Report of a system for diagnosis, categorizing and recording occupational mental ill-health

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Introduction

A major clinical role for occupational health is the recognition of work-related disease. Irrespective of the disease or illness in question, this task must involve identification of the workplace factors or exposures potentially responsible, and involvement with management in the investigation of those factors in relation to the particular case. This should lead to a clear decision as to whether or not the condition is occupational. The final phase is advice on the need for improved controls of situations where the disease and its occupational causation are confirmed.

Occupational stress as a cause of mental ill-health has a large media and public profile. While case law is still accumulating, there seems no doubt that such stress must be regarded as a workplace hazard, and as such is covered under the Management of Health and Safety at Work Regulations [1]. There is therefore a statutory requirement on employers to undertake a risk assessment for these hazards within the UK.

Most attempts to survey occupational illness within the UK now place occupational stress near the top of the list [2]. Despite this, the resultant mental illness is not included in the statutory system of occupational disease reporting in this country (Reporting of Injuries Diseases and Dangerous Occurrences Regulations, commonly known as RIDDOR) [3]. In the USA, the Occupational Safety and Health Administration has included mental illness in its rules of recording industrial injury and illness since 2001 [4]. However, there is no system of categorization based on causation or work factor included within this system.

Beyond the statutory systems, occupational mental ill-health has been included within the UK’s Occupational Physician’s Reporting Activity (OPRA) since the scheme’s inception in 1996 [5]. Within OPRA, psychological factors are included within category 5, ‘Other systems’, and the reporting physician is invited to specify a diagnosis and identify a suspected agent exposure or activity. The parallel Surveillance of Occupational Medicine
Stress and Mental Ill-health (SOSMI) system, introduced in 1999 for reporting by consultant psychiatrists, is based on the identification of a number of specified diagnoses [6]. With the exception of post-traumatic stress disorder, these do not give any indication as to the occupational factor or factors that may have been responsible for the condition—although the psychiatrist may specify a precipitating event or events. It is apparent, therefore, that the UK systems do not currently include an agreed set of criteria for occupational mental ill-health, and neither do existing reporting mechanisms attempt to break down the conditions in terms of causation using any standardized categorization of workplace factors or exposures.

Occupational health and safety initiatives within the National Health Service (NHS) in Scotland included a requirement for all NHS employers to gather a minimum dataset of occupational health and safety parameters [7]. The original specification for these data included not only the identification of work-related mental ill-health/stress cases, but also the sickness absence resulting from these conditions. It was quickly recognized that in the absence of a standardized system for recording and categorization, the collection of such data would be of limited value. The inclusion of these parameters was therefore deferred from the pilot minimum dataset collections [8].

Salus Occupational Health & Safety is an integrated health and safety services provider to a number of NHS employers, other public sector groups and private industry. Prior to 2001, occupational physician suspicion of occupational mental ill-health was recorded in an individual’s clinical record, but there was no formalized passage of this information to line management, involvement in investigation, or categorization and recording of confirmed cases. It was therefore decided to develop a standard operating procedure within the Salus Quality System capable of delivering the stated minimum dataset requirement.

Methods

The task of drafting the new procedure was delegated to a psychology sub-group consisting of occupational physicians, senior occupational health nurses and clinical psychologists. Drafts of the documentation were circulated and discussed with human resources (HR) colleagues from a particular NHS employer: The Lanarkshire Primary Care NHS Trust.

The outcome of this activity was:

1. The identification of four basic principles of occupational mental ill-health reporting (Appendix 1).
2. A simple system of three categories of occupational mental ill-health based on causation, with an additional fourth category relating to work or workplace factors but not considered to be relevant in terms of the duties of an employer under the Health & Safety at Work Act [9] (Appendix 2).
3. A system for initial recognition and diagnosis satisfying both the need for ethical compliance and the need for workplace investigation and line management contact before case confirmation can be completed (Appendix 3).

Explanation of the system

Principles adopted

The first two principles are that workplace considerations should be the predominant factor and that the ill-health should be recognized by national or international systems of disease classification. These principles conform closely to established case law in relation to common law cases, as well as the requirements of most pension schemes and insurance situations, where additional payments can be triggered for work-related illness or injury.

Classification system

While there are a large number of potential workplace stressors and pressures which can apply to a varying degree in any case of occupational ill-health, it was suggested that where developing a recording system any categorization should, if possible, be limited to a small number of generic groups. The nine factors highlighted by the Health & Safety Executive (HSE) [10] were considered but rejected. The slight loss of specificity was felt to be outweighed by the benefits of an easier to apply system.

It was considered that any classification system must identify causative factors. This would then allow adequate investigation and, if the diagnosis was confirmed, appropriate corrective action could occur. There is, however, limited research available on the identification of a simple classification to achieve this within a simple recording system.

Within these considerations, it became clear to the group that there was the potential for stress and resultant mental ill-health related to aspects of the work situation which were outside either the Health & Safety at Work Act responsibilities of an employer to prevent, or in relation to the employer’s duty of care. It was considered important for the system to be able to record such instances but to identify them separately from those which would be categorized as occupational disease.

The category system itself includes as group M0 those cases related to work or workplace factors such as job uncertainty, disciplinary procedures etc. which are beyond the duty of care of the employer. It is, however, important to note that there are clear managerial responsibilities in relation to the delivery of appropriate disciplinary process etc., and management action such as
In the absence of statutory consideration of passage of diagnostic information to the employer, it is considered that occupational health ethics determine that this information cannot be passed without the consent of the individual. This conclusion undoubtedly has the potential to limit the number of cases that can be investigated and a firm diagnosis reached.

