Muntendam symposium

The Assessment of Work Capacity in the United Kingdom

Professor Mansel Aylward CB
Director, Centre for Psychosocial and Disability Research, Cardiff University

AylwardM@cardiff.ac.uk
www.cf.ac.uk/psych/cpdr/index.html

Amsterdam: 13 November 2007

The Hypothesis:

The Assessment of Work Capacity is frustrated by the meaningless pursuit for objectivity

The Hypothesis: Some major consequences:

- Lack of consensus of opinion among health care professionals
- Erosion of public confidence in expertise of medical profession
- Failure of the Bio-medical model of illness and disability
- Disagreement about what constitutes capacity / incapacity for work
- Escalation of subjective health conditions among recipients of incapacity for work benefits.

Unbundling illness, sickness, disability and (in)capacity for work

- **Disease: objective, medically diagnosed, pathology**
- **Illness: subjective feeling of being unwell**
- **Sickness: social status accorded to the ill person by society**
- **Disability: limitation of activities/ restriction of participation**
- **Impairment: demonstrable deviation / loss of structure of function**
- **Incapacity: inability to work associated with sickness or disability**

**The terms are not synonymous: there is no linear causal chain.

Mental Health Problems: Challenges in Recognition and Assessment:

- Their subjective nature
- What constitutes "caseness"?
- Distinguishing recognisable mental impairments from subjective self-reported symptoms
- Validity of clinical guidelines for the rating of psychiatric impairments
- The ubiquity of mental "stress"

The Crux of the Problem:

The dilemma:

For the assessment of disability and (in)capacity for work,

How much should be based on:

- "Objective" measures of impairment and observed function

  versus

- "Subjective" self-reports of illness and functional limitations?

Common Health Problems: Predominantly Subjective Health Complaints

Illness Behaviour: What ill people say and do that express and communicate their feelings of being unwell:

- **Subjective Health Complaints have a high prevalence in the working-age population**
- **Not solely dependent on an underlying health condition (the limited correlation)**
- **People with similar symptoms (illnesses) may or may not be incapacitated**
- **Consumption of health care disproportionate.**

Prevalence of subjective health complaints in the last 30 days in Nordic adults (after, Eriksen et al, 1998)

	Any complaints		Substantial complaints	
	Men	Women	Men	Women
Tiredness	46%	56%	17%	26%
Worry	38%	39%	13%	15%
Depressed	22%	28%	5%	10%
Headache	37%	51%	4%	9%
Neck pain	27%	41%	9%	17%
Arm/shoulder pain	28%	38%	12%	17%
Low back pain	32%	37%	13%	16%

>50% reported two or more symptoms

Cardiff Health Experiences Survey (CHES): Face-to-Face Interventions [N=1000] GB population:

	Inventory:	Open Question:
Musculoskeletal	13.5%	32.5%
Mental Health	7.5%	38.5%
Cardio-respiratory	3.6%	11.9%
Headache	2.9%	24.8%
G/I	2.4%	7.8%
Without any complaint	72.9%	33.6%
At least one complaint	20.6%	66.4%
2 or more complaints	8.4%	26.3%

Severity of main complaint greater for open question than inventory

Subjective Health Complaints

- High prevalence in the general population (Eriksen et al, 1998; Ursin, 2003, Barnes et al, 2006)
  - *Symptoms: self reported*
- Unexplained symptoms in people accessing healthcare:
  - *On average < 10% symptoms attributed to organic causes (Kroenke & Mangelsdorff, 1989)*
  - *Limited objective evidence of disease, damage or impairment (Page and Wessely, 2003)*
- Regional (Pain) Disorders [Hadler, 2001]
  - *Low back, upper limb, neck, etc*
- Medically unexplained Symptoms in Outpatient Clinics:
  - *30-70 percent without identifiable disease (Bass, 1990, Maiden et al, 2003*

