Project Title

Impact of Changing Social Structures on Stress and Quality of Life: Individual and Social perspectives

Project Acronym/Logo:

STRESS IMPACT

Work Package 2

Review and Inventory of National Systems and Policy: UK

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List of Abbreviations

AMA	Adjudicating Medical Authority
BA	Benefits Agency
BSRM	British Society of Rehabilitation Medicine
CBI	Confederation of British Industry
CFS	Chronic Fatigue Syndrome
CIPD	Chartered Institute of Personnel and Development
CMO	Chief Medical Officer
CoA	Court of Appeal
DDA	Disability Discrimination Act
DEA	Disability Employment Adviser
DfEE	Department for Education & Employment
DfES	Department for Education and Skills
DLA	Disability Living Allowance
DoH	Department of Health
Dti	Department of Trade and Industry
DWP	Department for Work and Pensions
EAP	Employee Assistance Program
EC	European Community
EEC	European Economic Community
EO	Employer's Organisation
EU	European Union
GP	General Practitioner
HEA	Health Education Authority
HR	Human Resources
HSC	Health and Safety Commission
HSE	Health and Safety Executive
HSWA	Health and Safety at Work Act
IB	Incapacity Benefit
IIDB	Industrial Injuries Disablement Benefit
IR	Inland Revenue
LRD	Labour Research Department
LTA	Long-Term Absence
NHS	National Health Service
NIC	National Insurance Contribution
OECD	Organisation for Economic Co-operation and Development
OHA	Occupational Health Adviser
OP	Occupational Physician
PCA	Personal Capability Assessment
PHI	Permanent Health Insurance
RHS	Revitalising Health and Safety
SDA	Severe Disablement Allowance
SSP	Statutory Sick Pay
TUC	Trade Union Congress
WRS	Work-Related Stress

1. Introduction

1.1 The Current Situation

It has become clear that absence from work due to ill-health is an issue causing great concern for policy makers, the government and business. Routine employer surveys suggest that the vast majority (89%) of employers view sickness absence as a burden on business (Chartered Institute of Personnel & Development [CIPD], 2002). Work loss through ill health has social and economic consequences for the State, employers, individuals and their partners and families (NHSPlus, 2003). Whilst sickness absence in the UK appears to be relatively low in comparison to other EU countries[•] (see Figure 1 overleaf), large employer surveys indicate that 4.4% of working time is lost, equating to an average of 10 working days lost per employee per annum (CIPD, 2002). Government surveys of self-reported absence due to illness increases to 23 days per employee p.a. (Health & Safety Commission [HSC], 2002), a methodological consequence of self-report bias. Statistics from the government's Labour Force Survey suggest that 2% of the working population can be expected to be absent from work on any given scheduled workday (Barham & Leonard, 2002). Whilst absence rates are generally higher in large organisations, public and health services, and education with regional variations (see Table1), over two million working days are lost due to sickness or injury per week (Labour Market Trends, 2002). According to business consultants RobertsonCooper Ltd (2001), a 5% absence rate means that every employee is effectively receiving two weeks of paid absence per year.

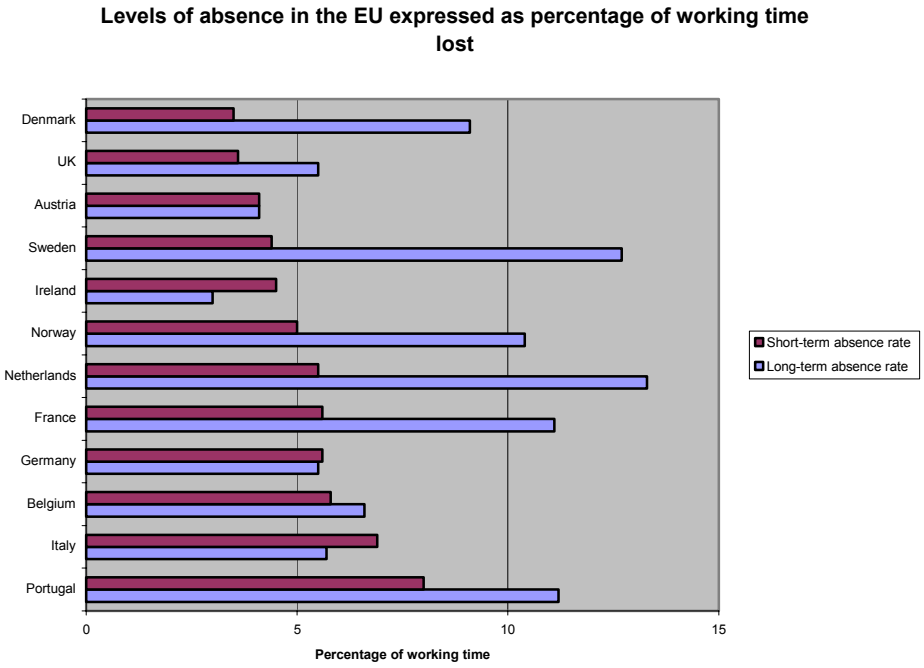
Table 1: Sickness absence rates by sector, organisation size and region

	Mean **working time** lost (%)	Mean **days** lost per employee p.a
Sector		
Public services	4.8	10.9
Manufacturing & Production	4.2	9.6
Private sector	3.7	8.4
Size		
1 – 500	3.9	8.9
500 +	4.7	10.7
Region		
Northeast	5	11.4
Southeast	3.6	6.8

(Adapted from the CIPD survey, 2002)

Figure 1

[•] This could be due to a less generous social security and benefit system.



The costs to businesses include sick pay schemes, overtime payments, replacement labour, lost or delayed production, a reduced service, disruption to work and low moral and apathy of present employees (ACAS, 2003). The Confederation of British Industry estimated the annual cost of sickness absence to be £10.7 billion, rising to £23 billion p.a. if costs to the state in terms of welfare payments are included (CBI, 2001). The CIPD calculated that sickness absence costs an organisation an average of £522 per employee[•] each year, which is a 7% increase from the 2001 figure of £487. Sickness absence has also been calculated to represent between 2 and 16% of an organisation's annual salary bill (Bevan & Hayday, 2001).

Although it is estimated that only 18% of sickness absence is long-term (i.e. one month or longer), this accounts for 40% of the working time lost (CIPD, 2002). According to the government's Green Paper (*Pathways to Work,* DWP 2002) and other statistics (i.e. CBI, 2001), 60% of employees who are off work due to illness (medical / psychological) for 5 weeks or more don't return to work and 80% of those long-term absentees moving onto Incapacity Benefits do not re-enter the workplace, with the UK heading the field in terms of working age incapacity.

1.2 Aims

[•] Calculated from Occupational / Statutory Sick-Pay and replacement labour. The effect of reduced productivity is rarely included in calculating these costs.

The aim of this report is to detail aspects of the UK's administrative, legal and welfare procedures for long-term sickness absence. Where possible, the emphasis will be on characterising the current situation specifically in relation to long-term stress related absence from work. In order to paint an accurate picture a number of sources have been consulted; these include Acts of Parliament, guidance produced by the DWP, best practice guidelines produced by employer and governmental bodies (e.g. the Cabinet Office), specific sickness absence guides produced by government and commercial bodies, policy documents obtained directly from organisations and various research reports that have been produced in journals.

The relationship of this report to the *Stress Impact* study is in its setting of the national context. Each of the partners across six EU Member States provides a similar report to enable a detailed overview of current practice in the treatment and management of stress related ill health in the workplace. These reports to some extent will provide a context for the *Stress Impact* study and elucidate what little is known about the process of absence, and more specifically stress-related absence. To enable the project to progress satisfactorily, there is a need for the institutional approaches to stress related absence to be detailed. The current report constitutes Workpackage Two of the EU project, and it is envisaged that Workpackages Three and Four will follow directly on from this review. Workpackage Three, for example, is concerned with the development of a conceptual framework and methodology which will be borne out of the current situation described by the various project partners in Workpackage Two. Also, the methodologies developed in Workpackage Three will be dependent upon the information provided in this report; for example, which organisations have access to and the names of Long Term Absentees [LTAs] and how these individuals are currently processed. Workpackage Four is concerned with the development of instrumentation and a stakeholder network. Workpackage Two is necessary for the identification of stakeholders, i.e. specific departments and organisations who deal with LTAs, or who have a vested interest in understanding or reducing LTA related to psychological stress. It is also anticipated that instruments, scales and questions for surveys and interviews will be informed in part through an understanding of current systems and policy. Knowledge of the LTA process described in Workpackage Two will be necessary for the developments of instruments that survey LTAs in workpackages Five, Six and Seven. For example, in order to conduct thorough interviews with absentees about their experiences and views on absence and stress, knowledge of current practice and systems is necessary.

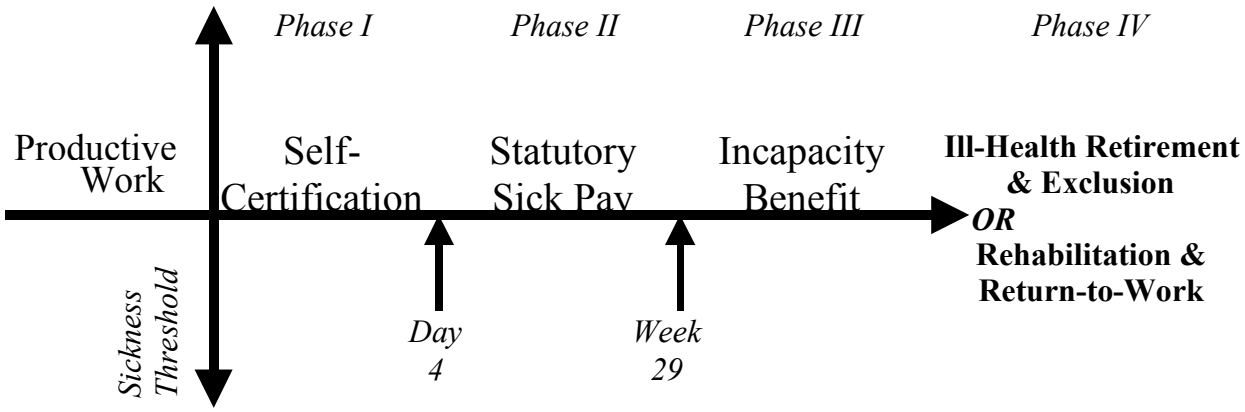
2. National Legislative Instruments

2.1 Introduction

The purpose of this chapter is to set out in some detail the main provisions and legislative systems in place to deal with sickness absence. Where possible, the situation with regards to stress-related absence from work will be discussed. Initially the focus will be on the specific benefit systems such as statutory sick pay and incapacity benefit, along with the current prevalence of stress related sickness absence with regards to these benefits. Next, the diagnostic systems used in sickness absence will be outlined, followed by a section on the role that General Practitioners (as principle actors) play in the sickness absence process. A section is then dedicated to vocational rehabilitation and the provisions that exist under current legislation. This is followed by an examination of the employment legislation in the UK and specifically how this relates to stress related illness stemming from the workplace. In this last section, the law surrounding stress litigation will be examined since this area seems the most likely route through which any subsequent legal duties will / are imposed upon employers.

Below is a graphical representation of the sickness absence process. This helps to conceptualise key time-scales and the main benefits involved during certain phases. Throughout this chapter each phase will be enlarged to allow a more detailed examination of what is involved during the phases.

Figure 2. **The Sickness Absence Process**



2.2 Social Insurance and Social Welfare legislation

A person incapable of working due to illness may receive income replacement from a number of sources including employer sickness benefits, State benefits, private insurance schemes, pensions and personal savings. Contributory Benefits (i.e. social insurance/welfare) are government benefits paid to those unfit to work as a result of illness, and who have met the requirements for a certain level of national insurance contribution in the 2 years prior to their claim. The way in which sickness absence is dealt with by employers and organisations is informed in two main ways: firstly, from legislation and Acts of Parliament imposing a duty on employers and organisations to make financial provision for employees who are unable to work due to illness (e.g. Social Security Act 1975). These include procedures for sickness certification and statutory rights to time-off work. Within this framework are also the benefit schemes set up by the government e.g. Statutory Sick Pay [SSP] and Incapacity Benefit [IB]. As long as employers or organisations are not in contravention of government legislation or employment law they are essentially free to manage sickness absence in a manner they chose and in accordance with policy they set out in employment contracts or company statements. Secondly, government organisations such as the Department of Trade & Industry [Dti], Employer's Organisation [EO], Department for Work and Pensions [DWP] and the Cabinet Office, produce guidelines for the management and 'best practice' in sickness absence. Employer bodies such as the CIPD, CBI and ACAS also provide 'best practice' guidelines and survey reports. European Agencies set targets for the reduction of sickness absence, thereby also influencing policies and systems within the UK.

A recent Green Paper, *Pathways to Work* (DWP, November, 2002), sets out the government's current position with regards to social welfare, unemployment and work related ill health. The Secretary of State for Work and Pensions states that the UK government is committed to the goal of employment for all and to helping those with health problems or disabilities fulfil their potential. The paper states that many of those unable to work due to ill health in fact desire a return to work, and so the government believes in giving people the chance to work and to be independent. The underlying philosophy is *'Work for those who can, security for those who cannot'*. Today's Labour government believes in Social Justice and the protection of vulnerable people in society i.e. those unable to work due to illness. The government is focused on inclusion, rather then the policies of a conservative government whereby those unable to work were excluded. One government objective is to support those moving onto state contributory benefits and then help them back into work. The government does not want to force sick people back to work and recognises that some conditions are too severe to allow work; in these cases the government aims to ensure that benefits are available to these people. The overall philosophy is collective: the government, employers, health professionals and employees all assume responsibility. The government has even mentioned abandoning the term 'Incapacity Benefit' because it sounds 'too negative' (DWP, 2002).

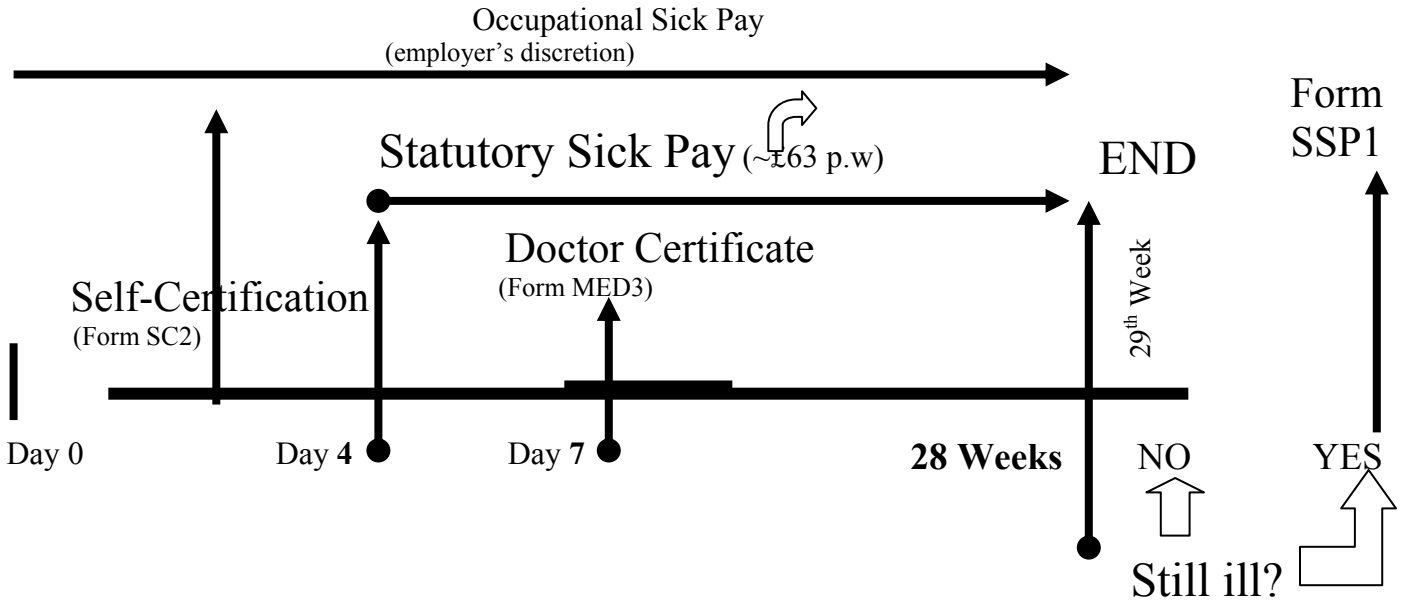
The general approach to welfare at work is evident in government led initiatives in partnership with industry and by targets to reduce the incidence of sickness absence and work related ill health (see Chapter Three). Current State philosophy is also reflected in programmes such as 'Securing Health Together', focused on occupational health issues through work programmes such as good health and safety practice, networking and partnerships, promoting skills required for implementing occupational health policies, support and advice (HSE, 2000). One interpretation of the Green Paper is that the government's approach leans towards policies for rehabilitating and reintegrating sick workers, rather than preventing ailments in the first instance (see examples in Chapter Three).

There is a general concern for health and well-being at work evident in an analysis of the government's approach, however, no specific strategy for mental health and stress is stated in the Green Paper. Rather, 'Mental & Behavioural Disorders' (which include stress reactions) have been identified as significant causes of work related ill health since the majority of claims for long-term state incapacity benefits are currently due to mental health complaints (see page 18). *Stress related complaints* are not singled out, but rather they are recognised as part of the problem. The Green Paper does however recognise the importance of work to physical and psychological well being:

> Work is an integral part of most adult lives. The ability to participate in productive activity contributes significantly to both physical and psychological well being. The range of potential negative consequences from being out of work extends well beyond the loss of financial rewards. It often includes loss of a role, social contact, daily routine, feelings of participation, and self-esteem and self worth.
>
> (Pathways to Work, DWP 2002, p.1)

2.2.1 Statutory Sick Pay [SSP]

Figure 3. **Phase I & II**



The statutory sick pay scheme was introduced in 1983 for the first 8 weeks of sickness absence, later extended to 28 weeks in 1986 (Moncrieff & Pomerleau, 2000). Rules for the payment and administration of SSP are set out in the Social Security Contributions and Benefits Act 1992, and the Social Security Administration Act 1992.

When an employee becomes sick absent employers and organisations have no requirement to pay employees for the first 3 days of absence as set out in the Social Security Contributions and Benefits Act 1992. Self-certification may be required if employers or HR stipulate. After 4 days of continued absence, employers are obliged to pay SSP for up to 28 weeks (max) in any Period of Incapacity to Work (PIW), unless they operate their own Occupational Sick Pay [OSP] scheme paying at or above the SSP rate. The key elements of SSP are that it is paid by the employer if the employee is over 16 but under 65, has been sick for at least 4 calendar days (including weekends/bank holidays), was employed when becoming ill and is earning enough to pay National Insurance (NI). SSP is also only payable on contracted working days i.e. on days that the employee would have worked anyway. Section 31 of the Social Security Contributions and Benefits Act 1992 states some of the conditions:

31.—(1) Subject to the provisions of this section, a person who satisfies any of the three conditions of subsection (2) below shall be entitled to sickness benefit in respect of any day of incapacity for work which forms part of a period of interruption of employment.

