FIRE BRIGADES UNION

MENTAL HEALTH AT WORK

AN INITIAL GUIDE FOR FBU REPS

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INTRODUCTION – WHY IS MENTAL HEALTH AN ISSUE FOR THE FBU?

Mental health is a huge issue for firefighters. The Fire Brigades Union takes the mental health of our members very seriously. Recent surveys have demonstrated the scale of the problem in our profession.

To assist officials and members to recognise and have a better understanding of mental health the FBU health and safety committee has produced this initial guidance document.

In recent years FBU conference has discussed a range of mental health issues. Resolutions were supported which involved delegates discussing:

- Harrowing cases of post-traumatic stress and suicide among firefighters
- Gender-specific guidance on mental health
- Ongoing issues around the stigma involved
- Effects of punitive attendance management policies

Conference instructed the executive council to produce mental health guidance designed to assist officials when dealing with mental health issues in the workplace. The national women's committee has raised particular mental health issues at previous conferences such as post-natal depression.

There is a clear link between income inequality and mental health well-being. Research has shown that poor mental health is at least twice as likely for those experiencing the most social disadvantages compared with those experiencing the least social disadvantages. This impacts on firefighters who, in recent years, have faced lower pay, longer hours, job insecurity, changes to shift systems, attacks on pensions and other arbitrary changes to working practices.

The recent 'blue light' mental health survey by the Mind charity has demonstrated the scale of the problem in the fire and rescue service. The FBU health and safety committee has recognised the concerns raised in various forums and is investigating the issues. It has produced this initial toolkit, which is designed to:

- Explain the range of mental health issues that can affect firefighters
- Help understand the issues for different sections of our membership
- Outline employers' duties in relation to mental health
- Assist FBU officials to represent and support members
- Provide a model absence management policy for use when members are suffering with mental health problems

This guidance document is an initial introduction to mental health issues affecting firefighters. The FBU is planning to look at specific areas in more detail and to produce further reports, which may require external expertise and assistance.

SECTION ONE - THE SCALE OF MENTAL HEALTH PROBLEMS

HOW IS MENTAL HEALTH DEFINED?

The World Health Organisation defines **mental health** as: "a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[1]

The Advisory, Conciliation and Arbitration Service (Acas) defines mental health as "the mental and emotional state in which we feel able to cope with the normal stresses of everyday life".[2]

National Institute for Health and Clinical Excellence (NICE) defines **mental wellbeing** as "a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society. **Mental wellbeing at work** is determined by the interaction between the working environment, the nature of the work and the individual".[3]

WHAT ARE MENTAL HEALTH PROBLEMS?

The Mental Health Foundation estimates that **one in four** people will have problems with their mental health at some point, ranging from day-to-day worries to long-term serious conditions. The majority of people who experience mental health problems learn to live with them – just as with physical health problems. About **one in a hundred** people will experience severe mental illness.[4]

Common mental health problems include:

- Anxiety
- Depression
- Post-natal depression
- Obsessive compulsive disorder
- Phobias (and panic attacks)

Severe mental health problems are:

- Psychosis
- Bipolar disorder
- Schizophrenia

Other types of mental health problems:

- Eating disorders
- Attention Deficit Hyperactivity Disorder
- Alcohol and substance dependency
- Dementia

THE SCALE OF MENTAL HEALTH PROBLEMS IN THE UK

The Royal College of Psychiatrists is the professional medical body for psychiatrists that sets standards of psychiatry in the UK. It identifies a number of mental health conditions.

TABLE ONE | COMMON MENTAL HEALTH PROBLEMS

Anxiety	Feeling tense, uncertain and fearful.	Anxiety - 5% Generalised - 2-5%
Depression	Intense feeling of persistent sadness, helplessness and hopelessness, alongside physical effects such as sleep disturbance, lack of energy or feeling general aches and pains.	8-12% in a year 5% chronic
Post-natal depression	A type of depression that many parents experience after having a baby.	10% of mothers
Obsessive compulsive disorder	Distressing and repetitive thoughts that come into the person's mind automatically.	2-3%
Phobias (and panic attacks)	Disorders where anxiety is experienced in certain well-defined situations that are not dangerous.	10 million - phobia 1-3% medically diagnosed

TABLE TWO | SEVERE MENTAL HEALTH PROBLEMS

Psychosis	When a person loses touch with reality, having changed perceptions about the world. This could include experiencing hallucinations, delusions or flight of ideas.	1 in 200 in a year 4% in lifetime
Bipolar disorder	Mood can swing between extreme high (mania) and extereme low (depression).	1-2% of adults during lifetime
Schizophrenia	A mental illness that affects the way people think.	1-2.4% of people

TABLE THREE | OTHER TYPES OF MENTAL HEALTH PROBLEMS

Eating disorders	Anorexia: a serious mental health illness where people keep their body weight low by dieting, using laxatives or excessively exercising. Bulimia: is typified by a cycle of 'bingeing' (eating large quantities) and then 'purging' (either through vomiting or using laxatives).	750,000 people
Attention deficit hyperactivity disorder (ADHD)	A group of behavioural symptoms that include inattentiveness, hyperactivity and impulsiveness.	5-26% among children
Alcohol & substance dependency	Continued misuse of any mind-altering substance that severely affects a person's physical and mental health, social situation and responsibilities.	2-3%
Dementia	A progressive irreversible condition that involves memory, thinking, concentration, problem solving, perception & language.	5% of people over 65 1 in 1,000 under 65

The TUC workbook, Mental Health and the Workplace (2015) has more detailed information on mental health problems and specific disorders.[5]

WORK-RELATED STRESS

The Health and Safety Executive (HSE) defines **work-related stress,** depression or anxiety as "a harmful reaction people have to undue pressures and demands placed on them at work".[6]

Stress is not a mental health diagnosis and is not a recognised mental health condition. Most people with work-related stress will have anxiety, depression or what is termed 'generalised anxiety disorder'.

Work-related stress is the **second-biggest occupational health problem** in the UK and costs the UK £3.6bn every year. Research has suggested that 30–40% of sickness absence is linked to work-related stress.

The latest HSE figures show:

- Stress is more prevalent in public service industries
- The total number of cases of work related stress, depression or anxiety in 2014/15 was 440,000 cases, a prevalence rate of 1,380 per 100,000 workers
- The number of new cases was 234,000, an incidence rate of 740 per 100,000 workers. The estimated number and rate have remained broadly flat for more than a decade
- The total number of working days lost due to this condition in 2014/15 was 9.9 million days, this equated to an **average of 23 days lost per case**
- Stress accounts for 35% of all work related ill health cases and 43% of all working days lost due to ill health
- The main work factors cited by respondents as causing work related stress, depression or anxiety were workload pressures, including tight deadlines and too much responsibility and a lack of managerial support.

Women are more likely to suffer from work-related stress than men. HSE reports that over the last three years, there were 590 cases of work related stress for males and 920 cases for females per 100,000 people employed.

Over the last three years, women in the 34-44 and 45-54 years ranges had significantly higher rates of work-related stress than the average across all persons.

An HSE report published in 2005 found "a significant association between work stress and **ethnicity"**. The report, Ethnicity, work characteristics, stress and health (RR308), revealed that 28% of non-white workers reported high levels of stress compared to 19% for white workers.