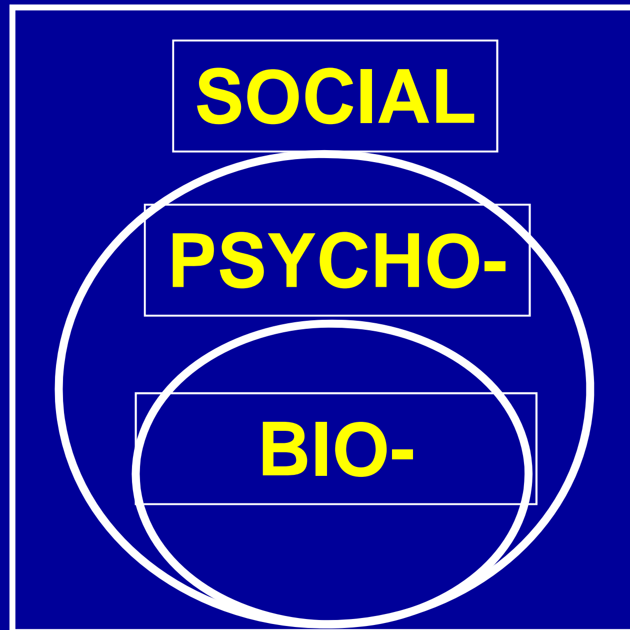
Common Health Problems: disability and incapacity

- High prevalence in general population
- Most acute episodes settle quickly: most people remain at work or return to work.
- There is no permanent impairment
- Only about 1% go on to long-term incapacity

Thus:

- Essentially people with manageable health problems given the right support, opportunities & encouragement
- ***Chronicity and long-term incapacity are not inevitable***

Why do some people not recover as expected?



- Bio-psycho-social factors may aggravate and perpetuate disability
- They may also act as **obstacles to recovery & barriers to return to work**

Cardiff Research: Early Findings:

Principal negative influences on return to work:

- **Personal / psychological:**
  Catastrophising (even minor degrees)
  Low Self-Efficacy
  Belief that "stress" is causal factor
- **Social:** Lone parents / unstable relationships
  "Victim" of modern society
  Rented or social housing
- **General Affect:** Sad or low most of the time
  Pervasive thoughts about personal illness

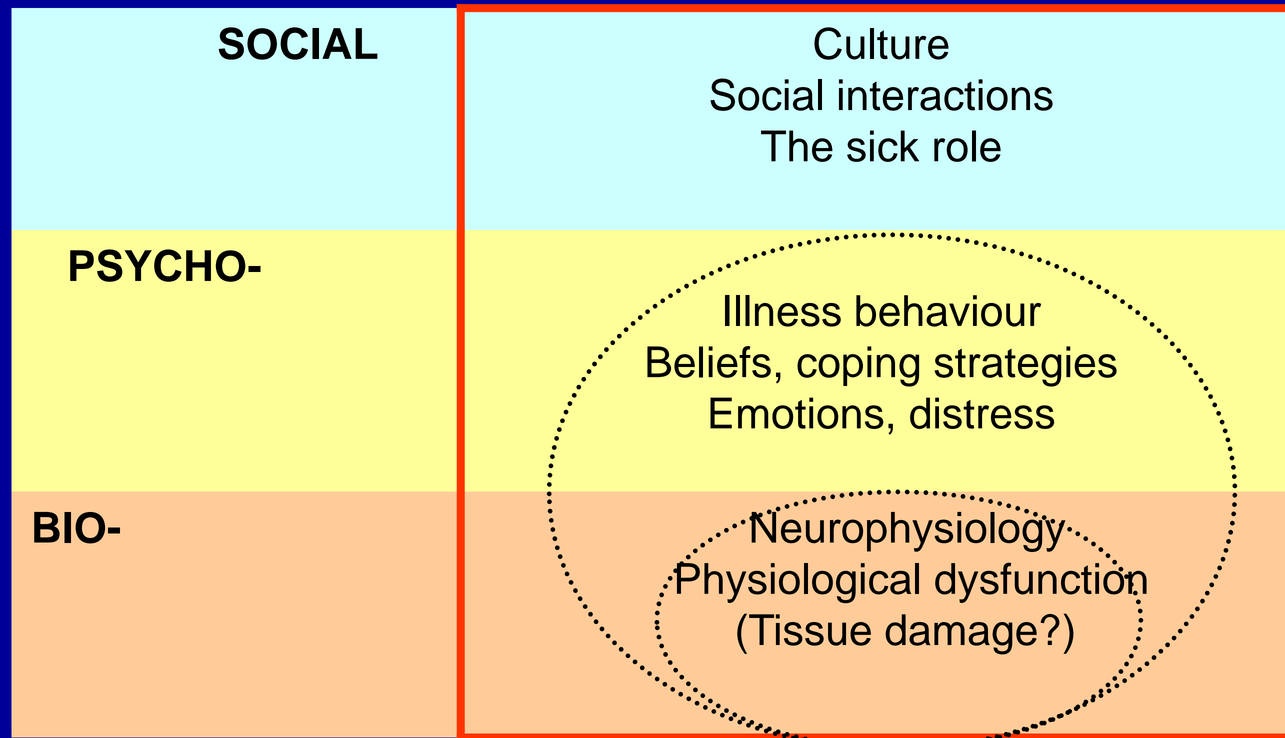
Early Findings: Negative Influences:

