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Workplace Interventions for People with Common Mental Health Problems**Key Themes from Round Table Discussions at London and Edinburgh BOHRF Evidence Review launches September 2005****Executive Summary**

Over 200 senior managers, HR professionals, policy makers and health professionals from the private and public sectors, DWP, Dept of Health and the Scottish Executive pooled their thoughts at the London and Edinburgh launches of the evidence review in September 2005. They identified the key future issues related to common mental health problems (CMHP) at work. Key evidence gaps have already been identified on pages 37 to 40 of the evidence review report (at http://www.bohrf.org.uk/downloads/cmh_rev.pdf)

Major needs/areas for attention include:

- Cost benefit study of CBT(Cognitive Behavioural Therapy) approaches
- More CBT practitioners
- Proper professional standards and accreditation schemes for all CBT practitioners
- Medicalisation of mental health problems in first sick note as absence from work for over 6 months has serious effects and will almost certainly lead to CMHP
- Good quality research into organisational interventions
- Identification of vulnerable groups well before CMHP arise
- Guidance on balance between degree of disclosure pre-employment and the ability to support work
- Future research
 - Must address expressed needs of employers/advisers
 - Must increase value of findings to policy and employment practice
- small scale studies/pilots dissemination of findings

Bringing employers and researchers together to produce research that will contribute to good employee health and performance at work

1. Changing Attitudes and Thinking

Terminology

Responsibilities

Terminology. Most people view common mental health problems at work as stress, but if it is linked with issues outside work then tend to call it something else. There were seen to be some basic issues to address here.

Is the apparent scale of common mental health problems real or displacement of another problem? This was acknowledged to be an interesting and difficult question by the Chairman of the Research Working Group. There is an increase in people claiming benefit. There is good evidence that the scale of the problem identified in the evidence review is a real problem. People tend to get categorised by what is written on their first sick note. People off work over six months will almost certainly develop a common mental health problem. Being off work so long is a real problem and needs dealing with.

Rights and responsibilities raised comments from several groups. This was in part coupled with the need for education and change in practice regarding key elements of terminology; and in part with the need for good guidance on the balance between the degree of disclosure at pre-employment stage and the ability to support employment.

Balance of employer/employee 'rights' was also discussed in the context of the perceived risk of performance management being construed as bullying and harassment.

Good managers were seen to have a key pre-emptive role in assessing their staff. If work is the problem, remedial action is required. If not work related the person needs help/support through a holistic approach (nb the evidence review showing that multimodal approaches are more effective than an approach having a single basis)

Identification of vulnerable people well before CMPH problems arise was identified by several groups as a key need.

It was widely felt that health professionals need to take a more balanced approach to common mental health problems. For example, need to inform GPs that work can have positive therapeutic effects (evidence shows that work is more often good for mental health than bad for it); CBT therapists need to be committed to work rehabilitation rather than viewing work and the workplace as a noxious influence. The issue of training health professionals to talk in a language that managers and line managers understand was highlighted.

People in jobs for which they are not suited and which they do not like doing were identified at Edinburgh as being a major problem in some areas, and often subject to common mental health problems.

2. Realistic, Practical Evidence Based Solutions

Practical tools to implement the evidence based individual interventions that will work in most organisations were seen as needing development e.g. what would training look like for supervisors and how best to do it; what are the effective components of "stress management".

Training, advice and guidelines packages for line managers including distance provision, was called for by many round table groups, recognising that the evidence shows the most effective approach is contact by line managers. Line managers are the group via which organisations usually devolve responsibility for addressing workplace issues.

3. Resources: Who Should Pay and Cost Benefit

Good cost benefit analysis was seen by many round tables as being of urgent and fundamental importance in persuading employers and others to invest in approaches to better manage CMHPs.

Government representatives, having heard the case for many more CBT practitioners, raised serious concerns about the professional standards/accreditation of practitioners working in this field. There were concerns that some currently, and very likely in the future, were operating without the hallmarks of professional standards.

