognitive, emotional, or behavioural impact arising from, or exacerbated by, work related risk factors." They identify that mental harm may be immediate or long term and come from single or repeated exposure. According to this definition the experience of mental harm requires a substantial impact on an individual worker. It is likely some part of this will only be accessible based on subjective experience which adds complexity to any evaluation. The definition also highlights that the harm can occur within the context of a pre-existing difficulty, can be immediate or delayed in onset and maintenance, and can result from a single exposure event or multiple/repeated events. These characteristics make mental harm different from many physical harms, which are usually more clearly identified as relating to a single event with an observable negative outcome for the worker. If a worker breaks a limb in an incident at work and requires hospital treatment, that is a specific intervention necessitated by an observable event. Exposure to a psychosocial event, or more often a series of events, may be less observable and the harm caused less externally apparent, and more gradual with no single event causing the harm.

Psychosocial risks are everywhere

It is worth considering why risks to mental health at work are so complex and important. Let's start with an example. Generally speaking, there are only a few places/tasks where a worker can be injured by a falling log, excluding an *Act of God*. These would be a worker felling/processing trees as part of a logging gang, a worker loading or unloading logs on a transporter, a stevedore moving logs at a port, or a worker in a sawmill. We recognise these as physically hazardous jobs and there has been a substantial effort to identify and manage risks to the physical safety of workers in such industries. The truth is that most workers are unlikely to be hit by a log during the usual course of their work.

Unlike a worker who is unfortunate enough to be hit by a log, exposure to psychosocial risks that can result in mental harm can happen to any worker, working in any industry, anywhere in New Zealand. Also, the range of psychosocial risks a worker can be exposed to are many and varied (more on this later) and vary across industries, work tasks, time, and worker. This last point is important because the fact that all workers are not equally vulnerable, even if they do the same job in the same workplace, is another critical complicating factor. A wide range of individual factors such as age ('newness'), gender, culture, work experience, life circumstances, personal resilience, and mental health status, contribute to which psychosocial risks a worker is likely to be exposed to, how the worker will respond to risk exposure, and how quickly they will recover (see for example, Clarkson et al., 2018; Curtis et al., 2018; Moyce & Schenker, 2018). For most workers, being hit by a falling log will result in physical injury, this is not the case with exposure to psychosocial risks. Mental harm resulting from psychosocial risk exposure involves a complex interaction between workplace factors, work design, risk/exposure, and personal/individual factors.

We should also not forget that all non-trivial physical injuries are likely to be accompanied by exposure to a degree of psychosocial risk and harm. A physically injured worker could have their ability to continue working in the short or longer term compromised, which can impact on their financial security and ongoing employability in the same role. Depending on the type of injury, it could lead to long-term physical or cognitive impairment as well as severe mental health difficulties. While this is likely to be distressing and anxiety-provoking for the worker, it can also impact on the worker's family and social networks. The point here is that workers are not exposed to *either* physical harm *or* mental health harm. If a worker is physically harmed, it is highly likely they will also experience mental health harm. Conversely, while psychosocial harm can occur in association with a physical injury, it is generally independent of it.

Further complicating the picture is that some of the same psychosocial factors that can result in mental harm can also yield positive benefits in other circumstances. An obvious example of this is stress. Past theorising and research on stress distinguishes between *eustress* (stress that is positive) and *distress* (stress that is negative) and refers to a continuum between the two as the arousal continuum (Breitenbach, Kapferer, & Sedmak, 2021). More recent public discourse often refers simply to *stress* (meaning negative stress) and burnout (meaning the result of chronic and unresolvable negative stress). This pathologising of stress ignores the positive motivation and focus that can result from short-term elevations in stress levels.

Psychosocial risks: What are they?

Thus far we have focused on risks to mental health and wellbeing (also referred to psychosocial risks) in general terms. Before we move on to detailing them more specifically, let's pause to clarify a couple of points.

Many people panic when they see the word 'psychosocial' – just take a breath, it's just a word. First use of the word is attributed to Gordon Hamilton, a Scottish climate scientist, who back in 1941 used it to describe the interaction between psychological and social factors. By 'psychological' we mean cognitions (thoughts), feelings (emotions) and behaviour. So, psychosocial risks refer to risks that are associated with a person's thoughts, emotions, behaviours and the environment. This is important for our work because it acknowledges the interaction between workers and their work environment, but also more broadly the interaction between workers as people and all aspects of their work, and their life outside work.

A popular way of conceptualising this broader approach to health and wellbeing, at least in Aotearoa New Zealand, is Durie's Māori model of health based on the four walls of the whare (house) (Durie, 1984). The model, called *Te Whare Tapa Whā*, represents the homeostatic balance of good health as being dependent on the interconnection and mutual support of four domains, like the four walls that support the roof of a house and provide shelter to the occupants. These domains are:

- Taha tinana (physical health)
- Taha wairua (spiritual health)
- Taha whānau (family/social health)
- Taha hinengaro (mental health)

Te Whare Tapa Whā is a biopsychosocial model of health (we add *bio* to refer to biological or physical health), although it is more explicit in drawing attention to the interconnected aspects of health.

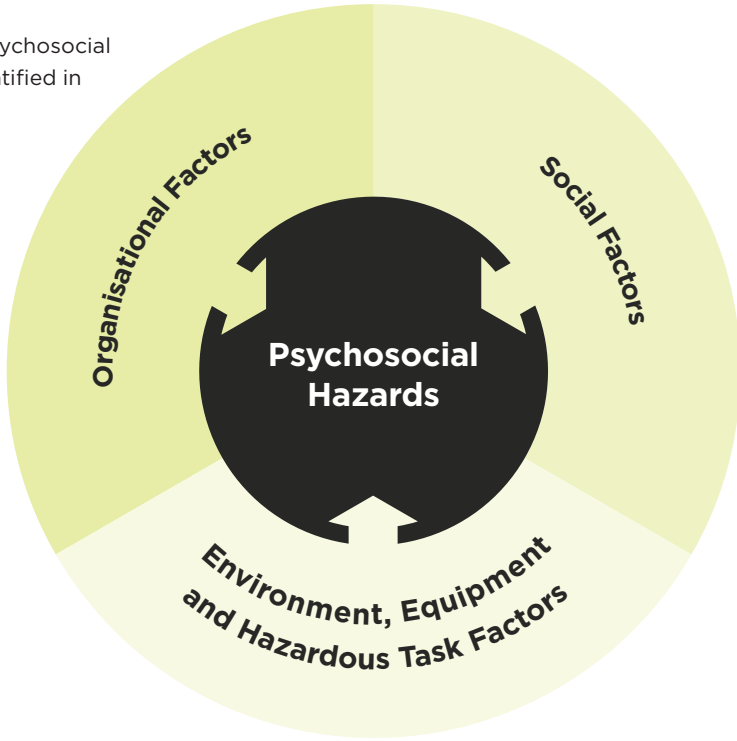
Te Whare Tapa Whā and other biopsychosocial models of health emphasise health in context and, therefore, are centrifugal in nature. That is, the broader conceptualisation of health and wellbeing requires that we adopt centrifugal thinking, which is ever expanding, finding meaning in the context of an event not just from the event itself. The direction of travel is away from the centre, capturing and analysing data that is wider in scope because it steps outside of the immediate workplace and covers more than a single time-point. Applying this to our logging example, there may be no real doubt that a log fell and injured a worker, but why did this log injure this worker on this shift? To answer this question we need to look at the tree/log and the worker, but also beyond to the processes used (or not), features of the work being undertaken (e.g., work pace, workload, worker control over the task), social factors (e.g., did they have support of colleagues? Were there adequate training systems in place?), the equipment being used (was it appropriate and well maintained?), characteristics of the worker and aspects of the worker's life (e.g., were they distracted by something inside/outside work?). These and a myriad of other questions form part of a centrifugal process where we only find out the answer to the question – 'Why this tree/log, this worker, at this time?' by expanding our field of enquiry. It is worth noting that as we expand our enquiry, the data points can become more dispersed, which means the connection between them can be weaker, adding to the complexity of the assessment task. This type of approach lends itself to focusing on systems and processes rather than a more restricted focus on the detail of individual events.

More traditional approaches to workplace safety can be characterised by centripetal thinking, where the direction of travel around a central point is towards the centre. That is, when a harm event occurs the data collected and analysis completed are focused on addressing that singular event, seeking to remove factors that might be considered less relevant or adding complexity. In part this may be because there is likely to be a single event to focus on, and data is largely objective and observable. This is not usually the case with mental health harm.

Now we have clarified some of our terms and frameworks, let us return to the issue of psychosocial hazards and risks. The recent publication of *ISO 45003:2021 Occupational health and safety management — Psychological health and safety at work — Guidelines for managing psychosocial risks* has helped clarify and categorise psychosocial hazards at work. It seems important that the Guidelines continue the trend of focusing explicitly on the identification of hazard/risk management rather than harm, building on the work of, for example, the Canadian Standards Association (2013) in their national standard, *Psychological health and safety in the workplace— Prevention, promotion, and guidance to staged implementation*.

ISO45003 categorises hazards into three primary areas related to how work is organised, social factors at work, and aspects of the work environment. Hazards become risks when the hazard is activated by, for example, the presence of a worker within a work system. If the worker is, for example, encouraged and supported to be vigilant, informed, and focused, the chance of the hazard resulting in harm will be low. However, when adequate safety systems are not in place and the worker is fatigued, distracted, poorly trained, overworked, the risk increases. Figure 1 identifies the three hazard domains identified in ISO45003 along with examples of the general hazard/risk areas. The Guidelines are an invaluable resource on the identification and management of psychosocial risks. However, one of the problems I see with ISO45003 is its failure to also include individual factors, those factors that are carried by the individual. Consider the example of high workload, a psychosocial hazard. Why is it that I can cope with a high workload more effectively on one day rather than another, or better in the morning than afternoon, and better than a colleague at work (but not as effectively as another colleague)? It is not the hazard that is at variance in these cases, but my own capacity, expectations, competing demands, level of fatigue, etc. These are individual and personal factors that can interact with work-related hazards. Some of these may be more directly related to work, for example, towards the end of a long shift or when working overtime, or in a job that has a high emotional exposure component such as within the Healthcare and Social Assistance sector. The point here is that if businesses limit their focus to hazards at work and ignore the worker variables and the interaction between these and workplace hazards, then mitigating risk and preventing harm may prove to be a more difficult and complex task. So, what is the answer? A business may not be responsible for risks that originate outside of work, but they need to take an interest in their workers if they want to manage psychosocial risks at work.

Figure 1
Examples of psychosocial hazards as identified in ISO45003



Organisation Factors

- Job security and precarious work
- Workload and work pace
- Remote and isolated work
- Job control and autonomy
- Roles and expectations
- Working hours and schedule
- Organisational change management
- Job demands

Social Factors

- Leadership
- Interpersonal relationships
- Organisational culture
- Recognition and reward
- Career development
- Support
- Supervision
- Civility and respect
- Work-life balance
- Violence at work
- Harassment
- Bullying

Environment, Equipment And Hazardous Task Factors

- Equipment availability, suitability and maintenance
- Workplace conditions (space, lighting, noise, temperature, height)
- Unstable environments and conflict zones

What workers need: The drive to thrive

WorkSafe has a vision of all workers returning home healthy and safe, but let's be clear what this means. The World Health Organization's definition of mental health (WHO, 2014) encompasses flourishing and thriving, not just the absence of mental illness. We can triangulate further on what workers (people) need by considering Maslow's *Hierarchy of Needs*, which coincidentally is also alluded to in the Canadian national standards (CSA, 2013).

Abraham Maslow first described his motivational theory in 1943. He was theorising about the motivational factors that drive human decision-making, that is, why people make choices and do the things they do (Maslow, 1943). He suggested there are five core needs that form the basis of human action:

1. Physiological/biological needs – e.g., water, food, warmth, rest
2. Safety needs – e.g., security, physical safety, employment
3. Love and belonging needs – e.g., intimate relationships, friendships, family, colleagues
4. Esteem needs – e.g., prestige, feelings of accomplishment, respect, recognition
5. Self-actualization needs – e.g., achieving our full potential

Maslow referred to levels 1–4 as *Deficiency Needs* and observed that failure to meet these resulted in harm to the individual. The final level is a *Growth Need* which can make a person happier, but a failure to meet this need does not result in harm. Psychological needs (levels 3–4) are considered to be of the same order of importance as the basic needs (levels 1–2). Relating this to worker wellbeing, keeping workers physically safe is not enough, businesses also have an obligation to keep them psychologically safe – actually to support them to thrive. In Maslow's terms this means also supporting their collegial and social engagement, treating them with respect, supporting their productivity and recognising their contributions, etc.

Hone et al. (2015) provides some useful pointers on how we can support New Zealand workers to flourish/thrive. They based their analysis on approximately 5,500 workers who completed the Sovereign Wellbeing Index which included a range of lifestyle, physical health, psychosocial and work-related indices. On the point of good work being good for workers, they found that 25% of those in paid employment were flourishing compared to 10% of those not working. The likelihood of a worker flourishing improved as their work-life balance improved and was positively associated with financial security. Among the other key findings were:

- workers who are supported to develop a high level of awareness of their personal strengths were ten times more likely to be flourishing than those with low strength awareness
- workers who are supported to *use their personal strengths* were 18 times more likely to be flourishing
- workers who feel *highly appreciated* are 30 times more likely to be flourishing
- workers with *high satisfaction* with the balance between work and non-work demands are ten times more likely to be flourishing.

This makes it clear that attending to social capital elements within an organisation (e.g., belonging, diversity, networks, participation) generates an environment where workers can effectively share their human capital, thus helping to heighten productivity (Isham, Mair, & Jackson, 2020).

Design to thrive

If we are planning how to scale the mountain that is work-related health and safety using HSWA as our guide, it may appear that by advocating for mental health and wellbeing we have added another 10,000 metres to the climb. This is not the case. What has happened is that strong winds of change have blown the clouds away to reveal the full magnitude of the task. There is an increasing body of evidence concerning the sorts of workplace wellbeing programmes that are most effective, and in which types of environments they are most usefully deployed (e.g., Hesketh et al., 2020; Pieper, Schröer, & Eilerts, 2019). The efficacy data also highlights complex interaction of workplace, worker characteristics, leadership and management approaches, dynamic social/environmental characteristics, and a range of non-specific factors that make it difficult to identify any systems which can be universally applied. With so many moving parts, as with all human systems, any approach needs to be thoughtfully applied to each unique environment with the full participation of all involved, in a way which is sensitive and flexible.

Bennett et al. (2016) propose a framework for understanding the 'wise use' and impact of evidence in the design and implementation of wellbeing programmes for the workplace, which leads to the identification of 13 integrated wellbeing levers, organised under three categories, which can be used to structure the development of systems of work which support workers to thrive (see Table 1). The balance of the 13 levers suggest that the keys are wise leadership and systems of work that emphasise and support collaboration and engagement with workers.

The above makes me think of the old adage, "Look after the pennies and the pounds will look after themselves". It is not about ignoring the larger and more financially valuable units but taking care to focus on the important things that we can have some influence over. Good employers look after their workers, support their wellbeing by facilitating both their basic and psychological needs. As workers thrive they support the business through their engagement and productivity. No smart business owner would spend $1mn on a machine and not invest in an approved maintenance programme to ensure the machine is running at maximum efficiency. Why would they not invest in the same way in their primary asset, their workforce?

Table 1
Wellbeing levers (adapted from Bennett et al., 2016)

PROCESS CATEGORIES	KEY WELLBEING LEVERS
Getting started: Wise leadership fundamentals	**Genuinely seek employee input** – seek to understand the needs of those served by the wellbeing strategy and then genuinely respond to such input in a timely manner.
	Make leadership engagement genuine – leadership engagement should be as genuine and discerning as possible (move beyond episodic gestures to more deliberate activities).
	View wellbeing as 'teamwork' – rather than 'taskwork'. Positive teamwork helps create a thriving workplace.
	Emphasise stakeholder priorities – start with 'why' there is a focus on wellbeing before discussing 'what' and 'how'.
	Build wellbeing into the culture – make wellbeing an integral part of the culture, rather than being seen as an additional programme or policy.
Setting the stage: Moving to design	**Proactively assess organisational readiness** – build programmes and "nudge the culture" in ways that are sensitive to organisational readiness.
	Show commitment to champions – support internal health advocates who have a personal and genuine interest in wellbeing.
	Make programmes clear, coherent, applicable – use external expertise where necessary, do not implement incomplete or poorly designed programmes.
	Establish metrics of relevance – identify metrics of relevance to assess programme growth and success. Select metrics that stakeholders agree with.

PROCESS CATEGORIES	KEY WELLBEING LEVERS
In motion: Design details and mechanics	**Use tailored interventions (modularise)** – to acknowledge that each worker will have a different wellbeing experience and journey.
	Foster comprehensive communications – intervention will succeed if the target audience does not understand it.
	Intentionally enhance the work environment – move from a "don't neglect" the environment attitude to "intentionally enhance" the physical work environment.
	Keep sight of details of programme integration – effective wellbeing programmes are fully integrated into the messaging, benefits and HR/H&S operations of the business.

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The Health and Safety at Work Act and psychosocial risks: Change the legislation or change our mindset?

Steph Dyhrberg

What is the problem?

A number of employers, human resource practitioners and lawyers seem to spend large parts of their working day dealing with the fallout of the often poor workplace culture in Aotearoa New Zealand. This is because there are high reported rates of bullying, 'toxic' culture, and sexual harm. Our systems of work have simply not traditionally been designed to prioritise a wellbeing model of workplace engagement.

The low levels of unionisation in the workforce in Aotearoa New Zealand may contribute to a reactive approach rather than a partnership approach which in other jurisdictions encourages addressing issues proactively on a broad sector basis.

The employment jurisdiction and institutions have developed a framework that is largely focused on individual grievances. Running cases through the Employment Relations Authority (or the Employment Court for breach of contract and statutory duty causes of action) takes significant time and resources. Litigation is generally only resorted to once the employment relationship (and often the person bringing the claim) is well and truly broken. The findings in an individual case seldom result in an improvement in the workplace.

Work-related psychosocial risks are workplace interactions or conditions of work that can negatively affect the health and wellbeing of workers (WorkSafe, 2019). Psychosocial risks include stress, overwork, bullying, harassment and poor management practices. The 2020/2021 UK Trade Unions Congress survey revealed 70% of safety representatives reported stress as being one of their top five concerns at work, followed by bullying and harassment at 48%, and overwork at 35% (Trade Union Congress, 2021). Despite the fact that psychosocial harm accounts for a significant portion of the harm people suffer at work, it has been rare for these risks to be seen as part of a health and safety practitioner's working day. This is starting to change.

It is well established by research that the effects of bullying, sexual harassment, prejudice, overwork, undue pressure, harsh management, low job satisfaction and other workplace stressors can be catastrophic (WorkSafe, 2019). Many research reports, guidelines, and policies start by stating what the unacceptable behaviour or factor is, and then how damaging it can be. Effects include shattered self-confidence, difficulty sleeping and eating, physical and mental health symptoms, heart and other

serious physiological illness, depression and anxiety, sometimes resulting in burnout and even suicide. Impacts on the workplace, the bottom line and the economy are significant, but seldom measured.

Why, then, has there been so little focus by the health and safety community on bullying and other sources of workplace stress and almost none on sexual harassment, as serious and common workplace hazards? There have not yet been cases in the District Court prosecuting breaches of the obligations on businesses to provide a safe and healthy workplace in relation to psychosocial harm.

Traditional, male-dominated sectors such as agriculture and horticulture, forestry, construction, maritime, manufacturing, transport and mining are riddled with physical hazards. Serious injury and death tend to get the most attention, and it is easier to deal with what you can see. Inspectors in the past were trained in inspecting mines, factories and the like, not complex interpersonal issues. It is encouraging to see a gradual change in some traditional male-dominated sectors. For example, the mental health problems besetting the construction industry are now being widely recognised and there are many positive initiatives underway across the sector to promote better awareness and practices in relation to mental health.

The Health and Safety at Work Act 2015 (HSWA) could be more overtly inclusive of psychosocial harm. There is no statutory definition of 'bullying'. Although the Act specifically applies to physical and mental health and section 16 of the Act defines a hazard widely to include a person's behaviour where it could cause harm, most of the specific duties are framed around physical hazards. There are a number of provisions discussing the types of work environments that have to be kept safe, the kinds of physical threats that may exist and a focus on plant, machinery and systems of work. Indeed, section 23 of HSWA lists the types of serious injuries and illnesses that have to be notified to the regulator. None of them relate to psychosocial harm.

In the past, WorkSafe New Zealand did not have specific resources dedicated to addressing psychosocial harm. Since 2017, WorkSafe has been increasing its focus on bullying as a serious workplace hazard. In the absence of a statutory definition of bullying, the 2017 guidelines *Preventing and Responding to Bullying at Work* (WorkSafe, 2017) are practically the legal and HR community's bible. The guidelines make it very clear that businesses have legal obligations to take all reasonably practicable steps to prevent bullying, to minimise harm, to take complaints seriously and investigate.

Many more organisations are implementing or updating policies to address bullying, sexual harassment and discrimination. There is a grey area in terms of definitions where there is a policy that is not aligned with the WorkSafe guidelines, what is the employer to be guided by? Failure to follow the employer's own policy will usually result in a finding of a procedural flaw or an unfair process. Conversely, if a policy is deficient, following it will not be sufficient: the court will assess whether all reasonably practicable steps were taken. My suggested approach (apart from having clear, accessible policies that are fit for purpose) is to always put health and safety obligations at the top of every priority list.

Sexual harassment has largely remained invisible to the health and safety community. This has been changing rapidly after the #MeToo movement focused attention on the prevalence of sexual harm, including in the workplace. There is now a suite of resources about sexual harassment on the WorkSafe website and many good examples of policies and processes are emerging.

Our attempted solutions

Many forms of unacceptable behaviour towards workers are unlawful by virtue of the Employment Relations Act 2000, Human Rights Act 1993, and the Crimes Act 1961, as well as the Harassment Act 1997 and Harmful Digital Communications Act 2015. The increasing capacity of WorkSafe to investigate and provide resources to address psychosocial factors in unsafe workplaces is a very useful addition to the regulatory environment.

Employees who have been harmed by a failure by their employers to safeguard their welfare in relation to psychosocial factors can also sue their employers under both the Employment Relations Act and common law. Some of the awards in those cases have been significant (for example in two leading cases *Gilbert*[1] and *Whelan*[2]). However, these are the rare exceptions. In the vast majority of cases of workplace harm due to stress, bullying, sexual and racial harassment, prejudice or hostile management practices, the employee simply leaves, broken. Most people simply do not have the mental and financial resources to take on an employer when they are suffering the after-effects of a significant workplace hazard. They also fear reputational harm, career disadvantage and victimisation.

The existence of these litigation options does not mean we should leave addressing these issues to either expensive civil claims or rare criminal prosecutions. The parallel regulators should work together to address accountability, compensation, and remediation (as does happen, to an extent, in, for example, significant industrial or aviation disasters). There is already a tendency of the various legal institutions to have regard to the approach each takes to compensation and sentencing when dealing with similar content. Greater cohesion and alignment of the different options would be sensible.

The approaches taken in other jurisdictions are largely of the guidance variety. A comprehensive exposition of various approaches is set out in a useful WorkSafe report *Psychosocial hazards in work environments and effective approaches for managing them* (WorkSafe, 2019). There are few examples of statutory definitions in relation to workplace stressors and psychosocial harm, including in Australia. The EU standards and guidelines do take a proactive approach, setting out not just definitions of psychosocial hazards but also actions required to prevent harm.

1 Gilbert v Attorney-General [2002] 2 NZLR 342
2 Whelan v Attorney-General [2004] 2 ERNZ 554

Moving forward

The question is, how do we address the need for a significant change in how we all (employers, lawyers, unions, HR/OSH practitioners and regulators) address these issues, to make workplaces safe for everyone? Should we amend the legislation? Should there be specific regulations? Should there be more guidelines and helpful resources? Should those have more formal official status? Should Crown agencies be doing more to educate employers in every sector about their responsibilities and how to meet them? Should WorkSafe be investigating and prosecuting employers for serious failures to eliminate and mitigate psychosocial hazards in the workplace?

The answer in my view, is yes: all the above. We need an integrated approach across all sectors, led by government agencies, employer bodies, and unions. The aim should be to start a national conversation about what healthy work looks like, how to change our workplace culture and how to ensure every worker is safe.

We need a legislative framework to clearly and coherently define psychosocial hazards in the workplace. Having debates and embarking on occasional litigation about what exactly is bullying, for example, is inefficient. That is why I believe we need to codify the case law into the legislation.

The defence to vicarious liability for sexual harassment under the Human Rights Act is that the employer can show they took reasonably practicable steps to prevent such conduct occurring.[3] The Act therefore requires proactive steps to be taken to prevent harm occurring, for employers to avoid vicarious liability for sexual and racial harassment. Health and safety obligations also require a proactive identification, elimination, and management approach. Yet this has not widely been recognised, nor translated into proactive planning to prevent psychosocial harm.

3 Human Rights Act s68 Liability of employer and principals

(1) Subject to subsection (3), anything done or omitted by a person as the employee of another person shall, for the purposes of this Part, be treated as done or omitted by that other person as well as by the first-mentioned person, whether or not it was done with that other person's knowledge or approval.

(2) Anything done or omitted by a person as the agent of another person shall, for the purposes of this Part, be treated as done or omitted by that other person as well as by the first-mentioned person, unless it is done or omitted without that other person's express or implied authority, precedent or subsequent.

(3) In proceedings under this Act against any person in respect of an act alleged to have been done by an employee of that person, i*t shall be a defence for that person to prove that he or she took such steps as were reasonably practicable to prevent the employee from doing that act, or from doing as an employee of that person acts of that description.* (emphasis added)

We should be describing (in regulations as well as policies) a wide range of actions that constitute sexual harm in the workplace as a hazard to be eliminated, rather than using the current definitions in human rights and employment legislation which are too complex and unduly focus attention on whether the impact on the victim really was so bad.[4]

In my experience, few employment lawyers understand the implications of these provisions of the Human Rights Act about vicarious liability, let alone employers. Insufficient attention is paid to prevention strategies, education, picking up on issues before they escalate, and upskilling managers, HR practitioners and employees. Too much emphasis is being given to making it easier for victims to speak up or saying, "we can't do anything without a formal complaint".

Failures by employers to be proactive in putting action plans into effect should have the same consequences in an enforcement action as neglecting to be proactive in preventing physical harm, for example not guarding machinery.

Many causes of workplace stress and harm (the impact of microaggressions in relation to sexism, ableism, racism, and prejudice towards the LGBTQI community, for example) are simply not even recognised by employers, so they are not identified as hazards. If they are not recognised, there is no hope of implementing an action plan to eliminate them.

4 Human Rights Act, s62

(1) It shall be unlawful for any person (in the course of that person's involvement in any of the areas to which this subsection is applied by subsection (3)) to make a request of any other person for sexual intercourse, sexual contact, or other form of sexual activity which contains an implied or overt promise of preferential treatment or an implied or overt threat of detrimental treatment.

(2) It shall be unlawful for any person (in the course of that person's involvement in any of the areas to which this subsection is applied by subsection (3)) by the use of language (whether written or spoken) of a sexual nature, or of visual material of a sexual nature, or by physical behaviour of a sexual nature, to subject any other person to behaviour that—

(a) is unwelcome or offensive to that person (whether or not that is conveyed to the first-mentioned person); and

(b) *is either repeated, or of such a significant nature, that it has a detrimental effect on* that person in respect of any of the areas to which this subsection is applied by subsection (3). (emphasis added)

Rather than guidelines setting out useful tips on how to prevent psychosocial hazards causing harm, in my view, we need these set out as requirements in regulations, as occurs for the management of physical hazards in certain sectors. We have seen what happens when self-regulation is matched with non-prescriptive definitions in other areas of health and safety.

Regulators need to take psychosocial harm far more seriously. WorkSafe is in the process of recruiting and training inspectors to do preventive work and catch dangerous workplace practices, toxic environments, and near-misses. WorkSafe now has a full suite of powers to compel compliance, including prosecution and significant penalties. We need sticks as well as carrots.

Government agencies have a significant role to play in educating employers and employees alike in what healthy work looks like and how to create respectful, safe work cultures. New Zealand is a nation of small/medium-sized businesses that do not have the resources to get all of this right by themselves. Educating by enforcement does not work; panel beaters and dairy farmers do not read Employment Relations Authority and Human Rights Review Tribunal decisions. It is famously easy to set up a company and be an employer in Aotearoa New Zealand: we need to ensure people can as easily comply with their important legal obligations to provide a safe and healthy workplace for everyone.

Health and safety professionals need to educate themselves and categorise bullying and sexual harassment, and other psychosocial hazards as serious, pervasive, and capable of causing serious harm. Together with their HR colleagues, they need to ensure PCBUs (directors and senior management) are aware of the legal and business risks to the organisation if these hazards are not sufficiently addressed. The human and business costs are huge, but we don't always measure this. What we don't measure, we can't manage.

New Zealand workplaces are notoriously low in productivity: in my experience and based on the research about the impacts on performance, absenteeism, and turnover of psychosocial harm, this is one of the factors. The links are clear in every engagement survey report I have ever read. Workplaces that genuinely value employee wellbeing have fewer employment relations issues, lower absenteeism, retain staff longer and stand out as "the ones to watch".

Connect the dots

We do not currently have workplaces that are safe, healthy, and respectful for everyone. We do not connect the dots between:

- psychosocial harm factors
- poor management practices
- a culture where it is too dangerous to speak up
- inappropriate policies and processes that harm people
- a lack of diversity and inclusiveness
- low productivity
- ill health, burnout
- difficulty attracting and retaining excellent staff.

Government agencies, regulators, unions, employers and their advisers need to work together to make sure we do all we can to:

- change the regulatory framework to clearly define what is prohibited and what PCBUs need to do to prevent psychosocial harm
- educate and upskill ourselves, managers and staff about psychosocial harm, how we need to change our workplace culture and the need for individuals to contribute to this change
- senior people need to role model exemplary behaviour
- provide excellent policies, processes and support
- where necessary, investigate and hold people accountable.

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Mentally Healthy Work: Obligations and opportunities

Hillary Bennett

Mental pain is less dramatic than physical pain, but it is more common and also more hard to bear. The frequent attempt to conceal mental pain increases the burden: it is easier to say 'My tooth is aching' than to say 'My heart is broken'.

(C.S. Lewis, 1940)

What is mental wellbeing and why is it important?

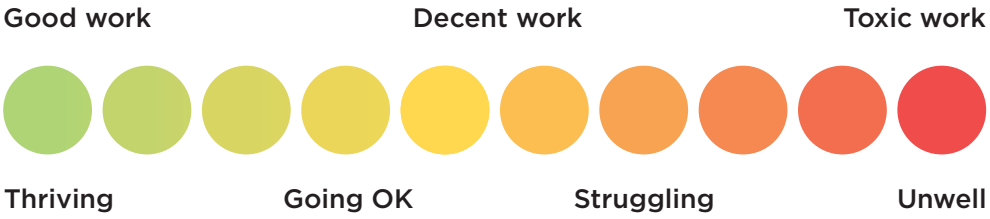
The World Health Organization (WHO) defines health as a "state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity", and mental health as "a state of wellbeing in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (World Health Organization, 2018). A similar, but simpler, view is that wellbeing is "an individual's ongoing state which enables him or her to thrive or not" (British Safety Council, 2018).

It is commonly agreed that we all have mental health every day, just as we all have physical health every day. Our mental health exists on a continuum, ranging from thriving to being unwell (Figure 1). Mental health is dynamic (i.e., where a person is at any time on the continuum can change depending on circumstances) and subjective (i.e., two people in the same circumstances may track differently along the continuum). "A myriad of factors influences health and wellbeing, though many are familiar only to those who experience them." (Black, 2008).

Figure 1
Mental Health Continuum

A person's work environment can have a significant impact on their mental wellbeing, but not all work is equal in terms of its impact: whereas 'good work' allows people to thrive, 'toxic work' can harm (Figure 2). In any workplace, there are likely to be factors that protect mental wellbeing as well as factors that cause harm. The duty to protect workers lies with those who create the risks. Understanding and managing the risk of mental harm and designing work to enhance mental wellbeing creates opportunities.

Figure 2
Mental Health Continuum and Work



Under the Health and Safety at Work Act 2015 (HSWA) organisations have a clear *obligation* to prevent harm to both physical and mental health:

> Workers and other persons should be given the highest level of protection against harm to their health, safety, and welfare from work risk, by eliminating or minimising these risks, as is reasonably practicable. (HSWA, Section 3(2))

Mental harm occurs when a significant cognitive, emotional, or behavioural impact arises from, or is exacerbated by, work-related risk factors (WorkSafe, 2020). The harm may result from a single or repeated exposure. It may be immediate (i.e., acute) or gradual (i.e., chronic). Chronic mental harm in the workplace is often referred to as work-related stress, although some of the contributing stressors may be acute.

Work-related stress arises where work demands exceed the person's capacity and capability to cope. In the short term, stress may not be harmful. However, if stress becomes excessive and prolonged it can cause both psychological and physical harm. Stress itself does not constitute a physical or psychological injury or illness, but it is an impairment risk. Other impairment risks that can result from poorly designed work are fatigue and substance and alcohol abuse.

Stress in New Zealand workplaces is having an increasingly significant impact. The NZ Wellness in the Workplace 2017 survey (BusinessNZ & Southern Cross, 2017) found stress was up 23% compared to previous years and the 2019 report found that reported stress levels of staff had risen by 23.5% across businesses since 2017. It also reported that absenteeism as a result of work-related stress had increased from 6.4% in 2016 to 22.2% in 2018.

Work-related risk factors that harm or impair mental health and wellbeing are psychosocial hazards. Psychosocial risk is the 'combination of the likelihood of exposure to work-related hazard(s) of a psychosocial nature and the severity of the injury and ill-health that can be caused by these hazards' (ISO45003, p. v).

The opportunity for all organisations, regardless of size, is to design mentally healthy work that enables people to thrive. A person thrives when they feel, and function, well across multiple domains of their life. When a person thrives, they are confident and have positive self-esteem, build and maintain good relationships, feel engaged with the world around them, live and work productively, cope with the ups and downs of daily life, and adapt and manage in times of change or uncertainty.

Decent work is described in Section 13 of the Human Rights Act 1993 as: "Everyone has the right to work, the right to equal pay for equal work and the right to a decent income and working conditions". In terms of mental wellbeing, decent working conditions may only allow a person to survive rather than thrive.

The cost to New Zealand businesses when people are not thriving is high. It is suggested that, directly or indirectly, 20% of workers in any organisation at any one time, will be affected by a mental health challenge (Ministry of Health, 2017).

Mental ill-health accounts for approximately 17% of the estimated burden of harm from work-related ill-health and injury (as measured by disability-adjusted life years lost) (WorkSafe, 2019).

Meeting obligations, seizing opportunities

For most organisations, the question of why mental health is important, at least from a legal perspective, is no longer the question. They understand their duty of care. The question organisations, big and small, are more focused on is – What needs to be done to demonstrate they care and to establish a mentally healthy workplace, that not only meets all legal obligations but also creates opportunities for people to thrive?

The Business Leaders' Health and Safety Forum's *Mental Health and Wellbeing at Work* sensemaking framework identifies four approaches that address the full range of the mental wellbeing continuum, supporting an organisation to meet its legal obligations, as well as support people to thrive (not simply survive) at work (Business Leaders' Health and Safety Forum, 2021a).

Mental Health and Wellbeing at Work framework

At the core of the *Mental Health and Wellbeing at Work* framework is the 'why', that is, we do this because *we care*.

The four approaches to demonstrate 'we care' are structured to address the full range of the mental health continuum from both an obligations/opportunities and proactive/reactive perspective.

As shown in Figure 3 the *Protect* and *Support* approaches enable an organisation to meet its obligations to prevent harm or support a person who is unwell. The *Foster* and *Reclaim* approaches provide opportunities for an organisation to proactively develop the mental health and capability of workers or reactively help workers who are struggling to restore their wellbeing.

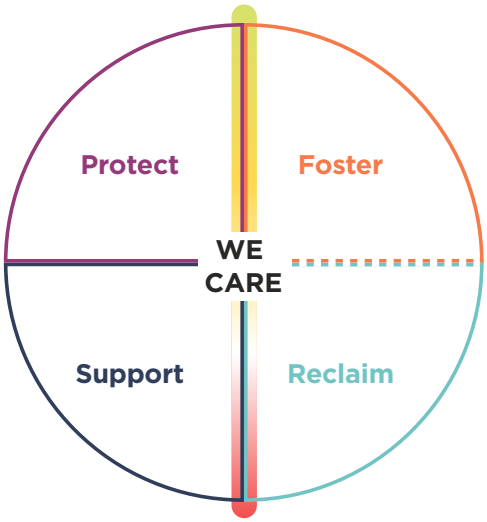
A wellbeing strategy should aim to protect workers from harm (i.e., by designing work in such a way as to eliminate or minimise risks to mental wellbeing) as well as include activities to foster, reclaim, and support wellbeing.