POST-TRAUMATIC STRESS DISORDER (PTSD)

Post-traumatic stress disorder (PTSD) involves developing strong feelings of anxiety after experiencing or witnessing something very traumatic. PTSD can cause flashbacks and nightmares where the person is reliving all the emotions experienced during the event(s). Post-traumatic stress disorder affects 2.6% of men and 3.3% of women.[7]

PTSD is a potentially severe and long-term mental health problem. Common symptoms of PTSD include re-experiencing the event in nightmares or flashbacks, avoiding things or place associated with the event, panic attacks, sleep disturbance and poor concentration. Depression, emotional numbing, drug or alcohol misuse and anger are also common.

People with PTSD usually develop the symptoms immediately after the traumatic event but some people develop symptoms much later. People experiencing PTSD may not seek treatment for months or years after the onset of symptoms because they do not think they can be helped.

The Mental Health Foundation says that debriefing someone who has experienced trauma immediately afterwards does not prevent PTSD.[8]

SUICIDE

The Office for National Statistics (ONS) defines suicide as "deaths given an underlying cause of intentional self-harm or injury/poisoning of undetermined intent". In 2014, the last year for which figures are available, some 6,122 suicides occurred in the UK.

Suicide is the leading cause of death among young people aged 20-34 years in the UK and is considerably higher in men, with nearly four times as many men dying as a result of suicide compared to women. Those at highest risk are men aged between 45 and 59 years, followed by men aged between 30 and 44 years.[9]

One reason that men are more likely to complete suicide is because they are less likely than women to ask for help or talk about depressive or suicidal feelings.[10] Recent statistics show that 72% of people who died by suicide over the last decade or so had not been in contact with their GP or a health professional about these feelings in the year before their suicide.[11]

The statistics highlight that talking about suicide is still highly stigmatised. Talking about suicide and understanding it better is necessary to help prevent further suicides.

FIREFIGHTERS AND MENTAL HEALTH

Mind, the mental health charity has been running a 'Blue Light Programme' of mental health support for emergency services staff across England. In April 2016 it released the results of an online survey, which included the views of over 200 firefighters.[12]

The main results for firefighters were alarming:

- 30% of firefighters had **contemplated taking their own lives** due to stress and poor mental health while working for the fire and rescue service
- 5% of firefighters had made an **actual attempt** to take their own life due to stress and poor mental health
- 57% of firefighters had contemplated leaving their job or voluntary role because of stress or poor mental health
- 92% of firefighters had experienced stress, low mood and poor mental health at some point while working for the fire and rescue service
- 61% of firefighters had experienced a **mental health problem** – such as depression, anxiety disorder, OCD, PTSD, bipolar disorder or schizophrenia – while working or volunteering in their current or previous role
- 51% of firefighters had taken time off work due to stress, low mood or poor mental health
- 36% of firefighters said that someone would be treated differently (in a negative way) if they disclosed a mental health problem at their organisation
- 40% of firefighters had been **prescribed medication** (such as antidepressants, sleeping tablets etc.) due to stress and poor mental health
- 59% of firefighters had sought medical help due to stress and poor mental health
- 3% of firefighters had been admitted to hospital due to stress and poor mental health
- 82% of firefighters agreed or strongly agreed that there needs to be **more emotional support** made available to fire and rescue personnel
- 85% of firefighters believed that there needs to be more investment in promoting good mental health among fire and rescue staff.

The Mind survey shows that there is a very high level of mental health need within the emergency services. Not only are a large number of personnel struggling with their mental health, but they are less likely to seek support or take time off when they are sick. In focus groups that took place as part of this research, participants spoke about their fear of stigma, admitting that they would often report in sick with 'flu' rather than discuss their mental health problems.

Last year the FBU obtained figures from the Samaritans, which estimated that at least 13 firefighters had died as a result of suicide over the previous three years. The tragic case of Lee Gaunt, the Greater Manchester firefighter who took his own life in 2015, highlighted the terrible toll of mental ill-health within the fire and rescue service.

Approximately 70-90 firefighters are discharged annually on medical grounds in England, however there are no figures on the proportion of ill-health retirements due to mental health problems. [13]

SECTION TWO - MENTAL HEALTH AND EQUALITY

In recent decades there has been significant changes to the workforce across the UK. There has been new efforts to outlaw discrimination and harassment at work. Government policy has also made connections between health at work and equality at work.

Broadly, unions have tried to make their health and safety work "**equality-sensitive**". This means making sure that differences such as gender, ethnicity, sexuality as well as age, religion and belief are included. It has meant trying to understand how different groups may face specific risks and an emphasis on getting a range of voices into the debate.

MENTAL HEALTH IMPACTS

There are some important differences in the prevalence of many mental health problems.

TABLE FOUR | COMMON MENTAL HEALTH PROBLEMS

Anxiety	Post-traumatic stress disorder affects 2.6% of men and 3.3% of women. The highest levels of anxiety are experienced in the 35–59 **age** group. On average, **all ethnic groups** report higher levels of anxiety than people who describe themselves as White British.
Depression	One in four **women** and one in 10 men will seek treatment for depression. **LGBT** people are at a higher risk of depression. Depression in **ethnic minority** groups is 60% higher than in the white population.
Obsessive compulsive disorder	Research suggests that there is no significant difference in rates of OCD across age, gender, ethnicity, religion or socio-economic group.
Phobias	2.2% of men and 3.3% of **women** have a medically diagnosed phobia

TABLE FIVE | SEVERE MENTAL HEALTH PROBLEMS

Bipolar disorder	There is very little gender difference in the incidence of bipolar disorder
Schizophrenia	There is no gender difference in incidence of schizophrenia Afro-Caribbean people are **three to five times** as likely as white people to be diagnosed with schizophrenia

TABLE SIX | OTHER TYPES OF MENTAL HEALTH PROBLEMS

Eating disorders	The most common **ages** for onset of an eating disorder is during the teenage years and in the early 30s. Of those people seeking help for their eating disorder 10% are male. However, research suggest that the female to male ratio is closer to **3:1**. Males suffering from an eating disorder are less likely to seek treatment. Recent research suggests that there is an increase in people in the 40s and 50s seeking treatment for eating disorders
Alcohol and substance dependency	Research suggests that 28% of **men** and 15% of women have a pattern of alcohol consumption that brings a risk of physical or psychological harm.

GENDER AND MENTAL HEALTH

Mental health problems affect women and men equally, but some are **more common** among women. The same numbers of women and men experience mental health problems overall, but some problems are more common in women than men, and vice versa.[14]

The Mental Health Foundation says that various social factors put women at greater risk of poor mental health than men. Abuse is often a factor in women's mental health problems. However, women's readiness to talk about their feelings and their strong social networks can help protect their mental health. Treatments need to be sensitive to and reflect gender differences.

WOMEN'S MENTAL HEALTH

Women are more likely to have been **treated** for a mental health problem than men (29% compared with 17%). This reflects women's greater willingness to acknowledge that they are troubled and get support. It may also reflect doctors' expectations of the kinds of health problem that women and men are likely to encounter.

Around a quarter of people who die by suicide are women. But women's greater emotional literacy and readiness to talk to others about their feelings and seek help may protect them from suicidal feelings.

Women are particularly exposed to some of the factors that increase the risk of poor mental health because of the role and status that they typically have in society. The traditional roles for women from some ethnic groups living in the UK can increase their exposure to these risks.