(2) The conditions of this subsection are that—

(a) the person is under pensionable age on the day in question and satisfies the contribution conditions specified for sickness benefit in Schedule 3, Part I, paragraph 2; or

(b) on that day the person—

(i) is over pensionable age, but not more than 5 years over that age; and

(ii) would be entitled to a Category A retirement pension if his entitlement had not been deferred or if he had not made an election under section 54(1) below; or

(c) on that day the person—

(i) is over pensionable age, but not more than 5 years over that age; and

(ii) would be entitled to a Category B retirement pension by virtue of the contributions of his deceased spouse, but for any such deferment or election.

Assuming the conditions have been met, if an employee earns more than £75 per week a standard rate of £63.25• is paid per week (Social Security Office, 2002). According to employer manuals produced by the Inland Revenue (2002), employers can choose not to operate SSP schemes as long as they are paying contractual remuneration; for example, a contractual clause meaning that the employer continues to pay employee's normal wages throughout illness. Essentially the employer has two choices: either to pay SSP or continue to pay wages at or above the variable rate of SSP or other OSP scheme; however there are no statistics available on the proportion of employers following these routes.

Employers are free to make their own rules and procedures on *how* and *when* employees notify their sickness absence, but the following legislative requirements apply as laid out in the Inland Revenue's CA30E manual (2002): Employers *cannot* insist that the employee notifies,

- in person
- by a specific time on the first day
- more frequently than once a week
- on a special form or via medical certificate.

Employers are also required to make employees aware of these rules. The SSP scheme does require employees to provide the employer with a reason for their absence within 7 days. Whilst this needn't be a doctor's certificate, a doctor's statement can be requested by an employer after 7 days of continued absence. Section 14 (subsection 1) of the Social Security Administration Act 1992 states:

Any employee who claims to be entitled to statutory sick pay from his employer shall, if so required by his employer, provide such information as may reasonably be required for the purpose of determining the duration of the period of entitlement in question or whether a period of entitlement exists as between them.

A typical procedure requests that an employee telephone by the first qualifying day for SSP (i.e. the 4th day). Self-certification (using employers' own form or using form **SC2** provided by the Inland Revenue, appendix A) is usually sufficient for absences

• Variable with tax year.

between 4 and 7 days. After 7 days of continued absence, the employee should provide a doctor's statement (i.e. **MED3**, appendix B). Where an employee is sick but for some reason is ineligible for SSP (e.g. contract is less than 3 months, or receiving Maternity Allowance) employers are obliged under law to provide the employee with form **SSP1**, which allows them make a claim for another type of benefit (e.g. IB). SSP is paid in the same way as normal wages or can be collected by a representative of the employee.

The government sets out that employers need to keep basic records of sickness absence and the amounts paid to sick employees, which are mainly for the purposes of tax returns. Since it is the Inland Revenue that administers SSP, they are the body that 'prescribes' the type of records employers are required to keep.

These records are simple and are used to roughly determine trends in a company's sick pay and whether it has fluctuated from previous years. *No* information is stored with regards to reasons for absence by the Inland Revenue [IR] (apart from basic paper records which are destroyed within a few years), meaning that no running record on the reported causes of sickness absence exist for SSP[•]. Employers are required to keep dates of all absences lasting 4 days or more and to record all payments of SSP. If an employee has received SSP for 28 weeks, employers are required to record the following: the first and last day of SSP and days when contractual remuneration was paid instead of SSP. The Inland Revenue provides standardised sheets to be completed by employers to enable them to comply with the law (see Box 1 below & appendix A for examples). Whilst not a legal requirement the government suggests that other records, such as Doctor's statements regarding the date and nature of an illness, are useful to keep as a matter of best practice.

Box 1: Standard claim documents for SSP (provided by the Inland Revenue)

Form SC2	Self-certification form
SSP2	Payments & dates of sickness absence
P32	Annual returns that include SSP for Tax purposes
P11	Deductions working sheet for National Insurance and Statutory payments.

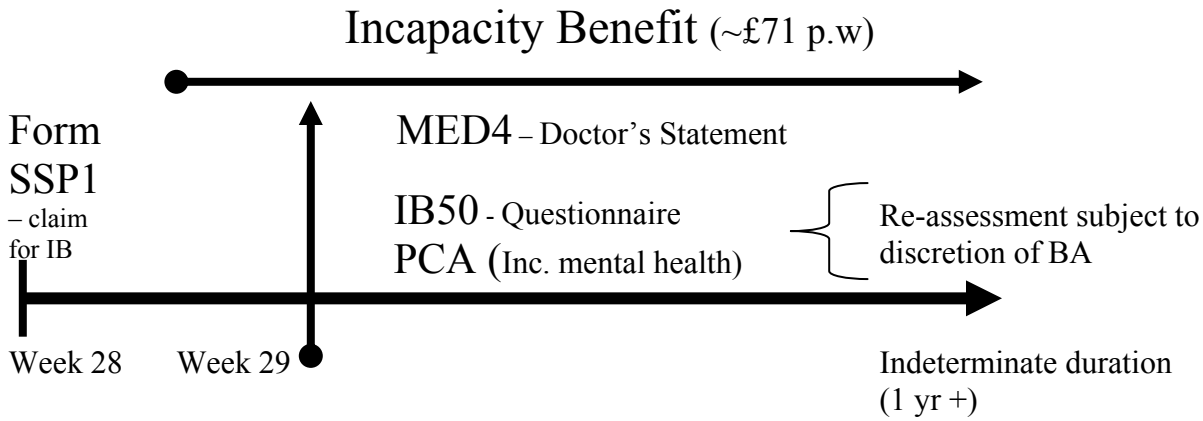
[•] Personal correspondence with a Tax Officer at the Inland Revenue. (15.02.2003)

The payment of sick pay usually ends when an employee returns to work. Other reasons include the end of their employment contract, 28 weeks of continued illness or pregnancy. At the end of SSP payment, the employer can, and usually does, claim the cost of SSP back off the Inland Revenue [IR]. If in the tax month SSP is more than 13% of the national insurance liability, the whole difference can be claimed back. Usually, the company deducts the costs of SSP from national insurance contributions (NICs). Employers can still recover the rate of SSP even if they have been operating their own Occupational Sick Pay Scheme. With regards to employee rights, the IR can adjudicate on decisions over SSP i.e. by using government medical advisors. However, disputes or arrangements over contractual remuneration of occupational sick pay must be dealt with between employer and employee.

If the period of entitlement ends after 28 weeks and the employee continues to be unfit for work, sickness absence claims now become the responsibility of the Benefits Agency following provisions in the Social Security (Incapacity for Work) Act 1994. They deal with giving out advice and assessing claims for day to day living expenses and other social security benefits.

2.2.2 Incapacity Benefit [IB]

Figure 4. **Phase III**



Incapacity Benefit replaced sickness and invalidity benefit in 1995 and is now the long-term state contributory benefit paid to those assessed as incapable of work due to bodily or mental disablement (Hiscock & Ritchie, 2001). Provisions for the administration of IB appear in the Social Security Contributions and Benefits Act 1992, the Social Security Administration Act 1992 and the Social Security (Incapacity for Work) Act 1994. Whereas decisions regarding an individual's capacity to work were previously a matter for GPs to deal with, the government created the Benefits Agency [BA] which now deal with all claims of long-term sickness absence (including diagnosis and administration).

Paid via the state benefits system, an individual is eligible for IB if SSP has ended and they are still unwell (i.e. after 28 weeks) provided they have made sufficient NI contributions. Alternatively, individuals may apply for IB if they are unable to obtain SSP for some reason, or under certain conditions IB is paid instead of SSP. An initial claim for IB requires the completion of form **SSP1** (see appendix B), with the inclusion of a Medical Certificate, a P45, a Birth certificate etc… It is a legal requirement for employers to forward this form to employees. The payment of IB is issued at three rates: the lowest rates are for short-term claimants who have either been ill for 4 days plus but cannot get SSP (@ £53.50); the second is for those who have been sick for more than 28 weeks but less then 52 weeks (@ £63.25). The highest rate is long-term IB, payable to those who have been unable to work for more than 52 weeks; this is currently set at £70.95 per week (Social Security Office, 2002).

Unlike SSP, there are formal procedures for the assessment of claims. The *'Own Occupation Test'* is applied during the 1st 28 weeks of incapacity to determine an employee's level of occupational functioning i.e. their ability to do their job•.This will be based on advice from the employee's own Doctor contained in form *MED3* (likely to include a statement that the employee should refrain from work).

The Personal Capability Assessment [PCA] is applied to most individuals in the 29th week and is the main medical test for individuals claiming IB. It differs from the *Own Occupation Test* in that it seeks to assess not whether the claimant is incapable of performing tasks relating to their occupation, but whether they are incapable of performing certain everyday activities relevant to work, namely Physical & Sensory abilities (Hiscock & Ritchie, 2001). 'JobcentrePlus'♥ attempts to identify those who are exempt from the PCA, which includes those with severe mental illness or paraplegia. Questionnaire *IB50* regarding an employee's perception of their condition and its effects on their ability to work is then completed; it also contains general questions about physical and sensory difficulties. *MED4* statements providing diagnosis of a condition and its disabling effects are then obtained from GPs (diagnoses are made in accordance with ICD-10). On the basis of this information, a *Decision Maker* will decide whether there is enough material to assess entitlement to benefit: a decision maker is not a medical Doctor but an individual with training in assessing the evidence of incapacity to work (IB1, 2002). The majority of cases are at this point referred to an Approved Doctor who is appointed by the DWP's Chief Medical Advisor. These Doctors work to high standards and are there to ensure those who have applied for IB receive a thorough and comprehensive assessment of how their illness or disability affects their ability to work by considering all the evidence. The PCA sets out a threshold of incapacity that must be met for entitlement to benefit. The application of the PCA is via medical examination by an approved Doctor and a questionnaire. As well as physical capability, there is a section on mental health assessing completion of tasks, daily living, coping with pressure and interaction with other people. The approved doctor seeks to investigate the nature and severity of the effects of the medical condition and how this affects day-to-day activities relevant to work• (IB214, 2002). Having considered evidence from the employee's questionnaire, information from the GP and advice from the approved Doctor, the decision maker makes a decision on entitlement to incapacity benefit.

The decision maker also sets a date for review. This is likely to be based on the prognosis with regards to recovery. There are no standard dates for re-assessment for IB and no upper-limit on the length of a claim♣. Claimants are notified of decisions and when a reassessment is due; if an employee does not meet the threshold they will receive no benefits although they may be able to claim others (e.g. Disability Living Allowance) or go through an appeals process.

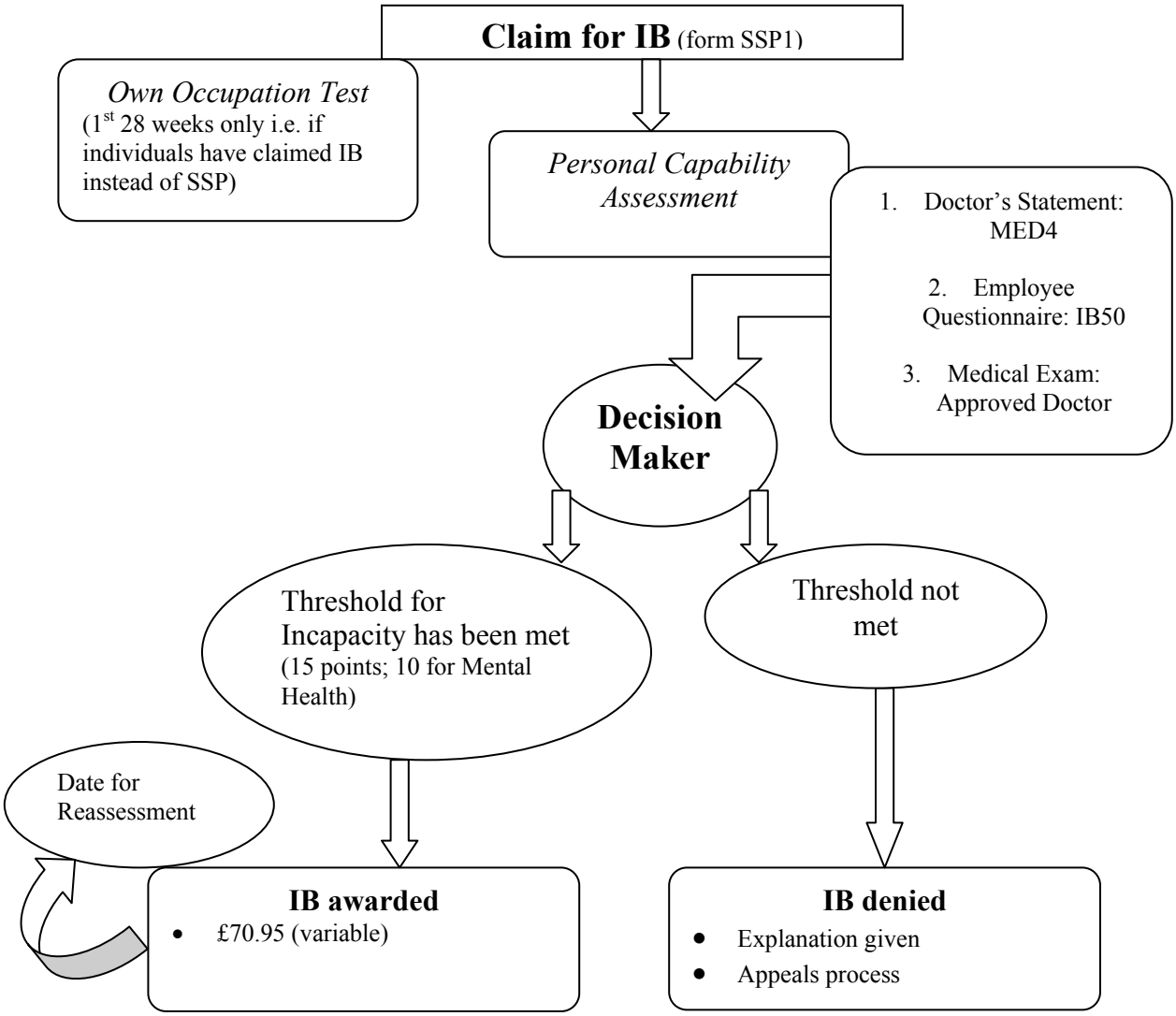
• This would usually apply to someone who has claimed IB from the beginning of their illness rather then SSP.

♥ An integration of services provided by Job centers and Social Security offices.

• A score ≥ 15 decides entitlement to the benefit.

♣ Personal correspondence with IB Claims Advisor at the DWP.

Figure 5. **Flow Chart to show the IB claims process & role of a Decision Maker**



In accordance with government guidelines (e.g. IB214, IB1), employees are requested and strongly encouraged to report any improvements in their condition. If they find that they are able to complete more activities, feel better over a prolonged period (perhaps as a result of surgery, a change in medication or the use of aids) they should inform *Jobcentre Plus* straight away. If this is the case, the DWP will re-assess the claim via questionnaire IB50 and Medical Examination.

As is the case with many other aspects of sickness absence management, the administration and practicality of sickness benefits rely on the integrity and organisation of people; the system is not perfect and contains many 'loopholes' open to potential abuse♥. Where a claim's authenticity is questioned, either by the employer or the BA, provisions exist under the Incapacity for Work Act (1994) to require the employee to attend for a medical examination with an Adjudicating Medical Authority [AMA]. If the employee fails to attend without good cause, they are treated as capable of work and ineligible for IB.

2.2.3 Prevalence of Mental Health claims

Work related stress (i.e. that attributed to the work environment) is a major concern for organisations. It costs UK industry £23 billion per year, and it has been estimated that 4% of the EU's GNP is spent on work-related mental health problems (O'Driscoll & Cooper, 2002). As previously noted (p.8) 'Mental & Behavioural Disorders' form the largest diagnostic group for those receiving long-term incapacity benefits. This seems to be part of a rising trend since there were less (702,000) IB claimants due to mental & behavioural disorders in 2000 (DWP, 2003). Work-related stress, or job stress, is important to organisations not just because of statutes such as the Health & Safety at Work Act (1974), but also because of the consequences of stress on individual health and well-being. Long-term psychological effects could include chronic fatigue and burnout, whilst physical disorders such as cardiovascular disease and reduced immune functioning have been noted. Long-term sickness absence is a further consequence of work stress. Those on sick leave due to stress are absent for an average 16 days according to an official from the Health & Safety Executive, Paul Roberts (2002).

Based on the current size of the UK working age population (28 million), 9.6% (2.7 million) are claiming IB. 35% of these claimants, i.e. 945,000, are diagnosed with 'Mental & Behavioural Disorders' (3.4% of the total working population), followed by 22% (594,000) for Musculo-Skeletal and Connective tissue disorders (see appendix C).

Frequency of Diagnoses for claims of Mental & Behavioural incapacity lasting 4 weeks or more: (DWP, 2002b).

Total: 821,400.

1. Depressive Episode: 401,300 (49%)
2. Anxiety Disorder: 99,700 (12%)
3. Neurotic Disorders: 85,000 (10.3%)
4. Drug Abuse: 40,300 (5%)
5. Alcoholism: 38,400 (4.7%)
6. Schizophrenia: 37,900 (4.6%)
7. Reaction to Severe Stress: 35,600 (4.3%) (i.e. 0.1% of working age population)

NB: figures are thousands, percentages in parentheses (rounded).
Anxiety disorder excludes 'phobic anxiety', which accounts for 1% of diagnoses.

♥ Personal correspondence with Revenue Officer (15.02.2003).

There is an ongoing debate in the UK regarding the level of provisions provided by the benefits system and to what extent they may influence individual decisions to return to work (positively or negatively). Disabled workers, for example, may struggle to find work that provides greater financial support than State benefits. Some commentators suggest that the notion of incapacity for work is reinforced and it is 'better to stay on benefits' (Sawney, 2002).

2.2.4 Diagnostic Systems

With regards to the assessment of stress as a cause of sickness absence, a number of points can be made. As noted previously, the Personal Capability Assessment [PCA] contains a section specifically for the assessment of mental health that seeks to differentiate between *severe and mild to moderate* mental health problems. Whilst the guidelines do not explicitly refer to 'stress related illness', mental health problems (which implicitly include stress) as a cause of working age incapacity are treated and assessed differently.