Protect interventions: Proactive work focus

There are two forms of *Protect* interventions: one focuses on the identification of potentially harmful work-related factors referred to as psychosocial hazards; the other on the design of 'good work' through the inclusion of factors that protect mental wellbeing.

Figure 3

Four organisational approaches to mental wellbeing at work



Obligations	Opportunities
Use these approaches to prevent harm:	Use these approaches to help people thrive:
Protect	**Foster**
Identify risks to mental health and wellbeing. Eliminate or minimise at source where practicable, and design in protective factors.	Develop the mental health and wellbeing capability of individuals and teams.
Support	**Reclaim**
Provide access to appropriate workplace and clinical support.	Restore the mental health and wellbeing of individuals and teams.
Protect/Foster	
Use **proactively** to build resilience.	
Reclaim/Support	
Use **reactively** once harm has occurred to restore health and wellbeing.	

Psychosocial risk assessment

Psychosocial hazards are factors that can affect a person psychologically or socially. In the work context, there are many such hazards that have the potential to cause physical and/or mental harm. Although these hazards are often referred to as psychosocial risks, this is not technically incorrect. As with physical hazards, risk is assessed in terms of the likelihood of occurrence and the severity of outcome. The international ISO45003 *Psychosocial Health and Safety at Work: Managing Psychosocial Risk Guidelines* (2021, p. 1) defines psychosocial risk as, "the combination of the likelihood of occurrence of exposure to work-related hazard(s) of a psychosocial nature and the severity of injury and ill-health that can be caused by these hazards."

In any workplace, there will be many psychosocial risks. Therefore, it is inaccurate, as many organisations do, to reflect 'psychosocial risk' as a single risk on a critical risk register. Bullying and job insecurity are two of the most prominent psychosocial risks in Aotearoa New Zealand businesses (Forsyth et al., 2021).

There are many psychosocial hazards, related to how work is designed, organised, and managed, with the potential to cause significant physical and/or mental harm, including stress, depression, anxiety, cardiovascular disease, musculoskeletal disorders, and substance abuse. These types of harm can occur on their own or in combination, and can be influenced by other hazards that can cause psychological or physical harm. Unlike physical risks, psychosocial risks are present in all types of work and vary across organisational levels, functions, and operations. These risks are subjective, seldom directly observable, and lack clear cause-and-effect relationships. Due to these attributes, these risks are sometimes referred to as 'wicked challenges' and, as a result, their identification and subsequent management has lagged behind the management of physical health and safety risks.

> The complex and politicised nature of psychosocial risks differentiates them from other work-related risks. (Potter et al., 2019)

No matter how challenging the assessment of psychosocial hazards and risks may be, the management of aspects of work that may cause mental harm is both a legal obligation and an ethical responsibility. It requires the commitment of leaders, the involvement of the people doing the work to identify both the risks and possible solutions, and a focus on the work, not on individual characteristics and vulnerabilities.

There are several ways to assess the psychosocial risks, each with their strengths and limitations:

- Job descriptions: Review of job tasks and responsibilities
- Task analysis: Analysis of work tasks, schedules, and locations
- Document review: Review of relevant documents (e.g., incident reports, risk assessments, health monitoring reports, absenteeism, and turnover data, EAP usage, etc.)
- Consultation with workers/contractors: Regular verbal or written communication with people doing the work
- Workplace inspections or observation: Trained external person observes the work in situ
- Audits: Internal or external review of risks against standards (e.g., HSE Stress Management Standards; Thriving at Work Mental Health Standards; ISO45003 (2021) Psychological health and safety in the workplace)
- Surveys: Workers complete structured questionnaires designed to assess psychosocial factors
- Psychosocial risk assessment: A group of workers identify and assess the psychosocial hazards related to their work

The Business Leaders' Health and Safety Forum's *Wellbeing by Design* process (Business Leaders' Health and Safety Forum, 2021b) describes how an organisation, regardless of size, can identify the psychosocial hazards or harmful work-related factors and related risks, as well as protective factors, occurring in naturally occurring work groups. The harmful and protective factors are related to four distinct aspects of work:

1. Task: The nature and demands of the work and how it is organised
2. Individual: The impact of work on a person and its meaning to them
3. Social: The relationships and personal connections at work
4. Organisational: The culture, systems, and employment processes at work

Good Work Design

> The fundamental premise behind the question "What is Good Work?" is simple: to move beyond preventing harm; if we identify the characteristics of "good work" and actively promote and expand their prevalence, we can displace "not so good work". (The Royal Australasian College of Physicians, 2013, p.3)

Poorly designed work with uncontrolled risks (i.e., toxic work) takes its toll on both physical and mental health. Conversely, there is compelling evidence that well-designed work (i.e., good work) reduces psychological distress, improving physical health and mental wellbeing.

'Good work' *deliberately* incorporates protective factors (e.g., acceptable workloads, flexible work schedules, positive work relationships, fair and consistent treatment) that not only safeguard workers from physical and mental harm but improve worker physical and mental wellbeing. The idea is that by identifying and promoting the characteristics of good work, we can displace toxic work.

Work that protects people also makes an important contribution to organisational outcomes. In short, good work matters because it prevents harm and enables people to thrive and the organisation to succeed. The Safe Work Australia Principles of Good Work Design, Health and Safety Handbook (2015) identifies the following 10 principles of good work:

1. Good work design gives the highest level of protection so far as is reasonably practicable
2. Good work design enhances health and wellbeing
3. Good work design enhances business success and productivity
4. Good work design addresses physical, biomechanical, cognitive and psychosocial characteristics of work, together with the needs and capabilities of the people involved
5. Good work design considers the business needs, context, and work environment
6. Good work design is applied along the supply chain and across the operational life cycle
7. Engage decision makers and leaders

8. Actively involve the people who do the work, including those in the supply chain and networks
9. Identify hazards, assess and control risks, and seek continuous improvement
10. Learn from experts, evidence, and experience

The Business Leaders' Health and Safety Forum's *Wellbeing by Design* framework can also be used to structure a Good Work Learning Team, a collaborative process to identify protective factors. Good Work Learning Teams involve inviting a group of workers doing the same work to participate in a facilitated conversation to share their insights and experiences as to what protects their wellbeing at work. The insights provided by a particular work group can be combined with insights gathered from other groups to provide an organisational perspective.

In summary, the *Protect* interventions assess risk to prevent physical and mental harm and design work to enable people to thrive. Although proactively preventing harm and designing good work is the preferred starting point for developing mentally healthy work, this work-focused approach is often overlooked in favour of interventions focused on individuals for several reasons, including face validity (e.g., providing resilience training to individuals sounds more like a wellbeing intervention than analysing staff workloads).

***Foster* interventions: Proactive individual focus**

Foster interventions aim to proactively develop individual mental health and wellbeing capability.

As organisations have looked for ways to support the mental health of their employees, the number of wellbeing interventions has proliferated. These interventions have ranged from:

- Information and resource sharing (e.g., wellbeing intranet resources, blogs)
- Mental health literacy and awareness raising (e.g., mental health awareness workshops)
- Psychological interventions (e.g., mindfulness training, resiliency training)
- Mental health apps (e.g., Mentemia, Headspace, Kynd)

- Workplace training (e.g., bullying, conflict management, fatigue workshops)
- Leadership training (e.g., support wellbeing training for managers)
- Wellbeing coaching (e.g., wellbeing conversations)
- Physical health (e.g., subsidised gym membership, fitness grants, physical assessments, yoga)

These interventions are individually focused, aimed at proactively assisting individuals to maintain or enhance their mental wellbeing. However, in the same way that 'not all work is equal', not all interventions are effective.

A review of evidence-based approaches to workplace mental health has argued that although while most workplace wellbeing initiatives are well-intentioned, there is limited understanding as to their relative impact. Little is known as to which interventions are most effective or even if they are effective at all (Newman, 2021).

Individual psychologically focused interventions assume that changing behaviours and emotional states can lead to improved wellbeing. Recent research shows the effectiveness of the psychologically based interventions that aim to improve wellbeing by changing behaviours and feelings is varied. Mindfulness-based and multi-component positive psychological interventions have demonstrated the greatest efficacy in both clinical and non-clinical populations (van Agteren et al., 2021).

In relation to interventions to build individual wellbeing capability, organisations cannot be faulted for their effort. Many have implemented a wide range of individual wellbeing interventions. What impact these interventions are having is, however, questionable. Efficacy may vary depending on whether interventions are:

- aligned to a clear wellbeing strategy with a clear purpose
- appropriate to the organisational context and size of the organisation
- targeting specific identified psychosocial risks or those factors assumed to be harmful
- having an impact and the desired outcome i.e., improving or sustaining wellbeing
- consistently applied across the organisation and embedded rather than one-off initiatives.

Reclaim interventions: Individual reactive focus

Reclaim interventions aim to restore the mental health and wellbeing of individuals who are experiencing some degree of distress.

Many of the *Reclaim* interventions are similar to *Foster* interventions but their focus and target groups are different. Whereas *Foster* interventions are intended to build the mental wellbeing of people who are currently 'going okay', *Reclaim* interventions are reactive attempts to restore the wellbeing of people who are currently 'struggling'. For example, depending on the context, mindfulness training can be used proactively or reactively.

Recently many organisations have implemented Mental Health First Aid (MHFA) or Psychological First Aid (PFA) programmes. The focus and content of these programmes varies significantly. For most MHFA programmes, the focus is on equipping individuals with the knowledge, skills, and confidence needed to support a friend, family member, or co-worker experiencing a mental illness, stress, or distress in their workplace, community, or whānau. These programmes teach people how to spot the signs and symptoms of mental ill-health and to feel confident guiding someone to appropriate support. As such these programmes aim at those people who are struggling or unwell. In this format, MHFA programmes are reactive. To be fair, there are some MFHA and PFA programmes that attempt to focus not only on supporting people who are struggling but also on supporting people to thrive.

Many organisations provide a range of wellness initiatives (e.g., yoga, massages, family days, wellbeing lunches and coffees, etc.). Although these initiatives have the potential to provide short-term relief from distress, they are more likely to have a lasting impact if they are aligned to an evidence-based wellbeing framework such as *Five Ways to Wellbeing* (Aked et al., 2008).

Five Ways to Wellbeing – developed by the New Economics Foundation in the UK and promoted by the Mental Health Foundation of New Zealand – is based on international evidence about what boosts and restores wellbeing, helps people to feel good, and helps them to function well. The Five Ways to Wellbeing are Connect, Be Active, Keep Learning, Give, and Take Notice. These five simple and proven strategies provide an evidence-based framework to organise both *Foster* and *Restore* wellbeing activities in a workplace.

***Support* interventions: Individual reactive focus**

Support interventions involve providing access to appropriate workplace and clinical support.

Support interventions such as Employee Assistance Programmes (EAP) have been the traditional focus of workplace wellbeing interventions, providing workers with support in relation to both personal or work issues that are having an impact on their wellbeing. Although this support is necessary, EAP is often referred to as 'the ambulance at the bottom of the cliff' as by the time the support is accessed, the person is already experiencing a level of distress and/or mental harm.

Leading for wellbeing

Preventing work-related mental harm is challenging. However, doing so is a legal obligation that also opens up opportunities to design work so that people thrive at work. While everyone has a role to play in creating a mentally healthy workplace, ultimately protecting and promoting mental wellbeing at work is a leadership issue. Change starts at the top. Leaders set the tone for how work is done, play a critical role in developing and enacting policies and practices that promote (or undermine) mental health and wellbeing, and have most influence in decisions concerning the design of work. Larger employers can also have a significant influence through their supply chains, customers, and contractors, to influence, encourage, and support smaller employers to take active steps to protect the wellbeing of their workers.

Leaders who allow a toxic workplace culture to emerge are breaching both their legal duties and moral responsibilities. Protecting wellbeing is not a *technical* challenge but an *adaptive* challenge. Technical challenges are easy to identify, can be solved by experts, and often fixed in a short time frame. Regrettably, wellbeing has been approached as if it is a technical challenge, with many wellbeing interventions representing technical fixes.

By contrast, *adaptive* challenges are complex, multicausal, and more difficult to identify. Solutions to adaptive challenges require people to challenge deeply held values, beliefs, and norms, and to learn new ways of doing things. Adaptive challenges take time to fix. Although the notion of protecting mental wellbeing with a technical fix may have some short-term appeal, a more permanent fix requires a critical look at both the way psychosocial risks are managed and work is designed for mental wellbeing.

Promoting wellbeing is more than simply offering fruit on a Monday and yoga on Wednesday. It requires a focus on the full mental health continuum. For an organisation to meet its legal obligations and seize opportunities to develop a thriving culture, a proactive focus on the work is required, as well as evidence-based proactive and reactive interventions to support individuals.

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How we kōrero about mental wellbeing matters

Vanessa Cooper

Workplaces reflect our communities and shape how we understand and experience wellbeing. Over time this has included the growing acknowledgment that *there is no health without mental health*. This acceleration in understanding has been driven by global pandemics, increasing rates of mental distress, generational changes in values and an emerging understanding of what matters for health, safety and wellbeing at work.

This awareness has led to a myriad of programmes, models, and courses designed to increase skills for prioritising wellbeing at work. Nevertheless, how we communicate about wellbeing, specifically our own mental and emotional wellbeing, has been slow to change.[1] In turn, we remain challenged to put new thinking and language into practice, that can help define the issues and needs, and ensure we are targeting our health and safety approaches to the right solutions.

In this chapter the changing landscape of mentally healthy work will be explained through the language and concepts of mental health that currently prevail, as well as those that are emerging. This will be explored by looking at:

- How we kōrero about mental health
- Why conversations are key to progressing mentally healthy work
- How wellbeing models and cultural narratives can facilitate new understandings

How we define the problem

Our words and kōrero shape our environment, they define what is valued, what is *normal* and therefore privileged. They define the boundaries of shame/whakamā, stigma and fear which has dominated discourses around mental health. To the point where many have not spoken about their struggle with mental health for fear that they were labelled mentally ill.

1 For the purposes of this chapter, mental wellbeing is the preferred term than mental health. Wellbeing encompasses broad, interconnected aspects of life and is the closest reflection of people's lived experience of their wellbeing. "Mental health' is often considered synonymous with mental illness and dominated by biomedical approaches which have less relevancy when talking about healthy work.

It's not surprising that mental health has been an area of heath which has historically been stigmatised and has a lot of discriminatory language. We don't have to look that far back to see the history of incarceration and inhumane treatment towards people who have been mentally unwell. To be mentally ill was seen as a moral failure or fault, and chronically so.

Although we have moved on, and know mental distress has multiple causes, culturally we still hold onto views that prevent real kōrero about the things that harm us at work – as well as those that can help. Mental health at work has been dominated by a medicalised approach which limits people's understanding and seeks to explain behaviour in terms of biology like brain dysfunction. And it's not that the brain isn't a fascinating thing, but the real story is a lot more complex.

Figure 1
A common image used to depict mental illness (disorders)

What do you think about when you look at Figure 1?

This is an example of a common image used in many reports published every year on mental health and work. These depictions reinforce a way of thinking and talking about mental distress. In this case, the lightning bolts coming out of the brain denote some functional abnormality, and by focusing on the brain reinforces the idea that the brain is damaged. It also supports a view that *mental* health is located in your head or, specifically, your brain.

Yet what constitutes mental health, or wellbeing, is as much about your whole body, meaningful connection with others, access to rest and recuperation, a sense of contribution and dignity. It is also well established that when mental distress is explained as neurological, genetic, or other biological abnormality, it increases social distancing and social exclusion towards that person (Jorm & Oh, 2009).

The main issue with this approach is that it allows the conversation to be only understood at an individual level, moreover a cellular level. Pulling the focus to the micro, ignores the context and issues of workplace culture and other practices which erode wellbeing like bullying, high workload, and lack of support. It's certainly interesting to learn about the brain but it's not where the locus of control is; we can't create mentally healthy work neurologically. So why spend so much time talking about, for example, de-escalating aggressive behaviour by explaining arousal in the HPA axis and disinhibition of the pre-frontal cortex?

Mental distress in Aotearoa New Zealand

We know that across the lifespan, almost half of us (47%) will meet the criteria for a diagnosable disorder (life-time prevalence) (Oakley Browne, 2006). Further, two-thirds (67%) of us know someone with a diagnosed mental illness (Kvalsvig, 2018). Experience of mental distress is not uncommon – in fact it is increasing, particularly depression and anxiety. We cannot prevent life having its negative impacts and we cannot prevent all harms from work. There is no screening tool to predict how someone will experience loss, bereavement, or respond to trauma or stressful work conditions.

When thinking about these challenges as a society and for the future of work, mentally healthy work approaches will need to support people by providing wellbeing-informed environments and universal prevention to protect and promote wellbeing. Prevention and early intervention are less about elimination strategies, as you can't prevent distress or challenges, but you can lessen the impact of them by having a culture where people can talk about and proactively manage issues. This means focusing on what people intrinsically value, what is important to people, rather than what is easy to change or measure (Kvalsvig et al., 2018). It is ineffective and potentially damaging to target specific workers without changing systems, practices, and environments – which is where many workplace hazards and risks lie.

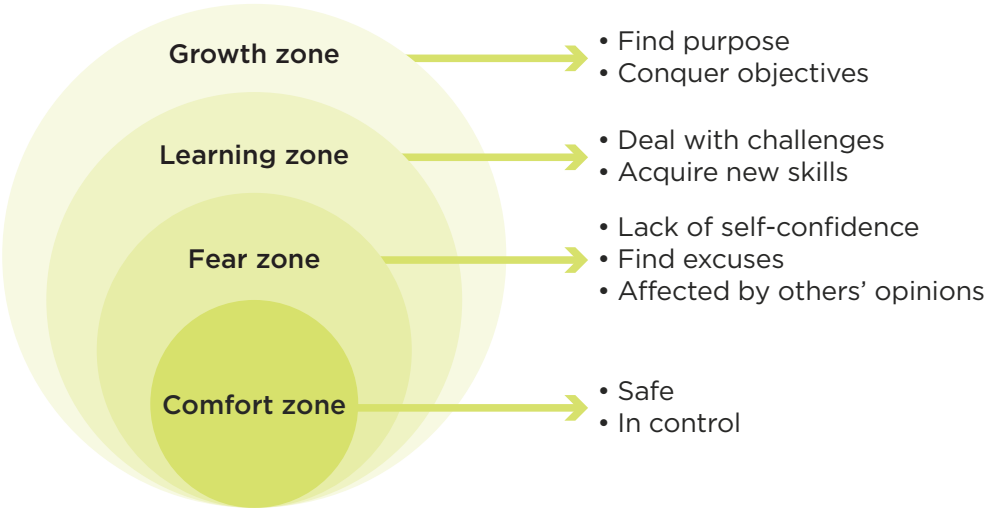
Engaging in kōrero

We need honest, authentic conversations to really manage the risks.

In order to have good kōrero on mental wellbeing and workplace practices, we need to do a bit of housekeeping – and that starts with each of us examining our assumptions. Humans have been designed with certain cognitive short-cuts and biases and sometimes this means we treat difference as a threat. This is known as the affinity bias, which is the tendency for people to favour others in their own social groups. This is partly why we hire people like us. It makes us feel comfortable.

To have real conversations we need to move out of our comfort zones, discuss challenges and grow new skills. This means being aware of 'quick thinking' which tends to activate implicit bias and entrenched views. Figure 2 shows that the comfort zone might feel nice but to get to learning and growing, you've got to go through some apprehension and fear.

Figure 2
Comfort zone to growth zone (growth mind-set) (Dweck, 2017)

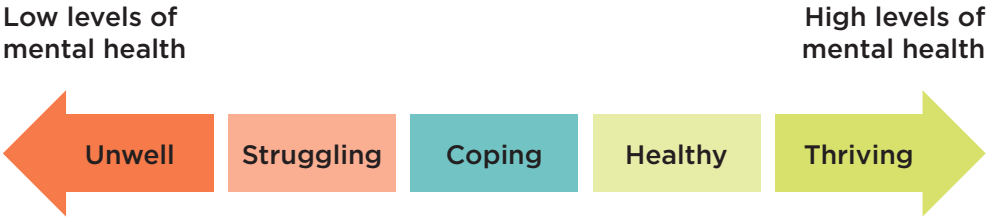


When we think about mentally healthy work, we are also fundamentally influenced by our quick thinking which results from our life experiences, values, and culture. This is also why diversity is so valuable, as different backgrounds bring different views and contribute to problem-solving.

Wellbeing v. Illness approaches

To facilitate the change, we need to broaden views on *mental health* which is often seen as synonymous with *mental illness.* Figure 3 shows a commonly used continuum with mental health at one end and mental illness at the other. Across the lifespan we can move back and forth with periods of struggle and times of thriving.

Figure 3
Single continuum model



But people do not experience wellbeing within the confines of one category. For example, a person may have significant struggles with low mood and fatigue but they might also have a supportive whānau and be driven by a strong sense of purpose and contribution in their work. When wellbeing is only considered on this single continuum, the interventions or controls will likely focus on improving individual resiliency or stress management skills – and this may not be where the solutions lie.

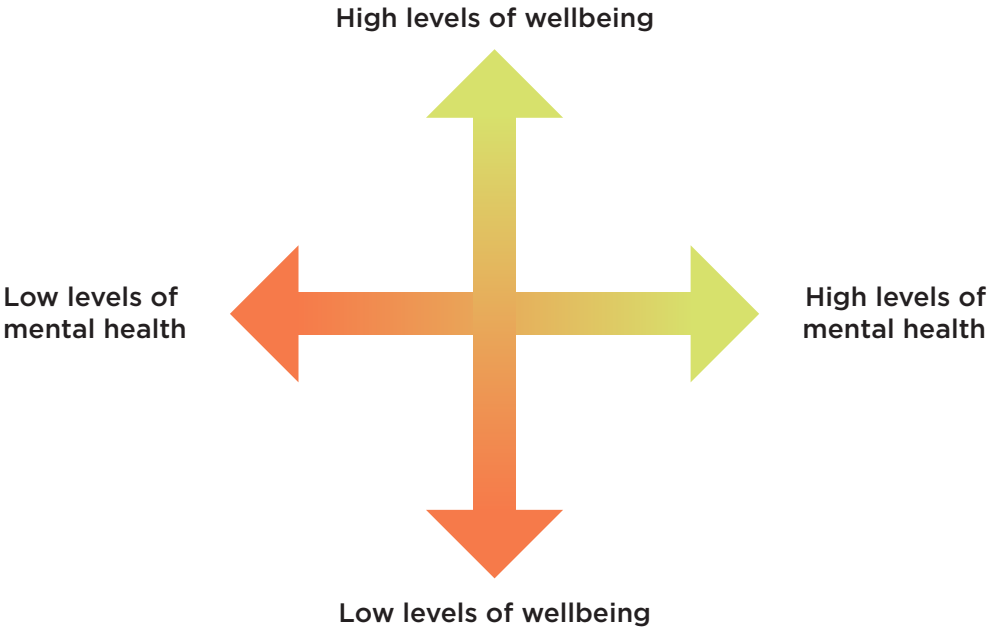
The Dual Continuum

To help us think a bit more broadly than a single element – *a person's level of mental health* – a second continuum can help us look at other factors that contribute to someone's wellbeing. What contributes to wellbeing or distress is multifactorial and is not predictable in most cases. For example, an individual may be struggling with their mental health but may have protective factors, that when taken into account present a very different picture.

Wellbeing is reliant on others, and as social beings our individual sense of wellbeing is entwined with those we live and work with. This is also supported by the evidence-base that wellbeing is interpersonal, it exists between people, rather than just within an individual (Kvalsvig et al., 2018). Further, this aligns with Te Ao Māori perspectives, and other cultural perspectives like Pasifika cultures and the Vā.

Figure 4 depicts this second vertical continuum. This continuum looks at wellbeing inside and outside of the individual and includes factors like how people interact in the workplace, the environment they work in, and how a role is defined and rewarded. When someone is feeling good and functioning well, they are said to be *flourishing.* However levels are relatively low (about 24% in New Zealand) (Hone et al., 2014; Seligman, 2011).

Figure 4
Dual continuum model (Keyes, 2002)



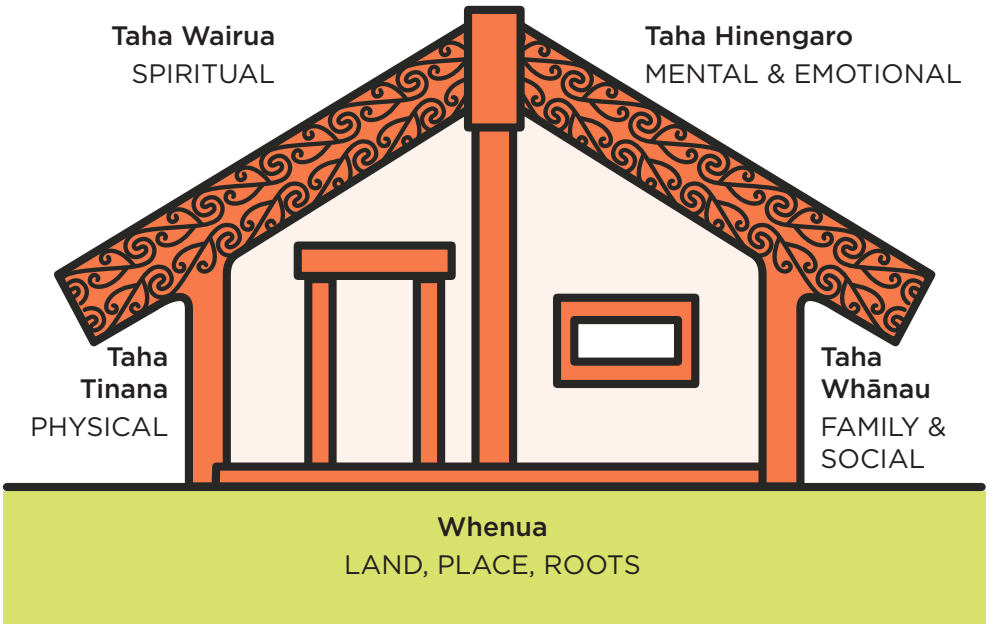
Honouring culture

We are a nation of many cultures, but our bicultural foundation is Te Tiriti o Waitangi, establishing the importance to include Te Ao Māori perspectives on work and wellbeing. Health and safety at work needs to include protection that encompasses Māori views of health and wellbeing. A commonly used approach is Te Whare Tapa Whā, developed by Sir Mason Durie, which is a simple heuristic to understand holistic approaches to wellbeing and expand our thinking on what mental wellbeing is.

Te Whare Tapa Whā demonstrates how wellbeing is made up of mutually reinforcing areas that support each other like the walls of a whare/house – te taha hinengaro (mental wellbeing), te taha tinana (physical wellbeing), te taha whānau (social wellbeing), and te taha wairua (spiritual wellbeing) (see Figure 5).

Figure 5

Te Whare Tapa Whā wellbeing model



Together, our overall sense of wellbeing is influenced by the resources we have in these areas. These can be positive (protective) or negative (risks) that we either bring to work or are created by the work environment (see Table 1 for examples). The environment of the workplace can be understood as the whenua or land in which aspects of wellbeing are supported. The second continuum (above) accounts for those areas of wellbeing that involve connection with others both in terms of wairua (spiritual) and whānau (family, social), but also our connection and belonging to place and space.

Under the Health and Safety at Work Act (2015), businesses are responsible for managing these risks and protecting people's health. This means understanding the needs of workers, and what contributes to and diminishes their wellbeing, as well as actively managing risks to workers, work, and the work environment. Incorporating cultural perspectives sets the context for diverse groups of people to talk about wellbeing, but that can only come from the inclusive practices and valuing of diversity.

Table 1 provides some examples of protective factors and risk factors when looking at wellbeing using Te Whare Tapa Whā.

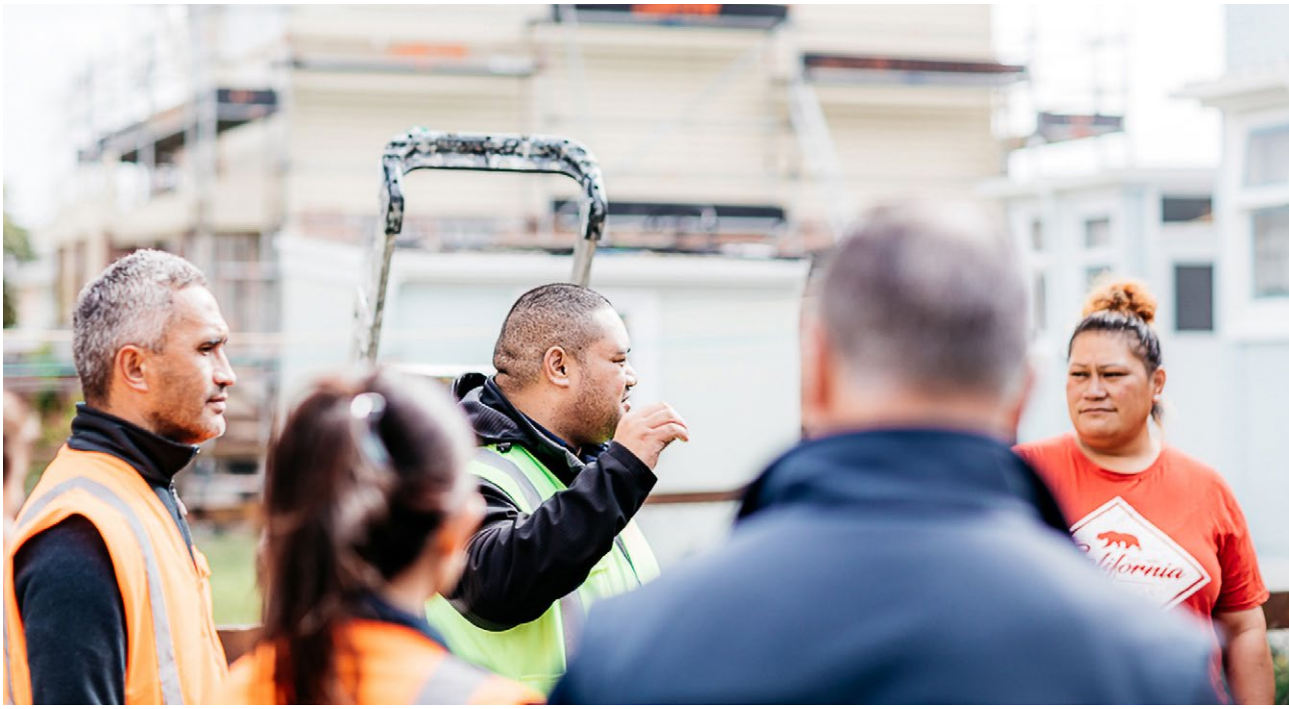


Table 1
Te Whare Tapa Whā and work-related protective and risk factors

PROTECTIVE FACTORS	RISK FACTORS
te taha hinengaro/mental wellbeing	
• Reasonable autonomy over workflow • Feeling heard, clear feedback mechanisms • Involved in relevant decision-making • Manageable workload and expectations	• Fast paced and/or demanding work • Exposure to traumatic events • Effort and reward imbalance • Insecure employment
te taha tinana/physical wellbeing	
• Adequate rest and recuperation • Comfortable physical work environment • Work well paced • Resources and tools support job tasks	• Long hours and shift work • Little rest • Repetitive tasks • Dislocated from others (remote/isolated)
te taha whānau/social wellbeing	
• Clear, timely communication • Respect and inclusion at work • Support from manager and colleagues • Work/life in balance/flexible working • Recognition of contribution	• Shifting goals, unclear expectations • Counterproductive work behaviours, e.g., gossip, withholding information • Exposed to negative interpersonal behaviours, e.g., bullying • Poor interpersonal communication
te taha wairua/spiritual wellbeing	
• Meaningful work • Sense of purpose • Learning and developing unique skills • Sense of mastery (skills utilised)	• Disconnected from others • Lack of meaning and contribution • Cultural exclusion and discrimination • Burnout and moral fatigue

How wellbeing can facilitate new understandings

Every year too many people are being harmed at work, and we continue to work in ways that erode our sense of self, our value, and our ability to contribute to a flourishing nation. We have been stuck in 'work as imagined' trying to relegate people and their tasks into tidy little bundles of work. Workplaces might reflect our communities, but they are also environments with specific rules and practices that determine appropriate behaviours and tasks. Work organises people into multiple, connecting systems, and there is hierarchy and power associated with roles and responsibilities. Conforming to these organisational and social norms can be necessary for keeping your job, your financial security and the social benefits associated with employment.

Within this context, the workplace culture also develops the norms of how we talk about our wellbeing and its loss. In this environment, it is difficult to stand up and challenge practices that erode wellbeing. Traditional health and safety approaches have tended to focus on an individual level and human error. Further, a focus on risk feeds our negativity bias and this thinking becomes a barrier to mentally healthy work.

Instead, we need to integrate wellbeing thinking into health and safety approaches, and this includes understanding barriers and facilitators of honest kōrero on mental wellbeing (and safety in general). This means considering the *organisation* as a source of risk and looking at organisational systems and practices that reinforce destructive or constructive behaviours. It also means the analysis of when things go right!

Modern workplaces acknowledge that the whole person comes to work and our expectations of what this means are changing. This makes understanding what people intrinsically value central to how workplaces design their work and environment to support wellbeing. To do this not only benefits businesses but has wider impacts on whānau and communities – as wellbeing is relational and cannot be achieved alone.

In the end, we need to be able to talk about our wellbeing – what is going right and wrong – specifically how work practices, relationships, and environments influence our wellbeing. Stress and distress do not clock in and out – stuff happens, whether at work or home or in the community. Workplaces need to consider the impact of external factors in people's lives and manage them in the workplace as a risk. It is only when people can speak with authenticity and vulnerability that trust can grow, and progress can be made.

The emerging view of wellbeing is built on holistic health that incorporates indigenous views and over two decades of evidence on the benefits of mentally healthy work practices. A good psychosocial safety climate is central to having a mentally health work environment. You need trust and vulnerability, and this is the hard stuff. It means leaders putting themselves out there and engaging in genuine conversations.

Around the world, the debate continues. The concern is, is it the right conversation? Currently we are in a position where we're trying really hard to solve a problem, but our problem definition has been fraught. What we are trying to achieve in workplaces is part of a wider shift in the understanding and, ultimately, the valuing of mental wellbeing. With rates of mental distress on the rise and increased rates of social isolation, workplaces have an important social function to provide people with contribution, belonging and a sense of purpose.

Using wellbeing frameworks can help us ground our problem definition under the very real human needs of people in work. This is a win-win for business, duty holders and workers with a clear return on investment. But we need to stop measuring the easy and the surface, and start having real conversations about what matters to us and the standards we want to see in the future of Aotearoa New Zealand and work.

So the wero (challenge) is to think more about wellbeing at work. Workplaces should be a place where people feel safe and can raise concerns. Mentally healthy work is not complicated. To the contrary it could be described as simple, as it is based on universal human needs – to connect, to belong, to feel a sense of contribution and to be valued. The nature of work is evolving but people remain central to our ability to get stuff done. There is no greater time to push further and look at your workplace. How do you understand and talk about wellbeing?

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Psychosocial factors: Pathways to harm and wellbeing

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The design and management of work are fundamental considerations for creating mentally healthy workplaces, and a major challenge for occupational health and safety. This chapter will introduce psychosocial factors as a key determinant of mentally healthy work and briefly outline the link between work and psychosocial hazards, before drawing upon three theories of work stress (job demands-resources theory; effort-reward imbalance theory; and organisational justice theory) to explain how psychosocial factors can lead to adverse outcomes for workers and the organisations in which they work. Psychosocial Safety Climate (PSC) is then introduced as one approach to the management of psychosocial factors. The chapter concludes with an overview of research findings on psychosocial factors, PSC, and mentally healthy work in Aotearoa New Zealand.

What are psychosocial factors?

The term 'psychosocial factors' emerged from the development of psychological models to define and address occupational stress (Cooper & Dewe, 2004), itself a much-researched topic throughout the twentieth century. The definition most widely used is that psychosocial factors refer to aspects of the design and management of work, and its social and organisational contexts, that have the potential to affect employee psychological or physical health (Cox & Griffiths, 2005).

Importantly, psychosocial factors can have a positive impact, helping to foster uplifting and enjoyable work, or they can have a negative impact (i.e., constitute psychosocial hazards), and cause harmful health outcomes for workers (Lovelock, 2019). Although work can give rise to psychosocial hazards, the International Labour Organization (2016) has also identified the workplace as the "ideal venue" for addressing and promoting worker health and wellbeing. Further, given the World Health Organization's (1986) definition of health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity", a mentally healthy workplace does not just feature the absence of workplace hazards but is one that actively facilitates and promotes healthy conditions of work (Leka, Griffiths, & Cox, 2003).

How does work give rise to psychosocial hazards?