The social factors particularly affecting women's mental health include:

- More women than men are the **main carer** for their children and they may care for other dependent relatives too - intensive caring can affect emotional health, physical health, social activities and finances
- Women often juggle **multiple roles** - they may be mothers, partners and carers as well as doing paid work and running a household
- Women are over represented in **low income, low status jobs** - often part-time - and are more likely to live in poverty than men
- Poverty, working mainly in the home on housework and concerns about personal safety can make women particularly isolated
- Physical and sexual abuse of girls and women can have a long-term impact on their mental health, especially if no support has been received around past abuses.

MENTAL HEALTH PROBLEMS AFFECTING MORE WOMEN THAN MEN

Some women find it hard to talk about difficult feelings and 'internalise' them, which can lead to problems such as depression and eating disorders. They may express their emotional pain through self-harm, whereas men are more likely to 'act out' repressed feelings, and to use violence against others.

ANXIETY

Women are twice as likely to experience anxiety disorders as men. About 60% of the people with phobias or obsessive compulsive disorder are women.

DEPRESSION

More women than men experience depression. **One in four women** will require treatment for depression at some time, compared with one in 10 men. The reasons for this are unclear, but are thought to include social factors such as poverty and isolation and biological factors such as the hormonal changes experienced by women. However, some researchers dispute the relatively low depression rate for men.

Post-natal depression is believed to affect between 8-15% of women after they have given birth.

Women's increased **life expectancy** means they are more likely than men to outlive their partner and move into residential care. This means they are more at risk of depression associated with psycho-social factors. Older people are often faced with more difficult life events and daily stresses than younger people and this may explain why they have a slightly increased risk of depression. Losses - whether bereavement or losses associated with growing old such as loss of independence because of physical illness or disability - can trigger depression.

Estimates suggest that 20% of older people living at home have symptoms of depression, rising to 40% for older people living in care homes. The majority of people affected are women. Those over the age of 85 are at particular risk.

POST-TRAUMATIC STRESS DISORDER (PTSD)

Worldwide, more women are affected by PTSD than men, largely because women are exposed to more sexual violence. The risk of developing PTSD after any traumatic event is 20% for women and 8% for men.

EATING DISORDERS

Eating disorders are more common in women than men, with young women most likely to develop one. Some 1.9% of women and 0.2% of men experience **anorexia** in any year. Between 0.5% and 1% of young women experience **bulimia** at any one time.

SELF-HARM

Many more girls than boys self-harm. Research suggests that between one in 12 and one in 15 young people self-harm in the UK.

MENTAL HEALTH OF WOMEN IN MID-LIFE

Women in 'mid-life', aged 45-60 years, may be juggling caring commitments for children and older relatives as well as doing paid work and facing physical health problems. They will also face the menopause and its effects. At the same time, mid-life women may find themselves in financial difficulty as a result of lifelong lower pay, part-time working, family caring, widowhood or divorce. This combination can increase their risk of experiencing mental distress.

DEMENTIA

Two thirds of people with dementia are women. Risk of dementia increases with age, and women have a higher life expectancy than men.

WOMEN AS CARERS

Most carers are women, whether they care for their children, partner, parents, other relatives or friends. Women carers are more likely to suffer from anxiety or depression than women in the general population. **Three quarters of people** who care for a person with a mental health problem are women and the average age of carers is 62 years.

ETHNICITY AND MENTAL HEALTH

Black and minority ethnic (BME) communities have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments.

In general, people from black and minority ethnic groups living in the UK are:

- More likely to be diagnosed with mental health problems
- More likely to be diagnosed and **admitted to hospital**
- More likely to experience a poor outcome from treatment
- More likely to **disengage** from mainstream mental health services, leading to social exclusion and a deterioration in their mental health

These differences may be explained by a number of factors, including poverty and racism. They may also be because mainstream mental health services often fail to understand or provide services that are acceptable and accessible to non-white British communities and meet their particular cultural and other needs.

It is likely that mental health problems go unreported and untreated because people in some ethnic minority groups are reluctant to engage with mainstream health services.

AFRICAN-CARIBBEAN PEOPLE

African-Caribbean people living in the UK have **lower rates** of common mental disorders than other ethnic groups but are more likely to be diagnosed with severe mental illness. African Caribbean people are three to five times more likely than any other group to be diagnosed and admitted to hospital for schizophrenia.

However, most of the research in this area has been based on service use statistics. Some research suggests that the actual number of African-Caribbean people with schizophrenia is much lower than originally thought.

African Caribbean people are also more likely to enter the mental health services via the courts or the police, rather than from primary care, which is the main route to treatment for most people. They are also more likely to be treated under a section of the Mental Health Act, are more likely to receive medication, rather than be offered talking treatments such as psychotherapy, and are over-represented in high and medium secure units and prisons.

This may be because they are reluctant to engage with services, and so are much more ill when they do. It may also be that services use more coercive approaches to treatment.

ASIAN PEOPLE

The statistics on the numbers of Asian people in the United Kingdom with mental health problems are inconsistent, although it has been suggested that mental health problems are often unrecognised or not diagnosed in this ethnic group.

Asian people have better rates of recovery from schizophrenia, which may be linked to the level of family support. Suicide is low among Asian men and older people, but high in young Asian women compared with other ethnic groups. Indian men have a high rate of alcohol-related problems.

Some research has suggested that **western approaches** to mental health treatment are often unsuitable and culturally inappropriate to the needs of Asian communities.

CHINESE PEOPLE

There is very little knowledge of the extent of mental health problems in the Chinese community. It has been suggested that the close-knit family structure of the Chinese community provides strong support for its members. While this may be beneficial, it may generate feelings of guilt and shame, resulting in people feeling stigmatised and unable to seek help.

SEXUALITY AND MENTAL HEALTH

Lesbian, gay, bisexual and transgender (LGBT) people are at higher risk of some mental health problems and alcohol and substance misuse. This can be related to the discrimination and lack of understanding they face in society.

Coming to terms with an identity that is different to most of your peers, or coping with ignorance, prejudice and discrimination, can be confusing and distressing. People who are lesbian, gay, bisexual or transgender are at **greater risk** of some mental health problems and alcohol/drug misuse.

Obviously being lesbian, gay, bisexual and transgender (LGBT) is not a mental illness. Yet the World Health Organisation only removed homosexuality as a formal psychiatric diagnosis in 1992.

SECTION THREE - THE LAW AND MENTAL HEALTH

Employers have legal duties under both **statutory and common law** that are relevant to tackling mental health problems. Statutory duties are those contained in Acts of Parliament, such as the Health and Safety at Work etc Act 1974 and the regulations made under it, as well as equality law, in particular laws prohibiting disability discrimination, now found in the Equality Act 2010.

Common law duties are based on principles that have been developed through decisions of the civil courts. The basis for these decisions is the common law of negligence. The law provides a remedy where the employer's breach of the duty of care owed to employees results in personal (psychiatric) injury.

Few workers have successfully used this framework to claim compensation for psychiatric injury resulting from mental health issues at work. However, **success in these kinds of cases is rare.** Hazards magazine has shown that the proportion of workers receiving compensation due to work-related stress, anxiety and depression, is just one in 754.