> In any case where mental health problems have been identified, the customer's own doctor(s) will be asked for information to help determine the severity of the problem. The process will distinguish between severe mental health problems and mild/moderate mental health problems. Severe problems involve the presence of mental disease, which severely and adversely affects a person's mood or behaviour, and which restricts their social functioning, or their awareness of their immediate environment.
>
> (IB214, 2002, p.19)

When considering the impact of these problems on a patient's ability to work, approved Doctors assess functioning using a set of mental health descriptors, with a score attached to each one. The descriptors form four broad headings: 1). Completion of tasks (e.g. *often sits for hours doing nothing' – 2 points*), 2). Daily living (e.g. *needs encouragement to get up and dress – 2 points*), 3). Coping with pressure (e.g. *Is unable to cope with changes in daily routine – 1 point*) and 4). Interaction with other people (e.g. *Mental problems impair ability to communicate with other people – 2 points*). The threshold for mental health problems is 10 points; this is calculated from the sum of scores for any activity e.g. Daily living = 11, or any combination of activities E.g.

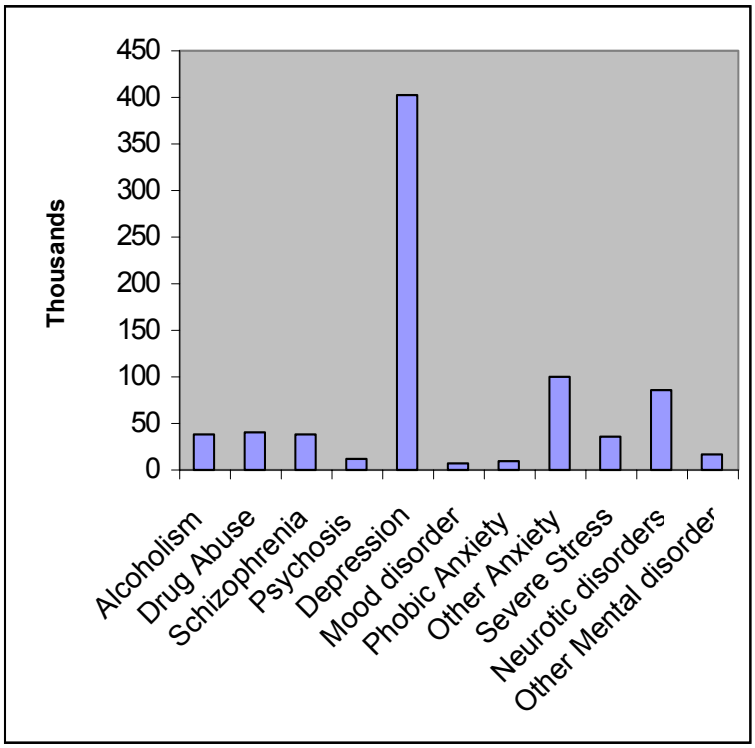
Daily living = 6 + Completion of Tasks = 6: **Total score = 12**

Thus an individual scoring more than or equal to 10 will be assessed as incapable of work due to mental health difficulties. Where a mental health problem is present in addition to Physical & Sensory difficulties, a weighting is attached to the score to account for the impact of mental health problems on the ability to work.

In addition, any diagnoses made by GPs or approved Doctors conform to ICD-10 guidelines (WHO, 1992). For example, the diagnostic categories for Incapacity Benefit claims produced by the DWP are coded using ICD-10. The category for 'Mental and

Behavioural Disorders' includes conditions such as Depression, Anxiety and Reaction to Severe Stress (see below).

Figure 6. **IB claimants with a duration of ≥ 4 weeks with Mental & Behavioural Disorders at 31st August 2002 according to ICD-10 – (taken from DWP 2002b)**



The Acute Stress Reaction criteria (F43) states that a patient has been exposed to a mental or physical stressor. There is some overlap with generalised anxiety disorder (F41.1), and a diagnosis of Mild stress reaction may apply where only symptoms of anxiety are noted (e.g. autonomic arousal symptoms, breathing problems), many of which are symptomatic of the classical stress response. More severe forms of stress reaction may be diagnosed in cases where additional symptomology is present not attributable to other mental or behavioural disorders e.g. verbal aggression, despair. Although DSM-IV includes a category for 'Acute Stress Disorder', this diagnosis pertains more to stress reactions following exposure to extreme and traumatic stressors. It has been reported that 70% of claims for Industrial Injuries Disablement Benefit [IIDB] are stress related in some way and psychological reactions to stress and PTSD are the most common reasons for advice being sought (DSS, 1998). Such claims attempt to establish psychological and psychiatric symptoms (e.g. PTSD) as a result of physical occupational diseases or accidents:

In Industrial Injuries Disablement Benefit (IIDB) psychiatric disorders feature among the 'prescribed diseases' where they are a manifestation of a physical occupational diseases (eg. Psychiatric symptoms of lead poisoning).

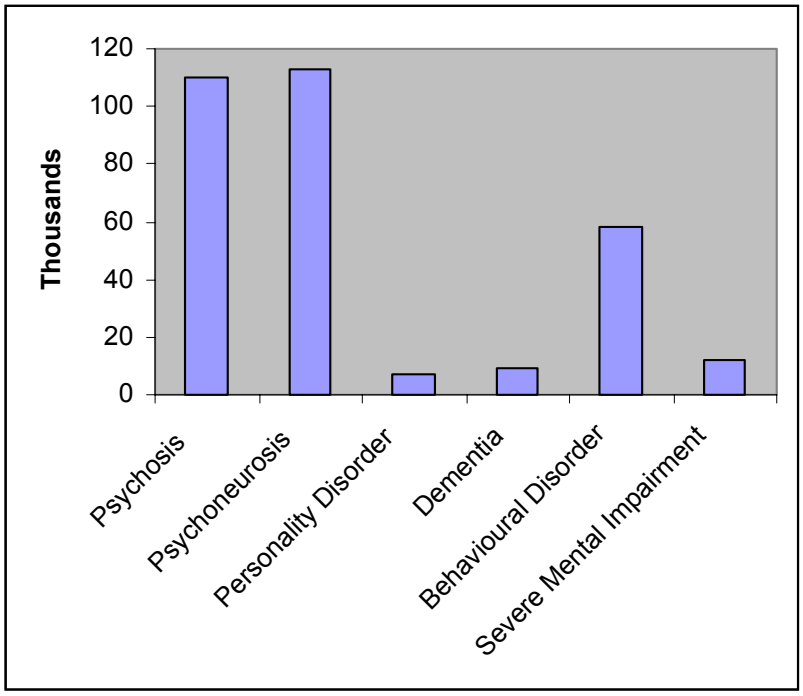
(DSS, 1998, pt.1)

The Department of Social Security• (1998) also reports that the process of attributing psychological stress to an occupational accident remains largely subjective:

> There is no 'scheduled' assessment for stress conditions and thus AMAs…have considerable freedom to determine the overall percentage level of disability (and award). Inevitably, the judgement is subjective. (DSS, 1998, pt.1)

The ICD-10 also includes a section specifically for problems related to employment and unemployment (Z56) and to burnout (Z73). Where substantial disability thresholds need to be met for benefits such as SDA or DLA (See p.10), more severe mental health problems appear in the statistics for the allocation of these benefits (DWP, 2002). Categories include Psychosis, Psychoneurosis, Personality disorder, Dementia and Severe mental impairment. Naturally, such conditions are more likely to meet stringent incapacity criteria, such as the requirement of 80% disablement and *substantial help with personal care* (see below).

Figure 7. **DLA Recipients by Mental Health Disability at 31st August, 2002 –** (taken from DWP, 2002a)



In addition to the diagnostic systems and procedures used by the State benefits system for the purposes of classifying reasons for claims (and by default reasons for absence), the Employer's Organisation [EO] produces guidance notes for how government offices should record the causes of sickness absence. By consulting various sources, such as the HSE, the EO has compiled an 'A-Z of Sickness Absence'. This guide

• Now renamed the Department for Work & Pensions.

includes the group *'Stress, Depression, Mental Health & Fatigue Syndromes'*. Wide ranges of disorders are listed from drug abuse and alcohol addiction through to depression, anxiety and burnout. However, there is considerable conceptual and aetiological overlap. For example, the authors fail to distinguish between CFS and ME, even failing to recognise their shorthand names. E.g. the list includes two separate categories for CFS and Chronic Fatigue; and Myalgic Encephalomyelitis & ME. This guidance indicates some recognition of mental health problems as possible reasons for sickness absence; however, it amounts to little more than a list of conditions. With regards to stress, the classification system fails to distinguish between stress as a facilitator and stress as a reaction. For example, Burnout is a long-term consequence of repeated exposure to stress, yet stress is grouped with burnout as a condition in itself. Moreover, no account is made for conditions, such as CFS and burnout, which are particularly related to long-term stressors.

What emerges is a system that recognises mental health problems as a specific problem in sickness absence, and which does provide for specific diagnostic and prognosis procedures. However, our interpretation of the current system is that neither ICD-10 nor DSM-IV are particularly suited to diagnosing the type of occupational stress that takes a long period of time to take effect. The criteria laid down in ICD and DSM may be more relevant for industrial injury cases rather than chronic conditions such as CFS or burnout. Moreover, there is no current difference in the way in which sick absentees with mental health problems are treated in comparison to other individuals. A specific diagnosis may be given, but this will not lead to greater or different benefits to an individual who has back pain – both would be processed in the same way as far as official guidance and practice is concerned. For IB claims, those with severe mental health complaints are treated as having automatically met the threshold for incapacity, and therefore are not required to undergo the PCA. However, many other (somatic) conditions are included as exempt categories:

a) Those assessed as 80% disabled for disablement benefit, War Pension or Severe Disablement Allowance purposes.
b) Those in receipt of the highest rate care component of DLA, War Pensions
c) Individuals who are terminally ill, registered blind.
d) Individuals suffering severe medical conditions:

- **Severe mental illness** involving the presence of mental disease, which severely and adversely affects a person's mood or behaviour, and which severely restricts their social functioning, or their awareness of their immediate environment.
- Tetraplegia
- Paraplegia
- Persistent vegetative state
- Severe learning disabilities
- Progressive neurological or muscle-wasting diseases
- Active and progressive forms of inflammatory polyarthritis

2.2.5 General Practitioners

On average, a GP issues around 20 medical statements each week for sickness absence, most of which will be for short-term incapacity (Sawney, 2002)[♣]. The role of General Practitioners [GPs] in sickness absence involves them making judgements about incapacity for work which they are not always trained for; there is a conflict between helping patients whom they regularly treat and upholding standards (Hiscock & Ritchie, 2001). Guidance in terms of GP's certifying role in sickness absence (form IB204) is produced by the DWP and outlines a Doctor's duty:

> Advice regarding fitness to work is an everyday part of the management of clinical problems and doctors should always consider carefully whether advice to refrain from work represents the most appropriate clinical management.
>
> (IB204, DWP, 2000, p.4)

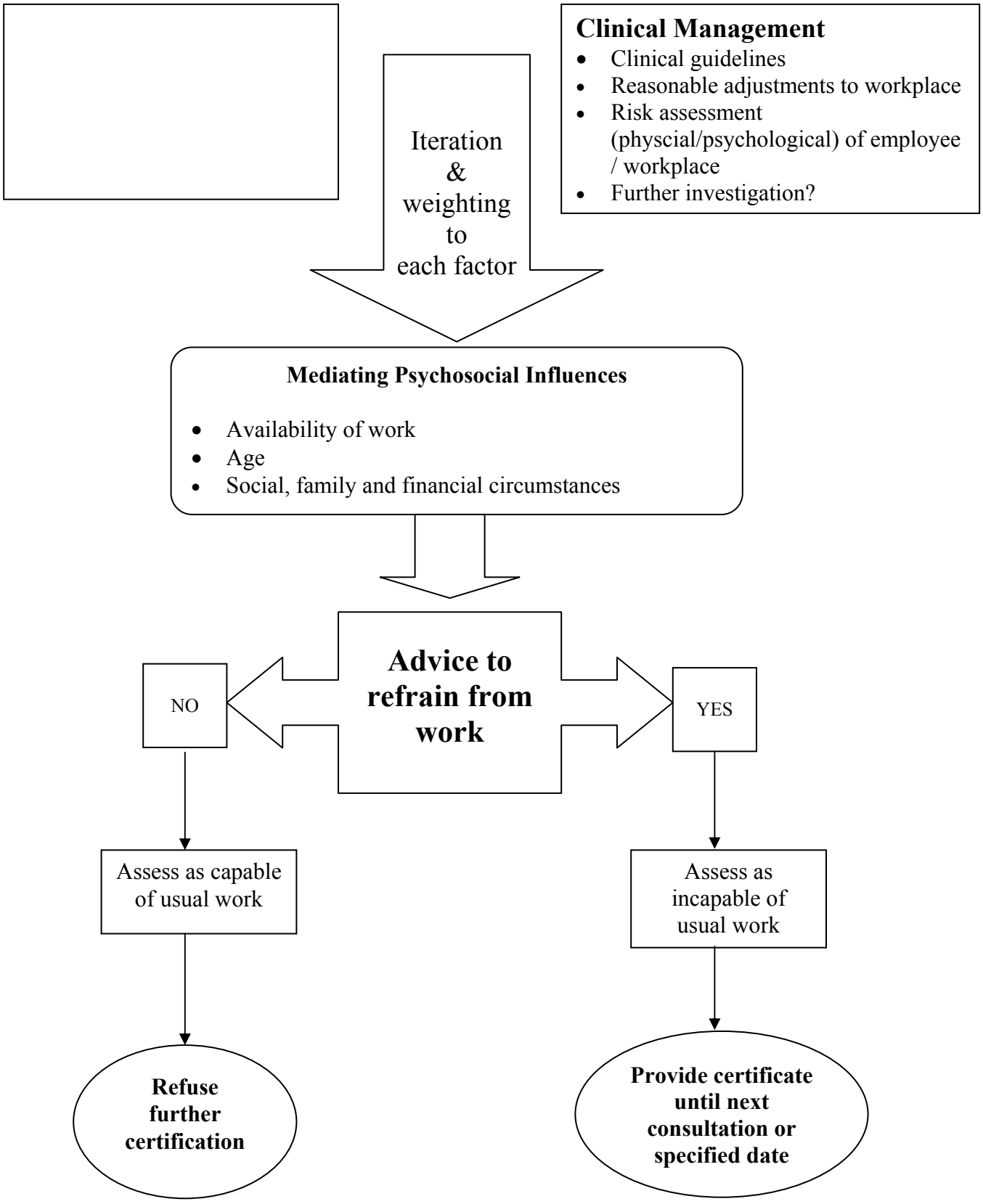
In the process of sickness absence GPs are likely to provide the following types of evidence (see appendix B): a *MED3* certificate, as used during SSP, is for the employee to take away with them; they can provide this to their employer or to the Benefits Agency [BA]. The diagnosis and details of a disability are contained within *MED4* that is issued to the employee around the time of the PCA. *MED5* certificates contain a diagnosis on the basis of a report from another Doctor. *IB113* is a factual report for the Medical Officer at the BA: this is a requirement for GPs under their terms of service and includes diagnosis, medical condition and prognosis.

The DWP guidance clearly states that sickness certificates should only be issued on the basis of a patient's medical condition and any consequent functional limitations in their ability to work. In reality, many other factors affect judgments on certification, including social, psychological and domestic factors. The chart overleaf shows the official government requirements (taken from IB204, 2000) for sickness certification, but also includes mediating factors in the process.

[♣] the DWP collects this data

Figure 8. **The official role of GPs in the certification process**

(Adapted from Hiscock & Ritchie (2001), p.28)



The Social Security (Medical Evidence) Regulations 1976 set out the format and rules for completion of medical statements of incapacity. NHS General Practitioners are required to issue certificates on the prescribed forms and in accordance with these Regulations. GPs may ask Medical Officers for advice on certification issues, completion of medical reports and medical matters relating to IB. The communication between a GP and employer is generally limited, although an employer may request information on the employee's condition and likely return to work. It is also true that there is no interaction with the Benefits Agency apart from forms and reports to be completed and the notification of results of the PCAs. In a survey of current practice it was discovered that...

> …GPs worked in a kind of vacuum with virtually no interaction between themselves and the BA, other than through forms, reports and PCA result notifications. Similarly…there was very little contact between employers and GPs.
>
> (Hiscock & Ritchie, 2001, p.70)

In the same survey by DWP researchers, it was discovered that employers seem unaware of the rules relating to sickness certification (e.g. often requesting a medical certificate before 7 days of continued absence) and don't seem to understand short-term certification issues (Hiscock & Ritchie, 2001). GPs do receive some formal training on the completion of sickness certification, although no audits exist to monitor GP certification practice. Research indicates that GPs are not occupational health specialists, have low expectations of success in patients returning to work, poor understanding of their own responsibilities, and negative experiences with vocational rehabilitation services available to patients (Sawney, 2002). It is not surprising therefore, that in a reform of the system the government is planning to undertake research into extending rights of certification to other practitioners (see Green Paper, *Pathways to Work*, DWP, 2002).

The GPs role in the new system will require professional ownership of incapacity certification, training in Occupational Health issues, information on current practice and improved guidance. The broader requirements, according to Sawney (2002), are to provide improved clinical support from OH and Rehabilitation services, research into healthcare factors which can help an individual remain in employment when they become sick or disabled, and better education on fitness for work for patients and employers. The current EU project (*Stress Impact)* hopes to address some of these issues and could inform theory and interventions for those on sickness absence.

2.2.5 Other Systems

Non-Contributory Benefit Systems

Severe Disablement Allowance [SDA] is paid to those persons incapable of work due to long-term illness or disability but who have paid insufficient National Insurance contributions to qualify for Incapacity Benefit. Individuals need to be 80% disabled, with claims assessed by an approved Doctor where percentage of disability is uncertain (IB204, 2000). Disability Living Allowance [DLA] is an example of another form of benefit, paid to those who need help with personal care, mobility or both due to illness or disability. Employees who are sick as a result of work-related illness may be entitled to DLA if they can show a clear link between the occupational factor and substantial care needs in connection with bodily functions. Based on current DWP (2002) statistics, 8.5% (2.4 million) of the working age population currently claim DLA; of these, 13% (310,000) of recipients have been diagnosed with a disability due to mental health disorders (1% of the total working age population).

Private Insurance Schemes

There are two likely courses of action in the case of long-term disability/impairment and retirement due to ill-health. Firstly, the employee's organisation may provide an Occupational Pension Scheme. These are schemes to which an employer and employee contributes. Such schemes involve benefit payments upon retirement. Some employees obtain income replacement plans through private insurers and some credit card companies that guarantee a fixed income instead of IB or SSP. Alternatively, Permanent Health Insurance [PHI] can provide cover against having an accident or critical illness preventing one from working. Benefits are paid until recovery and return to work or until an agreed date. *UnumProvident*, for example, is the UK's leading provider of income protection, selling various packages and providing their own rehabilitation specialists to help employees return to work.