The ever-changing work landscape creates new hazards and challenges for organisations. For example, accelerated by COVID-19, working from home brings a range of potential benefits such as increased flexibility, work-life balance, and reduced commuting, but also introduces potential psychosocial risks, such as social isolation, lack of support, and the blurring of work-home boundaries (Leka & Jain, 2010). Greater reliance on non-standard and precarious work arrangements also lead to lower job security and reduced control over working conditions. Increasing international competition and the constant drive for greater productivity have resulted in new forms of work organisation (e.g., lean production) which have been linked to employee exhaustion and poorer wellbeing (Huo et al., 2019), and are often coupled with restructuring and downsizing and resulting in job insecurity and difficult organisational change management. Further, as the workforce continues to diversify, the needs of different groups of workers require recognition, with implications for support, career development, training and communication.

Table 1 includes a more comprehensive list of psychosocial hazards and examples of these in a work context. In addition to the presence of these hazards are three further variables which can have an impact on the degree of risk they pose. First, psychosocial hazards can affect individuals differentially – what harms one may be of less harm to another. Second, psychosocial hazards can be cumulative so that risks increase as people are further exposed to the hazard. Third, psychosocial hazards can be additive, and the risk increases as the number of psychosocial hazards and non-work factors increases.

How do psychosocial hazards impact employee health and wellbeing?

Psychosocial hazards can both directly and indirectly impact worker health and wellbeing (Cox, 1993). While not all psychosocial hazards impact individuals in the same way, extensive research evidence shows that workers exposed to psychosocial hazards are at greater risk of a range of poorer wellbeing outcomes related to both physical and psychological health, including, for example, stress, exhaustion and burnout, anxiety and depression, musculoskeletal disorders, and cardiovascular disease (Leka & Jain, 2010; Siegrist, 2008). In turn, organisations in which psychosocial risks are present are more likely to face lower worker engagement, commitment, and job satisfaction, greater absenteeism and turnover of staff, and lower productivity (Leka & Jain, 2010).

We now turn to three prominent stress theories which provide an understanding on how the conditions of work may harm or facilitate worker health and wellbeing.

Table 1
Psychosocial Hazards

How work is organised	
Roles and expectations	Role conflict, ambiguity or change; unclear task guidelines and expectations
Job control or autonomy	Low participation in decision-making; lack of control over workload; low levels of influence and independence
Job demands	Underuse of skills; continuous exposure to people through work; conflicting demands and deadlines; repetitive tasks; fragmented or meaningless work; exposure to traumatic situations
Organisational change management	Prolonged/recurring restructuring; lack of transition support; lack of consultation and communication about workplace changes
Remote and isolated work	Working far from home or support networks; working without social/human interaction; working in others' private homes
Workload and work pace	Work overload or underload; high levels of time pressure; continually subject to deadlines; machine pacing
Working hours and schedule	Lack of variety; shift work; inflexible work schedules; unpredictable hours; long or unsociable hours; fragmented work
Job security and precarious work	Uncertainty regarding work availability; possibility of redundancy or temporary loss of work; low paid or insecure employment

Social factors at work	
Interpersonal relationships	Poor communication and information sharing; poor relationships between managers and colleagues; interpersonal conflict; harassment, bullying and violence
Leadership and supervision	Lack of clear vision and objectives; management style unsuited to nature of work; failing to listen; withholding information; inadequate communication and support; inconsistent or poor decision-making; abuse or misuse of power; lack of accountability; lack of fairness
Organisational/ work group culture	Poor communication; low levels of support for problem solving or development; lack of definition or agreement on organisational objectives; inconsistent or untimely application of policies/procedures
Recognition and reward	Imbalance between worker effort and reward; lack of appropriate acknowledgement or recognition of worker effort
Career development	Career stagnation and uncertainty; under-promotion or over-promotion; lack of opportunity for skill development
Support	Lack of supervisor or colleague support; lack of access to support services; lack of training/ information to support performance
Work/life balance	Tasks, roles or expectations causing workers to work in their own time; conflicting demands of work and home; work that impacts workers' ability to recover
Work environment, equipment, and hazardous tasks	
Inadequate equipment availability and reliability; lack of resources to complete work tasks; poor workplace conditions such as lack of space or lighting; working in extreme conditions (e.g. temperature or at height); working in instable environments such as conflict zones	

Source: Adapted from tables 1–3, ISO45003 (2021)

Job Demands Control-Support

One of the most recognised psychological theories of stress that accounted for interactions between individuals and their work environment is Karasek's (1979) Job Demands-Control (JDC) theory. Initially conceptualised as 'decision latitude' (control), the model suggests that the combination of a worker's work-related demands (workload or time pressures) interact with the decision-latitude (control and skill discretion) in their role to impact levels of psychological strain or stress. This model was later extended to include social support (JDC-S) – from colleagues or managers – as an additional factor that could mitigate psychosocial risk (Johnson & Hall, 1988). Accordingly, roles with lower levels of job demands and greater levels of control and/or support are more likely to result in positive outcomes for worker health. In this way, control and support act as 'buffers' against the demands of work, thereby reducing workplace stress (Wright, Eddy, & Kent, 2020).

A variation on the JDC-S model was later proposed by Demerouti, Bakker, Nachreiner, and Shaufeli (2001) who developed the Job Demands-Resources (JDR) model. Here, the authors expanded the model to include a wider range of 'resources' than control and support (e.g., rewards, participation in decision-making, job security) and suggested that the net 'buffering' effect of resources against job demands can result in work stress or burnout when negative, and employee engagement when positive (Demerouti et al., 2001). The JDC-S and JDR models are not without their criticisms – the former being considered too simplistic in a post-industrial world (Siegrist & Li, 2020), while the latter is thought to be too general in its conceptualisation of resources (Karasek, 2020; Widerszal-Bazyl, 2010). Despite these criticisms, it remains one of the more dominant and well-supported stress theories that explain how psychosocial factors at work interact to impact worker health.

Ngahuia works in a fast-paced, competitive organisation as a management consultant. Her work is incredibly busy, with consultants expected to be constantly bringing in new clients and increasing their billable hours. Her work is demanding – there's a lot of work to be done, and it is intensive work that requires her to think laterally and draw on the latest evidence from business research. It's not unusual for Ngahuia or her colleagues to work late into the evening to meet the deadlines of demanding clients.

While her work is highly demanding, Ngahuia wouldn't have it any other way. The nature of her job also allows her a high level of autonomy and flexibility over how she carries out her work, when she works and where she works. Her manager trusts that as an experienced consultant, she knows the best way to get her work done.

Were Ngahuia's manager to tightly monitor her work hours and process, the lack of control and resources coupled with the big and intensive workload is more likely to result in stress and burnout. However, in this case, being able to choose when, where and how she does her work allows her greater control over her work demands, and she is therefore at less risk of stress and burnout.

Effort-Reward Imbalance

Another interactional theory of stress is the Effort-Reward Imbalance (ERI) model proposed by Siegrist (1996) which suggests that stress and ill-health result from a continued imbalance in the level of efforts an individual exerts in performing their job, against the rewards received. Here, rewards include money, self-esteem, and career opportunities (Siegrist & Li, 2020). This model suggests that a high effort-low reward imbalance represents a failure of reciprocity, which violates social norms and produces strong negative emotions while activating a chronic stress response in the long term (Siegrist & Li, 2020). However, Siegrist (1996) also maintains that in certain circumstances individuals may continue to stay in a high effort-low reward situation, such as when they perceive limited alternative job options or for strategic reasons. A key strength of this model is its validity across different regions globally (Mutambudzi & Vanajan, 2020), as well as its applicability to other contexts beyond formal paid work such as caregiving or volunteer work (Siegrist & Li, 2020).

James is a store manager for a large chain store selling men's clothing. His pay is below the market rate for the responsibility that he has, but he was eager to take this job to gain management experience. At first, James felt that the rewards provided by this role balanced the effort he was exerting at work – he was gaining useful experience and learning a great deal about running the store and managing staff, which was an important step in his career progression. However, he has been in the role for almost two years now and has proven to be a highly competent and successful store manager – staff satisfaction is high and turnover is low, and the store has seen profits increase. James feels as though he is creating a huge amount of value for the business, but the pay, benefits and intrinsic rewards he receives in return no longer match the long hours, responsibilities, and other efforts required of James in managing the store successfully.

James is becoming increasingly disgruntled and upset with the clothing chain. He expected to be acknowledged and rewarded for his efforts and success well before now and feels that the chain is taking advantage of his willingness to work hard. Each month that goes by, James feels increasingly stressed and it is impacting his mental wellbeing.

Organisational justice

Organisational justice or fairness is another research avenue that attempts to explain links between psychosocial hazards and stress outcomes, such as burnout (see Cropanzano, Goldman, & Benson III, 2005) and other mental health outcomes (Elovainio & Virtanen, 2020). While different justice-related theories have been investigated, the underlying premise of these theoretical explanations is based on three aspects of justice: 1) fairness of processes and rules in decision-making, with the opportunity for input or control (procedural justice); 2) fairness with the outcomes of decision-making (distributive justice); and 3) fairness in the treatment of workers (relational justice). For example, Elovainio, Kivimäki, and Helkama (2001) found that higher levels of procedural justice (evident in higher levels of job control) and relational justice (evident in greater social support) were associated with lower levels of stress. Organisational justice theories of stress have been critiqued for their relevance to modern ways of working, such as remote or virtual working, (Siegrist & Li, 2020; Rupp, Shapiro, Folger, Skarlicki, & Shao, 2017) wherein workers may have different expectations of fairness and develop new forms of psychological contracts. This group of theories also remains comparatively less researched (Wright et al., 2020) than JDC-S or ERI models.

Alex has been a sales consultant for a food manufacturer for three years. They enjoy the role and would like to stay with the company and progress their sales career. The job involves office-based work, visiting clients, and attending marketing events. Everyone in the sales team has their own territory and reports to a regional manager who sets targets and reviews sales performance.

Since the pandemic began, work processes have changed and require significantly more time to complete. Sales targets have also increased, reflecting the greater demand through being an essential service. None of the sales staff had input into the changes to processes or targets, and several staff think that they disadvantage those with territories in Auckland which has often been locked down. Additionally, the regional manager appears to have favourites, granting some staff requests for target variations but not others. At their recent performance review, Alex was put under review for not meeting sales targets. Alex feels unfairly targeted for events outside anyone's control (the pandemic) and for changes to work demands on which they had no input.

As dissatisfaction grows due to the way they have been treated, Alex is finding it even harder to achieve targets, and feelings of stress and anxiety are increasing as a result. Unfortunately, as the job market is flat at the moment, Alex has decided to continue in the role at the expense of their wellbeing.

It is important to recognise that there is no single cause of stress, nor is it always possible to eliminate or minimise all psychosocial hazards in the workplace (Forastieri, 2013) – a challenge made additionally difficult due to the cumulative and differential ways in which these hazards interact to affect worker health and wellbeing across time. Thus, the causes of workplace stress cannot be addressed in isolation, and it becomes essential that such interventions are aimed at not only managing immediate or current hazards but in preventing their occurrence in the future. One means of doing this is through creating an organisational climate that is facilitative of and prioritises worker wellbeing – referred to in academic literature as a high 'psychosocial safety climate'.

Psychosocial Safety Climate

Psychosocial Safety Climate (PSC) reflects the process and policies that an organisation has in place to protect the psychological health and wellbeing of workers (Dollard et al., 2019). PSC comprises four key domains:

1. **Management Prioritisation**: The extent to which senior management prioritises psychological health and wellbeing of workers, considering it as important as productivity
2. **Management Commitment**: The extent to which senior management acts quickly and decisively when concerns about psychological health and wellbeing are raised
3. **Organisational Communication**: The extent to which there is good communication about psychological health and wellbeing, fed down from management to staff, and vice versa
4. **Organisational Participation**: The extent to which all levels of the organisation are encouraged to participate in psychological health and wellbeing matters

PSC has been found to be both an antecedent and a moderator of psychosocial hazards (Dollard & Bakker, 2010). At its core, PSC encourages an environment where workers feel safe and confident to communicate about issues that affect their wellbeing, there are opportunities for participation and consultation in such issues, and employee input is listened to and actioned by the organisation. As such, psychosocial hazards are able to be prevented prior to them arising, and existing hazards are able to be identified and addressed. A growing body of research shows organisations that foster a strong PSC are likely to benefit from lower levels of employee stress and burnout, greater job satisfaction and engagement, and generally better employee wellbeing (Dollard & Bakker, 2010; Idris et al., 2012).

Macro-level system influences on psychosocial factors and mentally healthy work

Since the changing landscape of work can give rise to several workplace psychosocial hazards discussed above, most intervention efforts have naturally been focused within the workplace context (Forastieri, 2013). However, it bears mention that a number of upstream macro-level factors – including socio-economic conditions, labour market structures, regulatory frameworks, welfare institutions, as well as social dialogue mechanisms and union representation – can collectively shape how psychosocial hazards play out at the organisational level, with differential implications for workers (Benach et al., 2007; Kortum & Leka, 2014). For example, gig workers such as Uber drivers may experience greater risks through the nature of their work (i.e., fragmented tasks, unpredictable hours and pay, working within tight deadlines) while also having less access to social protections, employment rights, and collective representation. In this way, labour market arrangements and policies can influence inequities in patterns of psychosocial risk. Together, this indicates the need to adopt a multi-level approach when examining the management of workplace psychosocial hazards.

Psychosocial hazards and PSC in Aotearoa New Zealand

Research on psychosocial hazards in the New Zealand context is relatively minimal. While scholars have largely focused on exploring the nature, prevalence and impact of individual hazards (see, for example, Bentley et al., 2010 on understanding workplace bullying and stress), there are few large-scale studies exploring psychosocial hazards in the New Zealand context.

One existing study that does shed light on psychosocial hazards and their impact on mentally healthy work is the New Zealand Workplace Barometer (NZWB). The NZWB surveyed around 1200–1400 New Zealand workers annually between 2018-2021 to gain insights on leading workplace indicators of mental health and wellbeing, namely psychosocial hazards and PSC. Results since 2018 indicate that many of the outcomes arising from psychosocial hazards evidenced in the international literature have a similar impact on workers here in Aotearoa New Zealand. Themes from the NZWB seem to indicate four key features of the work environment that have strong relationships with mentally healthy work:

1. **Organisational justice:** As previously discussed, organisational justice is about the perception that one is being treated 'fairly' within the employment relationship and across all areas of the organisation. The NZWB results show that where organisational justice is high, workers are likely to have better mental wellbeing, job engagement and satisfaction, and are less likely to experience work-family conflict or bullying and harassment.
2. **Inclusion:** Inclusion refers to the ability of individuals to be meaningfully involved in decisions which affect their work. Results of the NZWB indicate that non-managerial workers generally experience less inclusion than managerial workers. However, where inclusion is practised, workers at all levels are more likely to benefit from better mental wellbeing, work engagement and satisfaction, better co-worker support and more job flexibility.

3. **Management Competence:** Management competence refers to the behavioural competencies that managers hold in relation to managing workplace stress. Competencies include, for example, integrity, empowerment, conflict management, being empathetic and being accessible. Again, the results indicate that in organisations where management competence is high, workers are likely to benefit from greater co-worker support, better job satisfaction and work engagement, less bullying and harassment, and they are less likely to want to leave the organisation.

4. **Psychosocial Safety Climate (PSC):** As previously discussed, PSC reflects an organisation's prioritisation of, and commitment to, employee psychological wellbeing, along with opportunities for communication and participation in psychological wellbeing matters. For the four years that the NZWB has run, the overall findings show moderate PSC scores in New Zealand workplaces, meaning that workers are at moderate risk of psychosocial harm such as job strain and burnout, and this in turn poses moderate risks for organisations in terms of outcomes such as employee productivity, turnover and absenteeism. Although findings vary considerably by organisation, the results indicate that those organisations with stronger/higher PSC are more likely to benefit from better co-workers support, flexibility, engagement and satisfaction, and mental wellbeing, and are less likely to experience work-family conflict, bullying, and staff intending to leave.

Conclusion

The design and management of work, along with the social and organisational contexts, are strongly linked to mentally healthy work. Work that is well organised, competently managed and resourced, where strong interpersonal relationships and inclusive supports exist, is likely to encourage higher levels of employee wellbeing and other positive organisational outcomes. On the other hand, where work is poorly designed and managed, and where harmful or unfair social interactions are present in the workplace, work can be toxic for workers, leading to stress and poor mental wellbeing which, in turn, can be costly for organisations. Alongside identifying and addressing psychosocial hazards, research evidence points to the benefits of fostering a high Psychosocial Safety Climate, where there is prioritisation of and commitment to wellbeing by senior management, and where there is clear communication about wellbeing and opportunities for all levels of the organisation to participate in wellbeing-related issues.

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Māori in the workplace: Understanding drivers of mental health

Jarrod Haar

In New Zealand, Māori account for 16.7 percent of the population (Statistics New Zealand, 2020a), making Māori one of the largest indigenous groups (by proportion) in the world. For example, other indigenous populations include Australia (3.3 percent) (Australian Bureau of Statistics, 2018), American (1.3 percent) and Native Hawaiian, and other Pacific Islanders (0.2 percent) (United States Census Bureau, 2020). The United Nations highlight that indigenous populations inherit and practise unique cultural values, and retain characteristics (e.g., social, cultural, economic) that are distinct from the dominant societies where they live (United Nations, 2020). However, globally, indigenous peoples share common problems with poorer wellbeing being paramount (Haar & Ghafoor, 2021). Indeed, research suggests that globally, indigenous people have the worst wellbeing rates (Prout, 2012). The main reason for the disparity in wellbeing is income (Haar & Ghafoor, 2021), for which Māori are similarly affected.

Māori income, occupations, and unemployment

Māori employees have median earnings 10 percent lower than the dominant society – New Zealand Europeans (Statistics New Zealand, 2020b). The latest New Zealand Census data shows that amongst individuals earning the top income band ($150,000 or more), only 1.1 percent are Māori. This compares to 2.9 percent for other New Zealanders (Statistics New Zealand, 2021a), representing a 264 percent difference. Indeed, Māori are over-represented in all low-income groups, with a few examples being: 8.0 versus 6.8 percent (all others) for zero income, 11.7 versus 9.9 percent (all others) for income $15,001–$20,000, and 5.9 versus 5.6 percent (all others) for the $35,001–$40,000 group (Statistics New Zealand, 2021a). Thereafter, Māori have a lower rate of income compared to all others for every income level. Income is a vital factor in wellbeing (Ferrer-i-Carbonell, 2005). A meta-analysis on economically developing countries, with 111 independent samples, found a positive effect of economic status on wellbeing which was "strongest among low-income developing economies and for samples that were least educated. The relation was weakest among high-income developing economies and for highly educated samples" (Howell & Howell, 2008, p. 536). Specifically, towards indigenous populations, the importance of income has been argued to be a strong indicator of wellbeing. Having a constant stream of income provides indigenous workers not only with greater (and much needed) stability but can also be instrumental in the achievement of other valued cultural factors including autonomy (Yap & Yu, 2016).

One reason for this disparity is around education. Māori are more likely to have no formal education (25.3 versus 18.2 percent). Towards tertiary education, 8.4 percent of Māori have a Bachelor's degree compared to 14.6 percent for non-Māori. These rates are exacerbated at the highest qualification levels, with Māori having a Master's degree at 284 percent lower rate (1.3 versus 3.7 percent) and similarly a PhD at 267 percent lower rate (0.3 versus 0.8 percent). Another key income driver is around occupations. Māori are less likely to be managers (13.0% versus 18.0%), professionals (16.3% versus 23.0%), and more likely to be labourers (19.4% versus 11.3%) and machine operators and drivers (9.1% versus 6.0%) (Statistics New Zealand, 2021a). Furthermore, when we compare different employment status, we find Māori are significantly lower in self-employed roles (6.9 versus 17.1 percent).

Overall, from an economic angle whereby capital is controlled by the business owner, Māori are disadvantaged because they are not in control of capital to the same level as New Zealand Europeans. Māori are much less likely to be an employer (2.8 versus 14.5 percent) (Statistics New Zealand, 2019), representing a 515 percent difference in the likelihood of being an employer. Further, typically working in low paid occupations (e.g., labourers) also minimises the income potential. This can also affect Māori wellbeing, indirectly. For example, low paid occupations might require Māori to work longer hours, which itself is related to poorer wellbeing (Pega et al., 2021). Indeed, 16.3 percent of the workforce in Aotearoa New Zealand work 50 hours/week or more. While one in ten New Zealanders work multiple jobs of these, 20 percent work over 60 hours/week (Statistics New Zealand, 2019). Although this data does not delineate by ethnicity, evidence suggests Māori do work multiple jobs although possibly less than New Zealand Europeans (Pere, 2007). Overall, there have been calls for policies to enhance Māori occupational choice and job assignment for many decades (Brosnan, 1985), but change has been stubbornly slow.

Finally, it is important to acknowledge unemployment. Despite New Zealand having a low unemployment rate overall (4.0 percent overall), it is 252% higher for Māori (7.8 percent) compared to New Zealand Europeans (3.1 percent) (Statistics New Zealand, 2021b). Similarly, Māori are over-represented in the New Zealand underutilisation rate. This reflects the proportion of those in the extended labour force (including both unemployed and underemployed). This rate is 17.5 percent for Māori but only 9.2 percent for New Zealander Europeans (Statistics New Zealand, 2021b), representing a 190% higher rate for Māori.

Job factors driving Māori mental health

Job insecurity

It has been argued this disparity in unemployment rates is critical because amongst those Māori in work, they are likely to have different perspectives and shared stories around unemployment (Haar & Brougham, 2016).
Job insecurity is one of the critical factors facing employees, which can be present due to threats from new technology and international competition (Haar & Brougham, 2020). Job insecurity has a wealth of research showing it is detrimental on employee mental health (Jiang & Lavaysse, 2018). Basically, employees who perceive their job security is under threat tend to be worse off because they spend time and energy worrying about their future job, what they may have done to contribute to potential job losses, and then considering alternative job scenarios. An important issue with job insecurity is that it is a subjective perception and reality is less important. It does not matter if a job loss is real or imagined – the perception of having an issue is what leads to detrimental effects (Haar & Brougham, 2020). Further, it might be suggested that given Māori have a collectivistic orientation including in the workplace (Haar, Russo, Sune, & Ollier-Malaterre, 2014) and have strong whānau (extended family) influences around work issues (Haar, Roche, & Taylor, 2012), they might be especially prone to experience job insecurity issues. Consider that Māori are more likely to share work stories with family and friends and such conversations would include the inability to get a new job, or the threat of job loss, or actual job loss. It is likely these factors can contribute to Māori insecurity perceptions around their job, which can impact wellbeing. Hence, the overall unemployment rate being much higher for Māori likely impacts their insecurities around work due to economic vulnerabilities (Haar & Brougham, 2013).

Importantly, job insecurity can devastate the wellbeing of employees. An early meta-analysis reported a relationship between job insecurity and mental health, indicating strong links between perceptions of job insecurity and employee wellbeing (Sverke, Hellgren, & Näswall, 2002). A more recent meta-analysis (Jiang & Lavaysse, 2018) found job insecurity perceptions were significantly related to work-related wellbeing outcomes including emotional exhaustion and cynicism and job burnout overall. Further, job insecurity was related negatively to psychological and physical health and positive mood, and positively related to anxiety, depression, anger, and negative mood (Jiang & Lavaysse, 2018). Finally, a review (Mauno, Cheng, & Lim, 2017) found job insecurity was associated with impaired family wellbeing, with family/whānau being a critical dimension for Māori (Haar, Roche, & Taylor, 2012). Despite the potential important links between Māori and job insecurity, there has been little exploration.

While job insecurity studies in Aotearoa New Zealand establish similar findings to the literature around links to higher job anxiety and depression (Brougham & Haar, 2018) and higher emotional exhaustion and cynicism (Douglas, Haar, & Harris, 2017), those for Māori remain untested. However, as noted above, Māori are likely to suffer higher job insecurity and thus have poorer mental health outcomes. In the New Zealand context, research has explored the hypothesis that Māori employees will have higher job insecurity due to lower employer training (Gibson & Watane, 2001). While that hypothesis was not supported, they suggested systematic and endemic issues drive the higher job insecurity of Māori employees. There have been calls for more studies of Māori employee job insecurity (Haar & Ghafoor, 2021), and it is argued that Māori are likely to be strongly affected by job threat and unemployment rates, which is expected to detrimentally influence mental health (Haar & Ghafoor, 2021).

Job insecurity implications

Organisations and managers need to understand the destructive power of rumour and assumptions around job losses. They are destructive on mental health – even when not true. The easiest way to combat the detrimental effects of job loss rumours is to communicate effectively. Unequivocally refute any such rumours and lay the issue to rest. In strange times like COVID-19, where economic realities might fluctuate, it might be necessary to make such clear communications multiple times across the year. Organisations and managers are encouraged to confirm job stability when needed. Of course, sometimes organisations do need to lay off staff, but doing this one and clearly communicating the rationale will at least ensure those who remain have lower insecurities around 'being next'.

Other factors

Organisational-Based Self-Esteem reflects the esteem workers feel from their bosses and organisations around their work competence. One study exploring this self-esteem reported Māori and New Zealand Europeans employees did not differ in their self-esteem (Haar & Brougham, 2016). Importantly, the self-esteem for Māori employees was more beneficial in dealing with negative mood, being negatively related. While this effect was similar for Māori and New Zealand Europeans employees, it was especially beneficial for Māori employees. The implication for organisational leaders is to understand the importance of communicating positive work experiences to Māori employees. Organisations should encourage leaders to be forthcoming around praise and acknowledgement of good work. This appears to be a positive approach that aids Māori mental health.

Distinct from self-esteem from work, researchers tested the role of Māori cultural efficacy and found it was negatively related to mental health issues, showing the importance of cultural efficacy for Māori (Muriwai, Houkamau, & Sibley, 2015). Here, cultural efficacy refers to Māori perceptions around the extent to which they can engage appropriately with other Māori in social and cultural contexts. Indeed, this aligns with other research finding Māori working for an organisation that espouses positive Māori cultural values, leads to positive work attitudes (Kuntz, Näswall, Beckingsale, & Macfarlane, 2014). Organisational implication is to facilitate and aid Māori employees in understanding, engaging, and feeling confident in their Māori culture. Such resources (e.g., te reo classes) might provide benefits beyond the language.

Māori culture is aligned with collectivistic beliefs where the 'we' or team is more important than the individual (Haar, Russo, Sune, & Ollier-Malaterre, 2014). Exploring this aspect specifically towards Māori employee mental health, researchers found Māori working within a collectivistic context reported better mental health, with lower anxiety and depression (Brougham & Haar, 2013). Importantly, workplace collectivism had a strong effect on Māori mental health. Implications for organisations are around considering the role of teamwork and the value placed on the collective for the work and jobs and co-workers that Māori employees might need. Here, Māori cultural values around the group was especially valued by Māori employees. Placing Māori employees in teams and shaping reward mechanisms at the team level might be especially beneficial for Māori mental health.

Despite findings highlighting the importance of whānau for Māori job behaviours (Haar, Roche, & Taylor, 2012), a recent study explored work-family enrichment, which reflects the positive aspects of work and how they impact the family, such as building skills and providing resources (Haar & Cordier, 2020). The study found Māori with higher enrichment reported significantly higher positive mood and lower job stress (Haar & Cordier, 2020). Hence, positive work experiences are critical for building the mental health of Māori employees, and organisations are encouraged to provide Māori employees with experiences around understanding different viewpoints at work, building happy work experiences, and aiding employees to feel personally fulfilled from their work (Haar & Cordier, 2020). Combined, these experiences are likely to enhance the mental health of Māori employees.

Finally, researchers have begun to explore occupational stress in the workplace for Māori (Stewart & Gardner, 2015). This research highlighted that some aspects of occupational stress are different for Māori workers, and these can be important predictors of mental health. It can be beneficial for organisations to provide strong cultural safety and connect individuals with strong personal Māori cultural resources – Te Whare Tapa Whā (concepts of recreation, social support, self-care, and coping strategies) (Stewart & Gardner, 2015). These findings align with recent research around the workplace challenge for Māori scientists, and how Māori employees can end up working a double cultural shift, that leaves them burnt out (Haar & Martin, 2021). Organisational implications include encouraging and developing these culturally appropriate individual resources and providing greater understanding of workload issues for Māori professionals and providing greater cultural safety to aid mental health.

Organisational implications

Key to the literature is that organisations in Aotearoa New Zealand do have an important role to play in managing and facilitating better mental health amongst their Māori workforces. There are clearly many factors for organisations to consider, including workload issues around cultural roles (Haar & Martin, 2021) and providing clear communication and support around job insecurity. This is likely to be especially critical given the disproportionate level of unemployment held by Māori and stronger whānau connections that could lead to greater discussion and worry. There are clearly ways that organisations can build up and strengthen their Māori workforces too, through enhancing self-esteem, Māori cultural efficacy, and cultural safety. These are likely to be areas where more positive leadership can play a role in shaping these attitudes and behaviours. Further, richer work experiences and greater attention to teamwork are areas that can also aid Māori workforces to have stronger mental health.

Conclusion

Overall, the mental health of the Māori workforce is challenged. It is challenged broadly by structural issues in society which ultimately impact aspects like education, training, and job choice. However, it is also shaped by the work experiences of Māori. Of these, perceptions of job insecurity are likely to be critical for Māori employees, mainly because their contextual background around higher unemployment might facilitate such perceptions. There is much evidence to show that self-esteem and cultural efficacy might be robust and beneficial in responding to this. Hence, for working Māori, there is a potential for the workplace to provide both organisational support (e.g., cultural safety) and build personal resources that facilitate mental health. Overall, enhancing the mental health of the Māori workforce is likely to have important engagement, performance, and retention benefits to Aotearoa New Zealand organisations that provide additional encouragement for building better workplaces to make employee mental health paramount.

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Organisational culture for psychological health at work

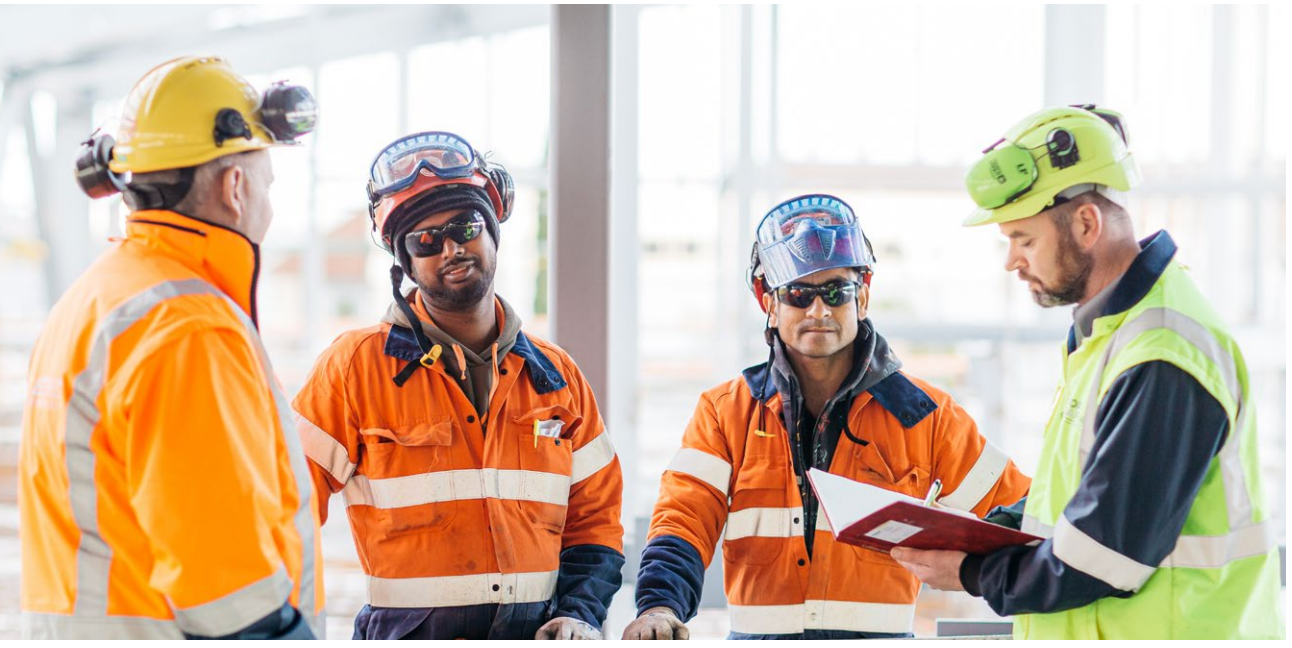
Kate Bone & Dianne Gardner

We appreciate the feedback given by our colleague Wikitōria Blandina Diamond (Ngāti Tūwharetoa me Ngā Puhi).

Organisational culture reflects what is rewarded, supported, and expected of managers and staff. This chapter defines culture and climate in organisations, outlines their relevance to psychologically healthy work, and presents suggestions about how cultures can support inclusive and unifying work environments, through leadership and engagement of staff at all organisational levels.

What is organisational culture?

Organisational culture is the set of beliefs, values, and assumptions that people within a workplace share and accept, their understanding of why they do what they do and what they think is important (Schneider, González-Romá, Ostroff, & West, 2017). It often exists without people being consciously aware of it, until something happens – a change, an incident – that highlights the way things are 'usually' done or understood within the organisation. The shared system of values, beliefs and assumptions that make up a culture can shape individuals' attitudes and behaviours, as they become accepted as the 'correct' or the 'only' way of doing things within the organisation. For these reasons, organisational culture has sometimes been defined simply as 'the way we do things around here', but it is important to remember that organisational cultures are dynamic and can be changed or managed un/intentionally (Smith & Bone, 2021).



Where does culture come from?

Culture arises from the organisation's history and traditions and the practices, policies and ways of doing things that have become normal over time (Schneider et al., 2017). It can also come from deliberate attempts to create a particular focus within the organisation. For example, some organisations pride themselves on family values and to show this they support work-life balance through flexible work practices that allow employees to pick their children up from school or take time off to care for their whānau when needed. These workplaces may also hold team-building days to create a close connection between workers and invite children and partners to staff events to support closer and more personal connections between workers. Culture can be understood (and changed) through practices of "everyday reframing" as subtle cultural norms and values communicate what leaders want (Alvesson & Sveningsson, 2016, p.45). The routines, rituals, stories, history, decisions, power structures, and behaviour of leaders all shape culture (Baek, Chang, & Kim, 2019). For example, if the manager of a call centre often stays an extra 30 minutes at work to finish off the paperwork from the day, then staff might come to understand that they are expected to do the same. Newcomers gather information from observing and talking to others, as well as from formal training and inductions, to learn the appropriate norms for workplace behaviour (He, Wang, & Payne, 2019). Workplace norms can be healthy (for example, supporting work-life balance) or unhealthy (for example, employees feeling pressured to work overtime without pay to complete their tasks). Once habits have been formed and normalised, it can be difficult to change them. Those who fit in become accepted as part of the team, and those who do not fit in may feel socially excluded.

Some organisations have strong cultures giving the organisation a distinctive identity and members a sense of belonging – for example, the emergency services and charitable organisations, both of which might attract workers driven by their desire to do good in the world. Others have multiple subcultures which differ between teams or divisions, like public service departments or schools. Even so, the subgroups should share the organisation's overall priorities and expectations – its culture, in other words (Baek et al., 2019). Strong cultures can create pressure for individuals to conform and comply with distinctive organisational norms; weaker or more fragmented cultures can be harder to identify (Nowak, 2020).

Within the context of Aotearoa New Zealand, organisational culture also reflects the broader bicultural context. For example, the Māori value of 'Tikanga' refers to customary practices, values and protocols which might underpin some organisational cultural norms and ideals. This could be reflected in the team singing a waiata/song each morning to start the day together, or somebody opening and closing meetings with a karakia/prayer. The Māori conceptualisation of 'whakakotahitanga' refers to the importance of consensus-building and respect for differences and participatory inclusion in relation to decision-making (Harmsworth & Awatere, 2013, p. 275). An organisation with this as a focus may hold regular hui/meetings to ensure that matters are thoroughly discussed with the team and all perspectives considered in decision-making. Recognition of Māori values provides unique ways of conceptualising how culture is informed, and practised, within the diverse context of Aotearoa New Zealand (Durie, 2011; Harmsworth & Awatere, 2013; Huria, Palmer, Pitama, Beckert, Lacey, Ewen, & Smith, 2019).

Organisational culture or organisational climate: Are they the same thing?

The terms organisational culture and organisational climate are often used interchangeably but they're not quite the same.

Culture is the 'deeper' and of the two: it rests on fundamental values, beliefs, assumptions, and norms and can be hard to pinpoint and describe, even though it shapes understandings about how people within the organisation should act and feel. For example, culture can shape the types of humour employees understand to be acceptable in the workplace, or the communication style (formal or informal, in-person or online) used to discuss matters concerning employees or customers/clients. Culture may be slow to change as it reflects established traditions, norms, experiences, and the organisation's history (Chatman & O'Reilly, 2016).

Climate is more visible: it is the perceptions and attitudes about the work environment, structures, and processes, rather than the underlying norms and behaviours (Chatman & O'Reilly, 2016). It is based on perceptions of policies, practices and procedures, and the behaviours that are rewarded, supported, or expected, in the everyday experience of work (Karanika-Murray, Michaelides, & Wood, 2017). It could influence, for example, whether employees use their sick leave to take a 'mental health' day off when needed or ask for workload support when under pressure.