In addition, the government has recently changed the law on "strict liability" making it more difficult for workers to win personal injury claims.[15]

NB) There may be some differences in the law in Scotland and Northern Ireland that are not highlighted in this section. Officials in those regions should ensure that these differences are recognised.

HEALTH AND SAFETY LAW

THE HEALTH AND SAFETY AT WORK ACT

The Health and Safety at Work Act 1974 (HSWA) sets the basic framework for health and safety law in the UK. It also established the Health and Safety Executive (HSE). Employers have a **general duty** of care under section 2 of the Act to ensure the health, safety and welfare at work of all their employees and this has been interpreted as including employees' mental health.

REMOVAL OF STRICT LIABILITY IN HEALTH AND SAFETY

The Enterprise and Regulatory Reform Act 2013 amended section 47 of the Health and Safety at Work Act 1974 (HSWA) so that employers no longer have a **strict liability** for the health and safety of their workers, for the first time since 1898. Workers cannot now rely on an employer's breach of health and safety law to win a personal injury claim. Instead, they must provide proof of negligence.

Strict liability refers to those few workplace regulations where, if the employer breaches those regulations, they will be liable in a civil claim even if they can argue they have taken "reasonably practical" steps to try and prevent the incident.

THE MANAGEMENT OF HEALTH AND SAFETY AT WORK REGULATIONS

Regulation 3 of the Management of Health and Safety at Work Regulations 1999 (MHSWR) requires employers to make a "suitable and sufficient" **assessment of health and safety risks**,

in order to identify the preventative and protective measures necessary to reduce those risks. This includes risks to mental health. In addition, risk assessments must be kept under review.

The Management regulations require employers to implement **preventative measures** by adapting work to the individual (especially regarding workplace design), choice of work equipment, technology, work organisation, working conditions, social relationships, and the working environment. If prevention measures are not practicable, then **control measures** are necessary.

MANAGEMENT STANDARDS FOR WORK-RELATED STRESS

Unions campaigned for an Approved Code of Practice (ACOP) on stress, but this was rejected by the HSE. Instead, the HSE published its **'management standards'** for work-related stress. The six standards are voluntary guidance and are not legally binding. They cover: demands, control, support, relationships, role and change.

Although the management standards are voluntary, they are a useful tool for reps who are attempting to combat stress at both an individual and an organisational level. As well as providing helpful proactive tools for a stress management framework, the management standards can be used reactively, to help negotiate on behalf of workers who have suffered psychiatric injury as a result of workplace stress, because they set a series of authoritative benchmarks that can be used to hold management to account in individual cases.

ENFORCEMENT

The TUC health and safety manifesto, Time for change, calls for more priority to be given to preventing stress-related illness with stronger regulations and enforcement. In 2003, West Dorset General Hospitals NHS Trust became the first employer of its kind to receive a **work related stress enforcement notice** from the HSE. In 2007, University Hospital of North Staffordshire NHS Trust was issued with multiple improvement notices following a work-related stress review. And in 2009, Liverpool Hope University was similarly served with an improvement notice for failure to manage worker stress levels.

SAFETY REPRESENTATIVES AND SAFETY COMMITTEES REGULATIONS

The Safety Representatives and Safety Committees Regulations 1977 give safety reps extensive legal rights to investigate and tackle workplace mental health issues. They have the right to:

- Investigate potential hazards – whether or not they are drawn to his/her attention by the employees he/she represents
- Examine the causes of accidents in the workplace
- Inspect the workplace and talk to members in confidence
- Take up members' health and safety complaints
- Be consulted by the employer about health and safety matters
- Obtain health and safety information from the employer
- Inspect health and safety documents held by the employer
- Take time off with pay to carry out their functions

Safety reps can gather information from management, for example, on sickness and incidents, which may be useful in identifying patterns of stress. They can conduct membership surveys

to build up awareness of stress at work and reveal the extent of the problem, they can talk individually to members, and inspections can be organised to identify the causes of stress. The full list of functions of safety representatives are outlined in Regulation 4(a) of the Safety Representatives and Safety Committees Regulations 1977 (SI 1977/500).[16]

EQUALITY LAW AND MENTAL HEALTH

Since 1 October 2010, the law prohibiting unlawful discrimination against disabled people is contained in the Equality Act 2010 (EA 2010). EA 2010 is largely a "consolidating" Act, which collected together the previous separate laws on discrimination creating one single piece of legislation. However, in relation to disability, and specifically **mental health disability**, the Act also introduced some helpful changes.

Under the EA 2010, a person has a disability where a physical or mental impairment has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities. For a person to be disabled under previous disability legislation, the impairment needed to impact on one of a list of specified "day-to-day activities". Specifically, to succeed in a claim based on a mental health disability, a claimant needed to show that the condition had an effect on his or her "memory or ability to concentrate, learn or understand".

The EA 2010 abolished this list, theoretically making it easier for workers with mental health problems such as depression to be able to demonstrate that they are disabled for the purposes of equality law.

It is important to remember that tribunals always require persuasive medical evidence of disability, including mental health disability. GP letters or Fit-Notes indicating that a worker is suffering from "work-related stress" are very unlikely to be regarded as adequate for this purpose. "Stress" itself is not regarded by the tribunal as a mental health condition for the purposes of disability discrimination legislation.

EQUALITY CASES

In the case of J v DLA Piper (UKEAT/0263/09), the claimant's offer of a job as a professional support lawyer for a large law firm was withdrawn after she revealed a history of depression. She brought a claim for **disability discrimination**, but the Employment Appeal Tribunal (EAT) concluded that her condition did not amount to a disability for these purposes.

In reaching its conclusion, the EAT offered some guidance as to when a mental health condition is likely to be regarded as a disability under equality law. While "**clinical depression**" will almost always be regarded as a disability, "reactive depression", in the form of the "anxiety, stress and low mood" a person suffers as a reaction to adverse circumstances such as problems at work, is less likely to qualify as a disability, although each case will continue to be examined on its own individual facts, in particular the severity of the condition.

In practice, the requirement for a condition to be "**long-term**" will often limit the scope for adverse reactions to life events to amount to disability. An impairment has a "long-term" affect if it lasts for at least 12 months, or for the rest of the individual's life. Recurring conditions may amount to a disability even if they appear to have gone away, provided they are likely to recur.

In the DLA Piper case, the tribunal helpfully confirmed that a patient's GP is fully qualified to

express an opinion as to whether or not that patient is suffering from depression. There is no requirement for a claimant to obtain specialist expert evidence of a mental health condition.

In practice, however, great care should be taken to make sure that the expert medical evidence, whether from a GP or specialist, is sufficiently clear and persuasive to provide the necessary guidance to the tribunal. This is one area where claimants frequently find themselves in difficulty.

SICKNESS ABSENCE AND DISABILITY

Section 15 of the EA 2010 introduced a new concept of "discrimination because of something arising in consequence of" a person's disability. Under this provision, unless an employer can objectively justify the treatment, they will discriminate against a disabled person if they treat that person unfavourably because of something "arising in consequence of" the employee's disability. This might include, for example, terminating a person's employment following a period of stress-related absence. The employer has a defence if it can show that it did not know, and could not reasonably have been expected to know, that the employee had the disability.

A cautious employer will be very **wary** of dismissing an employee with a long-term mental health condition, especially if there is any suggestion that it has been caused or exacerbated by work. Reps should therefore talk to members about the benefits of being as open as practically possible with their employer about their condition, including sharing medical evidence with the employer where possible.