According to the CBI's (2001) report, 11% of the UK population make provision for their healthcare i.e. not relying on the NHS, the vast majority (80%) of which is covered through company provided plans. This is perhaps a reflection of problems within the NHS, where expenditure on healthcare in the UK is one of the lowest in OECD countries. Sometimes if sickness is prolonged and irrecoverable, early retirement may be considered either through a Permanent Health Insurance scheme or an ill health 'early retirement pension plan'. The patient is likely to be defined as 'disabled' under the Disability Discrimination Act (1995), and so therefore the company suggesting early retirement will need to justify it against the alternative of making reasonable adjustments to working conditions and work[♥]. If the company carries Permanent Health Insurance [PHI], the decision of whether to put the employee onto benefit rests with the insurance company and their medical advisors. It is likely that they will require medical evidence

[♥] Note that this may be particularly hard to do in the case of stress-related illness where there are no agreed sets of stressor stimuli that cause stress. Even if a stressor is pinpointed, it is almost impossible to know by how much to reduce exposure to the stressor or how much to reduce it by.

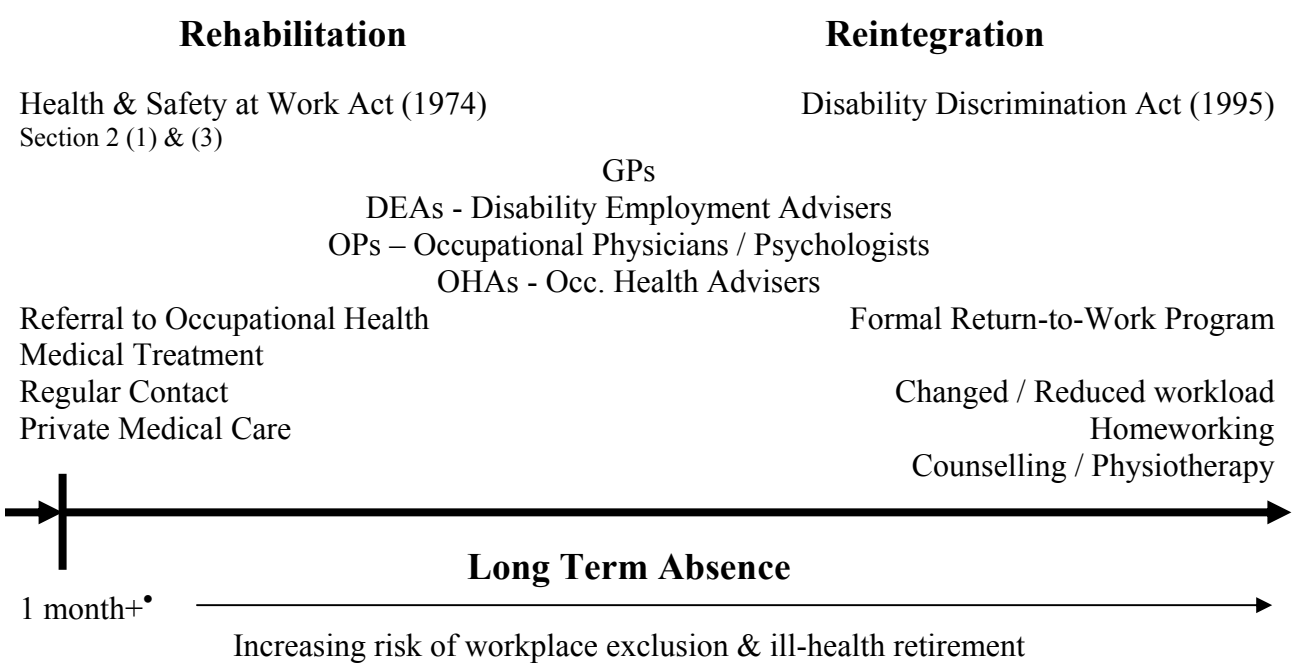
from the company's GP and/or Occupational Physician [OP]. If early retirement under the company's Pension Scheme is chosen, trustees will require an independent medical examination. OPs that make this assessment are strongly advised to be impartial to avoid claims of early retirement being used as redundancy exit (Cox, 2002a). The OP will also need a copy of the pensions plan♦, since the criteria deemed acceptable for ill health retirement differ considerably from one pension plan to another. Many pension plans may also be outdated; for example, conditions that used to be permanent are no longer due to medical advances e.g. Angina or Hip joint operations. The government has also raised concerns that early retirement on health grounds represents a socially acceptable exit from work, for both the employer and employee (HM Treasury report; Sawney, 2002).

All of the above affect the way in which sickness absence is managed. Whilst there are some specific duties and guidelines imposed on employers and employees, for example the rules regarding certification, organisations in the UK retain a high degree of discretion. In The Netherlands employers are obliged to submit a report on work-incapacitated employees to Social Security and to produce a work resumption plan. In Australia, where an employee has been sick for 12 weeks or more, the employer must co-ordinate a return to work plan (Whitaker, 2001). In the UK there are no comparative systems in place, which is perhaps one reason why the UK has one of the highest rates of working-age incapacity in Europe, the costs of which have a substantial impact upon the economy. Other differences in Europe include the fact that occupational physicians and Doctors are not required to verify the reasons for absence. In countries like Germany, for example, verifying reasons for absence is regarded as a breach of confidentiality in the doctor-patient relationship and highly unethical (Whitaker, 2001).

♦ It would be interesting to note whether pension plans include stress as an acceptable cause of ill health retirement.

2.3 Rehabilitation and Reintegration Provisions

Figure 9. **Phase IV**



Within the UK, there is no specific legislation with regards to helping employees back into their jobs or employment. Other countries in Europe have a legal obligation to accommodate a return-to-work and rehabilitation of workers. James, Cunningham & Dibben (2002) report that in Sweden, employers are required to assess the rehabilitation needs of sick absent employees and to undertake measures that will allow rehabilitation to occur. In the Netherlands, employers must produce a report for social security and also a work resumption plan. In Australia employers are obliged to establish a rehabilitation program, and if they have 20 or more employees, they must appoint a rehabilitation co-ordinator and a return to work plan for workers incapacitated for 12 weeks or more. However, despite the lack of explicit legislation, certain residual duties may apply following the Health & Safety at Work Act and Disability Discrimination Act (see p.34 & *2.4 Employment & Equality Legislation)*.

Loss of work through accidents, illness and disability affects patients and their families, colleagues, employers, NHS services and the State benefits system. Once an individual has been processed through the benefits system and receives income

• Widely accepted criteria for long-term absence.

replacement or support, the important question of their rehabilitation and return-to-work remains. As noted in Chapter 1 60% of sick employees who are absent for 5 weeks or more don't return to work and 80% of those long-term absentees moving onto Incapacity Benefit [IB] do not re-enter the workplace, moreover, once an individual has been claiming IB for 1 year, the average duration of their claim will be 8 years (DWP *Green Paper*, 2002). The Institute for Employment Studies [iES, 2002] reports that rehabilitation after long-term sickness absence has become a major issue for employers. This is due to a general trend of greater concern for employee well-being, but equally to increasing concern over the number of LTAs and early retirement on the grounds of ill health (Beaumont & Quinlan, 2002; Thomson & Neathey, 2002). With an aging workforce additional strain will be placed on the benefits system and more workers excluded; rehabilitation and prevention of work related illness will therefore become more crucial (Beishon, 2002). The current importance of rehabilitation has been summed up in the following way:

> There is clearly a common theme emerging: sickness absence inflicts a heavy price on UK business apart from the more insidious and difficult-to-quantify societal costs. Proactive vocational rehabilitation is fundamental step in stemming this avoidable loss. (Beaumont & Quinlan, 2002, p.294)

Vocational Rehabilitation refers to the restoration to health and general ability to work following mental or physical disease, or injury (Beaumont & Quinlan, 2002). Some argue that the focus of vocational rehabilitation should be on the functional capability of an individual rather than the medical diagnosis (Cox, 2002b). Rehabilitation programmes can be aimed at a broad range of disabilities including mental health problems, learning difficulties, physical or sensory impairments, progressive conditions and impairments arising from accidents (Riddell, 2002). According to the British Society of Rehabilitation Medicine (BSRM, 2000), vocational rehabilitation is a process whereby those disadvantaged by illness and disability are enabled access to, maintenance of and return to employment or other useful occupation. Job Retention refers to strategies to help an employee maintain their position within a company following ill health and reducing staff turnover. Job Reintegration refers to the strategies to help a return to work following ill health and resumption of previous duties as far as is possible or practical. In the UK, rehabilitation is influenced by charitable bodies, the Department for Education & Employment (DfEE), the Department of Health [DoH], the Department for Work and Pensions [DWP] and the Department of Trade & Industry [Dti]. An obvious additional influence is from organisations and their access to Occupational Health resources.

Bodies such as the Trades Union Congress [TUC](2001) have called for the government to impose a legal duty on employers to develop a rehabilitation policy as part of health and safety policy because reductions in sickness absence are unlikely unless a clear legal duty is imposed. One of the original objectives of the Government's *Revitalising Health and Safety* strategy (action point 31) was to pursue the legislative aim of placing a duty on employers to have a written statement on their policy for the rehabilitation and retention of those with temporary or permanent health problems. For various reasons the government has now abandoned this specific aim. Currently, there is no prospect of creating primary legislation to strengthen duties under health and safety law to include vocational rehabilitation (Wiley, 2002).

The official legal position is essentially that a duty placed upon employers to rehabilitate or retain employees lies outside provisions in the Health & Safety at Work Act [HSWA] (1974), being more of a matter for employment rights legislation (e.g. statutory rights to time-off). However, following recent advice, it appears that the general duty on employers under Section 2(1) of the HSWA to ensure health, safety and welfare of employees includes 'taking steps in the workplace to protect the health and safety of sick employees or others who may be affected by the actions of sick employees'. Protecting the health and safety of those in poorer health could reasonably be argued to include providing rehabilitation services or policy. In other words, the government's aims need not require new legislation; rather provisions already exist under current legislation through a careful reading. The government also reveals how a written statement for rehabilitation of sick absentees could be imposed using the HSWA:

"…we are advised that the duty in section 2(3) of HSWA to prepare and revise a written health and safety policy statement extends to consideration of the health and safety needs of vulnerable staff including those who had suffered illness or injury, from whatever cause. This would provide a peg on which to hang guidance on the content of the policy statement, e.g. a specific undertaking to make adjustments in the workplace, based on risk assessment, to protect the health and safety of employees suffering from the lasting effects of illness or injury and other employees who may be affected thereby".

(Wiley, 2002, p.3).

Such interpretation could mark the way in terms of creating guidance, discussion and consultation for rehabilitative provisions. Despite the lack of explicit legislative guidance, a system for rehabilitation does exist in the UK. The principle 'actors' include GPs, a Disability Employment Advisor (DEA) and Occupational Psychologists provided through *Jobcentre Plus*, Occupational Physicians [OP] and Occupational Health Advisors [OHA] provided through an Occupational Health Department. The DWP is currently the official arm of the government examining rehabilitation issues. A government guide for registered medical practitioners (IB204, 2000) sets out that GPs need to contact JobcentrePlus in cases of prolonged absence. GPs can then initiate the rehabilitation process by adding a note to MED3. A Disability Employment Advisor (DEA), who is specially trained to help disabled people find work, can then arrange for a rehabilitation placement or a period of vocational training. The role of the DEA is to provide practical help through special schemes designed to overcome problems encountered by those with disabilities in finding and keeping employment. The DEA may also refer individuals to the National team of Occupational Psychologists for more in-depth assessment and advice. Certain 'Therapeutic Work' is allowed under law for those receiving IB (e.g. voluntary work, duties as a councillor, paid work under medical advice). Following the advice of a Doctor, the law allows an individual to continue to receive benefits as long as the work:

1) helps improve, prevent or delay deterioration in the condition; or
2) is part of a treatment programme under medical supervision; or
3) is carried out when attending a sheltered workshop for those with disabilities.

In all instances, earnings must not exceed an agreed limit. Professional bodies like the British Society of Rehabilitation Medicine [BSRM] are currently highlighting the

need for a greater involvement of GPs in rehabilitation processes and the involvement of multidisciplinary teams. It also appears that the mandate of Occupational Health professionals has been expanded to include vocational rehabilitation. A revised definition of occupational medicine is now to:

> Case manage people who are on sick leave, working with community health professionals to ensure the earliest return of functional capacity and return to work.
>
> (Beaumont & Quinlan, 2002, p.294)

Whilst there is no formal policy, Occupational Physicians are asked to promote their own roles and services to the public (Beaumont & Quinlan, 2002). The CIPD (2002) survey reported that 89% of organisations claim to have strategies and policy to deal with long-term absence; these include (in order of frequency of use):

- Regular contact
- Return to work interviews
- Reduced or changed working hours
- Changes to workload and tasks
- Referral to occupational health
- Stress counselling / Employee Assistance Programmes
- Additional training on return to work
- Formal return-to-work program
- Change of work equipment
- Homeworking
- Physiotherapy
- Referral to private medical care

Similar results are also reported elsewhere (e.g. Thomson & Neathey, 2002). The provision of Occupational Health [OH][♠] services (either 'in-house' or outsourced) is an essential part of employee health and well being (Cox, 2002a) and in many instances will form the basis of any rehabilitative action. The CBI report (2001) suggests that only 30% of employees have access to OH provisions (Beishon, 2002). According to best practice guidelines issued by the Institute of Directors (Nash, Shute & Beishon, 2002):

> HR or Personnel typically notify the OHA or OP as soon as absence reaches 11 days. Depending on the information provided by HR, Occupational Health may respond in one of the following ways:
>
> 1) If diagnosis is clear-cut and simple, the OP will give immediate prognosis, estimated time of return to work and whether rehabilitation is required.
> 2) The OP may need to obtain further information by contacting the patient, or their GP or consultant before a prognosis can be given.
> 3) The OP may need to visit the employee at home in severe cases.

[♠] Occupational health departments are more likely in larger companies; there are no statistics available on the number of OH departments in SMEs (i.e. the majority of organisations).

At all stages OH is asked to maintain regular contact with the patient and discuss any progress that has been made. The OP will also liaise with the employee's medical carer or GP to ensure there is no delay in return-to-work. Before the employee is allowed to return, they must be seen by the OHA or OP in order to record precise medical details – this will ensure the correct rehabilitation programme and allow for modifications to the work environment to be discussed with HR and line management. Questions regarding an employee's fitness to resume work may involve the company's OH department or a company doctor's opinion. For example, the employee may be taking medication that may affect their ability to do their job safely. e.g. anti-depressants.

According to Beaumont & Quinlan (2002), a typical model of rehabilitation includes liaison with primary care and specialists (e.g. psychologists / psychotherapists in the case of stress) and making employees aware of OH provisions and the possibility for a 'phased return-to-work'. Also essential to the model is a graduated rehabilitation programme (i.e. reintegrative) with the aim of sustaining return-to-work and ultimately achieving a return to normal duties. OPs and other OH professionals, according to the Society of Occupational Medicine, need to be ready to respond to calls for the development of rehabilitative services; this reflects the current situation where no specific system exists although change is expected to arrive soon. According to some writers (e.g. Cox, 2002b), vocational rehabilitation should only be carried out by OH professionals who have a detailed knowledge of an employee's work, the needs of employers and how to assess functional capacity. Although not a legal requirement, employers are advised to carry out a vocational assessment as early as possible to assess physical demands, mobility, sensory and perceptual abilities and vocational requirements. Indeed, it has been reported that simply ensuring earlier referral to occupational health reduces the duration of sickness absence (Michie & Williams, 2003). In certain cases a Functional Capacity Assessment [FCA] is required, which is similar to the government's *Own Occupation Test* in terms of assessing ability to perform a specific job. The FCA can be carried out by any trained OH professional, but unlike the PCA, does not contain a section mental health; it focuses more on physiological functionality.

Employee Assistance Programmes [EAPs] may form a part of rehabilitation, particularly in relation to stress related illness. EAPs are larger and more complex systems of counselling (Harling, 2002). They usually will include 24-hour phone access, and where an organisation has its own OH department, face-to-face counselling from a qualified professional. In the USA, EAPs cover 80% of Fortune 500 companies. A typical EAP places a limit of 6-8 one-hour sessions, and are reported to be effective in reducing escalating healthcare costs. In the UK, use of EAPs is increasing, although it is suggested that the majority of issues raised during counselling are related to difficulties outside of work (Harling, 2002). However, a recent Department for Transport, Local Government and the Regions [DTLR] annual report (2001) on OH services found that work-related stress accounted for 51% of the counselling service's caseload. A recent review of the literature suggests that workplace counselling, through EAPs reduces stress levels by more than half and helps to reduce levels of sickness absence (McLeod, 2002). Stress counselling and EAPs therefore form an important part of rehabilitation for stress and other mental health problems.

Other components of Job Rehabilitation include a medical exam, time-off and flexibility upon return, the provision of special equipment and also retraining. Whilst all these strategies and provisions are rehabilitative, certain activities such as time-off and flexibility when first starting back at work can be conceptualised as reintegrative (although the distinction is not made). As reported by Butler et al, employees that received accommodations such as reduced working hours, modified working equipment and lighter work loads were significantly more likely to return to work permanently and less likely to experience further impairments stemming from their illness (cited by James et al, 2002). The Return-to-work interview is perhaps the clearest and indeed most widely used (EO, 2000; LRD, 1999) example of a reintegrative provision following LTA. Line managers typically invite employees to attend for an interview to demonstrate value for the employee and concern for their welfare. The interviews clarify for the employee the impact their absence has had in addition to an update of their sickness record. To avoid employees feeling that they are being mistrusted, the interview needs to be handled sensitively. The government expects its public sector employers to adopt these interviews across the board, and therefore recommend: that employers conduct return-to-work interviews after each spell of sickness, set clear guidance about the conduct of the interviews, record all actions agreed and give staff adequate training (LRD, 1999). In a recent literature review of vocational rehabilitation, Riddell (2002) describes thirteen further components.

