New, HSE Guidance on Work-Related Stress

Tackling work-related stress: a managers' guide to improving and maintaining employee health and well-being. (2001) HSE Books HSG218

HSE are committed to a programme of work to address those hazards which come under the general heading of work-related stress. This new guidance, HSG218, represents a part of a programme of publicity and education. It covers many of the issues described in the earlier guidance (1995) *Stress at work - A Guide for Employers*, but provides more assistance with understanding and identification of hazards.

HSC's longer-term strategy is to develop and agree standards of good management practice under headings such as Job Control, Demands, Role Conflict and so on. These management issues, when mismanaged at work, are believed by many to be key factors leading to the experience of stress. The aim of the above standards will be to ensure that situations that might be expected to be stressful, can be readily identified or, predicted, and managed out of the system. Once management standards have been agreed, further guidance will be written for employers and HSE inspectors, and further publicity can be anticipated.

In our view, the new guidance (HSG218) addresses some of the key issues that should, as a matter of general good practice, be thoughtfully managed at work e.g. job control and role clarity. Whilst the specific links between these issues and ill health may yet be uncertain, their importance in good management is generally accepted. Better management ought to lead to increased competitiveness.

On the subject of stress, it is particularly welcome to see the emphasis on discussion and consultation with staff as a practical way to gauge the importance of each of these management issues and their possible implications for workplace stress. There is consistent scientific evidence of the value of sincere consultation both in achieving business targets and, overcoming difficulties at the health/work interface.

Further comments on HSG218 are limited to areas where there is some uncertainty about the approach being espoused or the potential effect on liability for personal injury.

Comment on the approach

In general, HSE guidance identifies and describes practices that could be used as evidence of an appropriate standard of care. Up to now, and including HSG218, standards for stress prevention and management have been qualitative and therefore very difficult to measure, to test in the civil courts and to enforce under HASWA (1974).

Quantitative objective standards, [if they could be defined and agreed, and were accurate (suited to the purpose of preventing injury),] would probably ease the assessment of liability issues such as; breach of duty and, foreseeability, and should of course, make work less hazardous, where they are met.

Such standards would, in principle, presume a causal link between substandard management and some sort of adverse outcome(s). HSE has not (to our knowledge) accurately defined the adverse outcomes it seeks to address with management standards, nor the standard of proof required as a basis for presuming causal links between exposure(s) and outcome(s). While it may be that stress itself is the adverse outcome HSE seeks to address, stress is not in fact an injury. In short, standards for prevention of stress may have only a tenuous link with prevention of injury and as such would arguably be of little relevance to liability assessment.

It is our current view that accurate, objective standards even for stress management cannot be extracted from existing knowledge or publicly published research findings. The production of such stress prevention standards would therefore be by consultation, (in the light of whatever evidence there is), a process which should include the views of all those involved with stress risk management, including insurers.

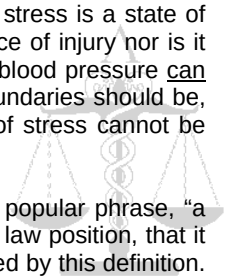
Fundamental scientific research into management standards would be highly complex if it were to be done properly. HSE has recently invited proposals for the performance of reviews of the existing literature.

Other comments on the guidance

Definition of Stress
The definition of stress adopted in the guide is in effect one of, a state of being, as opposed to, harm:

> '[Stress is]…*the adverse reaction people have to excessive pressures or other types of demand placed on them'*

An analogous state of being would be the finding of high blood pressure, which by itself is neither evidence of harm nor is it necessarily harmful. In the same way, the experience of stress is a state of being, a reaction to excessive pressures/demands, which by itself is neither evidence of injury nor is it necessarily injurious. The analogy breaks down when measurement is considered; blood pressure can be measured, though there still are arguments about where the high/normal/low boundaries should be, and what the relevant outcomes are for making such definitions. The experience of stress cannot be objectively measured, nor can it be precisely related to injury outcomes.