Organisations can have different climates for different aspects of work: safety climate (including psychosocial safety climate, the topic of another chapter in this book); or climates for customer service, productivity, competition, sales, and so on. These are all underpinned by the deeper layer of values and beliefs that make up culture. Culture is prescriptive: it describes what 'should' be; climate is descriptive: it describes what 'is' (Chatman & O'Reilly, 2016) .

It follows, then, that climate is easier to change than culture, although the principles for changing both are similar and start with leadership. As an example, a strong climate for organisational health reflects employee perceptions that there is active support from management for employees' wellbeing, that the organisation makes employee health a priority, and that it provides appropriate resources to help staff remain healthy (Kaluza, Schuh, Kern, Xin, & van Dick, 2020). This climate would rest on an organisational culture that values employee wellbeing as well as performance, and that accepts rather than stigmatises those who need support. In turn, the positive climate would affect leaders' awareness and sensitivity towards health issues, and would foster behaviours that support wellbeing such as designing healthy working conditions, being a positive role model for healthy lifestyles at work, and responding positively to employees who report feeling stressed or overworked (Kaluza et al., 2020).

Why does culture matter?

Culture underpins decision-making, responses to change, goal-setting, responsibilities, and rewards (Baek et al., 2019). Culture might, for instance, shape the way an organisation prioritises innovation or stability, collaboration or competition, respect or aggression, outcomes or process, attention to detail or speed of delivery, teamwork or individual achievement, and so on (Baek et al., 2019). Building a positive workplace culture means recognising that context matters, and that culture can change over time, and that multiple people and processes are involved in shaping, maintaining, and changing workplace culture. Factors that can affect culture range from individual differences to cultural, economic and political influences (Bone, 2015).

In terms of managing employee wellbeing and psychological health, some workplace cultures may need to adjust to reflect changing expectations – for example, as staff increasingly expect that their psychological health will be supported at work. Positive cultures which support wellbeing can improve engagement, recruitment, and retention and reduce the outdated and damaging stigma around mental health (Greenwood et al., 2019). A stigmatising culture means that people won't come forward to seek support for their mental health or argue for change if they are finding work harmful, so people don't receive help and working conditions are not improved. Understandably, perhaps, many people feel that disclosing their mental health concerns to managers or human resources personnel could affect their future opportunities in the organisation – or in other organisations if confidentiality is not respected (Greenwood et al., 2019). A positive culture reduces stigma and empowers staff to use programmes and processes that support their wellbeing.

Building a healthy workplace culture

Culture change starts with leadership. What leaders pay attention to, reward, monitor and discuss will focus everyone's attention and efforts (Schein, 2004; Smith & Bone, 2021). Leaders' perceptions of the organisation's culture for psychological health depends on their awareness of health issues in the workplace (Kaluza et al., 2020). Frontline staff and senior leaders may see the workplace culture differently and are likely to have various levels of knowledge about how the organisation supports psychological health.

Leaders need to take a hands-on approach to changing organisational culture. This means modelling mentally healthy work behaviours and being held accountable for staff wellbeing (Kaluza et al., 2020). Executive teams, managers and senior staff might, for example, be prepared to share their experiences or those of friends or family members who have experienced psychological health challenges. Leaders and managers can act to normalise actions and behaviours that reflect the desired culture and ensure that existing staff and newcomers know what the expectations are.

Starting to build a positive workplace culture can be as simple as taking the opportunity to have deliberate and action-backed conversations at work:

> Having a simple conversation between an individual and someone in their line management team to just say: 'How are you doing? What can we change? How can we better support you?' And to genuinely mean that because that simple conversation can go a very long way if we actually follow-up on that. (Teoh, 2020)

Leaders may be reluctant to ask about mental health or wellbeing issues if they do not know what to do with the answers they receive (Nguyen, Reinert, Hellebuyck, & Fritze, 2019). All senior staff should undertake training in how to name, normalise, and navigate psychological health at work (Greenwood et al., 2019). This does *not* mean becoming counsellors! It means knowing how to have difficult conversations, identify actions which can reduce stigma, understand mental health conditions, their prevalence and impact at work, and knowing how to recognize and respond to employees who may be struggling (Greenwood et al., 2019). A culture which supports psychological health is one which genuinely values diversity and fairness, and which respects people's potential and wellbeing as well as their performance. A positive culture values positive mental health, and provides respect and support without stigmatising or creating disadvantages for those who need support (Staglin, 2019).

How leaders can enable mentally healthy work

Improvements can start with a realistic assessment of the organisation's current performance, priorities, and available resources in relation to psychological health, as well as the identification of current needs and opportunities. Starting conversations around psychological health can be difficult if the organisation has traditionally not encouraged discussion of these topics.

People at different levels in the organisation, or at different sites or divisions, may see the culture in diverse ways, for example senior leaders may be more positive than frontline staff about the organisation's support for psychological health (Webber, 2019). Promoting good health/hauora means recognising that there are many different views of what 'health' means, how to achieve it, how well the organisation is currently performing and what improvements need to be made (Durie, 2011).

One of the most simple, but often overlooked, ways to identify whether a culture is positive or not is to encourage managers and employees within an organisation to participate in the development of cultural values, and to be involved in the assessment of how these are working for individuals, teams and the organisation as a whole. Context-specific conceptualisations of healthy leadership (Rudolph et al., 2020), Psychosocial Safety Climate (PSC; Dollard et al., 2018) and the potential need for interventions to improve organisational culture (Nielsen & Miraglia, 2017) are starting points. There are various questions one might ask to ascertain whether or not the workplace culture is positive at present (see Table 1).

Table 1
Example questions for exploring workplace culture

KEY PROBE	ORGANISATIONAL CULTURE CONSIDERATIONS AND QUESTIONS
Is there 'healthy leadership' within the organisation?	Leaders can prioritise psychological health, develop and communicate policies and procedures, and act as role models. What does 'healthy leadership' mean within the organisation? What does 'healthy leadership' within your organisation look like at present? How are organisational leadership practices seen by senior leadership and management teams? By employees?
Is there a strong psychosocial safety climate?	An organisation's psychosocial safety climate reflects the culture of an organisation and the value placed on healthy work experiences through policies, practices and procedures. Questions to consider are: Do employees sense that senior leaders and managers are committed to, and give priority to, a positive culture to support all employees in their workplaces? Do employees have an opportunity to participate in aspects of culture change that are important to them? Are they able to respond to negative aspects of workplace culture? How are the organisation's values communicated and enacted within the organisation? Does the organisational culture reflect an environment where people feel psychologically safe to raise concerns?

KEY PROBE	ORGANISATIONAL CULTURE CONSIDERATIONS AND QUESTIONS
Is an intervention required to nurture a positive culture?	If the workplace culture is in a less-than-desirable state, an intervention to improve workplace conditions (however big or small) may be required. Interventions should be participatory, i.e., they should involve joint decision-making so that staff as well as leaders have a sense of ownership and can use their expertise. It is important to consider the buy-in of people who will be affected by change, how the change will be implemented, the context in which it will take place, and how it will be evaluated and monitored over time. Would the organisation benefit from an intervention? How might people at multiple layers in the organisation contribute and participate in intervention processes and initiatives? How will the effectiveness of an intervention be meaningfully evaluated?

Information to answer these questions could come from anonymous online surveys or focus groups with experienced facilitators who can create a safe place for discussion around sensitive topics (Staglin, 2019). Factors which could be explored when discussing wellbeing at work include work pressure (having too many priorities at once); not taking leave due to workload; and not feeling supported at work (Webber, 2019). Other important factors include whether employees feel they have a say in decisions that affect their working lives; whether they have the resources they need to meet their work goals, and whether they have supportive meaningful connections with colleagues and leaders (Karanika-Murray et al., 2017). For instance:

- Are there unwritten expectations about long working hours?
- Is there evidence of sustained high workloads?
- Do people report frequent last-minute decisions needing action?
- How do Human Resources, peers, and supervisors react when staff members request parental leave or tangi leave or study leave?
- Are there parts of the organisation where morale is particularly low or particularly high, or where conflict is evident?
- Are staff aware of existing resources available to support psychological health, e.g., Employee Assistance Programmes, leave arrangements, work-family balance initiatives?
- What are the perceived barriers to using these resources?
- What terminology do people prefer to use when discussing health issues, e.g., ‘resilience’ or ‘wellbeing’ rather than ‘mental health’?
- Is communication about mental health issues clear and consistent?
- Do people feel safe in reporting their challenges, and do they receive appropriate support and resources when they do?

People who are the most stressed are likely to be those who are most reluctant to report that they are having problems. Collecting information is only the start and enthusiasm will quickly fade if nothing is seen to be happening. The findings from the information-seeking stage should be quickly communicated to all staff, along with information about programmes and resources already available and plans for the future. In reference back to the notion of 'whakakotahi' it is important to include diverse perspectives in organisational decision-making, so that a process of consolidation and unification can begin to reflect and embed employee values (Te Aka Online Māori Dictionary, 2021).

Where to from here?

Addressing existing cultures will take time but initial changes do not need to be vast and costly. To improve the culture for psychological health, it may be appropriate to start by improving work practices and working conditions. Observable changes can start to improve the climate (observable priorities) for psychological health, and the underlying beliefs and values (culture) will follow. Culture can seem abstract while everyday work practices and working conditions are visible but the two are closely tied and healthy leadership matters.

To reflect the bicultural context of Aotearoa New Zealand, an organisation might choose to focus on creating an inclusive and unifying environment that can affirm positive organisational values reflecting the input of all concerned (Durie, 2011; Harmsworth & Awatere, 2013; Huria et al., 2019). Some approaches can be quite simple: building support networks; opening discussion among managers about how to foster healthy work behaviour; replacing stigma with positive affirmation; starting the conversation around mental health; and leading by example. Other requirements may be to address work design: reducing psychological and physical demands of work; increasing employees' control over their work; creating a supportive and trusting environment; training leaders on building a positive organisational culture; designing and implementing relevant policies; providing support and resources; and encouraging communication (He et al., 2019). If leaders engage in health-promoting leadership by providing healthy work conditions and motivating employees to engage in healthy work behaviours, this improves wellbeing and, ultimately, climate and culture in the workplace.

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Health and Safety Representatives as enablers of workplace mental wellbeing

Paula MacKenzie, Ali Whitton, Ruth Pink

Nā tō rourou, nā taku rourou ka ora ai te iwi

With your food basket and my food basket, we can feed the people

This chapter covers:

- The role of a health and safety representative
- The challenges health and safety representatives face
- How businesses and organisations can support and enable health and safety representatives
- How health and safety representatives can use their role to support mentally healthy work

Health and Safety Representatives (HSRs) are workers who have been elected to represent other workers in their workplace under Health and Safety at Work Act 2015 (HSWA). From at least 1974, and more formally in 1992, New Zealand's legal framework has acknowledged the importance of consulting workers, or people who can represent the worker voice about health and safety concerns (Health and Safety at Work etc. Act 1974; Health and Safety in Employment Act 1992; Peace, Lamm, Dearsly, & Parkes, 2019). An experienced worker will be the best source of information about how to do their job. This is because a worker will often change and optimise their behaviour to suit the situation, whether that be time pressures, the equipment available, how the workplace is designed, or what resources they have access to. This can result in differences between how work was imagined by designers or decision-makers, and the reality that workers face when doing the job. Involving HSRs in conversations about health and safety can result in better identification of hazards and risks, practical and effective health and safety solutions, safer systems, increased reliability, and higher engagement (Human Performance Oil and Gas, 2021).

The Health and Safety at Work Act (2015) states the role of a HSR includes:

- Representing workers in health and safety matters
- Investigating complaints from workers
- If requested, represent a worker about a specific health and safety concern
- Inquire into anything that appears to be a risk to the health and safety of workers
- Make recommendations about work health and safety
- Promote the interests of workers who have been harmed at work, which includes rehabilitation and return to work matters

While HSRs can help other HSRs, their role is limited to representing the workers in their team, or defined work group. Under the Act, they are given specific rights such as being able to request information, attend interviews, inspect workplaces, and make recommendations. If HSRs are adequately trained, they can also halt work and issue Provisional Improvement Notices under the Act. The business or organisation is required to consult HSRs and ensure HSRs have the resources to complete their role. This includes time, training, and information about hazards or risks in the workplace (Health and Safety at Work Act 2015).

Given 'health' means both physical and mental health under HSWA and its predecessor the Health and Safety in Employment Act (1992), the role of an HSR has included assisting businesses to manage the risks to mental health for a number of years. However, the theoretical role of an HSR looks very different to the 2021 reality of HSRs' experience day to day.

WorkSafe New Zealand recently completed the HSR Discovery project where WorkSafe design researchers and selected independent research agencies connected with over 400 HSRs across New Zealand, through a range of interviews, workshops, webinars, site visits and conferences. Discussion was conducted in smaller groups (approximately 15–20 people) to ensure a range of industries and regions were represented. While the structure was flexible, HSRs were asked about their experience in the role. This included how they became a HSR, their motivations, what their role entails, the challenges they face and their thoughts on the future for HSRs. Specific questions about mentally healthy work were asked only if the HSR brought up mental health at work. The project team reviewed the content from all HSR initiatives and collated the key findings. Findings, messaging, and conclusions were reviewed by HSRs through additional workshops and are discussed below.

Based on Statistics New Zealand data regarding the number of workers in New Zealand, WorkSafe estimates that there are 35,000 – 72,000 HSRs in the country. Rather than being elected to the role, which implies a formal election with several candidates, the majority of HSRs are either self-nominated, peer-nominated, tapped on the shoulder by their employer or told that they have volunteered. HSRs often take on additional responsibilities on top of the role that they are employed to do. For some, this aligns with full-time health and safety roles, and for others this is additional work that they must balance with their primary role. Some HSRs are given small pay increases as an incentive for taking

on the role, but most HSRs take on the role without receiving additional tangible rewards or incentives. Therefore, it is not surprising that most HSRs are intrinsically motivated. They typically believe in advocating for and supporting the people around them and are driven to affect positive change. Several have witnessed or experienced health and safety incidents and understand the knock-on effects of such an incident to whānau and communities.

The role and experience of an HSR depends on the tasks they are asked to do, the support and resources they are given to do it, and the organisation they work for. Across the work system, there appears to be a lack of consistency and clarity about what the HSR role entails. In general, HSRs need more time and more support to do their job. The reason an HSR needs more time to perform their HSR duties is because they are undertaking duties that are wider than the HSR role is intended to be. These duties are often the responsibilities of other roles within their workplace. In this way, HSRs almost become akin to unpaid Health and Safety Advisors.

When asked what would assist their role, HSRs mentioned simple and reasonably sized role descriptions, shared understanding of the role across their organisation, and being valued and respected by their peers and leaders. They needed a time and a place to do their HSR work, simple and easy reporting systems, and timely feedback loops.

One of many examples of ambiguity within the duties of the HSR role are audits. If an HSR is *leading* an audit in their workplace then they are seen by their peers to be 'policing compliance'. This negatively affects the same peer-to-peer relationships that they need to be strong in order to have the trust of the workgroup they represent. The clarity needed is that HSRs should be *invited in* to *participate* in audits, but *never* lead them. The same applies for Standard Operating Procedures (SOPs) and delivering training – they can be invited in to represent workers but should never be leading those activities as they are actually the responsibilities of frontline leaders, Health and Safety Managers, or even fellow workers.

How can businesses or organisations support HSRs?

The legislative purpose of an HSR is to ensure the worker voice is represented. Having support from the business or organisation is crucial to the HSR's ability to create change and make the workplace safer. To be effective, they require support and openness from leaders, managers, and fellow workers. It appears that a mentally healthy work approach could help HSRs thrive. Psychosocial or mental health risks can be grouped into three categories: work design, relationships or social factors, and work environment (ISO, 2021). When we use this framework to consider the experiences of HSRs it becomes understandable why HSRs experience challenges in their roles. The table in Appendix A details the psychosocial risks listed in *ISO45003:2021 Guidelines for managing psychosocial risks,* how these link to HSR experiences, and actions businesses could take to support HSRs through these challenges. The estimate of 35,000 – 72,000 HSRs represent a significant number of individuals who could assist in promoting mentally healthy work. If we can support HSRs in managing their role and own wellbeing, this will assist them in putting their own (metaphorical) oxygen mask on before helping others.

HSRs and mentally healthy work

A range of opinions emerged from HSRs about how they thought their role should respond and be involved in mental health at work. Some HSRs took the role to promote healthy work and believe their role should take a more holistic approach, with statements including "for me, the core value is to care for people…it's my job to identify if the workplace is doing that (i.e., support the mental health of workers)." Others said they did not want to become 'wellbeing officers' and would no longer be interested in the role if it includes mental health. Some felt uncertain about the idea with statements including "I wouldn't expect them (other workers) to come to me about mental health, (I) wouldn't know what to do." Most HSRs felt that there needed to be more training and resources to assist HSRs in navigating risks to mental health in the workplace. The health and safety managers consulted felt mental health is very personal, too complex, too complicated, and should be reserved for mental health professionals rather than HSRs.

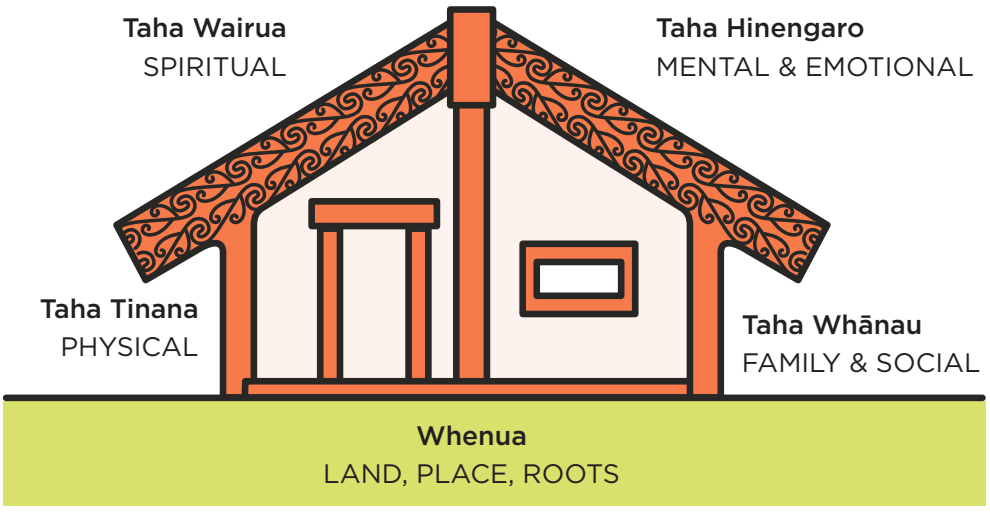
However, to promote mentally healthy work, we need to empower people to talk about wellbeing and workplace challenges. Mental health professionals play an important role in diagnosing and supporting people through mental illness and distress. However, mental illness and distress is only one part of mental health. The World Health Organization (2018) defines mental health as, "a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community." This holistic perspective of mental health also aligns with Te Whare Tapa Whā, a Māori model of health which includes taha tinana (physical wellbeing), taha wairua (spiritual wellbeing), taha whānau (family and social wellbeing), taha hinengaro (mental and emotional wellbeing) and whenua (land, roots) (Durie, 1984). A broader, holistic perspective of mental health means that every single person has the skills to talk about mental health, including HSRs.

Figure 1

An example of how Te Whare Tapa Whā could be used to assist HSRs

Te Whare Tapa Whā: Considering wellbeing as an HSR

TAHA TINANA (PHYSICAL WELLBEING)	TAHA WAIRUA (SPIRITUAL WELLBEING)
• What could cause injury in our workplace? • Are we at risk of any long-term health issues because of our work? • What are the hazards or risks to physical health in this role? • How do we manage the risks to physical health? • Do we have any initiatives that promote physical wellbeing? • Do our habits support healthy eating? • How does work affect our sleep? • Do our team experience any physical signs of stress?	• Do we promote bringing your whole self to work? • Does our workplace promote inclusion and diversity? • Could we incorporate cultural practices into our work more? • Do we have resources to support people's beliefs or religious practices e.g., prayer rooms? • Is our PPE suitable for all our team members? • Could we learn more about each other's backgrounds? • Do we promote activities that help people connect with who they are?



TAHA WHĀNAU (FAMILY AND SOCIAL WELLBEING)	TAHA HINENGARO (MENTAL AND EMOTIONAL WELLBEING)
• Do we have a positive workplace culture? • Do we have good relationships within our team? • How could we connect and build better relationships? • Could we work together more? • Do we have supportive managers? • Does our workplace promote discussing and reporting risks to mental health? • Do our policies support healthy work? • Do we have policies for managing conflict, e.g., bullying? • Do I know where to direct people if they want to report an issue that affects their wellbeing? • Do we get behind mentally healthy work initiatives e.g., mental health awareness week, pink shirt day?	• Does work affect workers' mental health? • Are there changes that could be made that would support wellbeing? • How do I support my own wellbeing? • Do I ask for help when I need it? • Do I feel comfortable talking to people who are struggling? i.e. I know I am not a counsellor but are happy to listen and refer people to support. • If not, what training could I complete to build my confidence? • Who can I refer to if people need support from a trained mental health professional? E.g. 1737, employee assistance programmes, supervision programmes, Mental Health Foundation.

HSRs play a core role in promoting a positive workplace culture, a key element of a mentally healthy workplace. They are often selected for the role as they already have good relationships with team members, are respected as a leader or someone the team is willing to listen to and are perceived as being approachable. They often appeared to be "a good fit for the role". If we can help HSRs connect the dots between the skills they already have, and the practical elements of psychosocial risk, they can become champions for mentally healthy work. While each workplace is different, the Te Whare Tapa Whā model could be used as a way to assist HSRs in building confidence and capability in this area. Figure 1 provides an example of how the Te Whare Tapa Whā model could be used to help HSRs identify psychosocial risks.

In a society where there is a higher expectation from employees to participate and co-design workplace initiatives (Heimans & Timms, 2014) HSRs will remain a crucial part of a collaborative, productive, and time efficient health and safety system.

Nā tō rourou, nā taku rourou ka ora ai te iwi (with your food basket and my food basket, we can feed the people). This whakataukī (proverb) speaks to community, collaboration, and a strengths-based approach where different parties have important things to offer in a shared goal of ensuring everyone flourishes. HSRs can be champions of mentally healthy work and help build positive workplace cultures. But they cannot do it alone. They need support and openness from managers, workplace systems and initiatives that support healthy work, and a proactive approach to managing risks to health (physical and mental) and safety from businesses and organisations. However, working together, business and organisations, managers, supervisors and HSRs can promote workplaces where everyone can realise their own abilities, cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their community.

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Appendix A

Psychosocial Risks and Learnings from WorkSafe's HSR Discovery Project

PSYCHOSOCIAL RISKS OUTLINED IN *ISO45003:2021 GUIDELINES FOR MANAGING PSYCHOSOCIAL RISKS*	**EXAMPLES OF CHALLENGES AND COMMENTARY FROM WORKSAFE'S HSR DISCOVERY PROJECT**	**KEY POINTS FOR BUSINESSES TO CONSIDER WHEN SUPPORTING HSRS**
How work is organised:		
• Roles and expectations • Job control or autonomy • Job demands • Organisational change management • Remote and isolated work • Workload and pace • Working hours and schedule • Job security and precarious work	Time considerations: • *"Doing my paperwork through smoko or in the evening in my own time"* • *"I do it in smoko hours as that is the only time we're all together. I turn off the radio to talk to everyone"* • *"I've got heaps of people under me so I need a couple of hours to get through the work vs someone who only has a couple of people might only need 30 mins"* Resourcing considerations: • *"I'm often too understaffed to go to toolbox meetings"* • *"Often I'm not able to send an HSR to meetings because we're down people and can't physically get off the line"*	Could the role be designed, structured, or organised better to enhance worker engagement, participation, and representation? Considering: • The best way to structure HSRs to ensure representation and access to HSRs by all workers. • Processes, frequency, and timeframes for feedback and engagement with HSRs. • How HSRs contribute to risk identification and management, organisational policies, and decision-making. • When HSRs are expected to do HSR duties and if this competes with their primary role.

PSYCHOSOCIAL RISKS OUTLINED IN *ISO45003:2021 GUIDELINES FOR MANAGING PSYCHOSOCIAL RISKS*	**EXAMPLES OF CHALLENGES AND COMMENTARY FROM WORKSAFE'S HSR DISCOVERY PROJECT**	**KEY POINTS FOR BUSINESSES TO CONSIDER WHEN SUPPORTING HSRS**
How work is organised (continued):		
	Structural/Design considerations: • *"Can we cut out some of the paperwork?"* • *"We just need a computer"* • *"Some guys can't read and write"* • *"Why don't we get all the Standard Operating Procedures translated so everyone can read it?"* Workload considerations: • *"$10 a week extra is not enough because of all the added stress I'm dealing with, it's so much work on top of my primary role".*	• Whether tasks and duties an HSR is expected to complete align with representing the worker voice. • The resources and accessibility of resources available for HSRs to use and share with others. • The confidence and training needs of HSRs. • The needs of HSRs at different stages in their HSR Journey.

PSYCHOSOCIAL RISKS OUTLINED IN *ISO45003:2021 GUIDELINES FOR MANAGING PSYCHOSOCIAL RISKS*	**EXAMPLES OF CHALLENGES AND COMMENTARY FROM WORKSAFE'S HSR DISCOVERY PROJECT**	**KEY POINTS FOR BUSINESSES TO CONSIDER WHEN SUPPORTING HSRS**
Social factors at work		
• Interpersonal relationships • Leadership • Organisational/ workgroup culture • Recognition and reward • Career development • Support • Supervision • Civility and respect • Work/life balance • Violence at work • Harassment • Bullying and victimisation	Relationships with Leaders: • *"If you don't have top level manager support and buy-in you're wasting your time"* Relationships with Managers • *"Training our managers, we need them to understand our role better"* • *"Management needs to walk the talk"* • *"I need management to take this seriously and follow through"* Relationships with workers: • *"I feel like a policeman. Reporting on your own guys can have a large effect on your relationship with the guys"* • *"They have glossy posters on bullying but honestly, I want to rip them off the wall. I've had two men holding me by the neck, up against a wall, shouting at me"* • *"You have to be easy to talk to and not take sides"* Support/Training for HSRs: • *"Should have refresher training every 1–2 years like first aid"*	How do leaders, supervisors and workers support HSRs? Does the culture and team activities enhance social connections? Considering: • How workers find out who their HSRs are • The opportunities HSRs have to network and collaborate with other HSRs • How Health and Safety teams and senior leaders support HSRs • Whether supervisors and managers understand and support the HSR role • How the business or organisation promotes wellbeing and social connection

PSYCHOSOCIAL RISKS OUTLINED IN *ISO45003:2021 GUIDELINES FOR MANAGING PSYCHOSOCIAL RISKS*	**EXAMPLES OF CHALLENGES AND COMMENTARY FROM WORKSAFE'S HSR DISCOVERY PROJECT**	**KEY POINTS FOR BUSINESSES TO CONSIDER WHEN SUPPORTING HSRS**
Work environment		
Work environment, equipment, and hazardous tasks	Physical and social work environment: • *"It would be good to have a location to log these incidents like an office, desk, with a computer"* • *"Me, a 23-year-old walking up to a 50-Year-old builder and telling him to put a guarding on his grinder is never going to go down well"* • *"Do you talk about health and safety? No. You talk about production…the guys think that is the priority"* • *"They want to bring it (mental health) up but don't know how to do it, so it seems like a joke at first"*	How does the work environment affect the HSR role? Considering: • The resources and training HSRs have access to • How the tasks and feedback mediums (i.e., computer work, paper based, verbal communication) align with HSRs primary roles • The access of HSRs to the work environment and the workers in it

Workplace bullying in New Zealand: A review of the research

Bevan Catley

What is workplace bullying?

Persons conducting a business or undertaking (PCBU) must effectively respond to workplace bullying to fulfil their legal and moral responsibilities and to prevent harm to both individuals and the organisation. Bullying is characterised by an individual experiencing repeated exposure to unwanted, negative behaviours. It is the persistent exposure to targeted, negative behaviour that is the essence of bullying and gives it its destructive force. It is also these same dynamics that can make an effective organisational response so challenging.

There is no definitive list of workplace bullying behaviours (see Table 1 for examples). A workplace bully is often adept at identifying vulnerabilities in their target and instigating behaviours that are likely to result in harm. At an individual level, bullying can be categorised in terms of work-related (or task) and person-related behaviours (Zapf et al., 2020). These behaviours can be direct (e.g., constant criticism of work performance; being sworn at) or indirect (e.g., spreading rumours; having information withheld). Targets typically report bullying behaviours as predominantly psychological with acts of physical aggression rare. Targets also tend to report experiencing a range of bullying behaviours (Zapf et al., 2020).

Table 1

Examples of Potentially Bullying Behaviour (WorkSafe New Zealand, 2017)

PERSON-RELATED BULLYING	WORK-RELATED BULLYING
• Being humiliated, ridiculed or belittled • Insulting or offensive remarks • Being ignored or excluded • Intimidating behaviour • Gossip or rumours • Tampering with personal effects • Intrusions on privacy • Threats of violence or abuse	• Persistent, unjustified criticism of work performance • Excessive or inappropriate monitoring of work • Having important information withheld or concealed • Given unachievable tasks or an unmanageable workload • Being underworked or assigned meaningless tasks • Denial of opportunity and/or voice • Training and/or resources withheld • Sabotage

In certain contexts, these behaviours can seem innocuous or even reasonable. What turns an ordinary workplace behaviour into bullying is when that behaviour is unreasonable, repeated and targeted. In a work setting, 'unreasonable behaviour' can be understood as behaviour that cannot be justified against organisational policy, practice or values and/or violates social norms of acceptable behaviour. Targets who experience behaviours that they find humiliating, ridiculing or belittling report these behaviours to be more severe and harmful than others that they have experienced (Zapf et al., 2020).

The wide range of bullying behaviours indicates that workplace bullying is a multifaceted rather than singular concept (D'Cruz & Noronha, 2021). D'Cruz and Noronha (2021) contend that workplace bullying can be considered as a series of 'varieties' based on three defining dimensions – (1) level of analysis, (2) location of the source and (3) form of misbehaviour. Accordingly, D'Cruz and Noronha (2021) identify and explain seven varieties of bullying. The first four varieties exist as distinct forms of bullying, but D'Cruz and Noronha (2021) maintain that combinations of these four have also been evidenced by researchers.

1. Interpersonal bullying: characterised by an individual persistently targeting another to the point of powerlessness and defencelessness. In this situation, both the bully and target are organisational members with the bully being the target's superior, peer or subordinate. Bullying can be downward (superior to subordinate), horizontal (peer to peer) or upward (subordinate to superior). Interpersonal bullying is what most have in mind when referring to 'workplace bullying'.

2. Depersonalised bullying: the subjugation of employees by the contextual, structural and processual elements of the organisation. Managers and supervisors involuntarily resort to intimidation without targeting or intent other than the realisation of organisational goals.

3. Extra-organisational (External) bullying: individuals beyond the organisation (e.g., customers, clients, suppliers) who engage in the bullying of organisational members.

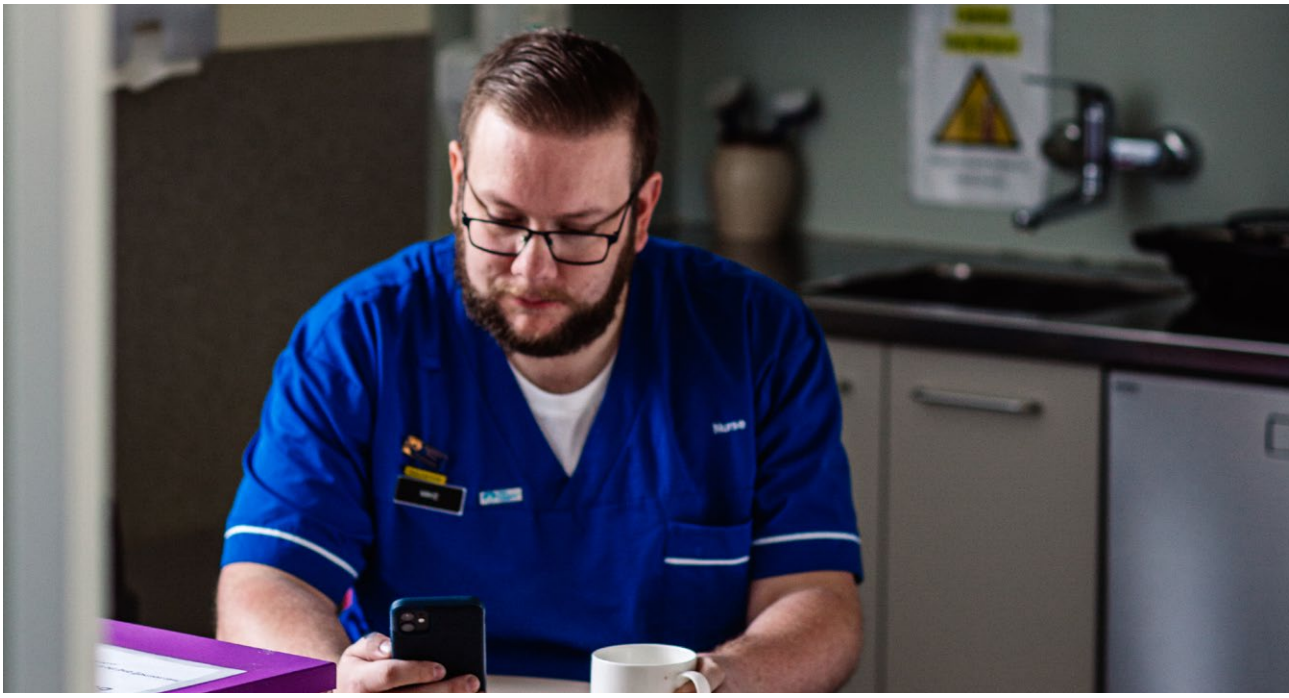
4. Cyber bullying: bullying behaviours conducted through a digital or virtual medium. Unlike face-to-face bullying, cyber bullying is characterised by its boundarylessness, invisibility, anonymity, concreteness and permanence.

5. Compounded bullying. A combination of interpersonal and depersonalised bullying whereby the target experiences bullying from another organisational member within the context of an oppressive work environment.

6. Dual locus bullying. An individual experiences bullying from other organisational members (interpersonal bullying) and from individuals beyond the organisation (external bullying).

7. Hybrid bullying. Bullying is experienced as both face-to-face bullying and cyber bullying.

As D'Cruz and Noronha (2021) note, these varieties of bullying highlight the complexity of the phenomenon and how it can be experienced in a number of different ways that are likely to change as the world of work evolves. It also highlights that all varieties of bullying consist of negative behaviours involving a range of human participants in a relational setting.



How widespread is workplace bullying in Aotearoa New Zealand?

In Aotearoa New Zealand, much of the public and regulatory focus and academic attention has been on interpersonal bullying. The exception is a small body of emergent research examining the dynamics of cyberbullying along with its relationship to face-to-face bullying (D'Souza, Catley, Tappin, & Forsyth, 2019; D'Souza, Forsyth, & Blackwood, 2021; D'Souza, Forsyth, Tappin, & Catley, 2017, 2018). Despite this attention, there is currently no representative and/or regular collection of data on the prevalence of workplace bullying that uses internationally validated measures. Reported prevalence rates vary widely dependent on how bullying is conceptualised and how it is measured.[1] Consequently, this makes it difficult to make comparisons between studies and to generalise rates to the broader working population. However, while the data collected by academics and government departments and ministries is far from complete, it does indicate that bullying is a significant and widespread problem in New Zealand workplaces (Table 2).

Initial research by New Zealand academics highlighted bullying to be a problem for nurses, junior doctors, dentists and those in higher education (e.g. Ayers, Thomson, Newton, Morgaine, & Rich, 2009; Foster, Mackie, & Barnett, 2004; McKenna, Smith, Poole, & Coverdale, 2003; Scott, Blanshard, & Child, 2008; Thirlwall & Haar, 2010). Bentley and colleagues (Bentley et al., 2012; Bentley et al., 2009b; O'Driscoll et al., 2011) conducted the first large-scale study of workplace bullying, surveying more than 1700 employees from four industry sectors and reported an overall prevalence rate of 17.8%.

1 For a detailed review and explanation, see León-Pérez, Escartín, and Giorgi (2021); Nielsen, Matthiesen, and Einarsen (2010); and Zapf et al. (2020). The two most common approaches to measuring bullying prevalence are 'self-labeling' and 'behavioural exposure'. With the first, respondents are directly asked if they have experienced workplace bullying with the question sometimes accompanied by a definition of bullying. With the second approach, an inventory of negative behaviours (typically, the 'negative acts questionnaire' (NAQ)) is provided and respondents are asked how frequently they have experienced any of these behaviours over time (weekly, over 6 months).