- Work evaluation (simulated or ecological to determine skills & relative performance)
- Job placements (testing abilities; to determine full or part time return
- In-house training (e.g. IT skills; 56% of those with mental health problems in one study) Personal development (e.g. confidence building)
- Residential training (e.g. a specialist environment; NVQs)
- Job search (help with job hunting)
- Jobclubs (e.g. fast track access to work; intensive job search)
- Project led recruitment (e.g. employers at centre of the process)
- Job matching (e.g. finding placements for disabled employees)
- Supported employment (e.g. for mental health employees; on-job support)
- Self-employment (e.g. support for new business; financial; home visits)
- Social firms (e.g. direct employment for disabled people, inc. mental health problems) Clubhouses (e.g. meaningful employment often for those with mental health problems

Crowther & Marshall report that in the UK, the vocational rehabilitation provided for those with mental health problems include Jobclubs, supported employment, Clubhouses and an ‘eclectic’ approach (cited by Riddell, 2002). As an umbrella term, rehabilitation for ‘mental health problems’ presumably includes stress-related illness with psychological manifestations. Generally these services are patchy and haphazard (Riddell, 2002). Those with learning disabilities often receive supported employment, whilst those with conditions such as Traumatic Brain Injury are likely to receive more specialist and specifically tailored interventions aimed at rehabilitation of cognitive deficits. Stress is perhaps a too general term and certainly there are no statistics on the success of rehabilitation for those LTAs due to stress related illness.

2.4 Employment and Equality Legislation

In the UK, legislation increasingly requires employers to assess and address all risks to employee health and safety, which includes their mental health (Michie, 2002). According to the Institute of Directors guide (2002), government health and safety guidelines now explicitly state that employers are responsible for employee's physical and mental wellbeing. This is known as common law and generally means employers must take reasonable care to protect their employees from foreseeable injury, disease or death at work – such duties are derived from the genre of health and safety legislation. Express expectations regarding absence behaviour may be laid down in the employment contract, but there are also 'implied terms'; these are the common law rights delineated by court rulings and periodically extended e.g. previous court rulings have shown employers have a duty not to put the employee at risk of stress (Hargreaves et al, 1998).

The following table summarises current legislation and how it may relate to stress at work:

Act / Regulation / Directive	Relevance to Work-related Stress
Health and Safety at Work Act 1974	Covers psychosocial hazards at work
Health & Safety at Work Regulations 1992	Assessment of hazards likely to cause sickness absence
Disability Discrimination Act 1995	Reasonable adjustments to the workplace, inc. psychological policy, if this caused stress disablement
The Management of Health and Safety at Work Regulations 1999	Assessment of psychological 'hazards'
Protection from Harassment Act 1997	Protection against stress arising from bullying
European Framework Directive (89/391/EEC)	Ensure health in all aspects of work
European Directive on Working Time 1993	Preventing stress related burnout
Organisation of Working Time Directive' (93/104/EC)	Recovery periods
Display Screen Directive (87/391/EEC)	Preventing Mental Stress

Organisations have a statutory duty under the Health and Safety at Work Act [HSWA] 1974 (and subsequent amendments) to maintain a safe and healthy working environment for all employees, including those that work from home. This very general requirement is the basis of most existing legal provisions of stress (Tudor, 2002). In terms of stress-related illness, health and safety legislation applies equally well to occupational stress according to D'Auria (2003) and it is now recognised that the HSWA covers psychosocial in addition to physical hazards at work (Smith, 1998a). The duty for employers is to assess and manage as far as is 'reasonably practicable'.

The Implications for absence management under the HSWA and further legislation introduced in the Health and Safety at Work Regulations 1992 include appointing risk assessors to identify workplace hazards and put in place preventative

measures against those risks (e.g. stress) likely to cause sickness absence[♣]. Related to this issue are provisions under the Disability Discrimination Act [DDA] (1995) which state that employers must take reasonable steps to modify the working environment if this is held to have caused a health problem. For example, if an employee is on long-term sickness absence and the employer wishes to dismiss this employee, the employer needs to have demonstrated that they made reasonable efforts to make adjustments to the physical environment or policies that caused the health problem (physical or psychological)[♥]. Cases of unfair dismissal may arise if an employer has failed to take steps to accommodate employee well-being.

The Management of Health and Safety at Work Regulations 1999 also add to the duties imposed on employers in terms of taking reasonable steps to assess and deal with pressures at work. The regulations require employers to undertake assessments of physical and psychological hazards, as well as steps to reduce those risks.

The DDA defines disability as '*physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities*'. An individual whose sickness is prolonged or irrecoverable is therefore defined as 'disabled'. Although the DDA does not make explicit reference to 'stress disabled' individuals, one can assume that disablement due to stress could reasonably be argued and even demonstrated in a court of law; however, many of the effects of the DDA have been undermined because of lack of awareness amongst employers and a reluctance of people to bring cases to court (Riddell, 2002). Where an organisation may consider early retirement on the grounds of ill-health, this option must be justified against the alternative of making reasonable adjustments to the employee's work and working arrangements (Nash et al, 2002).

European Directives are binding on the member states of the EC and must be incorporated into the law. The European Framework Directive (89/391/EEC) states that employers have a duty to ensure health and safety in relation to every aspect of work, based on the following principles: avoiding risks, combating the risks at source and adapting the work to the individual (EC, 1999).

EU Framework Directives[•] clearly reinforce the duties imposed by the DDA (1995). The most recent legislation relating to health and safety at work was The Working Regulations 1998, evolved form the European Directive on Working Time 1993. Amongst other things, the regulations entitle employees to limit their working week to 48 hours and to take 11 hours consecutive rest each day. The 'Organisation of Working Time Directive' (93/104/EC) states that Member states shall take measures to

[♣] The issues of stress audits by the HSE and EO have been rumoured, but no official practice or guidelines exist as yet.

[♥] There is currently some ambiguity regarding the provisions for adjustments to the psychosocial work environment where stress results in ill-health since there is no coherent risk assessment of psychosocial stressors according to Koukoulaki (2002).

[•] In the UK's legal hierarchy, the next level down from an Act of Parliament is Regulations, which in turn are used to implement EU Directives.

alleviate monotonous work. The Display Screen Directive (87/391/EEC) requires an analysis of workstations, in part to prevent problems of 'mental stress'. In terms of preventing sickness absence due to 'stress' concomitants such as burnout, these directives have implications for the management of sickness absence.

Stress litigation (i.e. claims for compensation due to stress related ill-health attributable to the workplace and other disputes) represents a specific way in which stress related LTA provisions are influenced. Stress at work litigation relies on the principles of Tort Law. This recognises a clear *'Duty of Care'* by the employer (which needn't be written as an express term in a contract). This duty is then clearly *'Breached'* resulting in loss or damage of a physical or psychological nature, which was *'Reasonably Foreseeable'*. A well known case (Walker v. Northumberland County Council) marked the beginning of a rising trend in stress litigation cases after the court held that the employer breached the common law duty of care, thereby causing psychological injury forseeably linked to that breach (Smith, 1998a). In the famous 'Walker Case' (cited in D'Auria, 2003), following stressful working conditions including workload, the employer failed to make adjustments and provide additional resources to alleviate the stressors. Subsequent to an initial breakdown, the courts held that the employer was responsible for a second breakdown, namely stress-related anxiety, which led to the claimant's ill health retirement. The claimant received substantial financial damages running into six figures. Contract law also provides protection for employees suffering from stress where there is a breach of an implied term i.e. that the employer will provide a safe system of work.

However, it has become clear that some serious ambiguities have arisen in the common law with regards to forseeability, causation and duty of care in relation to stress: As noted by one commentator "there is no reasonably practicable way for employers to form an objective balanced view of the combined effects of stressors, 'good' preventative management practices and the perceptions and reactions of the individual" (Dr A. Auty cited by Smith, 1998a).

Subsequent to concerns like these and other stress-related cases, the Court of Appeal [CoA] has issued guidance for courts dealing with work-related stress cases. The main points include a recognition that normal states of reference are difficult to establish in relation to mental health. Thus the CoA decided that it is not possible to predict who will succumb to minor psychiatric illnesses. The condition 'stress' is by itself insufficient for a claim; damage must occur, clearly originating from the workplace. Occupational differences in stress are not accounted for by the guidelines. The CoA does however extend consideration to factors including: nature and extent of work done by the claimant; normal workload for a particular job; intellectual demands of a job; whether there were unreasonable demands when compared with others in similar or comparable jobs. The guidelines suggest that companies need to be aware of stress in others in the same job or department and abnormal levels of sickness absence; as we know, however, relatively few organisations collect sickness absence data and even fewer systematically analyse them by diagnosis. The court failed to give judicial recognition to an HSE document (Tackling work-related stress: a manager's guide to improving and maintaining employee health and well-being, 2002). However, employers are advised to believe what

employees tell them regarding their stress levels, and there is no duty to conduct extensive searches into whether someone is stressed. Their duty to act is only imposed if the signs of stress are clear enough to observe. In making reasonable adjustments as set out in the DDA, employers may take an economic analysis. The courts would consider the size and scope of organisation, the resources available to it, demands and employee's interests. The guidelines state that employers could include extra measures such as mentoring, sabbaticals and counselling. The guidelines also state that an employer is unlikely to be found in breach of their duty if it offers counselling or treatment services.

Although it is not officially an employer's charter, the CoA document gives judicial endorsement to a coordinated approach to stress management. Indeed, as set out in the European Commission's Directive on the Introduction of Measures to Encourage Improvements in the Safety & Health of Workers at Work 1989, employers should develop "a coherent overall prevention policy which covers technology, organisation of work, working conditions, social relationships and the influence of factors related to the working environment" (Article 62) (cited in Cox et al, 2000). (Non-legislative provisions for stress are described in Chapter Three).

Workplace bullying (i.e. "offensive, intimidating, malicious, insulting or humiliating behaviour, abuse of power or authority which attempts to undermine an individual or group of employees and which may cause them to suffer stress", Unison, cited by Smith, 2000) is now cited as the most frequent source of workplace stress above long hours and workload (Smith, 1998c). Whereas stress cases involve the common law duty for a safe workplace, bullying as a subset of stress claims involve the duty to provide safe and competent fellow employees (Smith, 2000). Bullying cases are subject to tests of forseeability etc…where a clear link between a stress related illness and the bullying behaviour can be established. Court rulings have advised that an injury due to bullying needs to be a 'recognised psychiatric illness' rather than everyday 'stress'. Another possible provision in cases of stress caused by bullying is to hold an employer liable on behalf of a bullying employee under the Protection from Harassment Act 1997. Bullying could be argued to be a criminal act therefore providing grounds for dismissal of the bullying employee.

3. Non legislative provisions and initiatives on stress and LTA

3.1 Introduction

The aim of this Chapter is to describe some of the programs, initiatives or projects currently underway in the UK that are not a direct result of legal or statutory duties. The focus will be on those agreements or projects that may be related to stress and long-term absence.

Two specific initiatives launched by the UK government are outlined: Revitalising Health and Safety and Securing Health Together. Government plans, pilot schemes and research initiatives as a direct result of the Green Paper *Pathways to Work* are then outlined.

The next section then deals more specifically with those projects that are distinctive, such as the government's Job Retention and Rehabilitation Pilots and New Deal for Disabled People. Specific documents, such as the EC's Guidance on Work related stress are also mentioned. As crucial bodies in social partner agreements, the activities of the Trade Unions are also highlighted.

3.2 UK Initiatives

The statistics and current policy debate on stress in the workplace means that despite the lack of specific legislative provisions, numerous non-legislative provisions and initiatives with regards to health and safety and stress in the workplace are currently underway.

3.2.1 Revitalising Health & Safety [www.hse.gov.uk/revitalising]

Specific initiatives in the UK include Revitalising Health & Safety [RHS], launched by the government in partnership with the Health & Safety Commission [HSC] in 2000. This 10 year strategy seeks significant improvements in workplace health and safety by setting, for the first time, challenging targets aimed at reducing the incidence of work-related ill-health, the number of fatal and major injuries and working days lost caused by injuries and ill health. Further to the EC's general statement for a reduction in work-related illness, RHS aims to inject new impetus into the health and safety agenda and to find ways of reducing rates of accidents and ill health at work. Key RHS targets are to reduce work-related ill health by 20% and cut rates of sickness absence by 30%, both by 2010. The RHS strategy lists 44 Action points for achieving these targets under

thematic sub-headings. Not surprisingly, 'work-related stress' appears as a major theme with targets to reduce its incidence by 20% and days lost due to stress-related illness by 30%. The RHS actions points, such as developing agreed standards of management practice for example, have led the HSE producing reports and leaflets specifically aimed at employers (e.g. *Tackling work-related stress: A managers' guide to improving and maintaining employee health and well-being*. 2001 HSE Books) and individuals (e.g. *Tackling work-related stress: a guide for employees*). There are also projects underway to provide guidance on risk assessments for stress. Official policy from the HSC states:

> We will be:
> - Working with partners to develop clear, agreed standards of good management practice for a range of stressors;
> - Better equipping HSE inspectors and local authority officers to be able to handle work related stress during routine work;
> - Starting a project to involve others actively in developing a more comprehensive approach to managing stress;
> - Launching a publicity drive to help educate employers. To underpin this, HSE will be developing additional detailed guidance, drawing on the findings from HSE's research and adopting a particular focus on risk assessment.

RHS website (2003)

3.2.2 Securing Health Together

In addition to RHS, *Securing Health Together [SH2]* is complementary long-term strategy committed to encouraging compliance with good health and safety practice. It is an 'Occupational Health' strategy that 'underpins' RHS, evolved from Action point 28•:

> 28. The Health and Safety commission will work with a range of Government departments and other partners to promote and implement fully the new Occupational Health Strategy for Great Britain.

And it is concerned with:

> - Health risks arising from work affecting both workers and the public;
> - The rehabilitation of people who have been ill or who have a disability; and
> - Helping people to retain or improve their health through the work environment

RHS Website (2003)

SH2 shares many of the same targets with RHS, buts sets additional targets for occupational health (HSE, 2000):

> The reduction in the incidence of ill health arising from work activity in the public sector by 20%
> Everyone who has been ill is given opportunities to return to work, if appropriate; and
> Everyone who is out of work due to ill-health or disability is given access to opportunities to prepare for or take up work.

RHS website (2003)

• A full list of the 44 Action points is available at: www.hse.gov.uk/revitalising/rhs-02.htm

SH2 also sets out an approach to work-related stress [WRS]; 4 key elements include:

To work with partners to develop clear, agreed standards of good management practice for preventing WRS. To better equip enforcement officers to handle the issue in their routine work. To facilitate a comprehensive approach to managing WRS A publicity drive to help educate employers about what they can already be doing to prevent WRS

HSE website

Thus, clearly it is evident that non-legislative policies exist for long-term illness and sickness absence and rehabilitation back to work, and that which is specifically related to stress. According to Wiley (2002) "There are clear synergies between the HSE agenda to improve health and safety at work and the DWP's to sustain a higher proportion of people in work than ever before, while providing security for those who cannot work". SH2 has developed sectoral partnerships with other government departments including officials in the DWP, DoH and DfEs.

Specific projects[•] carried out by stakeholders in SH2 are also underway. For example, pilot studies to reduce stress in various NHS trusts have been underway and evaluated. Such initiatives demonstrate the government's concern with stress in the NHS and the high rates of sickness absence in the public sector. One aim of these projects is that where public health services lead the way in terms of reducing stress, the wider business community will follow. A recent government publication, *Work related Stress Initiatives* (HEA, 1999), presents three case studies of NHS Trusts that have attempted to reduce workplace stress and then measured outcomes using sickness absence data and surveys. Innovations in one Trust to reduce stress levels in nursing staff included monthly team briefings, clinical supervision, management visibility, training opportunities and mental health liaison nurses. The results of this and the other case studies were positive in terms of reduced staff turnover and sickness absence.

3.2.3 Pathways to Work

The government's Green Paper sets out plans that are relevant to LTA. It is proposing firstly to provide more choices for those moving onto IB, ensuring contact with DEAs. The *Jobcentre Plus* staff will also be directly involved in helping IB claimants to find work and support claimants back into work. The UK government intends to offer financial incentives, such as 'Return to Work credit'[•]. In order to achieve the government's aims, best practice guidelines will be provided for health at work and work resumption / rehabilitation. The provision of aids for recording sickness absence and ill health and injury at work are also planned; these will be disseminated in 2004 in the light

[•] Contributing projects can be found at www.ohstrategy.net
[•] £40 per week for 1 year if income ≤ £15,000.

of results of HSE commissioned research carried out by the Institute of Occupational Medicine [IOM].

The government also plans to establish online training for GPs managing LTA and to examine the possibility of extending powers for the issuing of sickness certificates to other healthcare staff e.g. psychiatric nurses, psychologists. These plans will be implemented in 6 pilot areas from late 2003.

3.3 Specific Initiatives & Projects

3.3.1 Health, Work and Recovery

The *Health, Work and Recovery* programme is the working title of the joined up agendas of the DWP and HSE, along with input from the DoH and DfES. This social partner agreement underlines the initiatives such as Revitalising Health & Safety and the Job Retention & Rehabilitation Pilots (see below).

3.3.2 Health & Safety Executive

As a kind of regional social partner agreement, five local authorities in the North West of England are piloting a 'Stress Tool' developed by the HSE (The Safety & Health Practitioner, 2003). This would be used to identify those organisations at risk of causing workplace stress. According to the report and other unsubstantiated claims, the HSE may introduce work-related stress audits in its routine inspections by the end of 2003. Further to management standards currently being piloted and again in 2005, organisations that fall short of a minimum requirement could be open to prosecution by the HSE.

Another social partner agreement is the *Job Retention and Rehabilitation Pilot* [JRRP], funded by the DWP in partnership with the Department of Health & HSE. The government intends to test how extra health and workplace support can help people recover from illness, return to work and keep their jobs. It is focussed on job retention and rehabilitation i.e. helping employees return to work as quickly as possible without loosing their current jobs, and helping businesses retain skilled and experienced workers (DWP, 2003). The pilot aims to include those absent for six-weeks or more with a wide range of illnesses, including musculoskeletal disorders, cardiovascular conditions and mental ill-health; those on LTA due to stress-related ill health would also be included in the catchments. The project, which will last for two years beginning in early April 2003, will run in six areas across the country: Glasgow, Teesside, Tyneside, Birmingham, Sheffield and Kent under different brand names e.g. 'Routback' and 'Healthy Return'.

The fundamental aim of the pilot is 'robust evaluation', the results of which will be disseminated in 2005, subsequently shaping future policy in this area. It is a good example of evidence based policy making.

3.3.3 EC Guidance on Work-Related Stress [WRS]

The European Commission has published a guidance document aimed at Member States, workers' and employers' organisations and other interested bodies and individuals (EC, 2002). The guidance was issued further to Framework Directive guidelines and a statement in the Treaty of Amsterdam:

> …a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities.
>
> (Article 152, The Treaty of Amsterdam, Cited by Levi 2002, p.13)

The guidance defines WRS and its effects on health, and then sets out guidance on possible ways to reduce its incidence. Rather than providing an assessment methodology of WRS, the guidance refers to risk assessment tools such as checklists and questionnaires.