Practical arrangements should be agreed and put in place to make sure **sensitive personal** information about the employee is handled appropriately. For example, the employee could agree that a rehabilitation team made up of the safety rep, an occupational health adviser, if available, an HR adviser and his or her line manager, can have access to medical information about his or her condition, to enable a rehabilitation plan to be put together, discussed and implemented.

The employer has a defence if it can show that the decision to dismiss was objectively justified. In practice, an employer will not be able to objectively justify a decision to dismiss until it has met its statutory duty to make all reasonable adjustments to accommodate the condition. Although an employee on long-term sickness absence because of work-related stress is not obliged to

suggest adjustments, it is a good idea to **engage proactively** with the employer to help develop a collaborative return-to-work plan and to suggest sensible adjustments, with the support of the union rep.

PROVIDING A COUNSELLING SERVICE

Providing a **counselling service** will not in itself excuse an employer from liability for injury caused by workplace stress (Intel Corporation (UK) Limited [2007] IRLR 355 HL). This was reiterated in Dickins v O2 plc [2008] EWCA Civ 1144. Many large employers, as well as some unions, do offer valuable confidential counselling services.

REHABILITATION FOLLOWING SICKNESS ABSENCE – THE "FIT NOTE"

The Statement of Fitness for Work or "Fit Note" was introduced in April 2010. Properly administered, and with the support of effective occupational health provision (either internal or external), the Fit Note should help to encourage a more proactive, collaborative approach to the rehabilitation of employees back to the workplace following a stress-related absence.
The Fit Note allows the GP, in collaboration with the patient, to suggest a return to work based on one of four possible options:

- A phased return to work
- Altered hours
- Amended duties
- Workplace adaptations

Revised Department for Work and Pensions (DWP) guidance advises doctors on how they can give the most useful advice about what patients can do at work and how they can return to the workplace as soon as possible. This could include exploring a period of home working or different ways of working. It says they should look at what a person can do, rather than what they can't. Employers and patients can then use the Fit Note to look at what can be done to help an individual back into work.

The guidance clarifies that the Fit Note is about someone's general fitness for work and is not tied to their most recent job, allowing flexibility to discuss what changes could help someone do some work.

CASE LAW AND MENTAL HEALTH

This section outlines several areas of concern involving mental health issues and provides a relevant example of case law in most instances. Case law demonstrates how, in the overwhelming majority of cases of serious psychiatric harm, there are usually plenty of warning signs and **opportunities to intervene** before an employee reaches breaking point. Frequently, the person is a vulnerable worker who returns to work following a period of ill-health absence and is then not properly supported over the long-term to help reintegrate properly back into the workplace.

Once an employee is back at work, the union rep can play a key role making sure that management provides the necessary on-going support and mentoring, and appropriate workload and responsibilities moving forward into the longer-term.

SICKNESS ABSENCE AND UNFAIR DISMISSAL

If an employee's sickness absence is the employer's fault, for example, because of poor working conditions leading to work-related stress, this does not mean that the employee cannot eventually be dismissed as a result of sickness absence. However, the employer must have done all it can practically do to help him or her back to work.

The case of McAdie v Royal Bank of Scotland is an important decision on long-term sickness absence in the context of mental health problems. The Court of Appeal confirmed that even where (as in McAdie's case) an employer has caused or contributed to the illness or injury, a dismissal carried out after proper consultation, and having **exhausted all reasonable options**, is likely to be fair (McAdie v Royal Bank of Scotland [2007] EWCA Civ 806).

An employer whose behaviour caused or contributed to an employee's illness will be expected to "go the extra mile" in looking at all the available alternatives before dismissing. However, eventually a point will be reached at which there is no alternative to dismissal.

ILL-HEALTH RETIREMENT AS AN ALTERNATIVE TO DISMISSAL

Some employers offer ill-health retirement to employees who become too ill to work. In First West Yorkshire Limited v Haigh (UKEAT/0246/07), the EAT held that where an employee is absent on long-term sickness absence and a pension scheme provides access to an enhanced benefit, the employer has an implied obligation to consider ill-health retirement as an alternative to a capability (ill-health) dismissal. Failure to do this in Haigh's case was a breach of contract and made the dismissal unfair.

LANDMARK CASES IN THE CIVIL COURTS FOR PSYCHIATRIC INJURY

A series of high profile cases in recent years have helped focus employer attention on the issue of mental health. These are civil court cases based on allegations of personal (psychiatric) injury. Whereas employment tribunal claims must be brought within a short three month time frame, individuals have three years from the date of the injury in which to bring a civil (personal injury) claim.

UNISON member John Walker was a social worker who had two nervous breakdowns and was retired on medical grounds as a result of increasing workloads. His employers were found guilty in the High Court of breaking their common law **duty of care** to him (Walker v Northumberland County Council [1995] IRLR 35).

In the Hatton case, lawyers argued unsuccessfully that teaching was such a manifestly stressful profession that employers should have procedures in place that would help reluctant individuals like Hatton to come forward and seek help. The Court rejected this view, concluding that employers are not generally obliged to inquire after their employees' mental health and that if they do make inquiries, they are entitled to take responses at face value, unless something in the surrounding circumstances would alert a reasonable employer to the employee's problem. To trigger a duty to take steps, the indications of impending harm to health arising from stress at work must be plain enough for any reasonable employer to realise that they should do something about it (Sutherland v Hatton [2002] IRLR 263 CA).

Another teacher, Mr Barber developed depression through overwork following a restructuring. He

tried several times to raise with his managers the fact that he was not coping, although he was not explicit about his symptoms. The House of Lords concluded that once Barber approached various members of the management team to tell them of his difficulties with overwork, this created a **duty of care** owed to him by his employer to do what it could to support him (Barber v Somerset County Council [2004] IRLR 475 HL).

The position in Barber was restated in another leading case, Hartman v South Essex Mental Health and Community Care NHS Trust. Hartman had a long history of mental health difficulties, including treatment for depression and anxiety. She was screened by the trust's occupational health department and disclosed a past breakdown on a confidential basis. She was passed as fit to work. The information was not passed to the employer. She subsequently developed a mental health condition. However, the Court concluded that Hartman's employer could not be taken to have known she was vulnerable to mental breakdown, because the information about her past medical history was given confidentially to the occupational health department. Hartman's claim was unsuccessful (Hartman v South Essex Mental Health and Community Care NHS Trust [2005] IRLR 293).

These cases demonstrate that, in principle, an employer's liability for psychiatric injury is no different from the liability for physical injury. There are **no "inherently stressful" occupations** and instead, each set of circumstances will be assessed based on its own facts. In Sutherland v Hatton, the Court of Appeal issued some useful guidance on the factors likely to give rise to liability.

PRACTICAL ISSUES ARISING FROM THE CASES

These cases are exceptionally difficult and expensive to bring, as well as being stressful and protracted, often lasting several years. The risks involved are greater than those involved in bringing a claim in the employment tribunal, especially because the loser is usually required to pay the winner's legal costs, as well as their own.