Since that time, further academic studies have reported the prevalence of workplace bullying in samples drawn from different working populations. The health sector has received considerable attention and the prevalence rates presented in Table 2 are consistent with international findings that indicate that it, along with education and public administration, are often associated with a higher risk of bullying (Zapf et al., 2020). Alongside these specific prevalence studies, several qualitative studies have indicated the pervasiveness of bullying amongst nurses (e.g., Blackwood, Bentley, & Catley, 2018; Blackwood, Bentley, Catley, & Edwards, 2017; Clendon & Walker, 2012; Huntington et al., 2011) and as a 'rite of passage' in medical training (Crampton, Wilkinson, Anderson, Walthart, & Wilson, 2015; Ferguson, 2015). A 2015 editorial in the *New Zealand Medical Journal* claimed bullying and harassment to be "endemic" in the health sector (Kelly, 2015: 18).

While not investigating prevalence per se, a number of other New Zealand published studies further indicate the pervasiveness of workplace bullying. Detailed qualitative studies conducted by van Heugten (2010, 2013) examined the experiences of social workers who reported being bullied at work. Catley et al. (2013) surveyed 252 OHS practitioners and reported that 29% agreed or strongly agreed with the statement that "workplace bullying is a problem in your organisation". Thirlwall (2015) examined the experiences of targets and HR workers in the higher education sector. Finally, Catley, Blackwood, Forsyth, Tappin, and Bentley (2017) analysed 56 cases heard over a four-year period before the Employment Relations Authority or the Employment Court where bullying was the central feature of the complainant's grievance.

Data collected by government agencies also reinforces the view of a widespread problem. Statistics New Zealand via the 2018 *Survey of Working Life,* reported around 300,000 workers (11%) experienced discrimination, harassment or bullying in the previous 12 months (Stats NZ, 2019). Data from this survey provided to MBIE and reported in their 2021 issues paper, indicated that rates varied from 18.8% in "health care and social assistance" to 4.9% in "agriculture, forestry, fishing and mining" (Ministry of Business Innovation & Employment, 2020). WorkSafe New Zealand's (2020) *Workforce Segmentation and Insights* survey reported that 15% of 4196 workers drawn from all industries reported experiencing bullying or harassment in the previous 12 months.

Table 2
Reported Prevalence of Workplace Bullying in NZ

AUTHOR	SAMPLE
Bentley et al. (2009b)	Education Healthcare Hospitality Travel
O'Driscoll et al. (2011)	Education Healthcare Hospitality Travel
Crebbin et al. (2015)	Members of the Royal Australasian College of Surgeons
Gardner et al. (2016)	General working population
Venkatesh et al. (2016)	Members of the College of Intensive Care Medicine of Australia and New Zealand
Plimmer et al. (2017)	Female members of the Public Services Association
Chambers et al. (2018)	Members of the Association of Salaried Medical Specialists
Gardner et al. (2020)	General working population
Bentley et al. (2021)	General working population
Stats NZ (2019)	*Survey of Working Life*
WorkSafe New Zealand (2020)	*Workforce Segmentation and Insights*

2 Negative Acts Questionnaire.

	BULLYING PREVALENCE		
MEASUREMENT SCALE	**NAQ**	**SELF-LABEL**	**WITNESS PREVALENCE**
NAQ[2] – Revised Self-labelling – definition	22.4% 18.4% 15.0% 11.4%	5.2% 4.8% 2.3% 1.5%	7.7%
NAQ – Revised Self-labelling – definition	17.8%	3.9%	Not reported
Self-labelling – no definition		39%	
NAQ – Revised Bespoke scale (Cyberbullying)	15% (B) 2.8% (CB)	1.7% (ill-treatment)	Not reported
Self-labelling – no definition		32%	Not reported
Self-labelling – no definition		43%	Not reported
NAQ – Revised. Self-labelling – definition	38.1%	2.5%	4.7%
Self-labelling – definition		17.7%	Not reported
Short NAQ		At least 13.8%	Not reported
Self-labelling – no definition		11%	Not reported
Not reported		15%	Not reported

The variation in conceptualisations of workplace bullying and different data collection methods makes international comparisons difficult. However, the studies conducted by Bentley and colleagues (Bentley et al., 2012; Bentley et al., 2009b; Bentley et al., 2021; Gardner et al., 2016; O'Driscoll et al., 2011) and Chambers et al. (2018) are amongst the few New Zealand studies that do use measures comparable with international research. Nielsen's (2010) meta-analysis of international studies which used a similar methodological approach estimated a comparable prevalence rate of 14.8%. A review of European studies by Zapf et al. (2020) indicated a comparable prevalence rate of 11.2% but with broad variations dependent on the sample population. Likewise, the review conducted by León-Pérez et al. (2021) reported wide variance in comparable prevalence across Europe (4.6 – 22%), America (7.8% – 14.7%) and Asia (14.8% – 18.5%). With the range of prevalence reported by Bentley and colleagues and Chambers et al. (2018) to be between 11.4% and 38.1% by sector and between 15% and 17.8% in general samples, New Zealand rates may be higher than international reports dependent on which sample population is being compared.

Who are the targets and perpetrators of workplace bullying?

Internationally, research investigating the dynamics of workplace bullying has generally relied on data from a single source – the target (Neall & Tuckey, 2014). As a result, much more has been reported about the characteristics of those who have experienced workplace bullying rather than from perpetrators. Typical characteristics of interest include gender, age, personality traits, relative minority status in the workplace, and organisational status relative to the perpetrator. With some exceptions, few New Zealand studies have specifically investigated these sorts of characteristics beyond reporting the general demographics of the sample. As with prevalence, the same cautions need to be exercised when generalising to the broader New Zealand working population. At best, our knowledge about risk groups is limited.

Gender

Bentley and colleagues (2012; 2009b) along with Gardner et al. (2017) reported no significant differences in exposure to bullying behaviours and in levels of self-identifying as having been bullied. In contrast, Gardner et al. (2016) reported that women experienced more workplace bullying but that there were no significant gender differences for cyberbullying. Similarly, the *Survey of Working Life* (Stats NZ, 2019) reported that women were more likely than men to have experienced discrimination, harassment, or bullying at work while WorkSafe's (2020) *Workforce Segmentation and Insights* reported a higher rate of bullying for women in their 30s. Gardner et al. (2020) have conducted the most extensive investigation into the relationship between gender and bullying. Overall, Gardner et al. (2020) reported that women, regardless of role, age or ethnicity, were more likely to self-identify as having been bullied at work than men.

Studies conducted in the health profession have reported that women experience more bullying than men (e.g. Crebbin et al., 2015). Chambers et al. (2018) reported that women experienced different bullying behaviours than men but that overall there was no significant differences in exposure. However, women were more likely to self-identify as being bullied and to have witnessed bullying behaviour (Chambers et al., 2018). Venkatesh et al. (2016) indicated that there were little differences by way of age or gender in the proportions reporting bullying.

The Survey of Working Life (Stats NZ, 2019) gives some insight into the relationship between ill-treatment, gender and occupation. Women working as machinery operators and drivers reported the highest rates of discrimination, harassment and bullying (20%). Women categorised as professionals (including school teachers, midwives and nurses) reported the next highest rates (17%) followed by community and personal services workers (16%). Men working in the community and personal services also reported high rates (18%) – the only occupational group where men reported higher rates of ill-treatment than women.

The Survey of Working Life also indicated that the experience of ill-treatment varied by job conditions (Stats NZ, 2019). Men who worked mostly night shifts reported experiencing more than twice the rate of discrimination, harassment, or bullying than those who mainly worked days. Similarly, women working varied shifts reported experiencing more than 1.5 times the rate of ill-treatment than those who mainly worked days.

Age and ethnicity

As with previous indicators, reported results vary dependent on the methods employed and the sample recruited. Additionally, the relationship between key demographic variables and bullying are often not reported – especially age. As a result, the research paints a very incomplete and inconclusive picture.

Research that reports the relationship between age and bullying offers only preliminary insights. The *Survey of Working Life* reported that workers aged 45–54 experienced the highest rates of discrimination, harassment or bullying (Stats NZ, 2019). Gardner et al. (2016) considered if younger employees were more likely to experience cyber bullying than older employees due to a more extensive involvement in online activities. However, Gardner et al. (2016) found little evidence of a greater exposure to cyber bullying at work for younger workers. Within the field of medicine, Chambers et al. (2018) reported that respondents aged 40–49 and 50–59 experienced significantly higher prevalence of bullying behaviours than other age groups.

In contrast to age, the relationship between bullying and ethnicity has been more widely reported. The *Survey or Working Life* (Stats NZ, 2019) reported higher rates of discrimination, harassment or bullying for Asian and Māori (13%) respondents than for Pacific and European respondents (11%). When examined in relationship to gender, women reported higher rates across all ethnic groups. The biggest differential was reported as being between Māori women (17%) and Māori men (8%). The study of medical specialists by Chambers et al. (2018) indicated that some ethnicities experienced higher levels of bullying behaviours than others.

Gardner et al. (2013) undertook an in-depth investigation into the relationship between workplace bullying and ethnicity. Gardner et al. (2013) reported that when respondents self-labelled as having been bullied, there were no significant differences between ethnic groups. However, significant differences were found when examining exposure to bullying behaviours. On this indicator, Pacific Island and Asian/Indian respondents reported somewhat higher rates of bullying than European and Māori respondents.

While there is merit in drawing on demographic variables to help identify groups who may be more at risk of bullying, what may be more important is the group's number relative to others. Gardner et al. (2013) has suggested that those who find themselves in a minority group at work (e.g. on the basis of age, gender, ethnicity or other personal attributes) may be at an increased risk of being targeted by others. A later study by Gardner et al. (2020) found evidence for this proposition when they reported that being in a gender minority at work was associated with more self-identification as having been bullied.

Role/level

Limited information has been collected about the organisational role or status of the target in the New Zealand context. The *Survey of Working Life* (Stats NZ, 2019) indicated that paid employees reported the highest rate of discrimination, harassment, or bullying (12%), followed by employers (9%), and the self-employed without employees (8%). Bentley et al. (2009b) reported that there were no significant differences across hierarchal levels for individuals who self-labelled as having been bullied. Significant differences were reported for exposure to bullying behaviours by organisational level with rates higher for first-line supervisors (20.7%) and lower for senior managers (6.8%). Just over 18% of non-managerial workers reported exposure to bullying behaviours. Gardner et al. (2016) found no significant differences between managers and non-managers in relation to workplace bullying, but managers reported more cyber bullying that non-managers.

Source/perpetrator of workplace bullying

In contrast to targets, even less is known about the characteristics of perpetrators of workplace bullying in New Zealand. Much of what has been reported relates to the organisational status and gender of the alleged bully – especially in the healthcare sector. Both O'Driscoll et al. (2011) and Gardner et al. (2016) provide some insight into the hierarchal status of the alleged bully. When respondents who self-labelled as having been bullied were asked to identify the organisational status of their bully (or bullies), O'Driscoll et al. (2011) reported bullies operating across a number of organisational levels. Targets reported their bully(ies) as their employer (31.6%), senior manager (36.9%), middle manager (32.8%), supervisor (36.4%), colleague (56.1%), subordinate (19.5%), and/or as a client or customer (26.9%). A similar broad range of organisational levels was reported by Gardner et al. (2016). Self-identified targets identified the bullying as being their supervisor, employer or manager (31%), peer (48%), subordinate (17%) and/or client (17%).

Crebbin et al. (2015) and Chambers et al. (2018) both reported on the characteristics of bullies in the health sector. From their survey of members of the Royal Australasian College of Surgeons, Crebbin et al. (2015) reported that over 79% of respondents identified the bully as male. Likewise with the membership survey of the Association of Salaried Medical Specialists, Chambers et al. (2018) reported that 36.8% of respondents who self-labelled as having been bullied identified the bully as male. Just over 35% reported an equal number of men and women. Surgical directors or consultants were the most frequently reported perpetrators of bullying, followed by medical consultants and nursing staff (Crebbin et al., 2015). Chambers et al. (2018) found that senior medical or dental staff (52.5%) were the most frequently reported perpetrators followed by non-clinical managers (31.8%) and clinical leaders (24.9%). These findings are consistent with earlier studies such as Scott et al. (2008) who reported consultants and nurses as the main perpetrators of bullying, and studies investigating nursing where the perpetrator was overwhelmingly a nurse and typically female, senior and older than the target (Clendon & Walker, 2012; Foster et al., 2004; McKenna et al., 2003). In van Heugten's (2010) study of social workers, the bully was almost always the target's organisational superior.

What is the impact of workplace bullying?

The impact of workplace bullying on individuals and the organisation has been extensively studied. Individual studies and reviews indicate workplace bullying to be associated with a wide range of harm to a person's physical and psychological wellbeing and work performance (D'Cruz et al., 2021; Einarsen, Hoel, Zapf, & Cooper, 2020; Samnani & Singh, 2012). New Zealand studies have both added to this picture and reinforced concern about the impact bullying has on people and organisations. The harm linked to workplace bullying can be considered according to the impact on the target, bystander and the organisation.

The impact on targets

Workplace bullying has been associated with a wide range of negative outcomes for those who experience it (for an overview, see Mikkelsen, Hansen, Perrson, Byrgesen, & Hogh, 2020). Studies utilising New Zealand samples report many of these same negative psychological and physiological outcomes (Table 3). However, as with the majority of international research, these studies almost always rely on self-report data and cross-sectional design and, combined with a lack of representative samples, makes it difficult to draw any conclusions about causal relationships or generalisability to the broader working population. Thus, as with the international research generally, it is far from clear which specific health correlates are an outcome of bullying and which are predictors of bullying (Nielsen & Einarsen, 2018).

As with prevalence, a number of quantitative and qualitative studies investigating the impact of bullying on targets have been conducted in the health sector. When asked about the impact of bullying, respondents have reported a detrimental impact on their confidence, self-esteem, concentration and the experiencing of a wide range of negative emotions (Blackwood et al., 2018; Clendon & Walker, 2012; Foster et al., 2004; McKenna et al., 2003; van Heugten, 2010). In a study of social workers, van Heugten (2010) reported that several participants were diagnosed with depression by their GP. A similarly wide variety of negative effects on physical health have also been reported by targets ranging from sleep loss to general debilitation (Blackwood et al., 2018; McKenna et al., 2003; van Heugten, 2010).

There is some indication of a positive impact around individual resilience as a result of being bullied. McKenna et al. (2003) reported that a very small number of nursing respondents reported that as a consequence of their experience they felt better able to "stand up" for themselves, "feel stronger" in themselves, or reassured by support from other staff. Similarly, van Heugten (2013) found that most of the social work participants considered that they had developed greater resilience. For these participants, reported van Heugten (2013), their sense of resilience was enhanced when they had received support from witnesses and managers alongside an improved sense of control over their situation. However, in both studies, any enhanced resilience existed in a context of overwhelmingly and consistently negative impacts to physical and psychological health.

Larger quantitative surveys of samples drawn from the general working population paint a similar, negative picture relating to individual wellbeing. Compared to non-targets, targets reported higher levels of psychological strain and psychological distress, and lower levels of psychological wellbeing (Bentley et al., 2012; Bentley et al., 2021; Gardner et al., 2017; O'Driscoll et al., 2011). The extent to which these impacts might vary according to age, gender or ethnicity in the New Zealand context is unclear. However, Gardner et al. (2013) reported that Pacific Island and Asian/Indian respondents reported lower levels of psychological strain compared to New Zealand Europeans despite reporting higher levels of bullying.

The impact on bystanders

Individuals who have witnessed or observed workplace bullying report many of the same negative impacts as those who have experienced bullying. Compared to non-witnesses, those witnessing bullying reported higher levels of stress, workplace demands and intentions to leave (Bentley et al., 2012; Chambers et al., 2018). Witnesses also reported lower levels of emotional wellbeing, peer and managerial support, self-rated job performance and affective commitment to the organisation (Bentley et al., 2012; Chambers et al., 2018).

Cooper-Thomas et al. (2014) reported on the findings of a study investigating the impact of bullying on observers and targets. The results indicated that bullying had a stronger impact relative to observing bullying but being an observer of bullying was still associated with negative outcomes at a level between not experiencing any bullying and being a target. Individuals who reported experiencing both bullying and being an observer, experienced higher levels of strain and lower levels of wellbeing compared to being a target. As Cooper-Thomas et al. (2014) write, this may be suggestive of a compounding effect of increased exposure to workplace bullying.

The impact on the organisation

The prevalence of workplace bullying and the wide-ranging effects it has on individuals has a considerable direct and indirect impact on the organisation. This is most evident in the responses from participants relating to the impact of bullying on aspects related to their work performance. However, there are also the additional costs associated with the management of complaints and potential legal proceedings. As with individual impacts, data is most extensive from the health sector but the findings are consistent with results from surveys of the general working population.

Evidence from research conducted across different sectors within the health industry indicate that bullying is strongly associated with a negative impact on work performance. As a result of being bullied, respondents reported that they were absent from work more, didn't want to go to work, were thinking about leaving their job, or expressed general disillusionment with their profession (Ayers et al., 2009; Blackwood et al., 2018; Chambers et al., 2018; McKenna et al., 2003). Respondents across several studies reported how bullying negatively impacted their competence by making them more prone to errors or resorting to defensive medical practice (Blackwood et al., 2018; Chambers et al., 2018). Ultimately, some respondents felt that the impact of bullying compromised service delivery and patient care (Chambers et al., 2018; McKenna et al., 2003). For those who expressed concerns about deteriorating levels of performance, concern was also raised about future employment prospects (Blackwood et al., 2018).

Beyond the health sector, bullying has been shown to be positively related to absenteeism and an intention to leave (Bentley et al., 2012; Bentley et al., 2021; Gardner et al., 2017; O'Driscoll et al., 2011). Bullied respondents also report lower levels of affective commitment and self-rated job performance than non-targets (Bentley et al., 2012; O'Driscoll et al., 2011). These respondents also perceived significantly less support from their supervisors, colleagues and the organisation generally (O'Driscoll et al., 2011). Organisational managers have also expressed beliefs that bullying negatively impacts staff morale, motivation and productivity and leads to an increase in associated administration which may be indicative of a potential impact on both worker and managerial productivity (Catley et al., 2013). Additionally, there are also the direct costs of legal proceedings and the potential for substantial but difficult to measure damage to an organisation's reputation (Catley, Blackwood, et al., 2017).

How does workplace bullying take hold in an organisation?

Interest in the causes, or antecedents, of workplace bullying has paralleled the strong interest in the magnitude and impact of the problem. This interest has yielded two dominant lines of enquiry (Nielsen & Einarsen, 2018). In the first, researchers have investigated the personality characteristics, or combinations of characteristics, of targets and bullies as antecedents (for an overview see Zapf & Einarsen, 2020). The second line of enquiry has focused on the organisational antecedents – typically expressed as the 'work environment hypothesis' (for an overview see Salin & Hoel, 2020). According to the work environment hypothesis, a poor working environment (e.g., work culture, job design, leadership, policy initiatives) is a precursor to workplace bullying (Nielsen & Einarsen, 2018). In essence, the stress and frustration that flows from the prevailing content and context of work coupled with management inaction or tolerance can lead to an individual(s) being bullied.

New Zealand research has mostly focused on the organisational antecedents of workplace bullying. As with the research on prevalence and impacts, almost all the quantitative research is cross-sectional, making it difficult to establish direct causation. Additionally, the research typically relies on self-reports which may, or may not, accurately reflect the actual work environment of the participants (Li, Chen, Tuckey, McLinton, & Dollard, 2019). Despite these limitations, which are a feature of the literature generally, the findings are consistent with international research that shows strong associations between workplace bullying and a poor work environment.

Table 3
Impacts Associated with Workplace Bullying

ASSOCIATED IMPACT	AUTHOR
Targets	
Psychological impact	
• Confidence, self-esteem and concentration	Blackwood et al. (2018); Clendon and Walker (2012); Foster et al. (2004); McKenna et al. (2003); van Heugten (2010)
• Negative emotions: fear, stress, anger, anxiety, sadness, shame, frustration, distrust and nervousness	Blackwood et al. (2018); Chambers et al. (2018); Foster et al. (2004); McKenna et al. (2003); van Heugten (2010)
• Depression	McKenna et al. (2003); van Heugten (2010)
• Psychological strain and psychological distress • Lower levels of psychological wellbeing	Bentley et al. (2012); Bentley et al. (2021); Gardner et al. (2017); O'Driscoll et al. (2011)
• Enhanced resilience	McKenna et al. (2003); van Heugten (2013)
Physical impact	
• Weight loss, over-eating, sleep loss, fatigue, headaches • Muscle tension, skin rashes, intestinal problems, hypertension, angina • General debilitation	Blackwood et al. (2018); McKenna et al. (2003); van Heugten (2010)

ASSOCIATED IMPACT	AUTHOR
Bystanders	
• Higher levels of stress, workplace demands and intentions to leave	Bentley et al. (2012); Chambers et al. (2018); Cooper-Thomas et al. (2014)
• Lower levels of emotional wellbeing, peer and managerial support, self-rated job performance and affective commitment to the organisation	Bentley et al. (2012); Chambers et al. (2018); Cooper-Thomas et al. (2014)
Organisation	
• Increased absences and intention to quit	Ayers et al. (2009); Bentley et al. (2012); Bentley et al. (2021); Blackwood et al. (2018); Gardner et al. (2017); O'Driscoll et al. (2011)
• Less willingness to want to go to work	Blackwood et al. (2018)
• General disillusionment with the profession	McKenna et al. (2003)
• Competence	Blackwood et al. (2018); Chambers et al. (2018)
• Service delivery and patient care	Blackwood et al. (2018); Chambers et al. (2018)
• Future employment prospects	Blackwood et al. (2018)
• Lower levels of affective commitment and self-rated job performance	Bentley et al. (2012); O'Driscoll et al. (2011)
• Perception of less supervisor, colleague and organisational support	O'Driscoll et al. (2011)
• Staff morale, motivation and productivity	Catley et al. (2013)
• Legal proceedings and reputational damage	Catley, Blackwood, et al. (2017)

In survey research, respondents have been asked for their perceptions about a range of job content and context factors related to the design, organisation and management of work. Much research interest has focused on the role of leadership and support from peers, supervisors and the organisation generally. Compared to non-targets, targets report higher levels of laissez-faire leadership (Bentley et al., 2012; Cooper-Thomas et al., 2014) and lower levels of collegial, supervisor and organisational support (Bentley et al., 2012; Chambers et al., 2018; Gardner et al., 2017; O'Driscoll et al., 2011). The *Survey of Working Life* (Stats NZ, 2019) also indicated the importance of workplace relationships. According to the findings, employees who reported an indifferent, bad or very bad relationship with either their manager or colleague reported a rate of ill-treatment three times higher than those who reported a good or very good relationship (Stats NZ, 2019). While it seems that all levels of support are important, the results of O'Driscoll et al. (2011) suggest that deficiencies in supervisor and organisational support may be more applicable to experiencing bullying than peer support. The absence of support is likely to contribute to a workplace culture indicative of a lack of social cohesion and inclusion (Bentley et al., 2021; Cooper-Thomas et al., 2014), or one that tolerates bullying as a workplace behaviour (Bentley et al., 2009a; Chambers et al., 2018).

A work environment characterised by unreasonable workloads and job demands has also been associated with workplace bullying. Plimmer et al. (2017) reported that pressure to work more hours, coupled with difficulties in accessing flexible working hours as a result of time and workload demands, strongly predicted ill-treatment. As a result, Plimmer et al. (2017: 338) concluded that ill-treatment can be a by-product of a work intensification strategy and where flexible working arrangements are inaccessible. In the health sector, Chambers et al. (2018) reported a similar association between work demands and exposure to workplace bullying.

Broader contextual factors have also been linked to workplace bullying. In the *Survey of Working Life*, perceptions of low job security were linked to higher rates of ill-treatment compared to respondents who had a perception of much stronger job security (Stats NZ, 2019). The same survey also linked a skills mismatch with experiencing ill-treatment. Respondents who perceived themselves as being either over-skilled or under-skilled for their job, reported a higher rate of ill-treatment than those who thought their skills matched their job (Stats NZ, 2019). Plimmer et al. (2017) also reported low occupational status, limited career options and job mobility as further risk factors for ill-treatment. As Plimmer et al. (2017) contends, these sorts of findings indicate that workplace ill-treatment goes beyond 'poor management' and the immediate circumstances of individual workers to where ill-treatment is embedded in the workplace dynamics and the broader employment relationship.

The association between a poor work environment and bullying also extends to bystanders. Witnesses have reported leadership to be more laissez-faire and less constructive compared to non-witnesses, and also reported lower levels of supervisor and colleague support (Bentley et al., 2021; Cooper-Thomas et al., 2014). Chambers et al. (2018) reported similar findings from respondents in the health sector. Amongst medical specialists, witnessing bullying was associated with high workplace demands, and low levels of peer and managerial support (Chambers et al., 2018).

Both the New Zealand and international research strongly indicate the existence of a poorly organised and led work environment in the development of workplace bullying. On this basis, there seems ample evidence to support the work environment hypothesis as predictive but an inverse relationship – that bullying leads to a poor work environment – is also plausible (Nielsen & Einarsen, 2018). Equally, the possibility that targets believe their work environment to be more deficient generally has to be a real consideration, although the findings from bystanders would appear to provide support for the perceptions of targets. Additionally, evidence in support of the 'work environment hypothesis' does not invalidate the importance of individual dispositions as potential antecedents. For any given case of bullying, there are likely to be multiple organisational and individual factors which interact in inconsistent ways dependent on the circumstances. These interactive effects and the way they might vary across organisational contexts and demographics is a largely under-researched area. However, it does indicate that singular, 'silver bullet' type responses are unlikely to be effective.

What are some of the ways bullying can be effectively managed?

Alongside broader societal and national regulatory initiatives, efforts to prevent and manage bullying in the workplace can be directed at both the organisational and individual level. These efforts can also be differentiated according to the level where the measure is designed to lessen the risk to health – that is, at the primary, secondary or tertiary level of prevention. As explained by Keashly, Minkowitz, and Nowell (2020), primary prevention consists of proactive measures to prevent workplace bullying occurring. Secondary measures are designed to detect bullying and reduce or possibly reverse the negative impacts on health and to prevent further exposure. Tertiary measures focus on restoration and rehabilitation and on the sustainability of changes to ensure that there are no further cases of bullying. Caponecchia, Branch, and Murray (2020) extend the dimensions to include the degree of specificity, the mode of intervention and the agent who is implementing the intervention to produce a taxonomy of workplace bullying interventions (Table 4). The taxonomy can be usefully used by both researchers and organisations to organise and assess existing initiatives and to identify priority areas.

Table 4
A Taxonomy of Workplace Bullying Interventions (Caponecchia et al., 2020)

ELEMENT	DESCRIPTION	SUBCATEGORIES
Specificity	Whether the intervention type is specific to workplace bullying or addresses other issues	Yes, no
Mode	Whether the intervention type is formal or informal in nature	Formal, informal
Agent	The person or body who is implementing the intervention	Individual, management, organisation
Focus	The person or group on whom the intervention is acting	Individual, target, perpetrator, bystander, work team, management, organisation
Time course	Timing of the intervention relative to workplace bullying events	Primary, secondary, tertiary

In terms of efficacy, a raft of specific measures have been proffered to prevent workplace bullying but there have been few studies conducted to evaluate their effectiveness (for an overview see Hodgins, MacCurtain, & Mannix-McNamara, 2014). New Zealand research investigating measures to prevent bullying have largely focused on respondents' perceptions of the efficacy of organisational and individual measures. In general, measures to prevent workplace bullying have a positive impact, particularly when they are perceived as being effective. The presence and perceived effectiveness of organisational measures have been linked to less bullying and to reducing the negative impact on wellbeing and performance (Cooper-Thomas et al., 2013; Gardner et al., 2017). Focusing on specific measures, Table 5 lists those that have been rated as "effective" by respondents in various studies. Relying on individuals to cope with bullying or enhancing their coping strategies is less likely to be effective. O'Driscoll et al. (2011) reported that the effect of problem solving and avoidance coping strategies to reduce the impacts of bullying is likely to be small.

Specific organisation-driven measures to prevent bullying appear to be relatively recent but are now a more widespread feature of New Zealand workplace health and safety initiatives. In 2013, Catley et al. (2013) found that 55% of their sample of OH&S respondents reported having a bullying policy and just 41% indicated that bullying was recognised as a hazard in their workplace. Training for managers or staff on the topic of bullying was rare (19%). In a later study utilising a different sample, Catley, Bentley, Anderson, and Tedestedt (2017) reported that 80% of organisations had some form of prevention measure in place. However, extensive knowledge and awareness of these measures amongst an organisation's workforce cannot be assumed. Gardner et al. (2017), for example, reported that just 30% of their sample knew whether or not their organisation had a particular measure in place.

Table 5
Organisational Initiatives to Prevent and Manage Bullying

STUDY AUTHORS	INITIATIVE
O'Driscoll et al. (2011)	• Open communication • Appropriate interactions • Workplace bullying policy • Complaints procedure
Cooper-Thomas et al. (2013)	• Workplace bullying policy • Respectful workplace environment • Clear procedures for managing bullying
Gardner et al. (2017)	• Clear consequences for perpetrators • Employee Assistance Programme • Collection and review of workplace bullying data
Plimmer et al. (2017)	• Job autonomy • Employee voice • Accesses to flexible work • Fair and formalised processes for appraisal and promotion
Forsyth, Ashby, Gardner, and Tappin (2021)	• Management competence • Inclusion • Strong Psychosocial Safety Climate

The measures in Table 5 indicate that social support is likely to be influential in buffering the relationship between bullying and its negative impact on the target. In particular, measures that aim to enhance the provision of strong supervisor and organisational support are most likely to have a positive impact on the prevention and management of bullying. The *New Zealand Workplace Barometer* project has linked positive perceptions of management competence with lower levels of workplace bullying (Forsyth et al., 2021). Based on in-depth interviews with nurses, Blackwood, D'Souza, and Sun (2019) developed a competency framework for managing cases of workplace bullying (Table 6) to guide professional development and performance assessment within the profession. Although a secondary prevention measure, this framework complements an additional preventative framework of competencies designed to promote healthy work in a healthcare setting.

In conjunction with competent and supportive managers, a well-managed work environment will likely contribute to a decrease in ill-treatment. Plimmer et al. (2017) reported that where individuals perceived they had job autonomy, employee voice, accesses to flexible work and processes that were fair and formalised, their likelihood of experiencing ill-treatment was low. Plimmer et al. (2017) write that these positive perceptions of the work environment are indicative of a positive organisational approach toward preventing and managing workplace conflicts. Perceptions of fairness and involvement are also likely to yield a greater sense of inclusion amongst workers. Widespread perceptions of inclusion lay the groundwork for a supportive culture, and inclusion can act as an important resource for employees to buffer against bullying. Results from the NZ Workplace Barometer indicate a negative association between inclusion and bullying and that those who were exposed to high levels of bullying were less likely to quit when they perceived a high-inclusion environment (Bentley et al., 2021).

Table 6

Management Competencies for Managing Workplace Bullying (Blackwood et al., 2019)

Availability	• Making time for staff • Listening – allow staff to be heard
Awareness	• Understanding and awareness of what bullying is • Understanding and awareness of the processes to follow
Coaching and mediation	• Providing guidance and advice • Facilitating discussion between staff • Questioning and investigation skills • Avoiding pre-conceived ideas or bias
Communication	• Being clear and transparent • Clarifying expectations and outcomes
Confidence and resilience	• Confidence to deal with conflict • Resilience in dealing with conflict
Consistency	• Ongoing monitoring of a complaint or intervention • Continually and consistently addressing behaviours
Dealing with known Issues	• Taking responsibility for managing bullying • Dealing with existing behavioural issues • Being solution-focused
Individual consideration	• Showing empathy and sensitivity • Providing validation of feelings and experiences
Proactive and early intervention	• Situational awareness • Early and immediate action
Reflection	• Self-reflection • Knowing own limits and when to seek support

The concept of Psychosocial Safety Climate (PSC) focuses on the "policies, practices, and procedures for the protection of worker psychological health and safety" (Dollard & Bakker, 2010: 580) and is largely determined by the actions of managers and leaders within an organisation (Dollard, Dormann, Tuckey, & Escartín, 2017). Argued to be an "upstream organisational condition" that influences working conditions (Dollard & Bakker, 2010: 593), there is evidence to support the effectiveness of a strong PSC in preventing workplace bullying (e.g., Bond, Tuckey, & Dollard, 2010; Dollard et al., 2017; Law, Dollard, Tuckey, & Dormann, 2011). PSC is a central component of the *NZ Workplace Barometer* and results support the view that a strong PSC is negatively related to perceived exposure to bullying (Bentley et al., 2021). Furthermore, PSC was reported to be effective in reducing the negative impacts of bullying (Bentley et al., 2021).

In one of the few investigations into the impact of a national regulatory measures, Catley, Bentley, et al. (2017) examined the impact of the introduction of WorkSafe New Zealand's "Best Practice Guidelines" (WorkSafe New Zealand, 2014). Respondents reported the guidelines to be useful – especially the information on definitions, employer role and responsibilities and the accompanying tools – and had triggered efforts around policy development, and training and awareness initiatives. Respondents reported the guidelines to be user-friendly and engaging and also felt more confident and better equipped to manage bullying in their workplace. An increased awareness of bullying in the organisation and more interest and discussion of the topic were perceived to be the immediate short-term impact but respondents noted little immediate impact on changes in behaviour. The results from the study were used to inform a revised version of the guidelines released in 2017 (WorkSafe New Zealand, 2017).

When organisational responses to address workplace bullying have stalled or proven unsuccessful, mediation is typically the next step in the dispute resolution pathway.[3] Despite mediation being considered effective in resolving employment disputes (Lempp, Blackwood, & Gordon, 2020), its effectiveness has been questioned in cases of workplace bullying (for overviews see Keashly et al., 2020; Zapf & Vartia, 2020). To explore this issue in more detail, Lempp et al. (2020) interviewed 25 practising mediators for their views on the appropriateness and effectiveness of mediation for workplace bullying cases. Lempp et al. (2020: 678) reported that mediators believed that mediation was not a "blanket solution" but could be effective particularly when used in conjunction with other dispute resolution techniques especially where these addressed issues in the broader organisational context.

Based on their findings, Lempp et al. (2020) offered 5 recommendations to enhance the likelihood of mediation being effective in resolving the case (Table 7). According to Lempp et al. (2020), the first two recommendations focus on addressing the emotional stability of the parties and any potential power imbalance between them. The third recommendation focuses on the organisational context while the fourth addresses the timing of mediation. The final recommendation addresses the issue of combining mediation with a prior investigation to determine the factual basis of the case.

3 https://www.employment.govt.nz/resolving-problems/types-of-problems/bullying-harassment-and-discrimination/general-process/

Table 3
Recommendations for Mediators (Lempp et al., 2020)

1. Mediators should pay particular attention to the emotional safety of the parties.
2. Mediators should discuss with the parties the possibility and potential benefits of bringing a support person to any joint meeting during the mediation.
3. Mediators should view their role more widely and consider possible avenues to influence the broader organisational contexts in which bullying occurs and address the structural causes of workplace bullying.
4. Low-level mediator interventions should take place as early as possible in a bullying case to stop the escalation of bullying behaviour and prevent further victimisation.
5. Mediators should consider the option of a combined intervention, encompassing both a workplace mediation and workplace investigation when dealing with a case of workplace bullying.

Both locally and internationally, the evidence for identifying and differentiating the efficacy of various interventions is thin. This shallow knowledge base is compounded by significant gaps in research relating to risk groups, antecedents and impacts. Despite the need for further robust research around interventions, current efforts do indicate areas that would seem reasonable to prioritise. For example, ensuring that organisations have an effective behavioural policy with clear standards, processes and expectations seems foundational to the prevention and management of workplace bullying.

The *New Zealand Workplace Barometer* (Forsyth et al., 2021) also provides insights into key areas for enhancing worker health and wellbeing. Results from successive years point to four pillars of healthy work: (1) organisational justice; (2) inclusion; (3) psychosocial safety climate and (4) management competencies. Thus, initiatives to enhance good working relationships in a respectful and fair workplace environment underpinned by an emphasis on job autonomy, employee voice and inclusion would be valuable. Work in these areas should be supported by investment in developing management competencies that enhances not only a well-managed work environment but also proficiency in managing workplace relationships. Finally, developing a strong psychosocial safety climate, where staff strongly perceive that senior leaders in the organisation place a substantial and sincere value on psychological health and safety also seems vital.

What are some of the challenges to managing reports of workplace bullying?

Despite possessing even the most effective of primary prevention measures, an organisation may still find itself having to manage a complaint of workplace bullying. Additionally, many incidents of bullying go unreported. Evidence from the New Zealand health sector indicates that reporting rates for bullying are low. Early studies by McKenna et al. (2003) and Scott et al. (2008) reported that 49% of first year nurses and 18% of junior doctors who experienced bullying lodged complaints about their treatment. Later studies by Crebbin et al. (2015) and Chambers et al. (2018) reported similar low reporting rates amongst those in surgical practice and senior medical specialists. Crebbin et al. (2015) found that 44.7% of respondents who experienced bullying and 56.1% who experienced sexual harassment did not take any action to address the ill-treatment while Chambers et al. (2018) found that 30.4% of those bullied made formal reports. In terms of the broader working population, Gardner et al. (2013) found that, when asked directly, fewer men than women indicated they had been bullied which may suggest that there are also gender differences related to reporting bullying.