3.3.4 Trade Unions

Stress has been steadily rising up the Trade union agenda according to Koukoulaki (2002). Trade Union activities in Europe essentially involve information spreading activity or the development of screening tools. In the UK, stress is included in collective agreements. For example, the Union *Transport Salaried Staff's Association* [TSSA] (representing 32,000 members) conducted a survey of stress amongst employees in the travel sector. The TSSA have issued guidance urging all those in the transport industry to adopt their 'model stress policy' which includes identifying stress and conducting risk assessments to eliminate or control WRS.

The Trades Union Congress [TUC] embraces the targets set out in Revitalising Health & Safety, asking unions to report on their activities to raise awareness of this strategy, providing space in journals, discussing the RHS targets with social partners and inviting Ministers to attend their events. The *Manufacturing, Science and Finance Union* [MSF], for example, held sixteen one-day conferences focusing on the top five workplace hazards, including stress at work, to raise employer awareness. In terms of discussions with employers, the TUC encourages sectoral agreements:

> The TUC strongly believes in a partnership approach to tackling stress. You will need allies especially if an employer doesn't yet treat workplace stress as a serious issue. Setting up a joint working group to tackle

workplace stress will help you to gain those allies. Partners for the joint working group could include the safety committee, safety managers, human resources and outside agencies working in health promotion.
(TUC, 2002, p.4)

An example of a specific social partner agreement was the publication of a document entitled 'Creating partnerships for prevention – joining up health and safety', issued by the CBI and TUC. Although social partner agreements on the psychological working environment can be found abroad, UK agreements are few and tend to be conducted at company or workplace level, according to the European Foundation for the improvement of Living and Working Conditions (2003). However, agreements can be found. For example, as far back as 1990 the National Union of Teachers [NUT] began to draft on the problems of WRS suffered by a disproportionately high number of teachers. The research tended to have a focus on organisational factors, but in July of 2001 a national agreement was reached between the NUT and Local Education Authorities [LEAs] on protecting teachers from excessive workload.

In 1990, the NUT was the first teachers' association to publish detailed guidance for its members on teacher stress. Since then, the issue has been a priority for the Union and its members, working with LEAs and the Health and Safety Executive to address the problem.

In light of such agreements, LEAs have issued guidance for governors, head-teachers, senior management and other school staff on the issue of how to tackle occupational stress.

The TUC has also worked with the *Engineering Employers' Federation* [EEF] to develop a new approach to stress at work (Tudor, 2002). This included a conference on issues of employee rehabilitation in 2001. Research conducted in the light of this conference showed that training managers on how to deal with WRS was successful in reducing stress related sickness absence. Since this time, a major conference on WRS has been held as part of the EEF's campaign on rehabilitation in partnership with the UK's National Occupational Health Forum (Booton, 2002). Key objectives from this conference included engaging stakeholders, disseminating advice and best practice guidelines all aimed at minimising WRS at the UK and European level. The EEF (2001) has also produced a document entitled 'managing work related stress guide'. All of this activity fits in well with its drive towards demonstrating the business case for effective health risk management and sound occupational health policies. The EEF's agreement and proactive approach to WRS has been used as an example of a sectoral agreement with the UK (see Booton, 2002).

Subsequent to the *European Week of Health and Safety at Work 2002*, the TUC (2002a) has also produced a 'Stress M.O.T' survey to identify workplace stressors and then assess how well the organisation addresses these problems. It is given to employees in areas of the workplace the employer is interested in and then a 'pass' or 'fail' is issued according to guidelines. It is mostly intended for employers and their management of WRS, but feedback to individual Unions and to the TUC is encouraged.

The public sector trade union, *Unison's* adoption of the Stress MOT policy is a good example of a successful sectoral agreement. Members of *Unison* all over the country assessed their WRS levels, including local government (e.g. county councils), the Police, Universities and local health authorities. The results were subsequently disseminated on the *Unison* website.

Related to the TUC's suggestion of 'mapping' stress in the workplace is a research methodology called *Body Mapping*. It is a non-scientific but useful way of assessing how work affects worker health. Employees simply mark the areas on a diagram where they have been made ill by work and then results can be 'mapped' (WRS is also included). RHS Action Point 29 includes body mapping techniques as part of its aim for provision of OH support, stating that it will:

> Pilot training of trades union safety representatives in body mapping techniques.
>
> (RHS Project Plan)

This aim has been achieved since this technique was recently presented at the *Safety and Health at Work Congress 2003* by a *Unison* health and safety representative. The technique is another 'tool in the OH armoury' according to Robertson (2003). This was an example of a social partner agreement, since the government trained the Union professionals, who then impart their knowledge to the wider business sector who will then hopefully adopt such techniques to reduce LTA (and that related to WRS).

3.3.5 New Deal for Disabled People [NDDP]

Further to the government's concerns about working age incapacity and consistent with their aim of helping people achieve their full potential through work, the NDDP aims to reduce LTA and illness and help those on long-term incapacity benefits (e.g. IB) back to work. Pilot programmes ran from 1998 to 2001 each with a project manager and team of personal advisers whose job it was to undertake an initial interview with the LTA or disabled individual and subsequently to organise services to improve their employability (Riddell, 2002); it is now operational. *Job Brokers* are assigned to cases through *Jobcentre Plus* to match their customers skills to vacancies and help them understand and compete in the labour market and also to provide support throughout (DWP, 2003).

The personal adviser service is specifically targeted at those with long-term illness and will undoubtedly include those absent from work due to stress. Initially it was social partner agreement between the Department of Social Security and Department for Education and Employment, which has now merged into the DWP. It has now become an example of a social partner, sectoral and provider agreement since in delivering the programme the *Job Brokers* will use vocational rehabilitation services funded by the Employment service and other organisations (Riddell, 2002).

3.3.6 ONE

This is a pilot to bring a single gateway to benefit for working age claimants to State benefits (e.g. IB). Similar to NDDP, Personal Advisers will provide appropriate guidance and support for those considering employment, training and rehabilitation. New claimants in the pilot areas will take part in work-focused interviews and follow-up interviews each time they attend for a PCA (as in the case for IB claimants). Medical reports will also be discussed at the interviews.

People are supported through claims rather left to their own devices once on benefits. It is clear evidence of the renewed governmental concern for rates of long-term absence and subsequent social projects that have been developed in light of such concerns.

3.3.7 BSRM

The British Society of Rehabilitation Medicine [BSRM] recently produced a report on vocational rehabilitation. This report reinforced the poor chance of a return to work as the amount of time in receipt of benefits increases. Practical initiatives suggested in the report include the creation of accredited training courses in vocational rehabilitation (BSRM, 2000). The BSRM also calls for a new *Institute for Vocational Rehabilitation Research* to be created to promote multi-professional research. This institute together with universities would work to raise awareness of the link between work and health and the need to reduce sickness absence and promote rehabilitation.

3.3.8 NHS Plus

NHS Plus was launched on 19th November 2001following Action Point 29 of *Revitalising Health & Safety* to create better access to occupational health support. This is currently a network of ninety participating NHS Trusts providing occupational health services to local organisations, with a particular focus on small to medium sized companies. NHS professionals provide a range of services including medical advice for sickness absence management, return to work and vocational rehabilitation.

3.4 Conclusions

On the basis of information outlined in this chapter, it is clear that non-legislative provisions for stress do exist in the UK. The genre in current government initiatives is the reduction of workplace accidents and ill health, including specific targets to reduce stress. Whilst there have been some anecdotal successes (i.e. Action point 29 of RHS), there have been few practical advances on these projects, a lack of contemporary updates and a general lack of activity in the action point areas. There are no quantifiable results (to date) to assess the success of UK initiatives such as SH2 or RHS.

Despite Union activity, as Koukoulaki (2002) points out, many of the stress related provisions being written by the Unions are procedural rather than setting clear obligations for employers. However, WRS is clearly on the Union agenda and agreements are in place to help sectors assess WRS. Whilst such agreements tend to be orientated toward prevention, they are useful non-legislative provisions in the battle against LTA related to stress.

Although other projects such as NDDP exist, evaluations of this service so far have not ascertained which types of service or service components work best (c.f Corden & Thornton, 2002). Moreover, such initiatives are not aimed at stress related LTAs.

Initiatives such as *NHS Plus* partly exist to increase revenue for the government, but they are indicative of the government's concern for issues such as vocational rehabilitation.

Overall, initiatives in the UK to help long-term absentees and those suffering from the specific problem of stress are underway, but these initiatives tend to lack any real activity or quantifiable results; where pilots are underway, these tend to be localised to specific regions or populations in the UK. Thus there is still a need to raise awareness and to be more proactive.

4. The Current Policy Debate

4.1 Introduction

The aim of this penultimate chapter is to build upon and make explicit some aspects of the current debate on absence due to work related stress and the provisions in the UK for those who are long-term absent from work.

It becomes clear from the literature and also specific surveys seeking the views of employers that work stress is perceived as a major 'issue' or problem. Some employers, most likely to be public sector, are currently implementing strategies for WRS that will lead the way in terms of policy and debate amongst other employers. The NHS, as an employer, service provider and government body, has also recently produced a report to inflame the current debate.

Stress at work, claims against employers and litigation cases are firmly on the Trade Union agenda. The discussion papers between the Trades Union Congress and various partners (e.g. service providers) are a crucial source of information on the current policy debate and indeed act as a bridge of communication between the government and employers. It is therefore the Unions that are most likely to influence policy in this area. A Joined-up rehabilitation service following long-term absence is the current 'hot topic' for Unions.

Service providers, including a large number of consultancy and private organisations, view work stress as a problem.

The government sets out a clear approach to the issue of WRS. Clearly the government, in conjunction with the Unions, are central to the current debate, which essentially focuses around provision of rehabilitation and return to work as quickly as possible.

4.2 Employers

In 1999, the HSC published a discussion document entitled *Managing Stress at Work* that sought to stimulate the debate on the current provisions for WRS. Following wide distribution of the document, around 850 responses were received from various employers (private, public sector) and individuals. Trade Union responses represented the views of many more. Overwhelmingly, 98% of respondents indicated that more should be done to tackle WRS. Employers also felt that they should not be held liable for work

stress originating from outside the workplace and outside their control (see p.38). Most significantly, the majority of employers (70%) felt that an Approved Code of Practice [ACoP] for work related stress is a worthwhile idea. In the legal hierarchy an ACoP stands below a regulation (Tudor, 2002) and would be useful in supplementing the provisions already be derived from existing legislation in the HSWA and DDA. However, the HSC agreed that prior to implementing such a Code, standards of management needed to be established. Since this time ACoP have not been implemented and are currently under review (Tudor, 2002).

The HSC/E survey also revealed that for most employers and individuals (i.e. 94%), the issue of stress at work is a health, safety and welfare issue that should be dealt with by central and local government under health and safety law. Employers also tended to support the notion that prevention was more important than cure when dealing with WRS. Responses such as these have influenced the government approach to stress both generally (see Section 4.7 below) and in specific targets to reduce it (see Section 3.2 above).

Employers such as the Inland Revenue state that the general issue of sickness absence is the employer's responsibility. Other government employers (e.g. the DfEE) view sickness absence as a management issue that can be reduced greatly. The government has sought to implement best practice absence management in schools across the country.

Various schemes relating to best practice for reducing stress-related absence can be seen in various public services and government departments. The Metropolitan Police Authority, for example, produced a report outlining measures they are taking to reduce sickness absence. Mental health disorders were the second most frequent cause for referral to OH (Van den Hende, 2002). In response, they introduced a pilot 'psychological' project stating that any individual with stress-related illness should be seen by a consultant psychiatrist within six-weeks of their first day of sickness. The psychiatrist or psychologist, in conjunction with a GP, with the aim of returning them to work quickly, can then give a diagnosis. The unique aspect of police work involves the potential for PTSD and related disorders; stress levels are also high. Such schemes may also be setting precedents for the management of WRS. The service plans to implement a stress audit to identify causes of stress, involving three-to-five thousand questionnaires and a series of focus groups.

The National Health Service is an example of an employer, but also a service provider and government body. A report issued in 1998, *Improving the health of the NHS Workforce* (Williams, Michie & Pattani, 1998), highlighted the occupational health hazards currently facing the NHS. The unique aspect of NHS work was highlighted as particularly stressful (i.e. dealing with people, disease and death), including a general increase in workload. The result, according to the report, is that the prevalence of psychological disturbances is higher in NHS workers than in the general population: 25% of early retirements are reportedly due to stress, whilst burnout and back pain are common health problems. A disturbingly high 21 to 50%

of Doctors suffer from high levels of psychological disturbance, whilst one in ten report that WRS causes serious clinical mistakes. Similar high levels of psychological problems were also reported in Nurses and Managers. It was also found that 14% of sickness absence was in fact caused by violence against staff. Williams *et al* (1998) make management recommendations such as counselling and stress management. These concerns will undoubtedly form part of the debate amongst government Ministers. The creation of *NHS Plus* for example, is indicative of government concerns generally, even if they are seen to be doing little to reduce the stressful psychosocial work environment for their staff.

4.3 Trade Unions

With regards to stress related absence, the TUC collects statistics on stress related claims against employers. The TUC *Hazards* magazine is currently highlighting a twelve-fold increase in work related stress cases in 2003, with compensation totals highest in the southeast. The Unions would like to be part of the prevention for WRS. In the consultation document *getting better at getting back* (TUC, 2000), stress is recognised as a cause of sickness absence. The focus of the consultation was on the less serious (in comparison to serious workplace injury) but much more common workplace health problems such as stress. The TUC advocates a multi-disciplinary approach to rehabilitation, especially for WRS, and outlines the following key principles:

- Rehabilitation policy should be part of health and safety policy
- The NHS[•] needs a rehabilitation policy in place.
- Early intervention is the key to preventing long-term absence
- Use of the 'case manager' approach[♦]
- Better NHS provisions e.g. psychologists

The TUC suggests that the UK is a safe place to work but has an 'appalling' record on rehabilitation. It has been estimated that the chances of returning to work after a major injury are 50% in Sweden, 30% in the US but just 15% in the UK (TUC, 2003):

> Hundreds of thousands of workers in Britain with relatively simple musculo-skeletal complaints and stress-related illnesses are taking extended time off work or retiring prematurely when rehabilitation could get them back to work in weeks.
>
> (TUC, 2003, p.2)

The TUC has been in discussion and has produced papers with the Association of British Insurers [ABI] and CBI. At a joint ABI/TUC conference in January 2003, relevant stakeholders, employers, Unions and rehabilitation service providers called for a national action plan to bring about improvements in the provision of rehabilitation services. The

[•] This has been addressed to some extent with the creation of *NHS Plus*.

[♦] Again, to some extent this has been addressed with the piloting of Job Brokers who manage whole cases.

aim was to build upon recommendations made in the Green Paper, such as earlier intervention and training for GPs. The head of the ABI said:

> We agree with many of the suggestions put forward in the Government's Green Paper – this shows that insurers and the government share common ground in pushing for a more comprehensive, co-ordinated approach to rehabilitation in the UK. The ABI/TUC joint consultation exercise has highlighted that there is clear consensus for change. The challenge now is to seize the opportunity to bring about long-lasting improvements in rehabilitation services.
>
> (Parker, J. ABI, 2003)

In a publication *Rehabilitation and Retention: what works is what matters*, the TUC (2002b) calls on employers to adopt the following generic principles when managing long-term absence:

- Clear policies on rehabilitation of ill/injured employees.
- Separate sickness absence from disciplinary proceedings (i.e. recognise that some absence is genuine)
- Work with the Unions and employees to develop policies.
- Respond actively to sickness absence
- Adopt a multidisciplinary approach
- Adopt the initial presumption that sickness absence is work-related
- Provide access to good OH services

The General Secretary of the TUC has also gone on to say:

> Rehabilitation is the missing link in welfare to work – it's the last piece of unfinished business in creating the welfare state.
>
> (Berber, B. ABI, 2003)

The TUC wants to play a central role in any system and highlights that insurers will benefit from investing into rehabilitation because of the potential to reduce claims and pay-outs[•] to those forced into ill-health retirement due to lack of rehabilitative provisions. The TUC also criticises the current rehabilitation system since some services are taxed, thus acting as a disincentives for employers to provide them. Moreover, until the Green Paper *Pathways to Work*, the UK's Benefit system has been based on a crude dichotomy between either 'fit' or 'unfit' to work. The TUC calls for prevention, rehabilitation and compensation to be centralised under one system with the appointment of a senior Minister to oversee this service (TUC, 2003).

Clearly the Trade Unions are central to the current policy debate. In a recent paper, Owen Tudor from the TUC outlines the likely future involvement of the Unions:

> …unions will also be pressing the case for a new concept – the sustainable workforce – which is designed to incorporate issues like the work-life balance, working time and productivity, and borrow from the environmental movement the idea that, if we use up or "burn out" our (human) resources, they will not last, with catastrophic results for the economy and society, as well as the individuals we represent.
>
> (Tudor, 2002, p.22)

[•] This currently stands at £750 million in pay-offs to injured employees

4.4 Providers

The Association of Personal Injury Lawyers [APIL] responded to calls for changes to the rehabilitation system following workplace ill health and injury. APIL believes that a rehabilitation policy should be a mandatory requirement in the same way that a risk assessment is a legal requirement of a health and safety strategy. They also propose that employers should have a statutory requirement to consider an employee's request for rehabilitation. The CBI (2001) reports that public and private spending on rehabilitation and healthcare is lower in the UK than many other OECD countries, hence APIL's concern:

> The current lack of investment in rehabilitation is a major limiting factor on the availability of services. Consequently, no matter how deserving a victim may be, if the cost is prohibitive the rehabilitation will simply not take place.
>
> (APIL cited by the TUC, 2002b)

The APIL proposes that employers should have a statutory duty to consider an employee's request for rehabilitation in much the same way that employers now have to consider requests for flexible working arrangements further to the Employment Act 2002 (see 2.4, Chapter Two). APIL also believe the business case for rehabilitation should be developed, especially in the case of SMEs who may see the cost as an obstacle. Likewise, it is debated that the NHS should be able to recover the costs of treatment in certain circumstances form insurers. APIL conclude that:

> …the government has a great deal of work to do to improve the co-ordination of rehabilitation in the UK. There is a real need to examine the role of the NHS and develop a more 'joined-up' approach.
>
> (APIL cited by the TUC, 2002b, p.11)

The UK Government has gone some way to address many of these issues (i.e. centralisation through Jobcentre Plus), but clearly debates between Unions and service providers such as APIL will influence future policy implementation.

Corporate Health Ltd is an independent occupational health and safety provider, with a mission statement to provide 'innovation and excellence in the provision of health and health and safety at work'. Their view on stress is that modern working conditions and a greater awareness has exacerbated the issue; they view it as a valid problem.