These cases demonstrate that a worker wishing to bring this sort of claim must produce persuasive expert medical evidence showing:

- That he/she has suffered **psychiatric injury** — stress on its own is not enough
- That the psychiatric injury was **caused by work-related factors** such as, for example, bullying, poor and unsupportive line management, excessive workload, long hours, poor work systems and processes and so on
- That psychiatric injury to this particular employee was **reasonably foreseeable**, for example, because the employer has been warned of the risk of psychiatric injury, either directly by the employee or a GP or rep, or because the employee has a past history of mental health problems which is known to the employer. It is not enough to tell the employer that the employee is suffering from stress. Instead, it should be clear to areasonable employer, looking at the surrounding circumstances, that the worker is likely to suffer from psychiatric injury if action is not taken
- That there was something that the employer, acting reasonably, **could have done** to avoid the injury

Those cases that have succeeded in recent years have usually involved an already vulnerable employee returning to work after an absence linked to mental health problems at work and not being given the on-going support and rehabilitative care required to reintegrate him or her effectively back into the workplace on a long-term basis.

It is the employer's knowledge of the employee's pre-existing vulnerability that makes any sub-sequent breakdown reasonably foreseeable, fixing the employer with liability for the employee's loss.

KEY PRACTICAL STEPS

These cases highlight four key considerations for reps who are dealing with and assisting a member who is suffering from a mental health issue.

1. Wherever practical, members should be encouraged to **share with the employer,** if appropriate via his or her rep, the nature of mental health problems, including the risk of psychiatric injury and practical suggestions as to relevant stressors and how they can best be avoided.

2. Members should be encouraged to be well-organised in **collating evidence** to back up any grievance, including keeping clear records, using email to record dates and times, and keeping a journal logging incidents.

3. Members should remember the risk that if, after consultation, investigation and a thorough review of medical evidence, there genuinely is no other way of reducing the risk of psychiatric injury to a particular employee, an **employer may be justified** in demoting that employee or requiring them to agree to a change of duties (which could be temporary or permanent), or even dismissal, in order to avoid that risk. Only in the most serious of cases might this be justified as a last resort.

4. In practice, a member may fear stigma and the risk of losing their job if they are open about the risk of psychiatric injury — especially at a time of economic uncertainty when jobs are at risk. Recent survey evidence shows how fearful employees are, increasingly choosing to hide their stress, pretending that any sickness absence is down to other factors.

DISCIPLINARY AND GRIEVANCE PROCEDURES

FBU reps have outlined that mental health issues are often being ignored by employers who turn to disciplinary measures as the first port of call. These two recent cases concerning similar uses of disciplinary and grievance procedures are helpful as they have confirmed that:

- Refusing to delay a dismissal hearing for gross misconduct until after an occupational health appointment and report, where the claimant suffered from work-related depression as a result of the disciplinary process, is discriminatory (Hibbert v The Home Office & Others [2013] UKEAT 0138/13/2410); as is
- Conducting a misconduct investigation into the activities of a branch manager suffering from depression without pre-warning him of the allegations, or allowing him to be accompanied to the investigation meeting, is discriminatory (Royal Bank of Scotland v O'Doherty UKEAT/0489/12/89).

SECTION FOUR - UNION ACTION ON MENTAL HEALTH AT WORK

The FBU strives to ensure that workplaces are a good place to work for everyone and recognises there are things we can do to improve the workplace environment for all. This will not only support people who already have a mental health problem, but may also help prevent others from developing them in the first place.

The FBU is currently looking at ways of supporting reps.

1. Receive **training** on mental health at work issues

2. Encourage members to raise their awareness of mental health issues

3. Review **policies and procedures** to ensure they are not discriminating against members with mental health problems

4. Be positive and supportive of members with mental health problems, and back this up with events and networking

5. Encourage employers to set up internal or external **support meetings** with people with mental health problems reporting concerns and recommendations to managers

6. Encourage employers to set up a formal **Employee Assistance Programme (EAP)** with FBU involvement.

NEGOTIATING A MENTAL HEALTH POLICY

If FBU officials are going to be successful in raising awareness of mental health issues it is important that they negotiate and implement a workplace mental health policy.[17] Some officials have already done this.

Where this is the case these officials should use the following as a check list to ensure that their policy includes all the points and to review it where it does not. In cases where a policy is unsuitable or no policy is in place the FBU official should approach management to address this issue.

A good workplace mental health policy should cover the following:

Recruitment and selection	Encourages, supports and provides reasonable adjustments for applicants with mental health issues.
Mental ill health definition	Clear definition of mental health and mental health problems – not limited to stress or anxiety.
Link to other policies and procedures	e.g. flexible working, disability leave, career breaks, grievances, disciplinary procedures, capability, sickness absence, performance management, substance abuse and dependency, dignity at work (harassment and bullying), training and development. Identifies how the mental health policy relates to other policies and procedures in the workplace and how the employer supports people with mental health problems through these linked policies/procedures.
Provision of some indicators of mental ill health	Signs that an individual may be having mental health problems e.g. changes in an employee's usual behaviour.
Promotion of good mental health well being	Identifies steps employer will take to support and promote mental health well-being.
Links to health and safety stress management policies	Identifies how the policy relates to health and safety policies and procedures on work-related stress, including reference to risk assessment and implementing control measures.
The role of line managers	Identifies the role of line managers in encouraging people to disclose mental health problems and their role in supporting people with mental health problems.
The role of human resources	Identifies the role of HR departments and staff, including monitoring the effectiveness of the policy and linked policies/procedures in developing a mentally healthy workplace; this could include services available through HR, such as occupational health or access to a confidential counselling service.
The role of union reps	Defines the roles of union reps, including shop stewards, safety reps, union learning reps and others such as equality reps; identifies the role reps have in the workplace to promote mental health, support members, represent members and monitor the impact of workplace policies and procedures on mental health.
The responsibilities and role of employees	Clarifies the responsibilities employees have towards each other on mental health issues; this could include roles for specific employees such as mental health first aiders.
Commitment to promote awareness	How the policy will be promoted as well as how awareness and understanding of the policy will be shared across the organisation.
A list of key contacts internal and external to the employer	Who employees can contact in the organisation should they need advice or support (for themselves or others in the workplace) as well as information about support and advice available in the local community.
Mental health first aid	Teaches people how to identify, understand and help a person who may be developing a mental health issue. It teaches people how to recognise the crucial warning signs of mental ill health. It also includes how to provide help on a first aid basis and effectively guide someone towards the right support services.

SICKNESS ABSENCE AND MENTAL HEALTH

HSE estimates nearly half a million people suffer from work-related stress, anxiety and depression, leading to some 10 million working days lost because of these conditions.[18]

However presenteesim (people coming to work when they are genuinely ill and should be at home recovering) is just as worrying if not more so. According to a survey by the Chartered Institute of Personnel and Development in 2013, 22% of those people coming to work when they are genuinely ill and should be at home recovering did so because there was an expectation in their organisation that you come into work no matter what.

This survey also reported that organisations where presenteeism was increasing were the ones with the largest increases in stress and mental health issues.

Recent FBU conference resolutions have identified an issue with 'aggressive attendance management policies' and 'non sympathetic employers who don't realise when an employee is suffering from issues beyond their control, when as a consequence it is support they require rather than warnings about their sickness records and disciplinary sanctions'.

Add to this the evidence from the recent Mind survey, which identified that:

- 85% of people in the fire service have experienced stress and poor mental health at work
- 37% think that colleagues would treat them differently – in a negative way – if they spoke about a mental health problem at work[19]

We can start to see the scale of the problem we face. In addition to this the stigma associated with mental health issues is equally as big as challenging mental health itself and if members are going to be encouraged to discuss their issues in an attempt to assist them then then they are going to have to be confident that they are not going to be faced with punitive absence management procedures.