Who pays provoked considerable discussion. Who should pay? Employer? It might prove expensive unless health insurance was in place. NHS? Individual? Shared payment? DWP? (especially for CBT?) (Of high interest to the DWP budget, which will benefit from a reduction in the number of people on Incapacity Benefit)

Should the provision of occupational health services be mandatory e.g. through the Management Regulations and the provision of health and safety assistance?

Who pays? Not talking about huge sums of money being necessary. Good cost benefit analysis will give employers the motivation to want to deal with CMHP regardless of the source of and irrespective of the causes.

4. Organisational Interventions

Organisational intervention studies of good research quality were seen as a key priority by several groups, because organisational as well as individual interventions are seen as important for prevention. The Research Working Group Chair emphasised that the lack of good published research evidence that organisational interventions work does not necessarily mean that they do not work; only that there is no good published evidence of their effectiveness. The Scientific Secretary commented that there was keen disappointment amongst the research working group that so little evidence regarding organisational interventions was found. She referred to the evidence review finding (page 40) that organisational level interventions should be designed to include individually tailored, focused training in, for example, coping skills. This might lead to organisational interventions being more effective.

5. Line Managers: Managing People and Rehabilitation

Line managers are the group via which organisations usually devolve responsibility for addressing workplace issues.

What type of contact with employees is recommended and by whom? The evidence clearly shows that contact with employees via managers and supervisors is best; training in how best to achieve this is needed. It is the making of contact rather than the content that is the most important aspect. No further research on contact is needed.

How best to support managers? They are busy; often scared of getting involved in mental health issues (not medical people), get jittery on such issues. Training, advice and guidelines needed for line managers.

Benefit of training, skilling, and recognition of the key contribution of line managers in fulfilling their key role in case management was seen as very important; by the time health professionals/HR get involved a case has generally reached a serious stage that is hard to resolve.

Identification of vulnerable people well before CMPH problems arise was identified by several groups as a key need.

The availability and uptake of realistic alternatives to incapacity benefit was seen as key success factor in rehabilitation. The "Pathways to Work" initiative was recognised, inter alia, as trying to address this issue.

Case management was identified as an emerging approach gaining some momentum. It straddles all stakeholders and achieves "joined up thinking". Surprise was expressed that it does not feature in the evidence report. It was explained that this is because little published research was found on the use of case management in the area of common mental health problems.

6. Consistency of Message and Coordinated Approaches

Mixed messages from some stakeholders, such as HSE and unions, regarding the effects of work on health were viewed with concern. Whilst delegates acknowledged that some work can be harmful to mental health, there was widespread acknowledgement that on balance work is beneficial for mental health.

How compatible is the evidence provided in the evidence review with the HSE Stress Management Standards? They are really looking at two different things, was the response. The stress management standards focus on interventions in the workplace. Even if workplace issues were fully resolved there would still be a lot of common mental health problems that impact work. The HSE Stress Management Standards looked at issues specifically regarding the workplace, and acknowledged that there is currently a lack of evidence on some of the issues. The evidence review report contained nothing contrary to the HSE Stress Management Standards.

7. Capturing and Sharing Small Studies and Pilots

Learning from small studies and pilot studies that might not necessarily “qualify” as robust research but which had given good results was highlighted. Particular mention of many such studies which do not get “upgraded” to robust quality research because of lack of resources. A role was seen for BOHRF in being willing to host these on its website e.g. as “problem”, “solution”, “effects”, “cost”, “benefits”.

8. Mental Health Policies

Some delegates, especially HR professionals, saw a need for sharing the effective elements of mental health policies, with the Scientific Secretary of the RWG acknowledging that work is needed on the scope and key issues contained in effective policies. Other delegates advocated integrated policies rather than a stand alone mental health policy.

9. Roles for BOHRF

Delegates identified the following roles for BOHRF in taking forward the evidence base for effective ways of managing CMHP and their impact on people and work.

- Guidelines on the evaluation of interventions
- Web page on small scale case studies that give good results but are not regarded as good quality research (usually because scarcity of resources prevents them being run to robust research methodology). These seen as usefully focussing on problem, solution, cost, effects/results
- There was a view for a similar role regarding the many small scale pilot studies, although others saw this as more an issue for DWP
- Publish methodology for good systematic evidence reviews

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