AIG: Medical and Rehabilitation provide "Assistance, care and return to work after injury through timely and effective Medical and Vocational Rehabilitation". Companies such as AIG recognise the poor chance of return to work and the financial scale of the problem.

The Personal income protection services of *Unum Provident* have a specific branch dedicated to rehabilitation services, including disability counsellors and a vocational rehabilitation co-ordinator.

4.5 Government

It has been noted that WRS represents not only an economic burden, but also a personal and societal problem leading to social exclusion and ill health retirement. This has been recognised by bodies such as the HSE, in partnership with the government, who have conducted longitudinal and prospective research into stress in the workplace; most notable the Whitehall II studies which examine aspects of psychosocial stress, physical health and mental well-being.

Two major HSE commissioned research reports (Nos. 265, 266) have set the tone for current government approaches to stress at work: the *Bristol Stress and Health at Work Study* (2000) and the *Whitehall II* cohort studies (2001). Both found self-reports of work-related stress [WRS] to be widespread and linked to a range of deleterious psychological and physical outcomes. Subsequent to findings like these, the current HSE/C approach to WRS is:

> To develop clear, agreed standards of good management practice for a range of stressors;
> To better equip HSE inspectors and Local Authority Officers to be able to handle the issue in their routine work, for instance by providing information on good practice and advice on risk assessment and consultation in the light of the above work; and
> To educate employers through a publicity campaign, with detailed guidance, drawing on the findings from HSE's research and adopting a particular focus on risk assessment.

(Tudor, 2022, p.27)

The Cabinet Office have also produced specific advice on management policy for sickness absence (*Working Well Together*, 1998) and a resource pack to help public services manage sickness absence more effectively (*Managing Attendance in the Public Sector*, 1999). Employees are recommended to be in organisations that care for health and welfare. In addition employees should make sure an organisation has flexible policies to accommodate the demands of everyday life. The Cabinet Office states that employers need to understand the specific links between work and health e.g. stress and mental health.

4.6 Conclusions

It seems that currently there is a healthy debate between employers about the issue of stress at work and how this may be causing sickness absence. The issue of work stress as a leading cause of absence is often in the popular press and we have seen how public service employers such as the NHS take the issue seriously.

The Trade Unions seem also to be adding to the policy debate, particularly in the area of rehabilitation. As we have seen the Unions have produced publications and consultation documents that will play a key role in shaping policy in this area.

Clearly there are many service providers who view stress as a problem, and have produced policy and documentation to this effect. The myriads of training courses and stress management providers in the UK have in common their espousal of stress as a 'problem'. However, whilst they view stress as an issue that needs to be tackled, it is also in their business interests to maintain this perspective. Thus whilst private service providers may not directly influence policy (particularly if they have no social partners), by exaggerating the importance of stress they are indirectly placing greater pressure on the policy makers to act. Some of the more professional organisations, however, have added sensibly to the debate suggesting that rehabilitation policy should be part of statutory health and safety at work policy.

Although many employers and organisations recognise the problem of stress-related sickness, it is still not clear where a solution will emerge from. As is the case for non-legislative provisions, the UK needs to see more action in this area.

5. Conclusions

5.1 Adequacy of Current Provisions

The government's aim of 'work for those who can and support for those who cannot' includes those individuals absent due to stress related complaints. The system of State Benefits outlined in Chapter Two could be simplified, but essentially they work. The long-term benefits such as IB are indeed providing for those who may be unable to work due to stress related illness. The government has made social provisions and imposed duties on employers to the extent that financially at least these people will be provided for.

However, the sickness benefit systems in place (i.e. SSP & IB) are open to potential abuse and despite their 'honourable' social intentions may ironically act as disincentives to work (Sawney, 2002), especially in the case of individuals that would financially be better off by remaining on benefits (DWP, 2002). Although employers are required to keep basic records on sickness absence, such records may not include stress or its origins.

With regards to the diagnostic process, the system of Approved Doctors and Decision Makers is adequate to the extent that trained professionals are dealing with claims of work incapacity. Tests such as the PCA are generally regarded as objective and cases of work related stress are assessed objectively i.e. an individuals capability is assessed in terms of its relevance to work. However, the role of the Decision Maker in setting a date for re-assessment is subjective. Although it is evident that current diagnoses conform to ICD-10 and DSM-IV, it has been suggested that these systems are not suited to the diagnoses of occupational stress and burnout (as causes of LTA); thus Decision Makers may struggle to adequately assess WRS cases. Categories in both systems may be more suited to cases of industrial injuries such as PTSD or Acute Anxiety. Although ICD-10 does include conditions of burnout (z-diagnoses), it does not appear from government statistics that these categories are in use (e.g. DWP, 2002b).

The role of GPs is worth highlighting as a problematic area. As suggested by several authors (e.g. Sawney, 2002) and in government guidance (IB204), GPs often experience a conflict of interests between patient loyalty and objective assessment when certifying sickness; subsequently the validity of 'stress' related illness can be called in to question. GPs are not occupational health specialists, and may lack experience in recognising stress-related illness, especially psychological manifestations. It has also been demonstrated in an extensive review and qualitative analysis that psychosocial factors, such as an individual's family circumstance, often influence a GP's decision to administer sick notes; moreover, the actual communication between government officials and the employers themselves is extremely limited (Hiscock & Ritchie, 2001). Therefore, our conclusion in this respect must be that the role of GPs in the sickness absence system,

and a system that is increasingly dealing with WRS, should be reviewed. A positive development in this area is the government reforms subsequent to *Pathways to Work* e.g. training for GPs in these areas.

The system and provisions made for rehabilitation and reintegration following long-term absence is generally inadequate in relation to stress-related illness. The desirable situation in the UK would be to have specific statutory duties imposed upon employers to make rehabilitative provisions, as is the case abroad. However, as we have seen, no statutory system or legislative impositions exist, except for those residual duties that can be extrapolated following a careful reading of current legislation in the HSWA and DDA. Although duties can be inferred from existing legislation (e.g. section 2, subsection 3 of HSWA), this is dependent upon legal debate in a court of law; in reality whilst these theoretical duties exist, unless employers have made express reference to rehabilitative provisions in an employment contract, they are probably unlikely to make provisions. Moreover, the CIPD (2002) report found that whilst many organisations (89%) claim to have strategies to deal with long-term absence and rehabilitation following such an illness episode, only a minority actually implement them. Whilst the TUC in partnership with the government are calling for greater provisions in this area, there is no foreseeable prospect of primary legislation, according to government authors (e.g. Wiley, 2002).

Despite these shortcomings, a fragmented system for rehabilitation does exist. In cases of stress-related illness, occupational psychologists may be available through a government adviser (e.g. a DEA). Employee Assistance Programmes [EAPs] are a common rehabilitative provision in organisations; however, it has been pointed out that most EAPs focus on non-work stress (e.g. Harling, 2002), diminishing the usefulness of these provisions in cases of WRS. Recent research has suggested that EAPs are effective in reducing stress and associated sickness absence (e.g. McLeod, 2002). Provisions such as return to work interviews may be useful in managing sickness absence, but there is no information on individual experiences of long-term absentees and their effectiveness for WRS. Moreover, these interviews are often viewed with suspicion and may cause uneasiness with line managers in terms of being intrusive. Workpackage Five of 'Stress Impact' will contribute to knowledge in this area. Overall, although there are vocational rehabilitation programmes for those with mental health and psychological problems, these services are patchy and haphazard at best (Riddell, 2002).

It is important to note that current indications are that 70% of the UK workforce does not have access to occupational health services (e.g. CBI, 2001). Without this basic provision for occupational healthcare, it is not surprising that psychological rehabilitation services are sparse; it is perhaps more important to concentrate on this shortcoming prior to focusing on specific areas of service.

The current legal provisions for stress are adequate to some extent. At the European and UK level, there is a general drive to include aspects of the psychosocial work environment in health and safety provisions. Common Law rights (i.e. those delineated by court rulings) in the UK have also been tested and found to include stress

(i.e. employers have a duty not to put an employee at risk of stress). The HSWA does indeed include a degree of obligation to account for WRS and subsequent amendments have added to these duties e.g. stress risk assessments. Long-term absentees qualify as disabled under the DDA, and so therefore provisions such as reasonable adjustments to the workplace apply for these people; the case of 'stress disabled' is a matter that can be argued. European Directives make provisions for the sensible design of workplaces (e.g. so as not to facilitate stress/ boredom) and Directives on working time have implications for avoiding stress and burnout. With regards to rehabilitative provisions, we have seen that the TUC has called for the Employment Act to be extended to include rehabilitation. Despite these provisions, however, the UK still lags behind other countries in this area, and it can be generally noted that much of the policy is non-binding with relatively few obligations to undertake rehabilitation.

In terms of non-legislative provisions, EU projects and initiatives have filtered down to the UK level. *Revitalising Health and Safety* and *Securing Health Together* are examples of this type of provision. However, evaluation of these initiatives and whether they are actually effective in terms of WRS remains to be seen. Other pilots are also underway, such as the government provisions for rehabilitation, but again we await systematic evaluation and dissemination of results. The EC (1999) guidance on WRS applies to the UK and has made available to employers some methodological provisions for WRS in terms of recognising, diagnosing and managing the problem. However, Koukoulaki (2002) suggests that this EC guidance has had little practical impact.

Although UK social partner agreements are few and far between, some Unions have produced model stress policies that they encourage employers to adopt. The TUC's *Stress MOT* is a good example of how the Unions are important to creating non-legislative provisions. As crucial as the Unions are however to the debate on work related stress and long-term absence issues, most of the provisions tend to be procedural and may not necessarily lead to adequate provisions.

At a general level, organisations in the UK retain a high degree of discretion in their management and approach to stress related absence, and absence that is long-term. In comparison to other countries, statutory UK provisions for rehabilitation and reintegration following long-term or stress related absence are poor. A more fundamental problem is that total UK public expenditure on healthcare, as a percentage of GDP (1%), still lags well behind other OECD States (CBI, 2001). If this underlying neglect on healthcare provision is not redressed, it is hard to see how the UK will catch up with other countries or be able to provide adequate and competent provisions for those forced out of work due to stress related illness.

5.2 Level of Awareness and Debate

It is clear that there is a considerably wide and extensive debate on work related stress and long-term absence. Publications by the EU (e.g. EC, 1999) and by the HSE (2001) are evidence of this. Employer surveys such as those carried out by the CBI (2001) and CIPD (2002) are also contributing to a high level of debate on the causes of long-term absence and current management practices. The highest level of awareness on the issue of WRS and subsequent illness is the World Health Organisation and its recognition of stress as a leading cause of ill-health at work. The EU also recognises stress as a major cause. The UK has subsequently adopted this standpoint.

The government's Green Paper that has been continually discussed is the most significant step forward in terms of raising the level of awareness on issues of long-term absence and exclusion, and pervasive causes such as mental ill health. The UK initiatives described in Chapter Three are building the level of awareness amongst the public.

The definition of stress and the whole concept may be causing a degree of confusion. Organisations and employees frequently report 'stress', however, awareness doesn't really extend beyond this umbrella term with its inherently negative connotations. If employers are interested in stress issues, they are likely to adopt the HSE's definition along the lines of an 'adverse reaction to excessive pressure'. As a recent HSE commissioned review found, there appears to be no standard, reliable and valid way to measure psychosocial hazards in the workplace currently in use (Rick et al, 2001). This is likely to contribute to confusion in this area.

In terms of diagnostic processes, it appeared in Chapter Two that the government Employer's Organisation has produced an inventory of 'A to Z' causes of sickness absence. However this inventory amounts to little more than a descriptive list of conditions, without any real understanding of work stress and how this interrelates with psychological and physiological conditions. Stress may be diagnosed during the certification process, but there is no research on the current organisational practice and how it may relate to stress.

Whilst considerable debate exists on the current legal provisions for the protection of workers against WRS (e.g. Smith, 1998a-c; Wiley, 2002), many of the effects of the Disability Discrimination Act have been undermined due to a general lack of awareness amongst employers and a reluctance of employees to bring their cases to court (Riddell, 2002).

On a positive note, research that has been carried out (e.g. Riddell, 2002) into issues such as sickness certification do recognise the mediating influences of psychosocial factors on decisions to certify. Thus, at an empirical level awareness is being facilitated. As previously noted in Chapter Two, the goal of the occupational health practitioner is currently being re-orientated towards the case management of those on sickness absences and towards vocational rehabilitation. Indeed, bodies such as *NHS Plus*

have a particular focus on vocational rehabilitation and recent publications (e.g. Williams et al, 1998) have highlighted the problem of stress in the NHS.

The level of awareness amongst employers is good to the extent that the majority of those surveyed feel more needs to be done to tackle WRS (HSC, 1999). Moreover, it is encouraging that at a time when primary prevention is largely neglected (cf. Koukoulaki, 2002), many employers are aware that prevention is better than cure. Trade Unions are publishing articles on WRS and are monitoring stress-related claims against employers. The TUC even exhibit a level of awareness based on empirical findings: in the management of long-term absence and rehabilitation, they suggest that early intervention is a key principle; indeed a recent systematic review found that early referral to OH services significantly reduced the duration of sickness absence (Michie & Williams, 2003). Lastly, service providers themselves are contributing to the debate by calling for rehabilitation to be part of the health and safety genre.

5.3 Future Policy and Legislative Directions

5.3.1 Summary of provisions on stress

The lack of explicit legislative provisions on work related stress is surprising given the statistics and findings from various surveys indicating that it is a leading cause of illness at work and sickness absence. Work-related stress [WRS] consistently tops the list of reported workplace hazards, costs the EU Member States over two-and-a-half billion Euros a year and is expected to be the second largest cause of global disease by 2010 (Tudor, 2002; Levi, 2002). Despite the associations between workplace factors and psychological ill health, evidence-based interventions to reduce these problems are scarce (Michie, 2002); moreover, no European country expressly refers to work-related stress in its regulations (Koukoulaki, 2002).

Whilst the incidence of stress litigation and compensation cases is growing rapidly, the law with regards to stress is still being tested (Beishon, 2002). Court of Appeal judgements last year clarified some critical points for employers, namely that the employee is more liable with regards to reporting stress whilst employers are only responsible for those stress cases that they are told about. Employee Assistance Programmes constitute, to some extent, a reasonable duty of care. In the UK in May 2001, two council workers received compensation for stress-related illness due to work overload caused by staff shortage, insufficient training and lack of recovery opportunities at work (Koukoulaki, 2002). As previously noted, stress litigation claims do to some extent influence the kinds of provisions employers are required to make in terms of protecting employees against stress. The question is whether the design and management of work is likely to lead to problems (i.e. stressful conditions) for a significant number of people; the provisions made for employees is that the employer is required to do what a reasonable employer would (Smith, 1998b); this would exclude becoming involved in personal stressors outside of the workplace. As Dr Andrew Auty points out, “Where a sensible policy or strategy is in place, and is followed, it will be harder for an employee to plead ‘stress’ and prove a breach of duty of care.” (cited by Smith, 1998b).

The current situation is that the way is open to draft and consult on guidance making the requirements of Health & Safety legislation more explicit for employees suffering from stress related illness (Wiley, 2002). The CoA guidance discussed in Chapter Two is the beginning of this process in terms of reinforcing the need to manage the problem of stress in the workplace. These guidelines were more about the management of the legal process rather than the provision of preventative duties, but they did redress the failure to recognise the importance of stress for the employee, employer, business and society as a whole.

5.3.2 Future Directions

The genre portrayed by the bodies such as the *European Foundation for the Improvement of Living and Working Conditions* with regards to WRS is that change can be expected over the next couple of years. In relation to issues of stress and psycho-social risk factors:

> It is to be expected that the likely increase in the number of workers affected and the action of the social partners (research, training, greater awareness and information) will lead in the next few years to more preventative action in this area at company level and in collective bargaining. (EF, 2003)

As previously noted, there is a great deal of support for an Approved Code of Practice for work-related stress; presumably this Code could include how to deal with employees who have experienced stress-related illness and subsequent absence. These Codes would be legally binding in terms of how employers deal with stress in the future. However, plans to make this a reality are still very much 'under review' – it is therefore not possible to suggest a timescale.

Currently the HSE are piloting new Management Standards on work-related stress which assess its organisational sources and set acceptable cut-off points. It is therefore possible that compulsory 'Stress Audits' may become part of legislation, requiring employers to assess levels of strain using standardised instruments (e.g. JSS, OSI). Obviously this would be significant for employers since the issue of WRS and associated ill-health would be part of their statutory agenda and would make them more 'vulnerable' to prosecution. Presently it is more problematic to prove a breach of duty, whereas this imposition would see a rise in successful claimants. As soon businesses begin to loose more money than at present, no doubt the issue will be treated more thoroughly. Although this duty was expected to be in place by the end of 2003, the HSE have refused to comment, leaving employers to anticipate their decision. 2005 is perhaps a more realistic target.

The results of the government's Job Retention and Rehabilitation Pilot [JRRP] will provide guidance on how to deal with mental health claimants and their subsequent return to work. There will be no immediate significant changes in policy since the results are not due until 2005. The British Society of Rehabilitation Medicine is a body that may influence policy on provisions for long-term absence and rehabilitation. The BSRM has already provided an extensive report in which it calls for the creation of an Institute for Vocational Rehabilitation Research. This would be a multi-disciplinary body with links to Universities. Proposals are that it would raise awareness on rehabilitation issues and the link between work and health. Accredited courses would also be created to meet the inevitable future demand for specialists in this area.

The Trade Union Congress (2003) has also stated that it wants to play a role in any future system of rehabilitation. Their vision includes the centralisation of vocational rehabilitation services, bringing provisions for benefits, advice and insurance together. The TUC has called for 'joined-up' policies in this area and a government Minister to act as an oversight in this area.

