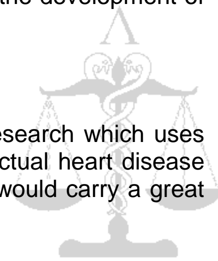
Stress Management Standards

HSE expects to produce the first in a series of management standards in 2003.

Cont…

It is our view that research evidence in support of management standards is thin on the ground.

Conversion of weak or suggestive evidence, into clear – cut guidance requires, in our view, a set of policy decisions. At this point it is not clear what policy guidance is being applied to the development of these standards.



Policy items to consider include:

Outcomes. Is any evidence-base in support of management standards limited to research which uses objective, diagnosed harm as the outcome? Outcomes of this sort would include actual heart disease and diagnosed mental illness for example. If so, guidance on protective standards would carry a great deal of weight in the context of liability insurance.

However, in the absence of high quality work of this sort there may be a tendency to rely on research which associates symptoms and subjective reports with, psychosocial factors at work. These outcomes would come under a heading such as wellbeing and not, health/injury. Outcomes of this sort would include high blood pressure, reported sickness absence, aches-and-pains and job satisfaction.

Clarity of policy on this issue is essential if we are to know the potential implications of the management standards for liability insurance.

Strength of association. Much of the literature finds strengths of association between stressors and outcomes to be of the order of between 1.0 and 2.0. (Higher values tend to have low precision.)

Associations at this level would not pass the test of "balance of probabilities" and certainly come nowhere near the requirements of "beyond reasonable doubt", the level that perhaps ought to be required for HSE prosecutions.

Typical policy on this issue would be that a finding would be accepted if there was consistent evidence of association.

Policy to adopt a precautionary approach, a reasonable approach or a beyond-doubt approach should be made clear.

Effect of interventions. Will any of the standards under development be tested before launch? Will the outcomes of interest be health-related or perception-related? Will it be certain whether the effect is specific to the intervention?

Dose-response relationships. Exposure standards are usually based on dose response relationships. Again this begs the question, what kind of measure of response is being used as the measure of outcome?

If dose response studies are being used for the development of standards of exposure, what metric is being used to decide an acceptable level of exposure? I.e. what is the acceptable cut-off point?

If the standard is “the lowest level that is reasonably practicable”, risk assessors will need to know the conversion rate between exposure and health related loss (or some other adverse outcome) before forming a judgement on the reasonable expense required.

Interdependence. Much of the literature talks about balancing or offsetting of psychosocial factors at work. For example, demands may be offset by control. In practice, workplaces come with a wide variety of balances such as social support, high salaries, comfortable surroundings, career structures, professional development, skill discretion... How are these balances to be reflected in any issue-specific standards?

HSE is not required to provide clarification of any of these policy issues, but if it is to claim that management standards are evidence based it would be helpful if they did.

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