These studies also provide insights into the specific reasons why many individuals chose not to report their ill-treatment. Common reasons provided by respondents included being unsure of the process or whom to report to, the person whom they would normally report to was the bully, or fears that they would not be supported if a formal report was made (Chambers et al., 2018; Scott et al., 2008). Concerns related to the outcome of a report also featured strongly. Here, respondents indicated fear for their future career prospects, that reporting would only make the situation worse, or were fearful of the consequences generally (Chambers et al., 2018; Crebbin et al., 2015; Scott et al., 2008). Amongst nurses, Blackwood et al. (2018) reported a similar fear of repercussions along with fears that their experience was not serious enough to warrant a complaint or that nothing would change as a result of complaining.

For those that do report bullying, research indicates that for many it sees a continuation of the negative experience. An internally conducted mediation process was reported as being generally unhelpful by participants in van Heugten's (2010) study of social workers due to the lack of impartiality. Furthermore, when reports of bullying escalated to formal complaints and/or legal processes, stress was exacerbated while the central concerns were often left unresolved (van Heugten, 2010). According to Scott et al. (2008), only 54% of junior doctors reported some improvement to their situation after making a complaint. Likewise, Crebbin et al. (2015) reported that a cessation in bullying was an uncommon outcome for respondents who took action. Instead, the more frequent outcomes reported by respondents included a continuation of the ill-treatment, further victimisation for making a complaint and leaving the organisation (Crebbin et al., 2015). Similarly, Chambers et al. (2018) reported that for the majority of those who reported bullying, the issue was not addressed and/or the behaviour continued.

The study by Blackwood et al. (2018) suggests that intervention is not experienced as a linear process by complainants. Instead, Blackwood et al. (2018) reported the experiences of interventions by complainants as being far more iterative and cyclical as they assess and re-assess their interpretation of their experience and their courses of action in response to their organisation's actions. Thus in the face of unsupportive responses from their organisation, targets question the legitimacy and wisdom of making a complaint which only discourages further reporting by them and potentially others. Without timely and supportive management action that serves to take the complainant seriously (see Table 7), the groundwork is laid for bullying to be viewed as tolerated and for it to become endemic in the workplace.

Studies by Catley, Blackwood, et al. (2017) and Thirlwall (2015) provide further insight into the difficulties and challenges faced by the complainant, HR and union representatives when a complaint is made. Examining organisational responses to bullying in the higher education sector, Thirlwall (2015) coined the term "organisational sequestering" to explain the individual and organisational responses when concerns about workplace bullying were raised by workers. For Thirlwall (2015), "sequestering" captured the response of managers, HR and, occasionally, union representatives who set aside or avoided concerns about bullying rather than attempting some form of resolution. According to Thirlwall (2015), sequestering played out in three broad ways: (1) reframing – repositioning the concern to make it something else entirely (e.g. as a personal matter, personality issue, a trivial misunderstanding, a defence mechanism, or non-existent); (2) rejigging – surface level solutions that do not address the underlying cause of the concern (e.g. changing communication lines and work patterns, providing coping techniques or access to counselling, or financial settlements) and (3) rebuffing – the active and passive pushing away of an individual's concerns and requests for intervention (e.g. veiled comments about the consequences of making complaints, generalised support; 'ghosting' meeting requests).

For individuals who experienced various sequestering responses to their concerns about bullying, the outcome was neither positive for them, nor for the organisation. In the target's case, this ranged from no support to some initial relief but then despair at the realisation of a lack of a permanent resolution. In all cases, the sequestering prolonged the bullying to exacerbate the impact and complexity. For the organisation, the tolerance of bullying only increased the likelihood of more distressed employees and situations that would only be finally resolved if one of the parties transferred or left the organisation.

An in-depth study of legal cases involving workplace bullying conducted by Catley, Blackwood, et al. (2017) provides insights into the challenges of managing complaints effectively and why complainants can be left with an acute sense of injustice at the end of the process. Catley, Blackwood, et al. (2017) identified five broad challenges to managing complaints of bullying that if not effectively overcome lay the basis for a subsequent legal grievance (Table 8). Importantly, an inability to overcome any number of these five challenges could leave the complainant aggrieved at the organisation's handling of their situation.

The study by Catley, Blackwood, et al. (2017) indicates that work environment factors can play a role in the way a complaint is managed. Blackwood et al. (2017) explores this connection further by examining how the work environment influences both the ability and willingness of management to intervene and the target and alleged bully's response to the complaint and the complaint process. Blackwood et al.'s (2017) findings indicated 12 key factors operating at different levels that directly and indirectly influenced the efficacy of interventions (Table 9). These factors have the potential to be a positive or negative influence but in Blackwood et al.'s (2017) study, the participants mostly focused on how these factors contributed to the challenges of effectively managing complaints of workplace bullying.

Table 8

Challenges to Managing Complaints of Workplace Bullying (Catley, Bentley, et al., 2017)

CHALLENGE	EXPLANATION	OUTCOME
'Sorting out' conflicting accounts	• HR prematurely dismisses the complaint because they perceive no substance due to a lack of 'evidence' or an 'explaining away' by the alleged bully via an alternative explanation	• Failure to investigate • Continuation of the bullying • The complainant often leaves
Following HR process	• Policies and procedures are lacking, incomplete or simply not followed	• An insufficient investigation • Continuation of the bullying • The complainant often leaves
Alleged investigation bias	• A lack of organisational support influences the complainant's perception of the investigation as biased and/or predetermined	• The complaint is substantiated and the bullying ceases, or the complainant resigns **OR** • The complaint is unsubstantiated, and the complainant resigns
An unwillingness to accept findings	• A drawn-out investigation, lack of communication and perceived lack of organisational support leads the complainant to refute the findings or allege an unfair process	
Complainant demands a specific outcome	• Complainant becomes focused on their desired outcome with alternative resolutions dismissed	

An important finding from Blackwood et al.'s (2017) study is the overlap between these factors and the antecedents to workplace bullying identified in local and international research. This indicates that a well-managed work environment is not only going to reduce the risk of workplace bullying but will also likely contribute positively to the management of bullying should it occur. While the factors and their influence presented in Table 9 are likely to be specific to the industry studied (nursing), it again reinforces the influential role of the work environment in both primary and secondary interventions.

Table 9

The Influence of the Work Environment on Bullying Interventions (Blackwood et al., 2017)

LEVEL	FACTOR
Societal	• Generational expectations • Lifestyle pressures
Industry	• Government pressures • Industry culture • Education and training • Culturally diverse workforce
Organisational	• Organisation culture • Executive level leadership • Location and community • Recruitment practices
Team	• Leadership and management competencies • Team structure

A consistent theme of the research that has investigated the complaints process is timeliness. If complaints were not effectively managed in a timely manner, they quickly increased in complexity and typically manifested into multiple complaints. Additionally, as reported by Catley, Blackwood, et al. (2017), managers were often influenced by a work environment that normalised bullying and by the reputations of the target and alleged bully that led them to be dismissive of the complaint and the complainant. As a result, simply relying on the presence of a high-quality policy will be ineffective if it is not enacted.

The challenges identified in this strand of research also provide clear 'lessons' for improved practice (Table 10). As set out in Table 10, organisational support is crucial in helping to prevent the complainant from experiencing further feelings of vulnerability and powerlessness. This support should also be extended to witnesses and to the alleged bully. However, policy and process will count for little if managers don't have the time, confidence and competence to enact them.

Table 10
'Lessons' for Improving Complaint Management Practice (Catley, Blackwood, et al., 2017)

Take all complaints seriously.
Proceed quickly but thoroughly.
Set aside individual reputations.
Don't blame the complainant. Focus on the behaviours and look for a pattern.
Protect and support witnesses.
Provide support to both the complainant and the alleged bully.
Follow the organisation's policy and procedures and keep good records.
Maintain the confidentiality of all parties.
Communicate the process and outcomes and keep the parties informed about progress.
Ensure resolutions are implemented and followed up.

Conclusion

Matching the rise in scholarship internationally, New Zealand research examining workplace bullying has steadily increased in the last 20 years. This growth in research is mirrored by the increased public, organisational and regulatory concern about the prevalence and impact of workplace bullying in New Zealand workplaces. The result is that there now exists a substantive body of scholarly work which is of interest beyond academia. This body of research indicates that workplace bullying is a pervasive and significant workplace problem that is deserved of the levels of concern.

Much of the research covered in this chapter is published in prominent international journals and is often cited by other international scholars. A number of studies measuring prevalence are consistent with a 'best practice' approach (Nielsen, Notelaers, & Einarsen, 2020) and thus provide robust insights into the pervasiveness of workplace bullying. Additionally, there is a strong applied focus with studies aimed at improving organisational practice (e.g. Catley, Blackwood, et al., 2017; D'Souza et al., 2021; Plimmer et al., 2017), understanding key industry sectors and risk groups (e.g. Bentley et al., 2012; Chambers et al., 2018; Gardner et al., 2020) or assessing regulatory initiatives and interventions (e.g. Catley, Bentley, et al., 2017; Lempp et al., 2020). Drawing on a range of data sources (witnesses, practitioners, mediators, court records) has also provided insight into the multifaceted nature of workplace bullying.

As with any body of work there are some important limitations. The lack of a regular collection of data utilising both a representative sample of the working population and internationally validated measures limits our understanding of the scope and scale of workplace bullying. This deficit also contributes to our lack of understanding about the groups most at risk of workplace bullying and the extent to which findings can be generalised to the broader working population. Research has also focused predominantly on interpersonal bullying from the perspective of the target. Thus, much less is known about other manifestations of bullying (e.g. cyberbullying) and the motivations and influence of other key actors (e.g. perpetrators, bystanders, managers). The reliance on cross-sectional design and self-report data has also made it difficult to establish precisely if any given correlated variable of bullying is a predictor, consequence or both. Finally, the lack of research investigating interventions and evaluating their effectiveness has limited the ability to provide clear guidance on

how to prevent and manage workplace bullying. None of these issues are unique to New Zealand research but indicative of the challenges inherent in the workplace bullying research generally.

As the New Zealand scholarship base continues to mature, these limits signal potential future lines of enquiry. There is clearly a need for research that utilises representative samples and/or incorporates longitudinal designs if we are to better understand the causes of bullying and identify risk groups. While continuing to focus on interpersonal bullying is warranted, other forms of ill-treatment also need investigating and from multiple perspectives. Despite their difficulty in conducting, investment in intervention studies that lead to identifying effective primary, secondary and tertiary interventions would also seem a priority area. If the problem of workplace bullying is to be successfully and effectively managed, a robust and evolving evidence base will be crucial.

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Stress – has it had a bad reputation?

Vanessa Cooper

Next time you're stressed have a think about what it's trying to tell you and the opportunities it might provide.

This chapter is purposefully taking a contentious approach to work-related stress to create some food for thought and perhaps challenge views about what 'stress' is. For some, this may seem like an argument in semantics. However, I will outline why stress is good, necessary, and central to mentally healthy work. This chapter will discuss:

- Why stress can be good – and shouldn't always be avoided
- How understanding workers needs can mitigate harmful stress
- How psychosocial safety is central to good stress management

Stress can be good

Stress[1] is a normal part of life. Arguably, much of life's meaning and contribution is borne from periods of stress and distress. It is present at births, weddings, and funerals. Stress is in all aspects of life, and we need these challenges and pressure to learn and grow.

In a work environment, it can be beneficial for workers to feel challenged and mentally stretched in their work at times. A little bit of positive stress can help keep the mind active and stop people from becoming bored (which can feel more stressful than being over-stretched).

Experiencing stress does not automatically mean that we experience harm. However, it would be remiss to not acknowledge the dire consequences for workers from harmful, chronic stress. These experiences can result in significant, life-changing impacts on workers' health and wellbeing. Early intervention is infrequently used, systemic practices that contribute to harmful stress are often left unaddressed, and the conversation turns to burnout – which is waiting much too late to intervene.

For work settings the focus should not be on avoiding stress completely, because this is an impossible task, but how stress is managed. The language we use and how we kōrero about stress is also important. For example, 'challenge' elicits a noble goal, a sense of achievement, a task of complexity or contest; whereas 'stress' elicits a sense of being overwhelmed or experiencing anxiety and tension.

1 Stress is defined in many ways but usually in negative terms. For the purpose of this chapter stress is understood as the physical, mental and emotional responses to unfamiliar, challenging or complex work. It can be associated with thoughts and feelings of "not being able to keep up with, or have the right tools to cope with, the work demands placed on them (workers)"

So why is stress good?

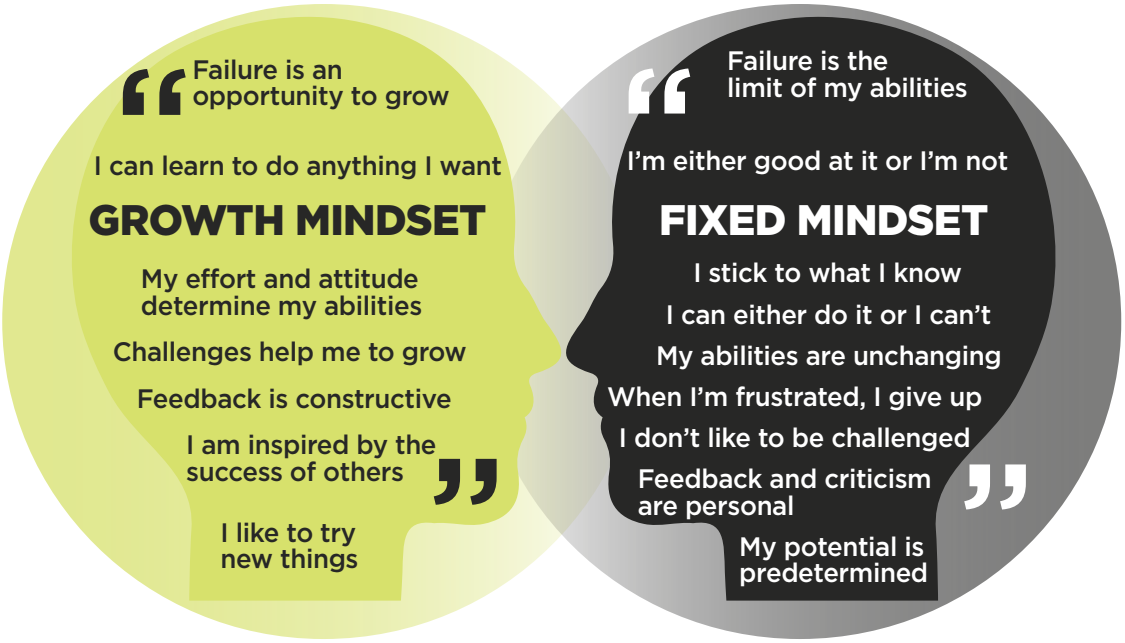
Stress can enhance motivation – we are all likely to remember a time when a pending deadline helped us focus and even think more clearly. The body's natural fight or flight system mobilises our resources and can sharpen our minds to focus on the task at hand and can offer us the boost to push through procrastination, doubt, or pontification.

Stress may feel overwhelming, but it forces people to solve problems. This can ultimately build our skills and confidence to tackle other tasks or issues in the future. Going through the process of stress, or facing a fear, can ultimately increase confidence and therefore resiliency to tackle similar tasks in a more relaxed state. When we are more relaxed, we are more creative problem-solvers. We also feel less threatened and more in control and therefore less likely to resort to mental short-cuts or biases that may lead to poor decision-making.

Times of stress can bond people and help build relationships, providing another protective factor – social connection – which is good for our wellbeing and productivity. Further, embracing stress is aligned with a growth mindset that sees the value in learning, hard work, and a tendency to be more collaborative. Healthy work, characterised by healthy levels of stress, keep people in that growth mindset in which information sharing, innovating, giving, and receiving feedback is the norm – all of which mitigate some of the causes of stress. When there is healthy stress, work is seen as a challenge rather than a drain on personal and organisational resources.

However, too frequently people are left to flail around with no support. For many the barriers to talking about workload and pressure are too fraught with downsides and can bring up feelings of being overwhelmed and a fear of failure. Among these barriers is the perceptions from others of not coping, being seen as weak or incompetent, and the potential of being cut off from future opportunities.

Figure 1
Growth mindset v. Fixed mindset



Understanding workers' needs can mitigate harmful stress

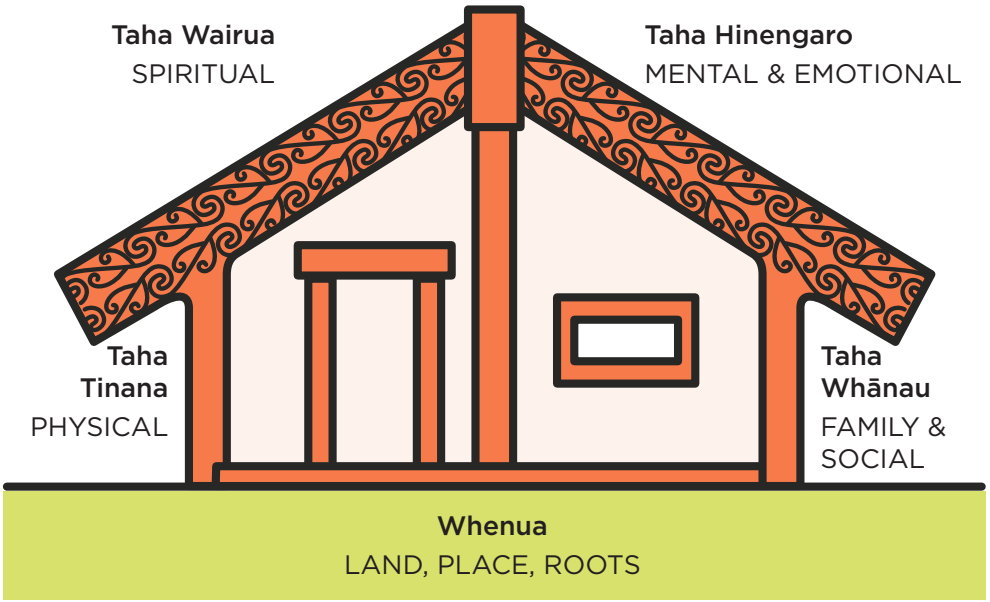
Businesses and organisations need to understand all aspects of their operations, including their people. This may seem an obvious statement, but too frequently the unique needs of workers are not considered as part of this picture. So, the question needs to be asked – who are your workforce?

There is a tendency to take a normative view of workers, and although a health and safety system needs to work for the majority of people, it is not robust unless it considers its most at risk. People do not come to work with the same needs or amounts of stress. It is not a level playing field. Knowing your workers can help prevent or mitigate risks associated with factors like low literacy levels, pressures from family responsibilities, or the impact of living in underserviced communities.

Although a business or organisation has little control over non-work-related stress, there is a duty to manage risks to health and safety in the workplace and promote the highest protection of health. For example, if a worker is stressed due to family problems, they may be distracted at work and this may lead to concentration issues, presenteeism, or interpersonal issues. The stressed worker could introduce health and safety risks to themselves and their colleagues, and these risks must be managed.

When stress becomes harmful it impacts multiple domains of life. Our ability to cope with stress relies on an interaction across multiple areas which are illustrated by Te Whare Tapa Whā (Durie, 1984 – see Figure 2). Looking at health holistically is helpful for thinking about how people experience their wellbeing – their physical wellbeing *Te Taha Tinana*, emotional wellbeing *Te Taha Hinengaro*, social wellbeing *Te Taha Whānau*, and spirituality *Te Taha Wairua*. It is important to acknowledge the dynamic of these interacting variables as few aspects of wellbeing are confined to one area. This helps us with defining the issues and finding the right solutions to resolve them.

Figure 2
Te Whare Tapa Whā



Sometimes, over the short-term we can draw on resources in other areas to pull through, equally when we are struggling with whānau issues or an illness, our ability to go that extra mile gets a lot harder. We know that interesting, highly rewarding work, with supportive relationships, and good rest can contribute to wellbeing. Whereas when work demands are excessive or there is incivility and conflict, these resources become depleted. In these cases, people are able to cope less or more depending on their access to other protective factors.

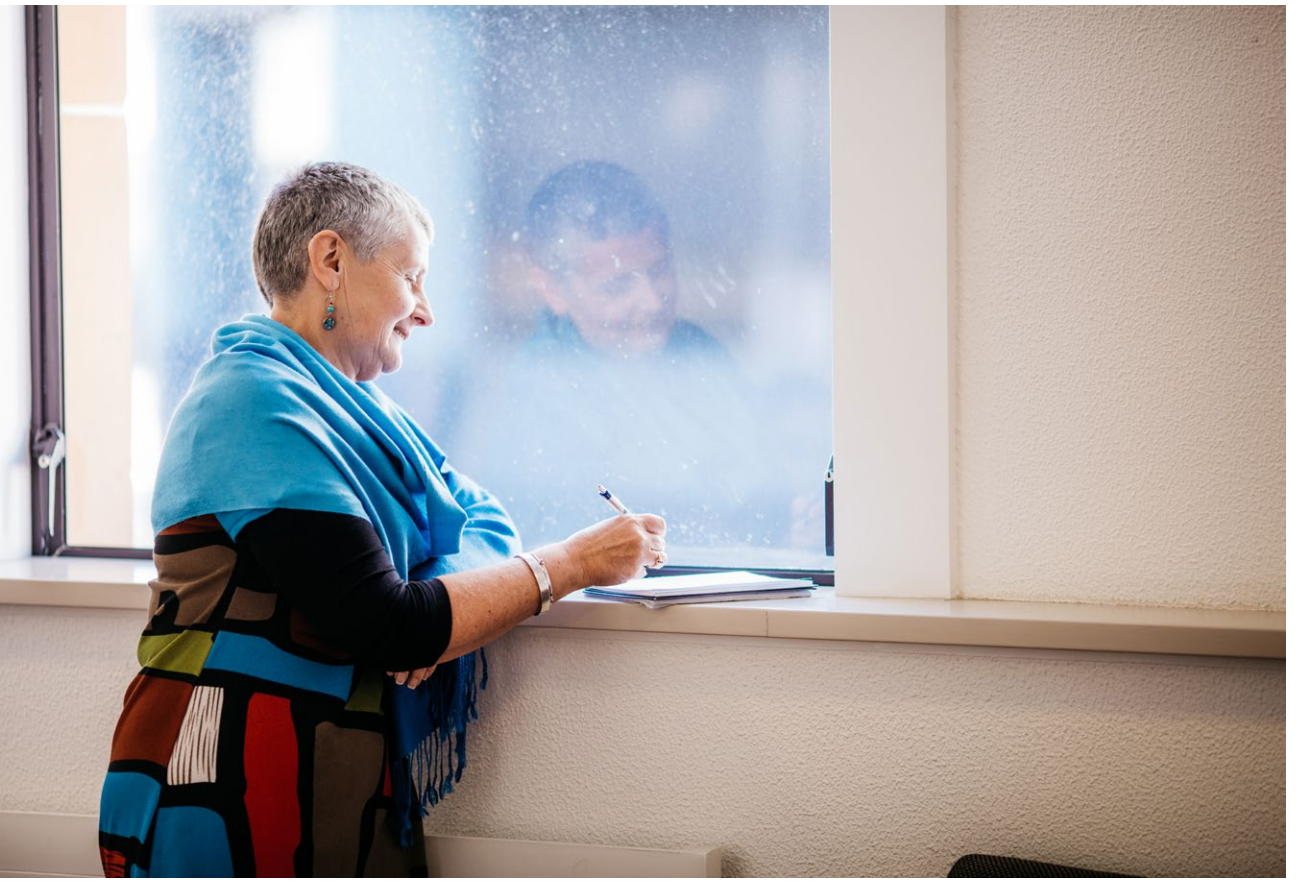
Stress contributes to many long-term illnesses and diseases, also known as non-communicable diseases (NCDs), these are illnesses like, cardiovascular diseases, cancer, diabetes, and a range of respiratory diseases, which begin often with stress-related conditions like hypertension, high cholesterol, obesity, and insulin resistance (Narayan, Ali, & Koplan, 2010). NCDs are the leading causes of premature deaths and preventable ethnic and socioeconomic health inequalities in Aotearoa New Zealand (Eng et al., 2011).

There is evidence that Māori experience work-related stress differently than non-Māori, potentially exacerbated by cultural exclusion and institutional racism. Exposure to stress in an occupation is different for ethnic groups, with Māori women more likely to report their job was very or extremely stressful than non-Māori women in the same occupation (Eng et al., 2011). Further, the type of work undertaken by Māori workers may add additional stress with high body strain tasks and low autonomy.

Both Māori and Pasifika are disproportionally impacted by precarious and non-standard work, and represented in low wage jobs where there is a correlation between poor job conditions, social inequality and health outcomes, including high levels of stress (Meehan & Watson, 2021). For example, 10.6% of Māori and 14.3% of Pacific employees are temporary workers, compared with 8.5% of European workers (Statistics New Zealand, 2019).

There are various gender-related factors that may impact on a person's vulnerability to work-related stress. Women are more likely to be exposed to bullying, violence, and sexual harassment in the workplace (World Health Organization, 2010). Women tend to have jobs with a lower degree of decision latitude. In addition, women do more unpaid labour in the home, which often cannot be delegated or postponed. Family violence continues to disproportionally impact on women (World Health Organization, 2010).

Although it is important to think about unique needs of your workers, it is also important to note that increasing an individual's stress management skills by itself is not enough. Treating the effects of stress without looking at the wider causes will only allow the stress to continue. Instead, look at organisational factors that may be contributing to stress, like decision-making and job control, and look to manage them in a systemic way.



Psychosocial safety is central to good stress management

Psychosocial is the interrelationship between a person's thoughts, emotions and behaviours and their social environment. From this perspective, the experience of stress results from the interaction of the worker, their tasks, the people they work with, and the environment in which it is all done.

Psychosocial hazards are the "aspects of the design and management of work, and its social and organisational contexts that may have the potential for causing psychological or physical harm" (Cox, Griffiths, & Rial-Gonzalez, 2000).[2] Psychosocial hazards are experienced differently for each person. And as stress is influenced by multiple factors and everyone has different thresholds, it is important to consider both individual and systemic factors. A hazard may be a risk to some, but not for others. The initial step of systematic hazard identification is very important when looking at psychosocial factors that contribute to stress.

Hazards can also be experienced in combination with one another, influencing and influenced by other hazards. Certain behaviours or interpersonal issues may arise from other risks that are not being managed. For example, one worker may flourish under complete autonomy while another worker may struggle with the lack of prescribed direction. For one, lack of *role clarity* is a risk, to the other only a potential hazard. If hazard identification is not thoroughly considered then solutions and controls may be based on the wrong assumption of what's contributing to the problem.

For people's stress to be managed and wellbeing to be prioritised, trust needs to be fostered. People will never be completely honest about their levels of stress and wellbeing if they feel they will be penalised for it. This is borne out in research that shows that people do not share their mental health status with their employer, and many do not seek support (Peterson, 2007). Poor psychosocial safety and lack of conversation is a good recipe for stress and burnout.

2 This definition acknowledges te taha hinengaro and te taha tinana but is limited by its exclusion of all of wellbeing (whānau and wairua).

Opening up the conversation and normalising talking about harmful stress can make workers feel comfortable raising issues, and alleviate the fear of being criticised, disciplined, or embarrassed. Make it clear to workers that their health and safety are important to you, and to the organisation. Communicate that it is safe and necessary for them to report harmful stress to you as soon as they feel that they are not coping, that they will not be punished for doing so, and that the information will be kept in confidence. Model this behaviour by talking openly about harmful stress, and emphasise that workers can report stress to anyone within the organisation such as their manager, an HSR, a trusted colleague, or someone else.

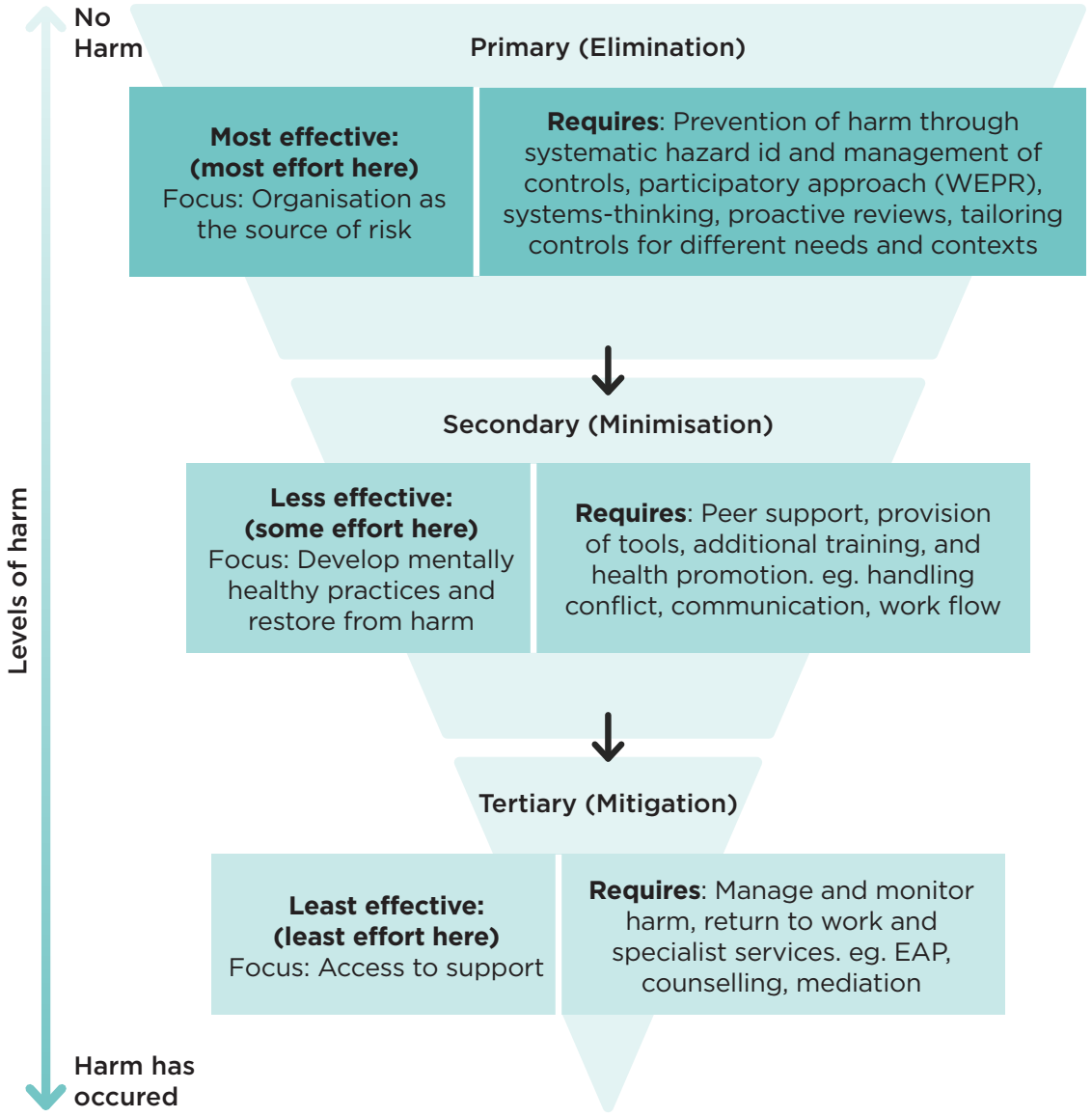
Levels of intervention to managing stress

Alongside good psychosocial safety and effective hazard identification, there needs to be greater understanding of working at different levels of interventions. Many businesses and organisations almost exclusively look at individualised approaches (tertiary) without any analysis of needs. Instead, businesses need to work at multiple levels of intervention, particularly the primary level that sees the organisation (its people, practices and environment) as the source of risk (see Figure 3).

Primary intervention means preventing (eliminating at source) potential risks as much as reasonably practicable. The focus is both the systematic identification and management of controls, as well as setting up systems and practices that enable worker wellbeing and a healthy place of work. The focus of control measures should be on designing good work, developing a positive culture, using inclusive, participatory approaches, and a proactive approach to eliminating risks at an early stage.

Figure 3

Levels of interventions for psychosocial safety and stress management



Leadership is essential

Ensuring leaders at all levels understand and are committed to psychosocial safety and managing harmful stress. Leadership throughout the business, particularly from senior leaders to mobilise organisational resources and the adoption of new practices. Leadership can demonstrate commitment by reinforcing behaviours and ensuring sustainability by including stress and psychosocial risk management in strategic plans as well as existing health and safety systems and processes.

Establish commitment from all levels of the business before putting processes in place

'All levels' means identifying champions and leaders with different perspectives of the business – these could be frontline managers, HSRs, union delegates, and senior leadership. By confirming this commitment from the start, you can make sure there is sufficient resourcing, clear chains of responsibility, support, and championship for minimising harmful stress within the business.

Ensure there is worker engagement and participation in place

You must engage with your workers and enable them to participate in improving health and safety. Particularly because stress is not always something that can be objectively measured. People who carry out the work usually have the best insight into the risks present in their workplace. One way you could engage with workers is by creating a working group that includes workers and their representatives.

Tailoring controls for different work groups and workers

Do a needs analysis to understand workers' challenges, and what types of controls they might find helpful. Considering the range of views, being comfortable with difference and valuing the diversity of response people bring to their work. But take the time to allow people to open up. Focus on both eliminating and minimising risks and increasing protective factors.

Make sure workers know how to report harmful stress

- Set up and clearly communicate ways for workers to report harmful stress through a variety of nominated people within the organisation or securely online. Encourage early reporting, and remind workers that there will be no negative consequences for doing so. Make sure that all information provided in harmful stress reports is kept confidential, as some aspects of the report may be sensitive or private.
- Use the data collected from reports of harmful stress to monitor whether your control measures are working effectively. Remember that managing risk is not a one-off event, and you should frequently revise and refine your processes.
- The following questions may be helpful to guide your thinking:
  - Did we assess the risks in the workplace correctly?
  - How well did our questionnaires and interviews work?
  - Have we helped workers understand what they can do themselves to manage harmful stress?
  - Are our communication and training processes adequate?
  - Did we successfully eliminate or minimise the likelihood of harmful stress?
  - Did we choose the right prevention methods – primary, secondary, and tertiary?
  - Which prevention plans have got good results? Which ones do we need to look at again?

Conclusions

In Aotearoa New Zealand the rates of stress are increasing, much like the rest of world. This could be attributable to the pace and lifestyle of the modern world, or to the complexity of work and the pressures of increased productivity. It may be that work-related stress co-occurs with other stress-related conditions or mental ill-health, which will see depression as the leading cause of disability worldwide.

The future of work might seem a little murky and complex, but the rewards will be greater. We need to harness 'work as imagined' and be bold to make these changes a reality. We need to be flexible with our thinking, and embrace a growth mindset to facilitate this change, seeing times of stress as directly contributing to our personal development and to providing a sense of meaning and contribution in our lives. Too many people are being harmed at work because of the stigma of admitting they are stretched, and we continue to work in ways that erode our sense of self, our value and our ability to contribute to a flourishing nation.

There is a resounding acknowledgement that work can be good for our health, in turn contributing to the wellbeing of whānau and community. The condition being that the nature and quality of the work environment should be safe and accommodating, whilst also being cognisant of people's needs and the diversity of people's responses to psychosocial hazards. This will likely mean leading the conversation and not expecting workers to necessarily start the conversation. Trust is essential to build and is based on reciprocal obligations and responsibilities. We can embrace stress when we have each other's backs and are rowing together in the same waka!

He waka eke noa – We are all in this together.

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Positive and negative spillover: An intersection of work and personal life

Paula MacKenzie

This chapter aims to:

- discuss how it is impossible to separate our work and personal lives
- explore the health impact that work can have on people
- highlight the opportunity for work to influence healthier societies.

> Leave your home life at home, focus on work when you are at work and on home when you're at home. (Employment New Zealand, 2021)

Managing the intersection of personal/whānau life and work life appears to be a challenge for workers, managers and organisations. In business articles you will find differing advice, with some advocating for the sharing personal information between managers and workers, while others suggest managers and workers keep their discussions work-focused (Knight, 2020; O'Hara, 2018; Wulfhart, 2021). The rationale given for sharing information about our personal/whānau lives, or suggesting that it is appropriate for a manager to ask about someone's personal/whānau life, is that demands in a person's personal/whānau life, can negatively affect individual and organisational performance (Ball, 2015; Chamorro-Premuzic, 2020; Inam, 2018; Society for Human Resource Management, 2017). However, this message may appear to workers as, 'Keep your personal/whānau life at home unless it affects work. If it affects work, tell us, so we can monitor your performance', which is not the same as a business taking a genuine interest in its workers.