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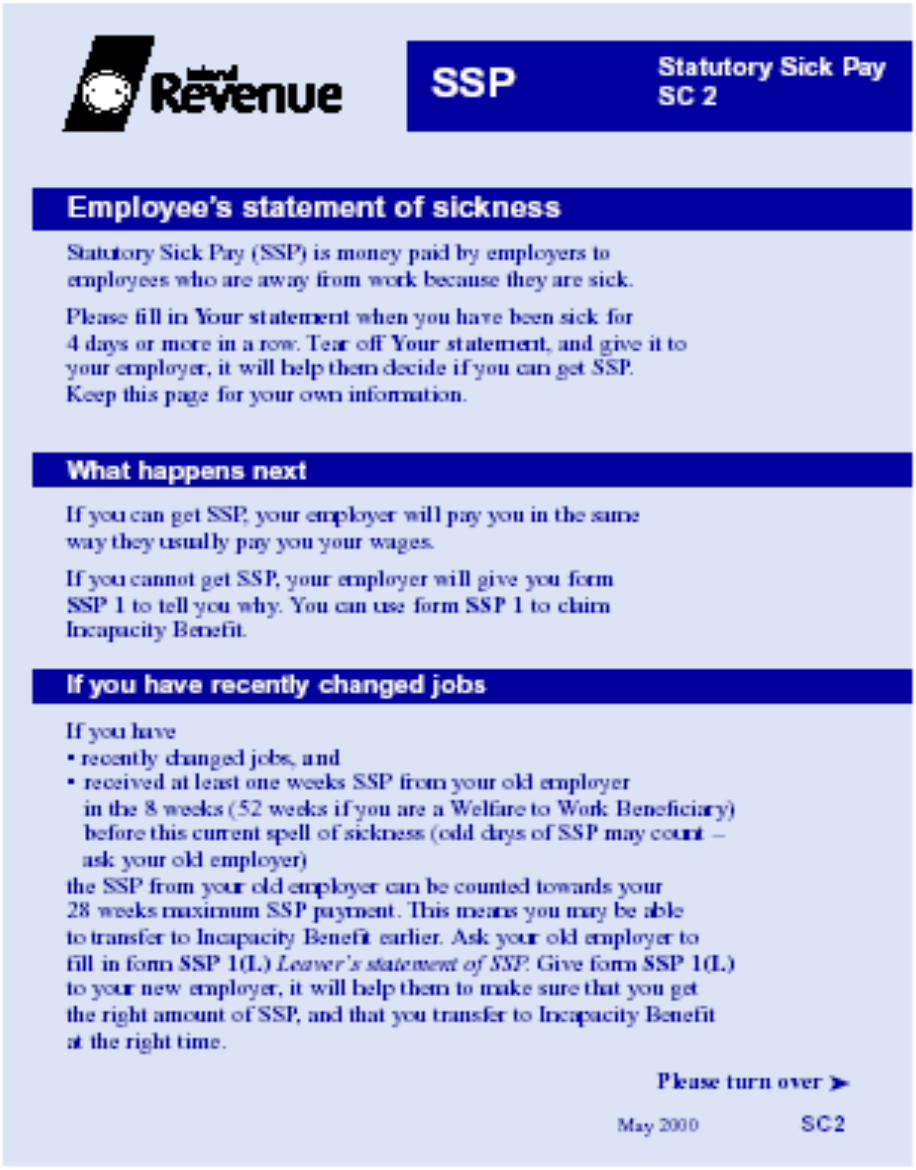
Appendix A



Revenue

SSP Statutory Sick Pay
SC 2

Employee's statement of sickness

Statutory Sick Pay (SSP) is money paid by employers to employees who are away from work because they are sick.

Please fill in Your statement when you have been sick for 4 days or more in a row. Tear off Your statement, and give it to your employer, it will help them decide if you can get SSP. Keep this page for your own information.

What happens next

If you can get SSP, your employer will pay you in the same way they usually pay you your wages.

If you cannot get SSP, your employer will give you form SSP 1 to tell you why. You can use form SSP 1 to claim Incapacity Benefit.

If you have recently changed jobs

If you have

- recently changed jobs, and
- received at least one weeks SSP from your old employer in the 8 weeks (52 weeks if you are a Welfare to Work Beneficiary) before this current spell of sickness (odd days of SSP may count – ask your old employer)

the SSP from your old employer can be counted towards your 28 weeks maximum SSP payment. This means you may be able to transfer to Incapacity Benefit earlier. Ask your old employer to fill in form SSP 1(L) *Leaver's statement of SSP.* Give form SSP 1(L) to your new employer, it will help them to make sure that you get the right amount of SSP, and that you transfer to Incapacity Benefit at the right time.

Please turn over ➤

May 2000 SC2

Employee's statement of sickness (continued)

If you go abroad

If you are sick, and

- there is more than 8 weeks between this spell of sickness and an earlier spell, and
- you are outside the European Economic Area (EEA), and
- your employer is liable to pay Class 1 National Insurance contributions for you

you may be able to get SSP if you meet the other conditions for entitlement.

You can find out more about this in leaflet CA86 *Employee's Guide to Statutory Sick Pay*.

Other help while you are sick

You can get more information about other help while you are sick in leaflet SD 1 *Sick and disabled?*.

If you do not have much money coming in while you are sick, you may be able to get Income Support. Income Support is a social security benefit for people who do not have enough money to live on. You can find out more about Income Support from your local Social Security office.

You can get leaflet SD 1 from

- any Social Security office
- most advice centres like the Citizens Advice Bureau
- any Post Office, (except in Northern Ireland)

If you want to know more about benefit entitlement while you are sick, ring the Benefit Enquiry Line for people with disabilities. The phone call is free. The number is 0800 882 200, or in Northern Ireland 0800 220 674.

If you have any problems with hearing or speaking and use a textphone or minicom, ring 0800 243 355 or in Northern Ireland 0800 243 787. The phone call is free. If you do not have your own textphone or minicom system, they are available from the Citizens Advice Bureau and main libraries.

If you want to know more about SSP, contact your local Inland Revenue (NI contributions) office. You can find the telephone number in the phone book under Inland Revenue.

Your statement

About you

Surname

Other names

Title Mr/Mrs/Miss/Ms

National Insurance (NI) Number

Date of birth / /

Clock or payroll number

About your sickness

Please give brief details of your sickness

What date did your sickness begin? / /

What date did your sickness end? / /

If you do not know when your sickness will end, leave this box blank.

- The dates you put in these 2 boxes may be days you do not normally work.
- If you are sick for more than 7 days, your employer may ask you for a medical certificate from your doctor. Medical certificates are also called sick notes or doctor's statements.

Was your sickness caused by an accident at work or an industrial disease? ☐ Yes ☐ No

If your answer was 'Yes', you may be able to get Industrial Injuries Disablement Benefit. If you want information about claiming this benefit, ask at your local Social Security office.

Your signature

Signed

Date / /

Tear off this page and give it to your employer.

Appendix B

FOR SOCIAL SECURITY AND STATUTORY SICK PAY PURPOSES ONLY

NOTES TO PATIENT ABOUT USING THIS FORM

You can use this form either:

1. For Statutory Sick Pay (SSP) purposes - fill in Part A overleaf. Also fill in Part B if the doctor has given you a date to resume work. Give or send the completed form to your employer.

2. For Social Security purposes –
To continue a claim for state benefit fill in Parts A and C of the form overleaf. Also fill in Part B if the doctor has given you a date to resume work. Sign and date the form and give or send it your Local Social Security Office QUICKLY to avoid losing benefit.

NOTE: To start your claim for State benefit you must use form SC1 if you are self-employed, unemployed or non-employed OR form SSP1 if you are an employee. For further details get leaflet IS252 (from Social Security Local Offices).

Doctor's Statement

In confidence to

Mr/Mrs/Miss/Ms .....

I examined you today/yesterday and advised you that

(a) You need not refrain from work

(b) you should refrain from work

for*† .....

OR until .....

Diagnosis of your disorder causing absence from work.....

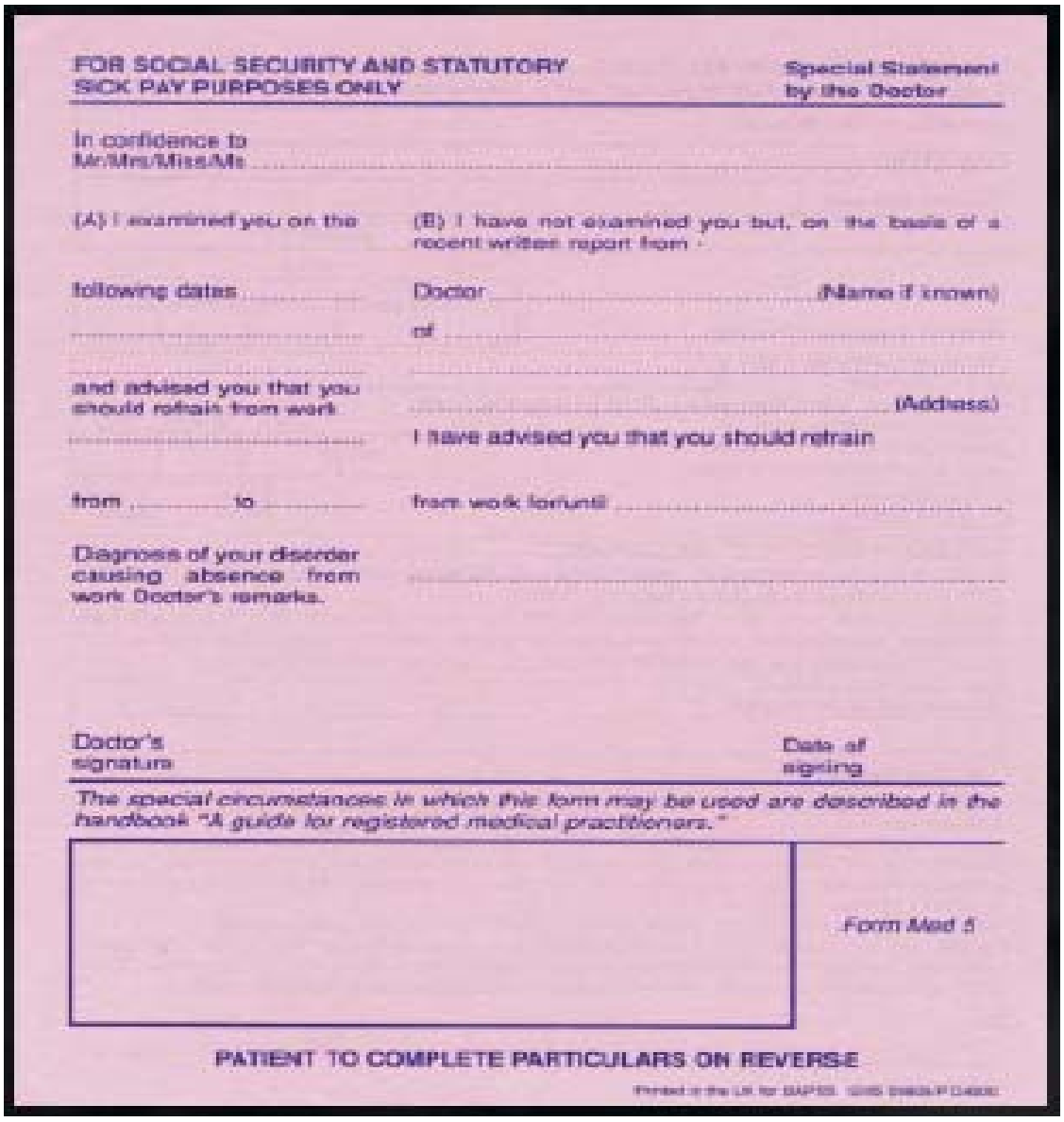
Doctor's remarks

Doctor's signature

Date of signing

Form Med 3

NOTE TO DOCTOR*† *See inside front cover for notes on completion*



FOR SOCIAL SECURITY AND STATUTORY SICK PAY PURPOSES ONLY

Special Statement by the Doctor

In confidence to
Mr/Mrs/Miss/Ms .....

(A) I examined you on the following dates .....

and advised you that you should refrain from work .....

from ..... to .....

(B) I have not examined you but, on the basis of a recent written report from -

Doctor ..... (Name if known)

of .....

..... (Address)

I have advised you that you should refrain

from work for/until .....

Diagnosis of your disorder causing absence from work Doctor's remarks.

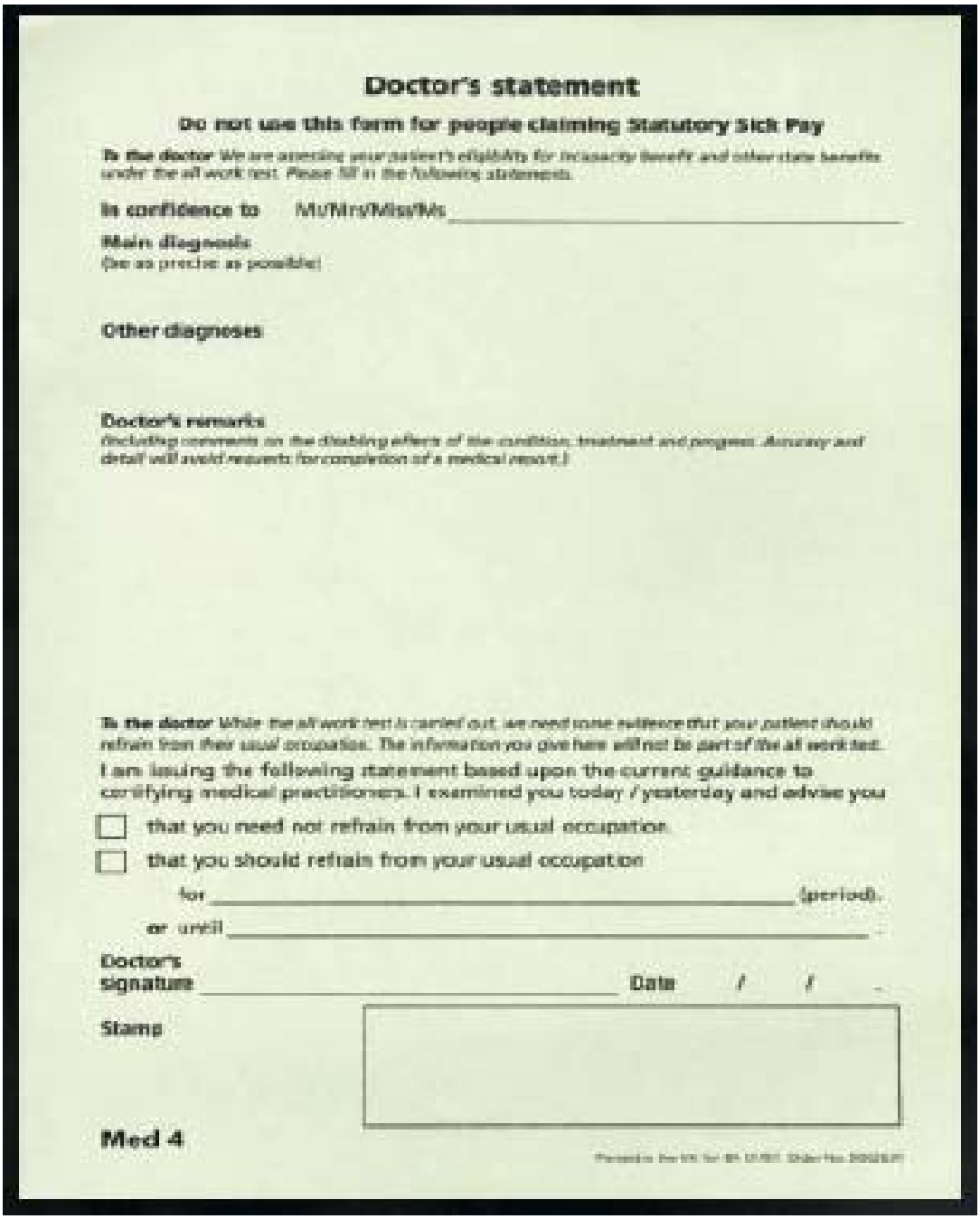
Doctor's signature

Date of signing

The special circumstances in which this form may be used are described in the handbook "A guide for registered medical practitioners."

Form Med 5

PATIENT TO COMPLETE PARTICULARS ON REVERSE



Doctor's statement

Do not use this form for people claiming Statutory Sick Pay

To the doctor *We are assessing your patient's eligibility for incapacity benefit and other state benefits under the all work test. Please fill in the following statements.*

In confidence to Mr/Mrs/Miss/Ms _____

Main diagnosis
(be as precise as possible)

Other diagnoses

Doctor's remarks
(including comments on the disabling effects of the condition, treatment and progress. Accuracy and detail will avoid requests for completion of a medical report.)

To the doctor *While the all work test is carried out, we need some evidence that your patient should refrain from their usual occupation. The information you give here will not be part of the all work test.*

I am issuing the following statement based upon the current guidance to certifying medical practitioners. I examined you today / yesterday and advise you

☐ that you need not refrain from your usual occupation

☐ that you should refrain from your usual occupation

for _____ (period).

or until _____.

Doctor's signature _____ **Date** / /

Stamp

Med 4

Appendix C

B7 Number of claimants of Incapacity Benefit at 31 August 2002, by Diagnosis Group[1]

Thousands

	All IB	Men	Women
All Cases	2,377.0	1,466.0	911.0
Claimants without any diagnosis code on the system	4.9	3.1	1.8
Certain Infectious and Parasitic Diseases (A00 - B99)	17.6	11.8	5.8
Neoplasms (C00 - D48)	33.5	18.6	14.9
Diseases of the Blood and Blood forming organs and certain diseases involving the immune mechanism (D50 - D89)	3.9	2.0	1.9
Endocrine, Nutritional and Metabolic Diseases (E00 - E90)	35.6	24.5	11.1
Mental and Behavioural Disorders (F00 - F99)	833.0	477.2	355.9
Diseases of the Nervous System (G00 - G99)	122.5	67.5	55.1
Diseases of the Eye and Adnexa (H00 - H59)	14.7	10.5	4.2
Diseases of the Ear and Mastoid Process (H60 - H95)	9.9	6.4	3.5
Diseases of the Circulatory System (I00 - I99)	179.1	144.2	34.9
Diseases of the Respiratory System (J00 - J99)	66.4	43.9	22.5
Diseases of the Digestive System (K00 - K93)	40.2	26.4	13.8
Diseases of the Skin and Subcutaneous System (L00 - L99)	15.4	10.2	5.3
Diseases of the Musculoskeletal system and Connective Tissue (M00 - M99)	521.2	314.1	207.1
Diseases of the Genitourinary System (N00 - N99)	17.5	8.2	9.4
Pregnancy, Childbirth and the Puerperium (O00 - O99)	4.7	-	4.7
Certain Conditions Originating in the Perinatal Period (P00 - P96)	-	-	-
Congenital Malformations, Deformations and Chromasomal Abnormalities (Q00 - Q99)	5.1	2.8	2.4
Symptoms, Signs and Abnormal Clinical and Laboratory findings, not elsewhere classified (R00 - R99)	272.0	168.8	103.2
Injury, Poisoning and certain other consequences of external causes (S00 - U23)	150.2	106.6	43.6
Factors influencing Health Status and Contact with Health Services (Z00 - Z99)	29.5	19.7	9.8

Note: [1] Diagnosis Group is taken from ICD10 published by the World Health Organisation

Note: these figures are slightly lower than those reported in Section 2.2.3; this due to adjustments made in light of the DWP Green Paper that reported more contemporary stats on mental and behavioural disorder claims as a percentage of the working population.