A key part of this guidance is to provide advice to assist officials who are negotiating agreements covering sickness absence and the rights and responsibilities of workers covered by the agreements.

This guidance has already outlined:

- What mental health is
- Examples of different equality impacts
- The health and safety law with some case law examples
- A good example of a mental health policy considerations

Key points to consider when negotiating an absence management policy dealing with cases of mental health

This specific absence management policy should consider all the previous points mentioned in this guidance.

It should recognise that it is unlawful to discriminate and should take measures to ensure that this is not happening.

It should be separate from the general absence management policy and should be a supportive approach and recognise the mitigating factors rather than a punitive approach – this is not a disciplinary issue.

It should ensure that all parties – management, FBU, members and experts – are involved at all stages and as early as possible.

The agreement would usually cover:

- Absence definitions such as sickness absence, disability-related absence, unauthorised absence how employees report sickness absence (including what needs to be reported, when and to whom)
- Levels of sick pay
- Procedures to follow when dealing with both authorised and unauthorised absence
- What information relating to absence will be recorded, who has access to the information and how it can and cannot be used
- The role of union reps in absence procedures – providing advice, support and representation to members in meetings to discuss absence rehabilitation and return to work – including reasonable adjustments
- The role of occupational health and human resources
- Identifying and tackling underlying causes of work-related ill health (including mental ill health)
- 'Trigger points' – levels of absence the employer considers to be of concern.
- Trigger points should not be used unfairly to discriminate against workers with disabilities, including those with mental health problems. This would include workers taking time off to care for someone with a disability. Union reps should also seek to negotiate exemptions from sickness absence triggers for any work-related ill health
- Reps may be required to represent members absent due to their mental health problem.
- Reps may also be required to represent members who have mental health problems through procedures where the issue is not related to the member's mental health problem. Trade unions and employers have a duty to make reasonable adjustments to support individuals with mental health problems and this may include adapting procedures if necessary

REHABILITATION

In an ideal situation the rehabilitation measures would form part of the absence management policy but equally it can be addressed separately. This section offers some areas that should be discussed with employers.

A reasonable employer should provide help for individual members on how to cope with stress and associated conditions. There is a lot that managers can do to support staff, such as ensuring they are not penalised for feeling the effect of too much pressure.

Employers should ensure that line managers provide support where problems have developed and, where necessary, refer the person on for further help.

The employer needs proper arrangements to support workers who are mentally ill and who are seeking to return to work. This can include arrangements for an early return-to-work interview, allowing people to return to work on a phased or gradual basis with reduced responsibilities, or part-time working until the person feels confident to return to their full duties. This should be fully supportive and should not financially penalise the individual concerned.

An ideal situation is where employers have comprehensive rehabilitation plans for all work related health issues, so that workers returning to work after prolonged sickness absence can be reintegrated properly.

Many employers provide support to staff through Employee Assistance Programmes (EAPs), which offer help lines, counselling and sickness absence monitoring. FBU officials should encourage and get involved in these. Unions and others have raised concerns about EAPs, in particular about the lack of fixed standards for EAP providers, and the qualifications and training of counsellors. The Court of Appeal ruling in Sutherland v Hatton emphasised the need for counselling services.

Some unions have engaged with providers to negotiate improvements. For example, many sufferers prefer to use this independent service rather than relying on one arranged by the employer.

Employers should be encouraged to provide confidential help lines for members suffering from mental ill-health.

RETURNING TO WORK

Members may suffer depression on returning to work after a period of prolonged absence from both physical and mental illnesses, new research by Loughborough University for the Mental Health Foundation has shown.

Its report, Returning to work (2009), found that nearly half (45%) of those who returned to work after a physical illness, such as chronic back pain, cancer or heart disease, reported mild to moderate symptoms of depression. And three-quarters of people who had been off sick with a mental health condition reported symptoms of continuing depression.

Researchers concluded that many employers could do more to help those returning to work after sickness absence. They found that shorter working hours, fewer tasks and support from colleagues were some of the key issues that were beneficial to the employee's mental health. Training was also essential to help improve understanding of the issues.

Many employers already use a stress risk indicator as part of their return to work/ rehabilitation process. An example of a stress risk indicator can be accessed via the following link:

www.hse.gov.uk/stress/pdfs/returntowork.pdf

Using a risk indicator similar to this is should be encouraged however it must be more than a simple paper exercise and will require real commitment to act on any findings.

There are a range of stress related HSE tools and templates that may assist officials when they are negotiating on this issue. These can be accessed following this link:

www.hse.gov.uk/stress/standards/downloads.htm

CAMPAIGNING AND ORGANISING ON MENTAL HEALTH

This document is just the first step in raising awareness around mental health issues in the fire service.

There are some key issues that have to be addressed and problems that need resolving.

There is still a great deal of stigma associated with mental health and FBU members are still not confident in speaking out about their situation. FBU members who do are still facing discrimination either directly or indirectly. The FBU has a duty to its members to campaign to protect members who are facing mental health issues.

There are some simple steps we can take at this stage of our campaign:

- Raise awareness of the issues
- Provide support when it is necessary
- Encourage members with mental health problems to talk about their issues
- Encourage them to get involved in the FBU

Here are some examples of notable events during the year to campaign around:

Month	Campaign
January	
February	Eating disorders awareness week
March	Self-harm awareness week
April	Depression awareness week Workers' memorial day (28 April)
May	Dementia awareness week Mental health awareness week
June	
July	Hazards campaign conference
August	
September	
October	Schizophrenia awareness week OCD awareness week (second full week of October) WHO world mental health day ADHD awareness week European health and safety week
November	National stress awareness day Alcohol awareness week
December	

As an FBU member or an FBU official you can provide support to your colleague who informs you/ appears to be/ may be suffering from a mental health issue by following these 10 steps

1. Be ready to recognise that the member may not be aware they may need mental health support. They may simply feel stressed or depressed, may be losing sleep or experiencing mood swings, or have a number of other problems. It may also be that the member is reacting to a recent event in their life.

2. Reassure the member that you and the union will support them as much as you can but try to be clear and realistic about what the union can or cannot achieve

3. Reassure the member that the issue will be treated with confidentiality, remembering the stigma that is attached or perceived to be attached to mental health issues

4. Give the member plenty of time to explain things to you in their own way; don't feel that you need to provide instant solutions – sometimes people just need to talk

5. Try to be honest about your limitations but explain the support mechanisms that you may be able to access. If you don't know what to say to the member or how to respond, don't pretend you do. Explain that you want to support them, that you will work together, and that you may need to find out more information to help both of you.

6. Ensure you have an understanding of requirements of specific legislation as this will help guide and ensure that reasonable adjustments are made. If you are in any doubt do not be afraid to ask for assistance advice

7. Ensure that the member is fully involved in any discussion with the employer in regards to any remedies and or adjustments to their working environment

8. Provide the member with some examples about the sort of reasonable adjustments that might help them to decide how they would like you to discuss the issue with the employer if appropriate.

9. Make no assumptions about the effects of the member's condition or their ability to do their job. Remember you are not an expert.