The intersection of work and personal life

Research uses to the term "spillover" to define how behaviours in one environment can affect behaviours in other environments in both positive and negative ways. The roles and identities we hold, attitudes and behaviours we engage with, and knowledge and skills we gain transfer to other environments (Galizzi & Whitmarsh, 2019). There are several terms frequently used in research to discuss spillover (Bakker & Demerouti, 2013; Hammer, Cullen, Neal, Sinclair, & Shafiro, 2005; Hanson, Hammer, & Colton, 2006; Wayne, Lemmon, Hoobler, Cheung, & Wilson, 2017. These are:

- Work-to-Family Conflict: work negatively spills over into personal/whānau life
- Family-to-Work Conflict: personal/whānau life negatively spills over into work
- Work-to-Family Enrichment: work positively spills over into personal/whānau life
- Family-to-Work Enrichment: personal/whānau life positively spills over into work.

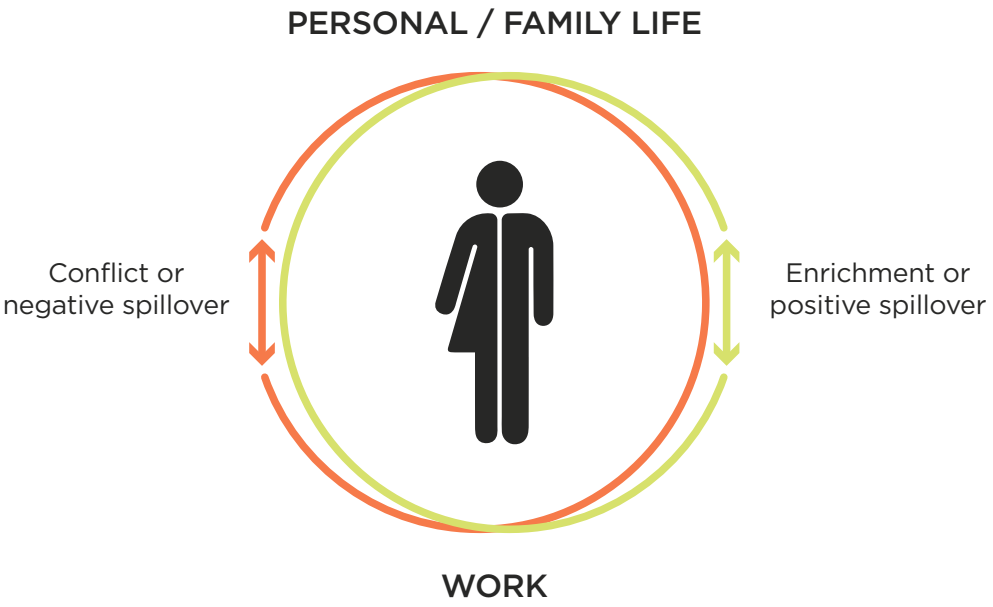
When research on conflict and enrichment is viewed together, it suggests that work plays a key part in our lives and communities. For the purposes of this chapter, I will refer to 'spillover' when discussing the intersection between work and personal/whānau life in either direction with both positive and negative outcomes. I will use the term 'conflict' when discussing spillover that has a negative outcome and 'enrichment' when discussing spillover that has a positive outcome.

The conservation of resources theory may explain how spillover can be both positive and negative, suggesting people gain and lose resources (social capital) as they interact with their environment. Resources can take many forms such as skills, energy, emotions, cognitive capacity, self-esteem, self-efficacy, values, intelligence, time, economic, social and health assets. Therefore, there are several resources that could be gained or lost from both work and personal/whānau environments. When work or personal/whānau life is demanding, this will deplete the resources available, which may cause conflict. However, when resources are gained or less resources are used, this will leave resources available for interacting in other environments, promoting enrichment (Lapierre, et al., 2018; Wayne, Lemmon, Hoobler, Cheung, & Wilson, 2017). In support of this model it has been found that experiencing challenges at home is associated with reduced job resources available the next morning, increased rumination or thinking about family concerns, increased negative attitudes, and the likelihood that the worker will flourish in the afternoon decreases (Du, Derks, & Bakker, 2018).

Hammer and colleagues (2005) found several correlations between worker experiences of conflict and enrichment, suggesting that spillover does not happen in isolation but is associated with further spillover. If a worker experienced family-to-work conflict, they also experienced work-to-family conflict. A similar pattern occurred with enrichment. If a worker experienced work-to-family enrichment, they also experienced family-to-work enrichment. This suggests that while psychological detachment can mitigate the impact of spillover in the short term (Debrot, Siegler, Klumb, & Schoebi, 2018), detaching our lives and completely separating work and personal/whānau life is easier said than done, and not the experience of most people. Research by Xu and colleagues (2019) further supports this conclusion when finding housework is associated with increased work fatigue, which in turn is associated with work-family conflict, lower marital satisfaction and higher rates of depression. Figure 1 illustrates the two-way relationship between work and personal/whānau life for both conflict and enrichment.

Figure 1

Illustrating the two-way relationship between work and personal/whānau life



The two-way relationship between work and personal/whānau life has the potential to create a cycle of conflict or a cycle of enrichment. Due to the connectedness of experiences, it is difficult, if not impossible, to determine a single stressor or catalyst for experiences of conflict. If we self-reflect and review our own experiences, or consider the experiences of friends, family/whānau, colleagues or others in our network, there will be numerous examples of where people experienced stressors in both their work and personal/whānau lives at the same time.

To consider an example, the New Zealand Employment Court reviewed a case in 2019 where a doctor was dismissed for prescribing medication to her partner and trying to cover up her actions. Initially the doctor was a high achiever, received university distinction awards, was rated highly by her supervisor, and offered a promotion. Her workload and patient demands increased, and she dealt with violence and challenging situations in the workplace. In response to this, she initiated a project to resolve issues and improve outcomes for patients. At some point her workplace found out that she had split from her partner when she turned up unfit for work and suspected to be using drugs. Next in the story we hear about interpersonal relationship issues with colleagues at work and blurred professional boundaries as she helped colleagues with personal matters. Following this performance monitoring, critique, and management become a core focus of the case until she is dismissed for breaching protocol (Corkill, 2019). The summary of facts in this case discusses both personal/whānau and work factors. These factors are likely to have resulted in the gaining and depletion of resources. Given the complex relationship that developed between personal/whānau and work-related factors, it is likely that the individual was experiencing a cycle of conflict during these times.

Most workers are unlikely to end up in employment court judgments, but all workers are likely to experience cycles of conflict from time to time. It is probable that almost every worker would say that they have thought about work outside of work hours or thought about their personal/whānau life during work times. To name a few examples, it could be dreaming about a work project, asking a friend/whānau member for advice about a work situation, discussing a work challenge, booking or attending personal appointments, experiencing a bereavement, or worrying about a whānau member who is facing physical or mental health issues.

If someone is going through a challenging time and experiencing conflict, either work-to-family, or family-to-work, it is important to acknowledge that this will likely result in that person experiencing further challenges. Individual, family/whānau, and organisational responses to a person experiencing challenges has the potential to create additional stressors that create a cycle of conflict. The little things make a difference. Zhou and colleagues found that when team members experienced acts of incivility at work, defined as low intensity, rude behaviours that violate norms for mutual respect, from either internal or external stakeholders, they were more likely to experience increased emotional demands, burnout, and work-to-family conflict (Zhou, Meier, & Spector, 2019). Businesses have an opportunity to positively influence their worker experiences by changing how they respond to conflict, especially family-to-work conflict. Asking how someone is, altering work demands, or offering practical and emotional support could be enough to stop a cycle of conflict, and instead promote enrichment.

While conflict is easier to recognise, hopefully everyone can identify examples of cycles of enrichment in their own experiences or the experiences of their friends, family/whānau, colleagues, or others in their network. If you were to self-reflect on your best day at work, or a time in your life where you felt like you were flourishing, you may have had resources remaining at the end of the workday; possibly more energy, motivation or time for the activities that are important in your personal/whānau life. Experiences of enrichment are correlated with supervisor perceptions of worker engagement, higher performance ratings and increased promotions and salary increases (Wayne, Lemmon, Hoobler, Cheung, & Wilson, 2017). When workers experience positive workplace cultures, that is, they can say their supervisor cares about their wellbeing, they are supported to influence their work schedule, they are offered development opportunities and feel confident that they can handle the demands of their job, they are more likely to say that work enriches their personal/whānau life (Carlson, Thompson, Crawford, & Kacmar, 2019; Lapierre et al., 2018).

Conflict and the impact for health and communities

Both work-to-family conflict and family-to-work conflict are stressors that increase psychological, behavioural, and physiological strain resulting in a higher risk of negative outcomes for workers (French, 2017). Conflict is associated with unhealthy behaviours such as substance abuse, extensive use of medication, alcohol use, smoking, limited exercise, poor food choices, and counterproductive work behaviour. While in the short term these behaviours may act as coping mechanisms, they may also contribute to mental and physical health problems. People who experience conflict are at higher risk of mental health issues such as depressive mood, clinical depression, anxiety, life distress, psychological strain, burnout, lower life satisfaction, and emotional strain. They are also at higher risk of poor sleep quality, fatigue, higher diastolic blood pressure, higher cholesterol, higher cortisol reactivity and neuroendocrine stress, and a cardiovascular stress response (Amstad, Meier, Fasel, Elfering, & Semmer, 2011; Barber, Taylor, Burton, & Bailey, 2017; French, 2017; Greenhaus, Allen, & Spector, 2006; Hammer, Cullen, Neal, Sinclair, & Shafiro, 2005; Sonnentag & Fritz, 2006; Zhou, Meier, & Spector, 2019).

French (2017) found after people experienced one episode of work-to-family conflict, unhealthy eating behaviours increased later in the day. Unhealthy eating was measured because it is a well-established predictor of societal health issues such as diabetes, obesity, cancer, and cardiovascular disease. Unhealthy eating occurred some hours after the conflict, suggesting conflict has the potential to have other long-term health effects for workers.

Conflict also affects our interactions with others. When workers experience conflict, negative family-related outcomes are common. Conflict is associated with lower marital satisfaction, negative marital functioning, lower family/whānau satisfaction, and reduced family-related performance. (Amstad, Meier, Fasel, Elfering, & Semmer, 2011; Lavner & Clark, 2017; Tuttle, Giano, & Merten, 2018). One example of this is a finding by Tuttle and colleagues (2018) that the work demands and emotional stress that police officers experience negatively impacts the police officer's family/whānau. They recommended businesses consider how their systems address the interplay between work and personal/whānau life. A range of initiatives such as wellness programmes, clinical engagements with families, and promoting activities that strengthen family functioning were recommended to assist police officers in managing their work/life balance.

When a worker experiences conflict, it can also affect their spouse or partner. Xu and colleagues (2019) found if a husband experienced work-to-family conflict, his wife was also likely to experience work-to-family conflict. How couples share experiences about their day may result in unhealthy stress transmitting to the partner as part of whānau life interactions (Amstad & Semmer, 2011; Carlson, Thompson, & Kacmar, 2019). Given that work-to-family conflict is associated with family-to-work conflict, it appears that one worker's experience could create a cycle of conflict for themselves and their spouse. While there are slight variations between married and cohabitating couples and gender differences, spouses or partners can experience lower job satisfaction, lower relationship satisfaction and poorer mental health when a worker experiences conflict (Yucel & Latshaw, 2020).

Longitudinal research on job displacement (losing your job through redundancy or restructure) shows it is associated with negative health outcomes for both workers and their spouses. Workers who lost their job due to a plant closing were more likely to be hospitalised for issues related to alcohol and mental illness up to a year after losing their job. The effects were still felt twenty years later where workers had higher rates of mortality due to heart-related issues, and male workers had a higher rate of suicide regardless of the other roles they held during those twenty years. Furthermore, spouses of workers who lost their job also had a higher risk for being hospitalised for alcohol-related issues, mental illness and cancer during the twenty-year period after the worker lost their role (Gathmann, Huttunen, Jenstrom, Sääksvuori, & Stitzing, 2020).

Research conducted in the 1990s found the emotional lives and behaviour of children, the unseen stakeholders of work, were affected by their parents' careers. The specific examples found in research are related to work-to-family conflict. Children experienced more behavioural issues when their fathers were distracted by work tasks at home, parents were physically present but noticeably on a work device, and fathers were overly invested psychologically in their careers (Friedman, 2018). Matias and colleagues (2017) found work-to-family conflict reduced parents' psychological availability to their children. If a parent experienced work-to-family conflict, their child was more likely to find it difficult to express and manage their own emotions. While everyone's personal and whānau situation is different, it appears that the physical and mental health of the people a worker cares about can be negatively affected by experiences of conflict.

From a business perspective, the workplace is also impacted. Conflict can negatively affect performance, citizenship behaviours, satisfaction, organisational commitment, and career satisfaction, as well as increase turnover intentions and rates of absenteeism (Amstad, Meier, Fasel, Elfering, & Semmer, 2011). Given studies have found that work colleagues have similar experiences of emotions and burnout (Amstad & Semmer, 2011), and workers who experience high-demand cultures experience more conflict (Abendroth & Reimann, 2018), groups of workers may experience cycles of conflict at a similar time. Regardless of the source, or if conflict affects one worker or the whole organisation, businesses should take an interest. Work may further exacerbate the issue and increase the risks to workers. While some of the health issues mentioned are recognised as risks to physical and mental health, the other health behaviours have indirect impacts for fitness for work, performance, and engagement.

Enrichment and the impact for health and communities

Having a job reduces the risk of health issues, and work is generally good for health and wellbeing (The Royal Australasian College of Physicians, 2011). New Zealand research shows that on average people report better wellbeing if they are employed versus if they are unemployed (Stats NZ, 2020). Medical practitioners are encouraged to help people experiencing health issues to get back to work as work can promote physical activity, provide a sense of community and social inclusion, allow workers to contribute to their society and family, provide a routine and structure, give financial security and reduce the risk that people engage in other risky behaviours (The Royal Australasian College of Physicians, 2011).

Hammer and colleagues (2005) found if a worker experiences either work-to-family or family-to-work enrichment, their spouse was also likely to experience enrichment and reduce their risk of depression. Imagine what our communities would look like if every person that went to work could say "my involvement in work makes me feel happy and this helps me to be a better family member". Research suggests that when a worker can say this, their spouse is more likely to have positive things to say about the worker's job such as "I frequently feel my spouse's job positively impacts the wellbeing of our family", "I frequently feel my spouse/partner brings work home (either physical or emotional) in a way that positively impacts our family", "I frequently feel my spouse's job provides benefits to our family" and "I hope my spouse will work for his/her current organisation for a long time'. Not surprisingly, enrichment is also associated with higher marital satisfaction for both parties (Carlson, Thompson, Crawford, & Kacmar, 2019).

Unseen stakeholders of work can also be positively affected by work. Children's emotional health appears to be better when their parents experience enrichment. The specific examples cited as being associated with children's emotional health are parents seeing work a source of challenge, creativity and enjoyment, fathers rating their job performance and job satisfaction highly, mothers having authority, discretion and control at work, parents believing family should come first, and parents being physically available to their children (Friedman, 2018).

Several societal systems interact to affect health outcomes and research is limited on what interventions will effectively tackle the social detriments of health and health equalities. However, the work environment shows promise for being an effective medium for interventions focused on improving health, especially for disadvantaged groups (Bambra et al., 2010). Hochli and colleagues (2019) researched a bike-to-work campaign, where participants had to bike to work at least twice per week. Biking to work was associated with more cycling or physical activity in leisure time, and healthier eating habits as participants ate more fruits and vegetables. Interventions that focus on the psychosocial work environment by considering work design, work hours, work rotations, job control and job autonomy appear to enhance work-life balance and show potential for improving general health and impacting health inequalities amongst workers (Bambra et al., 2009). By taking a holistic approach that considers the individual health of the worker and the environment they work in, workplaces can be leveraged to influence work-related and non-work-related attitudes and behaviours to promote healthier societies (Carmichael, Fenton, Roncarncio, Sadhra, & Sing, 2016; Kindig & Isham, 2014).

Business or organisation roles in creating change

Engaging in activities that promote enrichment and decrease conflict can have a significant return on investment for organisations. Enrichment has been associated with increases in revenue, productivity, engagement, performance, organisational commitment, and discretionary effort. In contrast, conflict is associated with increases in financial costs, turnover intentions, and higher rates of absenteeism (Kelly et al., 2008). A business or organisation cannot control what a worker experiences outside of the workplace. However, they can influence it by creating work environments that promote enrichment as well offering practical and emotional support to minimise the risk impact of conflict. Workplace wellbeing interventions can vary in their success and workplace policies vary in their ability to have a positive impact (Kelly et al., 2008). However, when they focus on how workers interact with their work environment, they can promote wellbeing, reduce rates of health harm and reduce the impact of intense workloads and stress (Chillakuri & Vanka, 2020; Donald, Johnson, & Nguyen, 2019; Millear, Liossis, Shochet, Biggs, & Donald, 2008; Spence, 2015).

Leadership and culture play a key role in promoting enrichment and minimising conflict. A culture that is innovative, supportive or promotes mastery is associated with more enrichment and reduced conflict, but a performance-driven culture is likely to promote both enrichment and conflict (Kopperud, Nerstad, & Dysvik, 2020). This suggests that a system that provides flexibility for an individualised approach is more effective. This aligns with research that has found correlations between spillover and work demands, work scheduling, supervisor support and social support (Kossek, Pichler, Bodner, & Hammer, 2011; Lapierre et al., 2018; Lott, 2020; Sok, Blomme, & Tromp, 2014; Wayne, Lemmon, Hoobler, Cheung, & Wilson, 2017). Insightful and informed leaders who can empower individuals, provide autonomy, and offer practical and emotional support appear to be crucial in effectively managing spillover.

Spillover and the effects of spillover can be measured through qualitative and quantitative measurements (Galizzi & Whitmarsh, 2019; Hanson, Hammer, & Colton, 2006). However, perhaps a place to start is by facilitating conversations with workers, and asking questions like:

- What impact does work have on your personal/whānau life? Does it help or hinder other activities?
- What challenges do you face managing your work and personal/whānau life?
- What can we do at work to support you in your personal/whānau life?
- How can we give you more autonomy when scheduling your work?

Taking an interest and genuinely caring about workers has the potential to promote the health of workers, families, workplaces, and reduce the health inequities in society.

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Systems of thinking, systems of work

Gareth Beck

You do not rise to the level of your goals. You fall to the level of your systems.

(Clear, 2018)

In his bestselling book *Atomic Habits*, author and entrepreneur James Clear (2018) observed that systems are the vehicles that take us to our goals. Systems can range from the familiar pragmatic systematic approaches seen in safety management, to abstract legal, cultural, and social systems that influence and shape our everyday work.

The shared aspects and interdependence of many systems means that in managing the risks associated with mental health, for example, we must first acknowledge that mental wellness is a complex, multi-dimensional output/goal of these system interactions. What, therefore, are some of the system elements that we can monitor, manage, and influence, to reach our destination – the aspirational goal of mental wellbeing for all?

Respondents in the annual Deloitte Global Millennial and Gen Z Survey (Deloitte, 2021) noted that businesses had improved their focus on mental health despite the impact the COVID-19 pandemic has had since early 2020. However, 40% of those surveyed felt they had not been supported during the pandemic, and that the absence of a strategic or systematic approach to mental wellbeing was evident in the 'scatter gun' approach adopted by their employers in promoting mental health. These perceptions are reflected in the statistics from the UK where nearly half of all working days lost annually to non-fatal workplace injuries/illnesses are due to work-related stress, anxiety and depression (HSE, 2021), a sobering statistic given this data was collected pre-COVID.

So, can we measure psychosocial risk factors within a business and ensure our systems of work are effective in addressing them?

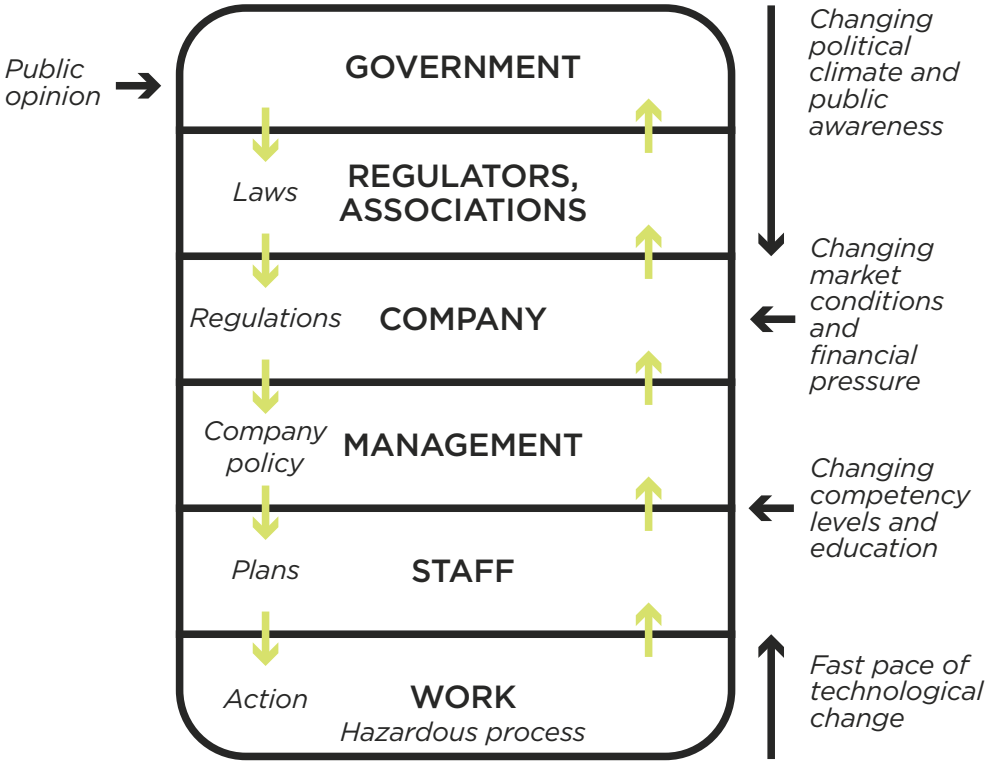
This chapter looks at where our efforts should be targeted to assess and measure workplace mental health and wellbeing, suggesting that any effort to improve worker mental health should consider that businesses are part of a broader socio-technical system in which different agencies and entities play a role and need to be considered when assessing risk. It will also outline the most common psychosocial risk factors in workplaces and some of the pitfalls in measuring these. Finally, I will also give a few of my thoughts and feelings around the subject along the way.

Assessing mental wellbeing risk in the workplace?

Socio-technical systems pertain to theory regarding the social aspects of people, society, and the technical aspects of organisational structure and processes. Rasmussen (1997) highlights this approach in his paper on a socio-technical system and highlights the disconnect between those doing the work and those in government and regulatory bodies. It is important to appreciate Rasmussen conducted his work almost 25 years ago, in Europe and in a health and safety context. However, the simplicity of the model (Figure 1) suggests that it can equally be applied to the assessment and management of risks around mental health at work in Aotearoa New Zealand.

Figure 1

Rasmussen's (1997) Hierarchical Model of Socio-technical Systems



Rasmussen (1997) argues that competitive markets tend to focus the attention of decision-makers upon short-term financial and survival factors, rather than long-term factors concerning welfare, safety, and environmental impact. Initiatives will focus on short-term goals at the lower levels of this framework (staff and work) rather than above the company level. Rasmussen (1997) states that due to advancements in technology the pace of change is much faster than the pace of management structures accommodations, and it is an even longer lag in adjustments in legislation and regulation. Currently, New Zealand's Health & Safety at Work legislation is only six years old but is this fit for purpose to assist in managing and tackling workplace psychosocial risks?

The hierarchical framework by Rasmussen (1997) suggests that for safe and efficient performance, the decisions and actions made at higher governmental, regulatory, and managerial levels of the system should propagate down and be reflected in the decisions and actions occurring at the lower levels (Figure 1). If change is to be sustained at a certain level, information needs to transfer up the hierarchy to inform the decisions at the higher levels. In many businesses, the controls that are required to manage psychological risks do not travel up the system because the structure is more of an hour-glass shape with all company, management and staff reporting into one person which can create a 'pinch point' . Another reason could be that there is a lot of 'noise' (distractions) between the levels meaning that little change is happening, and the wellbeing focus can be lost while appearing to circle between management, staff, and work.

This is supported in a study by Bentley et al. (2021), which adds to the growing body of work supporting the need to consider meso-level influences which includes distal social (e.g., legal, political and cultural factors) as well as organisational influence on the psychosocial environment and individual health outcomes. This is to complement the dominant focus on micro-level approaches, often at the individual level (Dollard et al., 2017), such as resilience, training and resources.

> To be well is to move fluidly between a calm and safe environment to an adverse, risky and exciting environment and back. (Aiko Betha, 2021)

The study by Bentley et al. (2021) is not telling us anything new as previously the International Labour Organization (ILO, 1986) defined psychosocial factors as the interactions between drivers such as job content, work organisation, management, and other environmental and organisation conditions on the one hand, and people's characteristics and needs on the other. In New Zealand we are required to eliminate risk or minimise these factors so far as reasonably practicable (Health and Safety at Work Act, 2015).

Anecdotal evidence suggests that when managing workplace hazards, we tend to be drawn more towards physical risks and less towards psychosocial risks. Machine guarding for example, can be diagnosed as being either present or not, the assessment of such eliciting a clear path of action to resolve any unacceptable risk. The complexity of mental wellbeing is by its very nature, difficult to assess and thus prescribe appropriate responses without consideration of the many aspects that shape mental health. It's not surprising therefore that our assessment of and responses to mental health are, (a) heavily reductionist and simplified given our current view of psychosocial risks, and (b) focused on the individual rather than the system within which they operate. That is, we generally address these issues at the lower levels of Rasmussen's framework (Rasmussen, 1997).

This perspective is clear to see in recent research from Australia which found that policies and practices associated with psychosocial risks are often limited to a narrow focus on explicit behaviours of bullying, harassment, aggression, and violence (Robertson et al., 2021) demonstrating that psychosocial risk management is heavily focused on the explicit behaviours of workers – the bottom of the socio-technical system. Factors such as workload, support, and job control were found to be rarely considered in organisational efforts to improve mental health, unlike consideration in the management of physical risks. The research strongly suggests that mental health is still perceived as a dispositional problem, a problem with the individual, a damning conclusion that demonstrates our concept of psychosocial harm has matured very little since the ILO's definition some 35 years ago, which also emphasised the organisational and system influences upon mental wellbeing in the workplace.

It could be argued that we have missed the mark when it comes to understanding psychosocial risk factors in the workplace, not just in Aotearoa New Zealand, but as Robertson et al. (2021) shows, in other jurisdictions too. If the goal of the health and safety profession is to ensure people leave work at the end of the day in at least the same condition as when they arrived (if not better!), then the profession MUST bring their skillset to the prevention of psychological injuries through risk management.

Instinctively we know this to be a largely accurate reflection of the status quo, much of our current efforts toward improving wellbeing is targeted at workers with less focus upon our systems of work. In addition, much more effort is placed on reactive measures, in response to a harmful event, than in preventing mental distress. A way to view at this is in a bow tie format where much of our effort is focused on the post-event consequences in the reactive space such as mental health first aiders or using EAP for counselling. Whereas there should be a focus on the other side of the bow tie to focus on preventing the harm in the first instance through better work design and work environment/culture among many influencing factors. This requires a shift in focus from the individual to a suitable position in the socio-technical system where we can maximise our influence over environmental conditions and move from the predominantly reactive approach to one which is proactive and preventative. To clarify, it is not that reactive approaches are not important, but they need to complement those on the proactive side as we consider all the tools available to us to manage the risks.

> When a flower doesn't bloom you fix the environment in which it grows, not the flower. (Alexander Den Heijer, 2018)

This approach to focusing away from the individual and on the proactive side of the bow tie is supported by international standards and guidance. These guidance documents provide insights into the type of system elements we could be monitoring, managing, and influencing.

What are these aspects of mental wellbeing that we can monitor, manage and influence?

The *National Standard of Canada for Psychological Health and Safety in the Workplace* (2013) was launched as the first of its kind to help guide organisations towards mentally healthy work. The standard identifies 13 workplace factors that can affect workers' psychological health and safety. The standard acknowledges that these factors are organisational/systemic in nature and therefore, at least theoretically, within the influence of the workplace. The 13 factors are:

1. Organisational Culture
2. Psychological and Social support
3. Clear Leadership and Expectations
4. Civility and Respect
5. Growth and Development
6. Psychological Demands
7. Recognition and Reward
8. Engagement
9. Workload Management
10. Balance
11. Psychological Protection
12. Protection of Physical Safety
13. Involvement and Influence

More recently these factors have been incorporated into *ISO45003:2021 Occupational health and safety management — Psychological health and safety at work — Guidelines for managing psychosocial risks* (ISO, 2021) which provides practical guidance on managing psychological health in the workplace. ISO45003 is written to help organisations using an occupational health and safety management system based on *ISO45001:2018 Occupational Health and Safety Management Systems Standard*. Table 1 gives the ISO45003 identified risks in three categories and within the Guidelines there are examples of what could be improved to manage that risk. Note that ISO45003 also provides examples and elaborates more around each of the risk factors.

Table 1
ISO45003 – Psychosocial Hazards

HOW WORK IS ORGANISED	SOCIAL FACTORS AT WORK	WORK ENVIRONMENT, EQUIPMENT AND HAZARDOUS TASKS
• Roles and Expectation • Job control or Autonomy • Job demands • Organisational Change Management • Remote or Isolated Work • Workload and Work Pace • Working Hours and Schedule • Job Security and Precarious Work	• Interpersonal Relationships • Leadership • Organisational/ Workgroup Culture • Recognition and Reward • Career Development • Support • Supervision • Civility and Respect • Work/Life Balance • Violence at Work • Bullying and Harassment	• Environment • Equipment • Hazardous Tasks

Not all risk factors in the guidance documents above will be applicable to every business size, type and work activities but they provide a great starting point for a broader consideration of psychosocial risk rather than putting a single line in a risk register denoting 'psychosocial hazards'. They also confirm the earlier observation that mental wellbeing is multi-dimensional, that we cannot focus on one element alone, but need to look at their interdependence, their relationship with other system components. Whilst some elements may already be monitored, managed, and influenced, there remains much to learn about the more abstract elements proposed by these standards, e.g., civility and respect: how do you measure that? Maybe we should not be surprised to discover that there is already a developing research literature in this area, along with some reasonably reliable assessment tools (Clarke, Sattler, & Barbosa-Leiker, 2018). However, there is still much work to be done in this space, but what is painfully obvious is that current approaches to managing physical hazards are insufficient to manage the complexity of mental wellbeing.

How can we measure/assess mental wellbeing in the workplace?

> ...what we measure shapes what we collectively strive to pursue — and what we pursue determines what we measure (Stiglitz et al., 2009)

Organisations need to have processes in place to monitor and measure a wide range of internal functions, such as financial resource allocation and performance, distribution efficiency, production and outputs. This will include monitoring those socio-technical systems that could impact the organisation. Mental health and wellbeing amongst workers should be no different. There is not a simple (or even difficult) formula for measuring workers' mental health and wellbeing, rather it is important for each organisation to learn how to confidently reflect on its own unique way of doing things and pull out the measurements which are applicable to the business and its workers. As Stiglitz (2009) implies, measurement is not abstract or disconnected from the business and its processes, and those selecting the metrics (owners, managers and workers) need to consider what is important to measure and how this will impact on the workers and the business.

There are a variety of methods businesses currently use to gather data from the variety of sources. According to Saunders (2015) 'method' is the technique and procedures used to obtain and analyse research data, including for example questionnaires, observation, interviews, and statistical and non-statistical techniques. Table 2 shows some methods, benefits, limitations, and examples to consider.

Table 2
Examples of methods to gather data with their benefits and limitations

TYPE OF METHODS	BENEFITS
Interviews	Development of relationship; selection of suitable candidate; can collect sufficient information; time saving; increasing knowledge
Focus groups	Interaction and deepness; intelligibility; non-verbal aspect; time saving; variety points of view
Surveys/questionnaires	Can cover a large sample and can get the quantitative numbers and qualitative comments
Case studies	It is possible to collect detailed information and can be great for learning and relating to workplace examples
Ethnography	Get more realistic picture of work in real life and real time with great insight of behaviours, attitudes, and motivations; extended observations giving more insight whereas focus groups you get limited time

LIMITATIONS	EXAMPLES
Record problems; lack of attention; time consuming. For non-structured interviews can be hard to record	During regular catch-ups with employees (not necessarily structured); Exit interviews
Possible group biases; can be hard to measure	Health and safety reps/committees or have a mental health committee. Learning teams. Units in the organisation; Single parents, emerging professionals
Might not get into the intricacies of a complex concept such as wellbeing. Results can differ depending on how the survey is constructed and how you frame the survey questions (Tiller et al, 2020). Can be impacted by outside factors (e.g. remuneration, time of the year, workloads). Can be labour intensive	Psychosocial safety climate – PSC-12 (Hall et al, 2010); The World Health Organization – Five Well-Being Index (WHO-5); Work Productivity and Activity Impairment Questionnaire: General Health V2.0
Can be quite complex. May depend on the data that is available as to what can be interpreted making analysis difficult	Looking at near misses, incidents, EAP reports as well as using real world examples from outside the workplace e.g. news articles
Complex. Limited by the perception of the individual undertaking the study with attribution bias. It may be wise to notify the employees you will be doing this study, but they may change their behaviours now they are alerted to what you are doing. Will be time intensive. Requires particular skill sets (not for everyone)	Observing work processes and work as a whole, which will include team dynamics and influences on work

How are we approaching measuring within my own business? Where I work, we have been measuring our people's wellbeing through quarterly surveys for some time now, which has allowed us to benchmark. Anecdotally, the conversation has changed over time through initiatives that started with HR and H&S and have now been taken on by our workers who continue to drive them in a self-sustaining way via a mental health committee. Through surveys and peer support networks we can see that some of our workforce have high workload as well as stress and anxiety within their roles, which comes from this workload and is having an impact outside of work. Because of this data/analysis of the workload and stress, our company carefully considers the additional capacity of our employees and business when we bid for new contracts. When providing supports to our people in a more holistic wellbeing sense such as wellbeing apps, mole mapping, webinars, etc. We also consider how these are applied to employees' home life to lower the barriers to accessing services as well as upskilling mental health literacy of our communities.

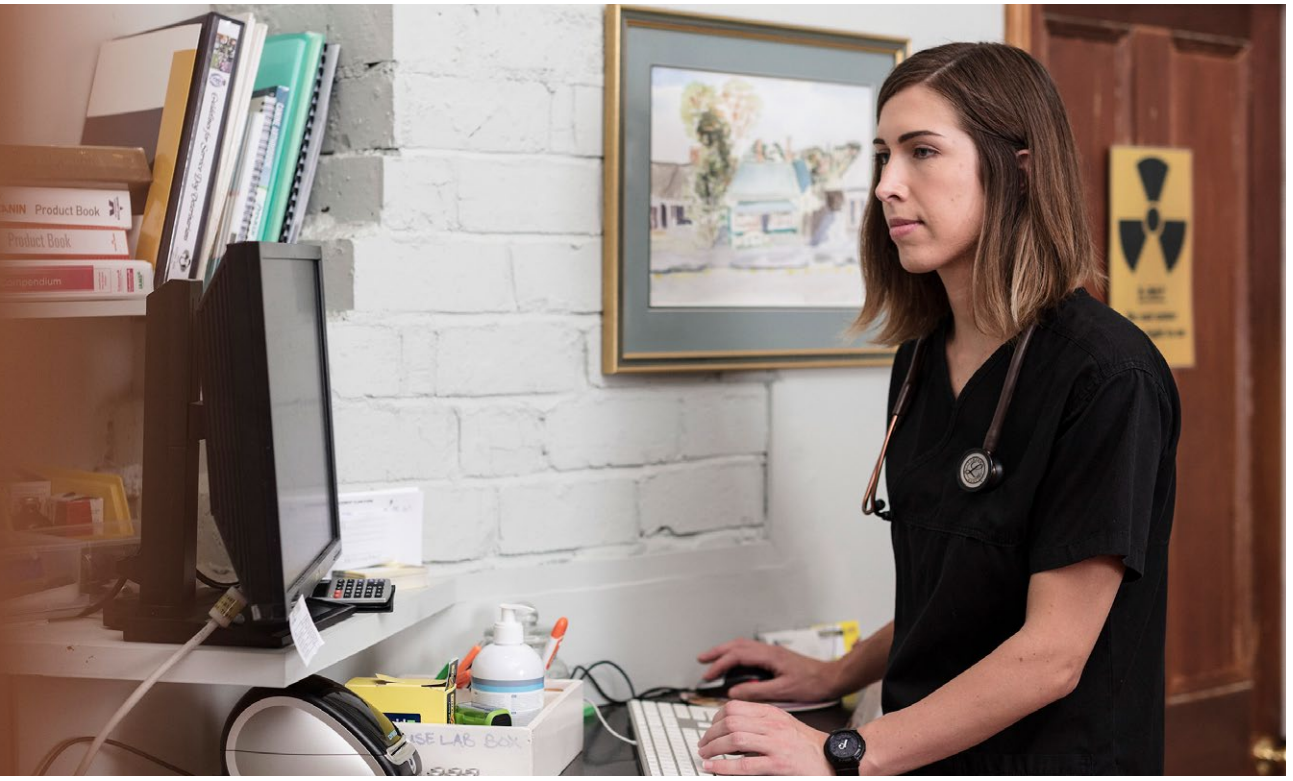
Going forward

As the quote at the start of this chapter suggested, it is systems that will drive the change around psychosocial risk. If these systems are broken at the top, middle or bottom, we will keep on failing in our mahi to keep workers safe and healthy and support them to thrive, however hard we try. Rasmussen (1997) highlighted that we work in complicated dynamic systems, and businesses need to work together with governments, regulators and educational systems to change things around mental health on a broader scale and not just within their own businesses. Also, we need to shift the focus from the individual and tackle the risks associated with mental health in the workplace in Aotearoa New Zealand. When we are measuring and monitoring using the variety of methods and methodologies above, we need to ensure we consider these external forces that could be impacting our workers' mental health and wellbeing.