Pilot

Having developed a draft system, the categorization and reporting of occupational mental ill-health was piloted within Lanarkshire Primary Care NHS Trust for the financial year running April 2002 to March 2003. The system of managerial referral within this employer involves referrals for occupational health assessment being forwarded through HR to the occupational health provider, with managerial reports forwarded back, copied to HR professionals. The system documentation had been developed with the HR function of the employer and subsequent discussions were held on the system before the pilot was instigated.

The pilot was limited to the lead consultant occupational physician for the employer in question, who saw 363 employees during the year, these being both management and self-referrals. This caseload represented the full range of clinical conditions presenting in NHS occupational health practice. A total of 23 cases triggered the procedure and the need to seek information from management. Of these, eight individuals withheld consent, and were therefore not classified as occupational illness. Fifteen cases were therefore raised with management and HR. The results of these cases to date are presented in Table 1.

Seven cases were categorized as occupational mental ill-health, one in category M1, one in category M2, four in category M3 and one in both categories M2 and M3. One case was categorized as ‘non-occupational workplace mental ill-health’ in category M0. A single case following investigation was not confirmed as occupationally related and no entry on the system was made. A further six cases remain in the process of investigation with ongoing management/HR correspondence with occupational health.

One of the cases confirmed on the system as occupational ill-health in category M3 was subject to a claim for industrial injury benefit under the NHS Scottish Public Pension Scheme. This resulted in a request for an occupational health report. This process was greatly facilitated by the documentation and recording of the case in a formalized system with clear criteria for diagnosis and categorization. The introduction of the system coupled with existing recording processes for other occupational disease has allowed the employer to include mental health cases within its minimum dataset
returns for 2002/2003 in relation to occupational illness and resulting sickness absence.

Discussion
In general, it is considered that the pilot of the system has been successful, providing a documented standard procedure for the categorizing and recording of occupational mental ill-health. The total number of cases categorized in this way is most greatly affected by the requirement to obtain patient consent before proceeding with investigation and line management contact. The categorization system has proved easy to use. The boundaries of the categorization system appear clear, and in only one case was there a need to identify two categories in a single case. The system has undoubtedly raised the profile of occupational mental health. While in some cases management information has been limited to simple written responses to the questions raised by the occupational physician, it is now more common for meetings with line management and HR to discuss the case before a conclusion is reached. Delay in reaching a conclusion can occur in circumstances where formal grievance or disciplinary actions occur. In these circumstances, it is clearly appropriate for the occupational physician to have all the available evidence before categorization takes place. The resultant outputs from the system allow inclusion of stress related mental ill-health problems within datasets on occupational ill-health incidence and morbidity. The system also facilitates the completion of reports in relation to occupational causation and claim for industrial injury/illness benefit.

Conclusion
A simple system of categorization and recording of occupational mental ill-health has been produced and trialled in a single NHS employer. Its details are circulated and publicized in an attempt to seek peer review and comment. The system appears to provide a possible way forward for a standardized NHS or UK national system for recording occupational mental ill-health.

References

Appendix 1: Basic principles of occupational mental ill-health reporting
1. Only cases where, in the view of an occupational physician, work or workplace considerations are the predominant factors in inducing mental ill-health will be recorded. A crucial test will be whether it is considered that, in the absence of the occupational incident or exposure, there would not have been a significant difference in the individual's underlying mental health.
2. Occupational stress is regarded as a physiological process or response rather than a diagnosis of ill-health in itself. Individuals will only be recorded on the system where occupational factors have resulted in significant ill-health recognized by national or international systems of disease classification (ICD 10/DSMIV), i.e. depression, anxiety etc.
3. It is important to attempt to include some estimate of the causative factors of work responsible for the mental ill-health. Without such data, appropriate corrective action and learning from experience cannot occur.

4. There are work related factors such as job uncertainty, termination of employment, and the operation of disciplinary procedures which, even when handled appropriately by management, may nevertheless result in stress and, in turn, mental ill-health. It is not considered that these events are preventable under the legal obligations placed on management by the Health & Safety at Work Act and, as such, they will not be recorded in the system as occupational mental ill-health. The system will, however, record separately under a category entitled ‘Non Occupational Workplace Mental Health’ instances of this type.

Appendix 2: Categories of occupational mental ill-health reporting

M1 Significant occupational mental ill-health related to specific workplace exposures, i.e. toxic chemicals, risks of violence and aggression, noise, etc.

M2 Significant occupational mental ill-health related to the imbalance of capability and workload/work contact, i.e. work overload, work underload, lack of autonomy, etc.

M3 Significant occupational mental ill-health related to inter-personal or intra-organizational relationships at work, i.e. bullying, managerial style, workforce attitude, etc.

In addition to the three categories of occupational mental ill-health, data are also recorded on the incidence of the following category:

MO Significant mental ill-health related to work or workplace factors, but not in relation to the duties of the employer under the Health & Safety at Work Act, i.e. job uncertainty, termination of employment, operation of disciplinary procedure, etc. (Note that the existence of a disciplinary case or job uncertainty etc, does not in itself determine the categorization of any mental health as MO. Against a backdrop of MO issues, significant mental ill-health can occur related to M1, M2 or M3, and should be categorized accordingly.)

Appendix 3: Diagnostic system

1. The responsibility for diagnosis rests with the specialist in occupational medicine. This process may involve seeking reports, clinical examination and investigations.

2. These investigations should normally include consideration of the workplace, including direct contact with line management. Contact with management involving direct consideration of the clinical case may only proceed where patient consent has been obtained. In circumstances where the diagnosis of occupational causation cannot be confirmed without managerial contact and the patient withholds consent, the case is categorized as not confirmed.

3. When a decision is reached as to whether the condition is related to work or not, in all cases the individual is informed of this conclusion.