The guide clearly defines stress as necessarily adverse, thereby ensuring that the popular phrase, "a little stress is good for you", becomes , by definition, unsound. The current common law position, that it is reasonable for managers to allow reasonable pressure, is not apparently challenged by this definition. By definition then, stress occurs when pressures are unreasonable.

Well being and/or Health?
The distinction between the management of well being and the management of health hazards is in our view crucial to the assessment of any liability implications of this guidance (HSG218) and subsequent management standards.

Objective measurements of stress (either at the population or individual level) and potential strength of association with ill health outcomes, is notoriously difficult. The origin, degree and duration of stress required to cause or aggravate ill health is, as far as we know, unknown either for robust, normal or for vulnerable individuals or populations. It follows from this, that a purely scientific definition of either reasonable or, precautionary standards to prevent injury outcomes cannot be achieved.

However, standards that aim to reduce the self-reported experience of stress should in principle be verifiable and therefore meaningful, at least to the extent that self-reports are reliable. The self-reported experience of stress could be related to feelings of well being, almost by definition.

There are many ways of recording a person's views of how they are feeling. However, most published research of this sort has made little if any prospective distinction between robust, normal or vulnerable members of the study population. Indeed it is difficult to know what factors would be used to identify or distinguish these categories of vulnerability. Psychologists have developed tools for measuring personal factors such as self-esteem, sense of competence, self-efficacy, positive affect and negative affect, actual depression and changes in mental health over the last year, for example. Some or all of these could be used to identify robust, normal or vulnerable people (depending on the particular outcome of interest) and therefore properly characterise the populations employed in stress research. Without accurate characterisation it may be very difficult to interpret the meaning of such research.

Science is generally better at identifying the unusual. It remains plausible that reported associations of low perceived well being with stressors at the population level have been 'discovered' because the population included vulnerable people. If this were the case, then standards for stress free management would be biased towards the care of the vulnerable. The validity of this approach could be debated, as could its relevance to liability for personal injury. A standard of care that is based on the presumption of vulnerability, while possibly admirable, may not necessarily be an appropriate standard at common law. A clear statement of the standards to be adopted by HSE in deriving management standards would help clarify this issue.

In our view, the objective scientific link between self-reported well being at work and, objective or official measures of ill health outcomes, is not strong. Management of well being at work (as if it were a measure of the potential for injury), therefore implies a precautionary approach to management of ill health.

One, perhaps philosophical, problem with this management of 'preservation of well-being' aim, is whether or not such an aim is the proper target for HSE. If the outcome of interest is not actually ill health (or rarely is ill health) then, is stress a legitimate issue for the HSE to address? The view of the HSC on this issue is clearly **yes,** but with an instruction to HSE to join forces with other government departments.

However, for liability insurers the problem is potentially very real. If prevention and management standards are set by HSE, using this more precautionary approach, it may well be that this approach steps outside the usual scope of the word 'reasonable', as used in civil law.

Causation

It is suggested (HSG218), that chronic exposure to extreme stress provides the link with ill health and therefore brings stress into the remit of HSE. However, the guide is somewhat uneven on this point, at times it seems to imply that any stress no matter how fleeting, could be harmful.

A clue to the assumptions being adopted by HSE can be found from the history of the development of HSG218. The original draft guidance stated that prolonged or intense stress can lead to anxiety and depression, heart disease, back pain, gastrointestinal disturbances and various minor illnesses. However, this has since been modified to a more accurate statement that it can lead to increased problems with the above list of outcomes. For example, anxiety over the conditions at work could lead to greater perception of low back pain and therefore increased problems at the health/work interface, perhaps manifesting as a belief in the need for avoidance of further exposure. This does not imply that stress causes back pain, but does correctly link the experience of stress and the experience and affects of back pain. The underlying assumption at the outset was that there were clear links between stress and causation of physical injury. While the causation assumption has since been modified, the original scope of the guidance has not. In our view the title of the guidance would be more accurate if it referred to *maintaining employee psychological health and sense of well-being.*

In terms of causation, the distinction is important for liability insurers. For example, people with heart disease have more reported problems coping with life if they are also reporting the experience of stress, but this does not, and should not, imply that stress causes heart disease. People with heart disease find it harder to walk up hills, but this does not mean the hills caused the heart disease. It is our experience that the research into links between stress and ill health outcomes does not generally accurately account for the interaction between the experience of stress and the experience of objectively measured physical ill health. For example, heart disease may feel worse in psychosocially poor environment, but is it actually worse? It may one day be shown that there is a causal link, but in our view, this has not yet occurred.