Organisations seem to be starting to understand the need for investment in their employees' mental health with a study by Deloitte (2020) showing that a $1 investment will return anywhere from $3 to $12, a rate of return which is piquing interest in organisations. Over the next 5–10 years, this conversation will only get louder as COVID-19 has shone a light on this area and appears to be here to stay for a while. Also, our workforce will change as we get more Gen Z and Millennials who are more open to talking about their mental health (American Psychological Association, 2018) than previous generations. It will be a risk this next generation will want to address in their workplaces, as they hold businesses to account.

When I look back at where we have come from five years ago in my own workplace and as a Health and Safety professional, I believe we have matured with our approach to mental health and wellbeing as we can now have the conversation in the workplace. However, there are businesses that do not know where to start and are searching for the 'right' answer. As I hope you would have seen from reading this chapter, there is no perfect answer to measuring mental health in the workplace and I do not know any business that is close to the 'right' answer. It is variable and dependent on each business, with their own work culture, and organisational structure as well as the socio-technical system each organisation sits within. Great organisations are those that are constantly reviewing and challenging themselves and using a variety of methodologies and measurements. Businesses should be adapting and evolving their approach with any risk within the business, and right now this is what we should be aiming for by measuring psychosocial risk and the impact it is having on our people's wellbeing.

Context is also important and there are not the established and accepted good practices that can parallel those associated with physical hazards. We are too focused on reactive responding rather than proactively addressing the known causes of mental health problems in the workplace. The ISO45003 and the NSW Code of Practice for Psychosocial Hazards at Work (SafeWork NSW, 2021) will help us move toward this proactive space. It gives me hope that businesses and health and safety professionals will use these frameworks to question and challenge themselves, their thinking and where they are at. I also hope we will be more inclined to take a multidisciplinary approach to tackle the risks around mental health in the workplace by partnering with professions such as Organisational Psychologists and our Human Resources team to look at it from many different perspectives. As mental health and wellbeing is a multidimensional concept, so too is the approach we should take to monitor, measure, and manage this risk in the workplace.



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Growing a wellbeing movement at work

Zaynel Sushil & Kim Watts

How well do we know the wellbeing of our employees and our workmates? It's a tough question to answer but it is one that is becoming more common within organisations. A 2021 workplace wellbeing survey across 600 organisations in Aotearoa New Zealand found 84% of workplaces agreed staff wellbeing initiatives contributed to the retention of high-performing employees (Employers & Manufacturers Association, 2021). The body of evidence is growing in New Zealand, demonstrating the value and return positive wellbeing can have for organisations (Metzger, 2019).

There has been significant research to demonstrate that good engagement practices (workers – managers – business leaders) lead to better wellbeing and productivity outcomes in workplaces (Metzger, 2019). Unfortunately, relatively few business leaders lead engagement with their employees, rather they may contract external consultants to lead this activity. This may be because many individuals in leadership positions are uncertain about how to lead such engagement. Carasco-Saul, Kim and Kim (2015) identified *transformational leadership* as the most successful form of leadership for positive employee-engagement outcomes in comparison to other leadership styles. Transformational leaders are influential, inspirationally motivational, intellectually stimulating, and considerate of individual followers (Shuck & Herd, 2012).

So, do you know what kind of leader you are? If not, go and find out. If you call yourself a leader then we encourage you to remember one thing from this chapter: the way you engage with your colleagues and employees matters. It matters every day you walk through the front door of the office or join a virtual meeting.

Building a movement, such as building a shared focus on wellbeing, relies heavily on how engagement is managed, and this chapter will unpack five ways to influence leaders and navigate resistance and hopefully convert the naysayers into wellbeing champions. These five ways are:

1. Careful use of data and evidence to illustrate the impact wellbeing can have on the bottom line of an organisation
2. Leveraging champions into your conversations with decision-makers
3. Growing connection between people through cultural and place-based activities
4. Deeply understanding employee voice and their wellbeing aspirations
5. Creating consistent feedback loops to show progressive wins to everyone in your organisation

All these things help create conditions for a wellbeing movement to start and to grow. The case studies introduced in this chapter are informed through real-world practice with thought leaders, what they are implementing in their workplace, their insights, breakthroughs and failures to grow a culture of wellbeing within organisations. The first and most important lesson here is you don't have to be in a position of power to start a wellbeing movement within your workplace or industry, you just need to start a conversation.

There is an art to starting these types of conversations and you get better at it over time, but first let's consider the word 'movement'. What do we mean by this? In the history of work, we've seen many movements. They usually start with one passionate voice in the room but can quickly grow into an entire workforce calling for change related to diversity and inclusion, gender pay equity, or greater corporate social responsibility. These are all relevant movements within 'work'. All these movements are intrinsically linked to employee wellbeing. At this time of writing, we are still in a global pandemic. This has given the workplace wellbeing movement an Overton Window, a time when things can feel politically acceptable to the mainstream population. Wellbeing is front and centre for all leaders. Things like flexible working and virtual meetings have become normalised and made life easier for many people, especially mums and dads and those caring for others. But regardless of the benefits many have felt during these strange times, have business leaders realised that the economic wellbeing of their organisations is linked with the wellbeing of their people? Often leaders will say they struggle to understand how wellbeing impacts their bottom line. In response, the key message to those leaders is – when you lead with wellbeing, you create intergenerational health and wealth for your company and your people.

Case study: Rosebank Business Improvement District (Rosebank BID)

In March 2020 right before New Zealand went into a COVID-19 related lockdown, Healthy Families Waitākere, the Rosebank Business Association alongside Business Lab partnered to grow workplace wellbeing within the Rosebank Business Improvement District in West Auckland. In the first week of lockdown, we saw leaders scramble to use technology they had never used before, we saw leaders struggle with the potential impact of lockdown, and we saw leaders genuinely concerned about the wellbeing of their employees. The thought of letting go of staff was mentally and emotionally challenging for them. Leaders shared these feelings in a virtual forum with other leaders who felt the same. They were in the unknown together and being in the unknown together felt better than being in the unknown alone.

1. Careful use of data and evidence

In 2018, before the Rosebank initiative, we were invited to a board meeting of a medium-size organisation to demonstrate the value employee wellbeing can make to their business performance. We shared some data and insights on the return on investment of wellbeing for organisations. For instance, one meta-evaluation (Chapman, 2012) looking at the economic return of worksite health promotion programs found on average programs:

- decrease sick leave absenteeism by 25.3%
- decrease workers' compensation costs by 40.7%
- decrease disability management costs by 24.2%
- save $5.81 for every $1 invested in employee health and wellbeing.

We failed in that meeting but learned that not all leaders understood wellbeing or had a shared definition for it. We were naïve to think that all board members are thought leaders and would already be aware of the benefits of wellbeing. One board member described wellbeing as a 'minefield' while another felt the government was shifting responsibility onto businesses. We walked away having learned there are different leadership mindsets to wellbeing and presenting just the benefits of wellbeing is not enough. In that meeting we found three recognisable types of leadership mindsets:

- Leaders who are champions for wellbeing
- Leaders who are sceptical about wellbeing
- Leaders who resist wellbeing

Knowing this helps when trying to influence how leaders think. Carefully using data and insights and noticing how leaders respond can help reveal leadership mindsets towards wellbeing. It doesn't help if everyone thinks the same at a leadership level. Diversity of experience and world views all matter – it can either support or hinder your wellbeing movement. Being adaptive early on in your engagement style can help create the pre-conditions for a trusting relationship with leadership.

Many times, we approach "why we should invest in workplace wellbeing" with some issue in mind, for example, the construction industry in Aotearoa New Zealand experiences the highest number of suicides among vocational industries. So, the goal becomes to reduce suicides. A national study on health and wellbeing in the construction industry found that builders were overrepresented in industry suicide at 21.7% and that depression is the leading risk factor for this (Bryson, Doblas, Stachowski, & Walmsley, 2019). Our engagement in presenting data and insights to leaders has found that it can quickly create narratives about a workplace or industry in a negative way and this will more often switch leadership off from meaningful engagement.

"Are problems like substance use and depression actually the responsibility of workplaces to address – they seem like big problems and beyond my control?" said a leader of a construction firm, a valid opinion we thought. Data and insights can feed fear or feed aspiration. How you present data and insights matters and should be strengths-based.

At this point, we realised the conversation about workplace wellbeing with business leaders had to shift from focusing on big issues such as substance use and depression to things leaders have control over such as company values and culture, job design and workforce development. This resulted in the innovation team reframing the conversation into how might industry values, job design and workforce development support employee wellbeing?

Reframing is a simple exercise you can apply to shift the dialogue with leaders from a deficit or fixed perspective towards growth and openness. One way to do this is to create 'How might we ...?' statements like the one above. The trick is to keep it practical and relevant to an insight or observation about an issue or challenge.

2. Leveraging champions

Coming into the Rosebank BID one of the first things the innovation team did was identify a wellbeing champion in the business community. We weren't going to make the same mistake twice, so being intentional about our approach was crucial. We found one board member at the Rosebank Business Association who was passionate about community development, so we brought them into a conversation about the innovation project. Together we created a pitch and led engagement with the other board members.

Influencing leaders can be very challenging, even using the right language, alongside relevant data and insights sometimes is not enough. What is most effective is finding leaders who are wellbeing champions and getting them around the table with those who are sceptical or uncomfortable with the topic. Having champions who can share their lived experience about why a wellbeing initiative is important and valuable convinced other leaders and shareholders to give wellbeing a chance in Rosebank.

Our work in several areas such as health, local governance and community development has found using champions as an effective influencing strategy where leadership is on the fence about moving forward with wellbeing. There are several reasons for this. Some leaders assume they will have more work or feel wellbeing will cost more money to implement. This is when data and insights about what is true are important to present. Leading coaches on leadership highlight that the most significant factor driving a successful wellbeing initiative is leadership belief and not just buy-in. Leaders must believe wellbeing is the right thing to do for their organisations.

- **Buy-in**: Buy-in is getting others to agree with an idea or concept, so they will support the idea and implement the necessary goals and actions. When a person is trying to buy in to something new, they may say, "I would buy in to the idea if I knew for sure it would …"
- **Belief**: Does not require proof. A person can choose to believe in an idea or principle without proof or even despite proof that shows their belief could be wrong.

3. Growing connections

Returning to the Rosebank BID case study, the innovation team were challenged from the very start by some leaders who wanted certainty around business outcomes from the innovation process. It was also a situation where values did not align at the start. So how do you collaborate with someone when core values do not align? We were intentional about building a relationship with leaders in a culturally centred way and used tikanga-based approaches as part of the engagement process. Stakeholders were guided by whakawhānaungatanga, a process for building relationships and identifying common attributes between people. This was a critical success factor for growing a trusting environment between workers and leaders who would ultimately lead the initiative. Whakawhānaungatanga was not a time-limited event but embedded within the entire three-month innovation process. A generous amount of time is required to form trusting relationships especially when heading into a new venture. Below are some tips about what to prioritise in the early days of starting a wellbeing conversation at work.

- Lead by example – people holding the space can demonstrate this by sharing their pepeha, a way of introducing yourself in te reo Māori. It tells people who you are by sharing your connections with the people and places that are important to you.
- Create opportunities for engagement – in workshops we planned ice breakers to start conversations focused on personal values and ways of being. For example, what does a good day at work look like? What makes you happy at work?
- Be consistent – dedicating 10 minutes before every session to building a relationship is more fruitful than a longer one-time event at the start of any workshop series.

Our engagement with the business leaders found when leaders think of wellbeing, they tend to default to ideas such as counselling, health checks and physical activity initiatives. We dived deeper to understand why leaders placed importance on these ideas and found they were seen as ‘door openers’, ‘knowledge sharing’ and ‘connection building’ opportunities for the business community and workers. All of which were seen as pre-conditions for growing leadership belief in the Rosebank Wellbeing Initiative among other staff and business leaders.

Building a strong connection was vital for ongoing discussions on how we shift from addressing the symptoms of stress at work to their root causes. A question that was explored numerous times with business leaders was one that led to commuting and traffic congestion being identified as one of the top stressors for workers in Rosebank. The Rosebank Business Association then mobilised to undertake an impact assessment of traffic congestion on employee wellbeing through a series of drop-in sessions with workplaces and continue to engage their political leaders to find a long-term solution. Some workplaces have created flexible working policies to support staff to work from home, while others have changed start and finish times to minimise stress caused by traffic congestion. It is a complex problem that will take a whole community approach to solve.

In contrast, a regional council in 2011 made a substantial financial investment in programmes to support employee wellbeing. Departments and teams got a slice of the pie, a wide range of activities were funded from social gatherings and physical activity initiatives to awards. Wellbeing surveys were completed every quarter and after a year of implementation, the programme evaluators noticed little or no change in employee performance, employee retention, or an increase in job satisfaction. The funding was discontinued the following year. What went wrong? A couple of things actually. Leaders at the top didn't meaningfully engage staff on ways to support their wellbeing and as a result, solutions created were top-down and did not address real areas of need. The core team lacked representation from across the business unit and struggled to effectively reach into different departments, and no one bothered to truly clarify what success should look like. Not being intentional about engagement can burn social capital (friendship, trust, loyalty, respect) between employees and management and lead to a vicious cycle of employee disengagement.

4. Understanding the employee voice

Qualitative lived experience data is the information gathered about how people experience the world around them. It is data that is deep and rich in stories and is generally collected through interviews or group discussions. The important thing is this approach can help amplify the voices of those who might be most affected by a particular problem. In 2018 a group of workplaces from South Auckland agreed to explore the wellbeing of shift workers (Alliance Community Initiatives Trust, 2018). The innovation team used an empathy-led approach (Mattelmäki, Vaajakallio, & Koskinen, 2014) to engage employees from five different workplaces over a two-week period. There were three critical success factors for getting rich information from employees. These were management support, the space, and types of questions.

- **Management support.** Ensuring middle managers were invited by their leadership to provide ideas on the best ways to engage their teams was crucial for ongoing support and understanding of any resistance the innovation team could face. Inviting team leaders to co-host helps build trust in this process.
- **Provision of space.** Curating the space for the conversation was really important with plenty of messaging within the workplace to ensure employees were aware ahead of time – for example, posters and emails. Spaces that worked well for the engagement were the kitchen cafeteria, shop floor, and greenspace outside, in comparison to board and meeting rooms and machine-operating areas.
- **Question type.** A list of 1–3 well-refined open-ended questions proved to be far better than 5–10 questions or an online survey. Questions needed to be conversation starters rather than try to unpack a technical aspect of the job. Examples of questions that worked:
  - What does a good day at work look like?
  - What three things do we need to improve to make work more meaningful?

These are just some critical success factors to consider – they help to build psychological safety. Psychological safety describes an organisational or team climate in which people are comfortable being and expressing themselves (Edmondson, 1999). A recent McKinsey Global Survey found only 26% of leaders instil a climate of psychological safety (De Sment, 2021). When there is psychological safety, team members feel they can take interpersonal risks without fear of embarrassment, rejection, negative labelling or punishment. Understanding the level of psychological safety at your workplace is important before you can effectively address wellbeing. Innovation research shows employees are less likely to share openly about the causes of stress if they, (a) do not trust the engagement process, and (b) do not feel trust or feel safe at work (O'Donovan & McAuliffe, 2020). There is no easy way to assess the level of psychological safety at a workplace, so it's best to assume from the very start that not everyone at your workplace experiences the same level of psychological safety. In this situation, doing the above and undertaking this safety check might further grow psychological safety.

Safety check for yourself and your team:

- When did you last reflect on your team values?
- When did you last talk about failures and what you learnt from those experiences?
- When did you last hear about a concern at work?

If it's been a while, then perhaps look at the original Psychological Safety Scale (PSS) by Edmondson (1999).

5. Importance of progressive wins

Progressive wins help build continuity of engagement, providing essential nutrients for trust to grow between leaders and the implementation team, creating a mutually reinforcing relationship. What are progressive wins? These are wins along the way that help you achieve your big goal. Progressive wins can be achieved as a result of important insights gained through failure, the development of new relationships and even new ideas. In Rosebank, we heard leaders often asking about what's not working and what did we learn? Here is a quick framing tool you can apply in your next conversation with peers and leaders.

1. We tried (name activity) and (describe event) happened. What we learned was (___). As a result I/we decided to (action).
2. We set out to (name activity) and as a result, something unexpected happened (Describe what happened). Now we have a breakthrough for (name action/decision).
3. Our current challenge is (name it). I think we can solve it with leadership support and that would be a significant win for the initiative.

Action can create excitement and every movement needs excitement (enthusiasm, buy-in, belief) to grow. In the Rosebank BID case study, leaders told us that they needed to get some 'runs on the board', they needed to create 'FOMO' the fear of missing out on the wellbeing wave, and that people in their business community like to see action. From an innovation viewpoint, we wanted any action to be informed by workers in the community; however, reaching workers during the peak of COVID-19 was a formidable challenge, so we ran with insights shared by business leaders and worked hard to engage with workers along the way. This approach meant leaders felt their ideas were heard. One insight that stood out was how many leaders felt a lack of connection and relationship to other businesses in the local community, and lack of connection with other business leaders which led to silo-entrepreneurship and prevented help-seeking behaviour from leaders.

This was a notable experience and opportunity area to explore further so we framed this up as a design question. How might we grow connections in new ways between workplaces in the business community? We generated 15 ideas across five themes and prioritised them based on practicality – how easily can we get this action started? We framed this as 'activations' with the strategic intent to help businesses and workers connect with the tangible aspects of wellbeing (knowledge sharing and connection building).

We tested three ideas with business leaders to understand the critical shifts required to normalise staff participation in wellbeing activities 'during paid work hours'. Our first test invited workplaces to join in a community volunteering experience for two hours. We engaged 20 businesses and only one agreed to participate. The remaining organisations could not justify letting staff go off-site due to COVID-19 and the backlog of tasks. The second activation tested the idea of free health checks for staff during paid work time. This idea was popular. The third activation tested if businesses would engage in a play-based business challenge. This activation engaged 163 workers across 23 workplaces in the business community. Our key reflection on the processes reported here is that consistent engagement pays off – people notice and engage. As a result, we have business leaders wanting to learn more about the Rosebank wellbeing initiative. Activations such as the above help create excitement and connect people with something they can feel, touch and experience. Activations build and demonstrate credibility in front of peers and leaders. Over time it helps create a shift in narratives about a place. In Rosebank, the narrative is shifting from a place for business success to a place for business, people and community success.

Share your progressive wins with passion and excitement and ensure you clearly explain what these little wins mean for the initiative. Being able to articulate small wins on a regular basis keeps leaders informed and confident about the process especially when they feel outcomes are not clear from the start. In Rosebank, we experienced many little wins such as launching the first community-wide survey on wellbeing, presenting to local boards gaining their support, and publishing success stories which all helped to grow the wellbeing movement. Our consistent communication about these progressive wins to the Rosebank Business Association governance board, alongside feedback they heard from workers and leaders in the business community, led to a breakthrough that we did not expect during the height of COVID-19.

The board agreed to include wellbeing as a strategic priority in their annual plan and long-term strategy and allocated funding towards it. This has given the initiative an opportunity to grow, creating a shared sense of achievement across all partners, business leaders and workers. But the story doesn't end here for Rosebank. The foundations for the wellbeing movement to grow are in place and it's only a matter of time until wellbeing becomes business as usual.

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Mentally healthy work in the public service

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The New Zealand public sector

The public sector is made up of a passionate and committed workforce dedicated to serving Aotearoa New Zealand. Yet the work that these people undertake on behalf of Aotearoa New Zealand poses a number of potential risks to their mental health and wellbeing. Evidence suggests that certain roles in the public sector are more likely to experience worse mental health outcomes than employees in non-public sector roles, highlighting the importance of prioritising mentally healthy work in the public sector.

The public sector consists of diverse and complex workplaces that support the government in developing and implementing their policies, and in delivering high-quality and efficient public services to Aotearoa New Zealand. Employing over 429,500 people (18.5% of New Zealand's total workforce), the public sector as a collective is one of the largest employers in Aotearoa New Zealand, requiring its workers to undertake a wide range of duties within a variety of work environments (Public Service Commission, 2021). This creates an array of interesting and unique contexts in which workers may be exposed to mental health (psychosocial) risks, making the public sector an exciting workforce to examine when considering how we create and enable mentally healthy work. Research specific to mentally healthy work in the New Zealand public sector is limited but a significant body of international literature shows that many of the roles undertaken within the public sector encounter psychosocial risks that are associated with significantly worse mental health outcomes than in many non-public sector roles (Huddleston et al., 2007; Lyra et al., 2021; Kyron et al., 2021; Ross et al., 2021).

How the public sector approaches health and safety, both within its work and the requirements it places externally, can contribute to better health and safety outcomes for workers across a wide range of New Zealand workplaces. This makes the public sector an important area to explore when we look more specifically at work-related mental health – not only in how mental harm manifests and is managed within its own workforce, but also the potential for significant influence on psychosocial risk management more broadly across New Zealand.

This chapter will examine:

- What are the key psychosocial risks in public sector work?
- How are psychosocial risks managed in the public service?
- What are the opportunities to create mentally healthy work in the public sector?
- The importance of mentally healthy work in the public sector for New Zealand more broadly

For the purpose of brevity, this chapter will speak specifically to the maturity of psychosocial risk management within a selection of public service and state sector agencies and departments.

What are the key psychosocial risks in public sector work?

Public servants often face a unique combination of psychosocial risks due to the nature of public service work. Many of these are risks that other New Zealand workers also encounter in their work, as well as some psychosocial risks that are particularly unique to public sector. The types of psychosocial risks a public service worker may face depends on the nature of their agency's work (or undertakings), the nature of the individual's work, and various external pressures or expectations placed on the agency.

To help understand the types of psychosocial risks workers face, Denhof et al. (2014) have provided a useful framework outlining three potential sources of psychological harm:

1. Organisational factors (e.g., role conflict, difficult social interactions, low organisational support, insufficient education and training)
2. Occupational factors (e.g., high workload, mandatory overtime, low decision-making authority, immersion in harsh physical environments, etc.)
3. Traumatic events (e.g., direct and indirect exposures to violence, injury, death, or other distressing events and experiences).

While many New Zealand workers may be exposed to psychosocial risks categorised under one or two of these groups (particularly organisational or occupational factors), the public service is unique in that many of its workers have a good chance of being exposed to all three through the normal course of their work.

Traumatic events

Public servants may work in unique environments and undertake tasks not often required in other sectors, exposing them to certain psychosocial risks not often faced elsewhere. Some of these tasks have inherently high levels of risk to both the physical and psychological wellbeing of workers. This particularly occurs in roles where workers have to 'run towards' harm or disaster, such as defence force personnel, police officers, corrections officers, and fire and emergency services. These are some of the public sector workforces who are frequently exposed to all three categories of psychosocial risks (Ross et al., 2021). The potentially traumatic psychosocial risks in these types of work can include exposure to threats, violence and aggression, physical harm or danger to themselves or others, suicide, distressing materials, and high-pressure environments (Regehr et al., 2019; Richardson et al., 2020; Kyron et al., 2021). These types of psychosocial risks have a higher potential to cause serious psychological harm, which is highlighted in findings from international research.

Enforcement or investigative roles in the public sector, such as social workers, crime photographers, and investigators of exploitation, may similarly experience psychological harm from work that exposes them to threatening or distressing situations or materials. It is often not until after repeated exposure that the culmination of psychological harm results in a recognisable 'mental injury' (Thwaites, 2021). This was seen in the Brickell v Attorney-General case in 2000 where the claimant, a police video photographer who had filmed and edited horrifying material over a 15-year career, presented with post-traumatic stress disorder 10 years after finishing his work.

Key findings

- Firefighters in Australia are twice as likely to suffer from post-traumatic disorder than the general public. New Zealand firefighters are also reported to experience higher rates of mental health issues (McCann, 2019).
- Corrections workers are more likely to experience post-traumatic stress disorder, depression and anxiety than most other occupations and the general population as a whole (Regehr et al., 2019).
- Police have significantly higher rates of suicidal thoughts than the general Australian adult population, and 49% of surveyed police have some form of PTSD due to prolonged exposure to traumatic events (Kyron et al., 2021; den Heyer, 2021).
- First responders exposed to events such as suicide experience significantly higher rates of suicide, potentially due to work-related Post Traumatic Stress Disorder (PTSD) (Lyra et al., 2021).
- Post-traumatic stress was prevalent among New Zealand military personnel. Trauma was strongly associated with this (Richardson, 2020).
- Workers repeatedly exposed to physically painful and/or fear-inducing experiences in their working conditions experience higher rates of suicidal ideation (Van Orden et al., 2010).

Occupational and organisational factors

Plimmer and Cantal (2016) highlighted that public service workers face non-traumatic work-related psychosocial risks that are also experienced in other sectors, including inadequate leadership, bullying by colleagues, uncompensated work hours, and workload. The 2021 Public Service Census revealed that only 52% of public servants were satisfied with their work/life balance, potentially indicating that the latter two risks need to be managed more effectively (Public Service Commission, 2021). This finding was even greater in female public servants, with only 50% reporting that they were satisfied with their work/life balance compared to 56% of their male counterparts. Similarly, only 46% of those who hold management responsibilities were satisfied with their work/life balance. These levels were significantly lower than that of the broader New Zealand workforce, in which 76% of workers reported being satisfied with their work/life balance (Statistics New Zealand, 2018). This is unsurprising given the average public service manager reported having to work an extra 7.2 hours (18%) per week beyond what they are contracted to do, almost equating to an extra day of work each week. However, given that flexible work may mitigate some of the harmful effects of poor work/life balance, it is positive to see that 78% of public servants reported having some form of flexible working arrangement in place.

Public service workers are also somewhat unique in some of the external pressures they face. Many workers in Aotearoa New Zealand are required to work in high-pressure circumstances where a rapid and accurate response is required at short notice and a high level of performance and accountability is expected. However, while many in the public sector face these pressures, they also face a much greater level of external scrutiny in the form of the media and the ability for artefacts, emails and other similar content to be made public under the Official Information Act. These psychosocial risks are often faced by roles relating to public health response, parliamentary services, regulatory enforcement, social services, and intelligence and security.

Public service workers are also affected by external pressures that influence prioritisation, funding, and resourcing decisions in their agencies. A unique characteristic of the public service relates to those who hold influence over the public service agencies/departments and the work they do. While all public service organisation Chief Executives have a dual role as chief executives and Officers under HSWA, they also have a Minister who sets priorities to be achieved by the organisation, and through this may indirectly influence where the organisation places its efforts and resources. A Minister is not considered to be an 'Officer' under HSWA and has no legal health and safety obligations placed on them personally in relation to the agencies that they oversee, yet they still have significant influence over the organisation. This differs materially from the way that members of a Board of Directors are classified as Officers under HSWA and have legal obligations placed on them personally under HSWA to ensure health and safety is factored into their strategic decisions. This creates a relatively unique dynamic in which an individual who has the potential to significantly influence what an organisation prioritises and where its resources are focused may not be as actively incentivised for ensuring that health and safety is appropriately prioritised and resourced.

How are psychosocial risks managed in the public service?

It is currently difficult to accurately assess the state of work-related psychosocial risk management and the degree of psychological harm that workers may experience in the New Zealand public service. This is because of the relative lack of data and insights on psychosocial risks, as well as when and where psychological harm is occurring. The available data usually reflects the few instances of significant harm, seemingly once it has reached a significant enough level to warrant reporting. Early indicators of psychological harm or exposure to psychosocial risks are not often captured within public service agencies.

One of the challenges facing many New Zealand workplaces is the relative lack of overall maturity of our health and safety systems – and the public service is no exception. In a 2020 public service health and safety survey, most agency representatives reported psychosocial risks or mental health as one of the key critical risks that they face (Government Health and Safety Lead, 2020). Yet less than half of them reported having a system in place to effectively determine how and when their workers were being exposed to psychosocial risks, the level of exposure, and the impact on workers, despite this being a legal requirement under HSWA.

An additional challenge is that the data the sector has on the state of psychosocial hazards and the harm experienced is frequently inaccurate. Where data does exist, most public service agencies have typically relied on employee engagement surveys, or use of employee assistance programmes, sick leave and turnover. These data sources are often unreliable for indicating the true psychosocial risk landscape and are limited in their ability to identify specific psychosocial risks, types of harm, or explain the interaction between psychosocial hazards and potentially protective factors.

Data on lagging measures, such as the number of cases of bullying, work-related stress or fatigue, is of little benefit too. While a very high number of work-related stress, bullying, and/or fatigue cases *may* accurately indicate that work-related psychosocial risks are being poorly managed, the opposite can't be assumed to be true. A low number of stress, bullying or fatigue cases may not mean that psychosocial risks are being well managed, but rather that workers aren't reporting these incidents when they occur, or the harm being experienced simply hasn't yet reached a significant enough level for the individual to consider reporting it. It is important to keep in mind that agencies with low reporting on psychosocial risks or low numbers of incidents may be experiencing underreporting, rather than being a psychosocially safe workplace.

Without having clear signals that work and work systems may be causing psychological harm, it is unsurprising that the public service has typically placed most of its focus on supporting individual workers to withstand psychological risks to do with their work or recover once harmed, rather than reflecting on whether they (as a PCBU) are providing a reasonably safe system of work. These interventions have also often been put in place to improve mental health generally, rather than targeted towards specific psychosocial risks that the agency has identified specifically relating to their operations. This reflects trends and approaches of other sectors, in which the overwhelming focus has been on individual wellbeing (e.g. resilience training, mindfulness), individual 'wellness' initiatives in the form of generalised programmes targeting worker diet and fitness (e.g., free fruit, step challenges), and individual psychological intervention (e.g., employee assistance programmes) (LaMontagne et al., 2014).

These interventions are all well intended and may send a positive message that the agency cares about their workers' wellbeing. However, a generalised focus on wellness programmes or on individual resilience to enhance worker mental health does not adequately or systematically address the work-related factors which may create or contribute to poor mental health, nor does it provide the high level of protection for workers required by HSWA (particularly in workforces exposed to such significant psychosocial risks). As an example, a recent meta-analysis of several secondary and tertiary interventions (namely crisis interventions, psychoeducational programmes and exercise programmes) demonstrated that these had no effect on the experience of stress or psychopathology on workers (Evers et al., 2020). These interventions are also not sufficient to demonstrate that an agency is meeting their obligations under HSWA to identify, assess, eliminate/minimise and monitor psychosocial risk factors.

What are the opportunities to create mentally healthy work?

With the introduction of the *Health and Safety at Work Act 2015* in 2016, and as New Zealand's health and safety capability has begun to mature, the public service is increasingly recognising the need to address mental health in a systematic manner to meet legal requirements by providing 'mentally healthy work'. Public service agencies are increasingly recognising that the focus on mental health in the workplace needs to progressively shift from focusing solely on the individual worker to primarily focus on the conditions created by work and the workplace (Government Health and Safety Lead, 2020).

When asked in 2019, many public service agency health and safety teams reported not having a framework to conceptualise or make sense of their approach to managing psychosocial risks. While all agencies had a range of mental health interventions and initiatives in place, most agencies weren't applying this within a systematic or targeted way towards *work-related* factors (Government Health and Safety Lead, 2020). Similar to Aotearoa New Zealand as a whole, public service agencies have not typically had a strong understanding of how to identify work-related psychosocial risks, the types of interventions (controls) that could be put in place and/or how to monitor and assure themselves that these interventions are in place and working effectively. Many agencies reported that most of their focus was on reactive (tertiary) interventions that support workers once they are experiencing mental harm, such as employee assistance programmes, or interventions such as resilience training and peer support programmes (secondary interventions) that help individuals to cope better with stress. However, agencies reported very little focus placed on how work is designed and managed to eliminate or minimise psychosocial risks in the first place (primary interventions). This approach can be considered managing the consequences of the risk, rather than preventing the cause of harm by managing the risk.

Supported by the Government Health and Safety Lead, there is now a significant shift to rebalance the sector's focus towards designing better work and workplaces with the explicit intent of eliminating or minimising the level of exposure to psychosocial risks, instead of simply supporting workers to withstand psychosocial risks. A growing number of public service organisations have now formally identified psychological risks as one of their '*critical health and safety risks*' (i.e., risks with the potential to serious harm) (Government Health and Safety Lead, 2020). This is a positive sign and a shift towards a systematic and structured approach to identifying, assessing, managing and monitoring psychosocial risks.

Like PCBUs in other sectors who actively collaborate for health and safety benefits, the public service has an opportunity to achieve widespread change by taking a collective approach to these challenges. An example of this is the sector-wide programme of work for *Positive Workplace Cultures* which leverages the unique scale and scope of the public service to lead significant change in New Zealand workplace culture. Led by two public sector Chief Executives, the programme looks to provide a sector-wide direction to public sector support leaders to create workplaces that are inclusive, diverse and safe for all workers. Reflecting the growing recognition that bullying and harassment are within the scope of health and safety matters to be addressed, this seeks to build on the '*Model Standards for Positive and Safe Workplaces*' issued by the Public Services Commissioner, outlining the *minimum* expectations for staff and organisations in the State Services. The Positive Workplace Cultures programme goes beyond these minimum expectations to focus on the *aspirational*, providing a forum for collective engagement and development to drive sector-wide change.

A similar approach has been seen on a lesser scale within the public service health and safety approach to psychosocial risk management. The Government Health and Safety Lead mental health programme of work is currently driving a collective focus on how the sector approaches psychosocial risk management. The Government Health and Safety Lead's approach encourages member agencies to focus on aligning to shared frameworks, to identify their work-related psychosocial risks, and to rebalance their efforts to prioritise the creation of mentally healthy work, rather than a reliance on individual resilience and/or psychological intervention after harm has occurred. This increases the likelihood of individual agencies meeting their duties under HSWA, but also supports a

collective shift and advancement of how mental health/psychosocial risks are managed in the workplace. Placing more focus on creating mentally healthy work and workplaces increases the potential for a positive change for a significant number of workers.

The public service now has an opportunity to reimagine how it defines and measures performance in relation to psychosocial risks and 'mentally healthy work'. Like physical safety, the focus for psychosocial risk management has traditionally been on measuring the number of negative events or adverse outcomes occurring in order to determine whether 'success' has been achieved. But in the same way that generalist safety professionals are increasingly moving away from measuring the absence of negative events as a measure of 'success', there may be merit in shifting to a strengths-based approach for measuring and achieving psychosocial risk management. This would see agencies placing their focus on measuring the presence of organisational capacities and capabilities that enable good outcomes to emerge from work systems and organisation settings, such as high levels of actual and perceived management competence, work-life balance, and a positive psychosocial safety climate – things that are known to positively impact worker mental health (Forsyth et al., 2021).

The importance of mentally healthy work in the public sector for New Zealand

The approach that public service agencies (and the public sector as a whole) take to mentally healthy work is important to New Zealand for several reasons. Firstly, the sheer scale of the sector, with its diverse range of PCBUs and undertakings, means that a significant number of workers may be directly impacted by the way the sector meets its health and safety obligations. Secondly, as a major purchaser of goods and services, the public sector also influences health and safety outcomes of potentially thousands of other workers by setting health and safety expectations within its supply chains and the non-governmental organisations (NGOs) it works with. Thirdly, the public sector can influence health and safety outcomes by the way it sets standards, acts as a regulator, and determines where to direct funding. The ability to influence health and safety outcomes should not be seen as purely relating to physical risks and harm – the opportunity for the sector is to positively influence the mental health and wellbeing of a vast number of New Zealanders by shifting its focus to the design of mentally healthy work and setting expectations through supply chains and NGOs that mentally healthy work is a foundational expectation for all.

The management of psychosocial risks in New Zealand workplaces, including the public sector, is undoubtedly in its infancy. However, it is an area that has been earmarked as a priority and is now seeing commitment and meaningful action to understand and achieve lasting change. As agency Chief Executives continue to engage with sector initiatives, and as health and safety leaders increase their system capability to manage psychosocial risks, the public sector continues to aspire to be a leader within Aotearoa New Zealand for creating mentally healthy work and positive workplaces.

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Good work has always been good for workers, and engaged, happy workers have always been good for business and good for the community. However, it is only recently that these truisms have been widely accepted and have started to drive health and safety systems and practices in the workplace.

This book fills a gap by providing a collection of local resources to guide practice across Aotearoa New Zealand.