10. If risk assessments are to be undertaken, ensure that it is only to identify what reasonable adjustments can be made to enable the member to do their job and that they are is kept informed at all stages

Remember - you are not a trained counsellor. The aim is that you:

- Spot early signs /symptoms of mental health problems,
- Get involved as early as possible and gain the members trust
- Have the knowledge and confidence to assist someone and know your limitations
- Know where further advice can be sought and guide the person
- Stop the situation from deteriorating
- Ensure the person is protected from the stigma attached to mental health issues
- Talk to and meet with the right people – managers and experts to ensure you get the best advice and assistance for the member.

You need to go away and look at how your employer deals with issues of mental health and whether or not their policy is fit for purpose – if not you need to raise this immediately.

TIME FOR CHANGE: MIND YOUR LANGUAGE!

Certain language can cause offence and may be inaccurate when used in news stories that involve someone with a mental health problem. Here are the most common, as well as some alternative suggestions.

Avoid using:	**Instead try:**
'A psycho' or 'a schizo'	'A person who has experienced psychosis' or 'a person who has schizophrenia'
'A schizophrenic' or 'a depressive'	Someone who 'has a diagnosis of' 'is currently experiencing' or 'is being treated for...'
'Lunatic' 'nutter' 'unhinged' 'maniac' 'mad'	'A person with a mental health problem'
'The mentally ill', 'a person suffering from' 'a sufferer', a 'victim' or 'the afflicted'	'Mental health patients' or 'people with mental health problems'
'Prisoners' or 'inmates' (in a psychiatric hospital)	'Patients', 'service users' or 'clients'
'Released' (from a hospital)	'Discharged'
'Happy pills'	'Antidepressants', 'medication' or 'prescription drugs'

Other common mistakes:

- 'Schizophrenic' or 'bipolar' should not be used to mean 'two minds' or a 'split personality'
- Somebody who is angry is not 'psychotic'
- A person who is down or unhappy is not the same as someone experiencing clinical depression

FBU CASES ON MENTAL HEALTH

The FBU has won a number of personal injury claims with mental health implications in recent years, mostly involving post-traumatic stress.

UNION DEFEATS EMPLOYER CHALLENGE TO BOARD OF MEDICAL REFEREES' DECISION

The London Fire and Emergency Planning Authority (LFEPA) failed in its judicial review of the decision of the Board of Medical Referees that FBU member Martin Coogan was permanently disabled and entitled to an ill-health pension.

The board found that Mr Coogan was permanently disabled due to depression. LFEPA's legal challenge was based on the contention that there should have been a specialist psychiatrist among the board members.

It said that Mr Coogan had been assessed by an independent qualified medical practitioner in relation to sleep apnoea and depression and that a specialist in sleep apnoea had been appointed to the board, so a psychiatrist should also have been.

However, it became clear by the time of the hearing in November that Mr Coogan had placed no reliance on sleep apnoea as permanently disabling him.[21]

£250,000 FOR BADLY INJURED FIREFIGHTER

A member who suffered extensive injuries and was lucky to escape with his life when he fell into a 20ft pit while trying to put out a blaze has received £250,000 in compensation. He was attending a fire at an iron castings firm in Cardiff in September 2004. He was walking through the building with an employee of the firm to find the best way to tackle the fire when he fell down the unguarded pit which contained a mixture of oil, water and discarded steel parts.

He broke his left wrist, right elbow, received a puncture injury to his leg and ruptured ligaments in his right knee. He also suffered from **post-traumatic stress disorder.** It took almost two years to recover from his injuries and when he returned to work he had to undertake light duties.

The iron casting firm admitted liability for the accident and settled the claim out of court. Although now back on full duties, the member still suffers aches in his injured joints and is concerned about the impact this will have on his work in the future.[22]

In another accident involving a fire appliance, an FBU member suffered back injuries and **post-traumatic stress disorder.** His claim settled for £31,000.[23]

A retained firefighter employed by the Derbyshire Fire Authority was awarded £30,000 by a court after a knee injury put an end to his career with the fire service. He also suffered post-traumatic stress as a result of the continual pain and inability to work, or to walk without the aid of a stick.[24]

£800,000 FOR FIREFIGHTER WHO LOST HIS LEG IN MOTORBIKE CRASH

A firefighter who had to have his lower leg amputated after he was knocked off his motorbike received £800,000 in compensation. The member from Durham was hit by a car in May 2002. Among other injuries, he suffered a seriously broken ankle and underwent five operations to fix it. They all failed and in November 2006 his left leg was amputated below the knee. He now has a prosthetic leg and is still receiving counselling for **post-traumatic stress disorder.** He had to leave the fire service.[25]

CRUSHED BY CAR

The wife of an FBU member, who suffered multiple fractures when she was crushed against a wall by a car which mounted the pavement, has received £30,000 compensation. She was injured in south west London and was in hospital for several days afterwards. She continues to suffer from **post-traumatic stress** as well as from the physical effects of her injuries. Cases such as this show the value of the union's legal service, with union lawyers prepared to take on cases that claim firms and no-win no-fee solicitors will not.[26]

SECTION FIVE - FURTHER INFORMATION

ACAS

The Advisory, Conciliation and Arbitration Service provides free and impartial information and advice to employers and employees on all aspects of workplace relations and employment law. It produces statutory Codes of Practice and advice and guidance on employment matters.

acas.org.uk

Alzheimers Society

The Alzheimers Society is the UK's leading dementia support and research charity.

alzheimers.org.uk

BEAT

Beat is the UK's eating disorder charity.

b-eat.co.uk

Depression Alliance

The Depression Alliance campaigns to end the stigma of depression.

depressionalliance.org/about-us/

Equality Advisory & Support Service (EASS)

EASS advises and assists individuals on issues relating to equality and human rights, across England, Scotland and Wales.

equalityadvisoryservice.com

Equality and Human Rights Commission (EHRC)

The EHRC is an independent public body with the mandate to challenge discrimination and to protect and promote human rights.

equalityhumanrights.com

European Agency for Safety and Health at Work

The Agency prepares, collects, analyses and disseminates information on occupational safety and health (OSH) issues with the aim of improving occupational safety and health in workplaces across the EU.

osha.europa.eu/en

Health and Safety Executive (HSE)

The HSE is responsible for shaping and reviewing regulations, producing research and statistics and enforcing health and safety law in England, Wales and Scotland.

hse.gov.uk

Mental Health Foundation

A charity that engages in research, campaigning and training programmes on mental health and learning disabilities.

mentalhealth.org.uk

Mind

The charity Mind provides advice and support on mental health issues. It campaigns to improve services, raise awareness and promote understanding about mental health.

mind.org.uk

NHS Choices

The NHS website has a wide range of advice and practical tools for raising awareness of mental health issues, self-management of symptoms and sources of further specialist help.

nhs.uk/livewell/mentalhealth

OCD-UK

OCD-UK is the charity dedicated to improving the mental health and well-being of people in the UK affected by Obsessive-Compulsive Disorder.

ocduk.org/

Samaritans

The Samaritans offers emotional support 24 hours a day, 365 days a year.

Tel: 08457 909090

Time to Change

An anti-stigma campaign run by mental health charities Mind and Rethink Mental Illness.

time-to-change.org.uk

Trades Union Congress (TUC)

tuc.org.uk

SECTION SIX - REFERENCES

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