Science does tend to show that stress and perceived pain can be causally related (aggravation). The mechanism for the apparent link is not yet understood, but an important finding is that such pain is not usually localised in one region of the body. Reports of links between stress and back pain or RSI for example, often fail to ask whether pain was also felt more generally. Pain is not an injury.

Risk assessment

The new guide provides seven broad categories of management that could influence a person's sense of well being. These are:

- culture,
- demands,
- control,
- interpersonal relationships,
- change,
- role clarity, and
- individual factors such as training/skills/previous episodes.

Absolute measurement of any of these is of course, expected to be difficult.

The value of direct engagement with staff is emphasised and although potentially difficult, this would seem to us to be the most likely method of identifying real problems under the above headings. HSE also propose that proxy variables such as sickness absence, performance appraisals, productivity and staff turnover could also be used to discover if any of the above factors may be leading to tangible problems at work.

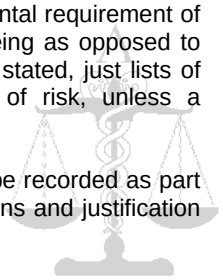
Both methods are necessarily reactive. In our view reactive risk assessment is the only practical way to know if your system of work is biopsychosocially appropriate. Proactive risk management of stress may not yet be reasonably practicable, though may become so, if appropriate standards were known.

The guide then goes on to describe the seven factors in detail. This is the main focus of the guidance and is informative and educational.

It becomes apparent, however, that the seven factors are not mutually independent. Setting aside the obvious potential for some confusion, the lack of mutual independence of these factors should not be a bar to understanding at a qualitative level. However, lack of mutual independence makes it increasingly unlikely that objective management standards for each factor can be determined and set in isolation.

[Aside: The problem of independence could, in principle, be offset by the use of selected ratios, such as the demand/control ratio. This at least allows the possibility that any adverse effects on perceived well being due to high demand can be offset by the benefits of high control. Such, self-evident ratios are currently being tested in scientific experiments. However, for completeness, each ratio should be tested for independence from other ratios. For example, control should be viewed in the light of role clarity. In turn, role clarity may be influenced by culture.]

This balancing of positive and negative exposure would seem to us to be a fundamental requirement of a meaningful assessment of risk. [In this case the risk is of an adverse state of being as opposed to injury]. Lists of hazards should not be mistaken for a risk assessment; they are as stated, just lists of hazards. Lists of hazards may not be an appropriate basis for management of risk, unless a precautionary approach is being adopted.



Opinion of the balance between for example, high demand and high control should be recorded as part of a risk assessment. Such opinion would form the basis of an analysis of the reasons and justification why actions were or were not taken.

Rehabilitation
Recognition that rehabilitation should form an active part of work-stress management is probably appropriate. Efforts to ensure successful rehabilitation ought to highlight areas of work where there was an adverse imbalance between positive and negative exposures e.g. the effects of excessive demands exceeded the effects of high decision latitude. Further episodes for the absent individual, and possibly at a wider level, could therefore be avoided. Rehabilitation offers the opportunity to improve prevention, it provides a window on perceived reality.

There are of course difficulties in being certain of the cause of absence and correct identification of the factors at work that should be modified. The guidance relies on there being an atmosphere of trust and effective communication between managers and staff. Evidence provided by rehabilitation research emphasises the need for a cooperative, sincere, consensual approach and the need to maintain good relations during periods of absence.