- **Occupational:** Job dissatisfaction
  Limited attendance incentives (esp. work colleagues)
  Attribution of illness to work
- **Cognitive:** Minimal health literacy
  Self-monitoring (symptoms)
  False beliefs
- **Economic:** Availability of alternative sources of income / support

- **Obstacles to recovery and return to work are primarily personal, psychological and social rather than health-related “medical” problems.**

- **A bio-medical model cannot adequately address these issues**

Biopsychosocial Model



Strengths of BPS Model

- Provides a framework for disability and rehabilitation
- Places health condition/disability in personal/social context
- Allows for interactions between person and environment
- Addresses personal/psychological issues.
- Applicable to wide range of health problems

Assessment of Work Capacity and Enabling Return to Work in the UK:

- A fusion of the bio-medical and bio-psycho-social approaches to work capacity assessment and work-focused interventions
- A structured functional assessment of capacity and (potential) capability
- A division of labour between Medical Experts and Non-Medical Decision-Makers
- A separate support programme and condition management for Return-to-Work

Evidence & Assessment: UK:

Evidence:	Sources:	Independent check:
•Medical Evidence on Health Condition	•General Practitioner's Statement Claim Form	•Health Professionals Medical Records Independent Medical Assessment
•Functional Capacity Assessment	•Self-reporting questionnaire	•Medical Expert Scrutiny Independent Medical Assessment

Eligibility for Incapacity Benefits:

- Exemption from Personal Capability Assessment:
  - Severe (and enduring) health conditions
  - Severe and permanent impairments
  - Severe (defined) mental illnesses
  - Receipt of certain other disability benefits
- Structured functional assessment:
  - Limitations and/or restrictions
  - Validated scoring system (single and co-existing disabilities)
  - Benefit "threshold"
- Independent Appeals Service

Support into Work

Evidence:	**Sources:**	**Independent check:**
•Obstacles to recovery and (return to) work	Self-report questionnaire	•Independent Capability Assessment Personal Advisor (DWP) interview
•Support needs		•Employment Focused interview (condition-management)

UK Government "Pathways to Work" Initiative

- Return to Work Payment

  £40-120 Mandatory Work-Focused per week

- Interviews (Case Managers)

- New Condition-Management Programmes:

  (focus: m/s, Mental Health; Cardiorespiratory)

  - helping people to understand and manage their condition

  - using CBT and related interventions

Principles of Condition Management:

- Voluntary option routed through the Personal Advisor
- Cognitive/educational interventions common to all conditions
- Evidence based
- Tailored to individual needs – biopsychosocial approach
- Case-managed
- Goals “owned”; not imposed.

Successful Strategies:

Practical Elements of Condition Management

- Address the main health conditions
- Clear work focus, vocational goals, outcome measures
- Address biological, psychosocial and social components
- Address individual’s obstacles to RTW
- Increase activity and restore function
- Shift beliefs and behaviour using CBT (talking therapies)
- Working partnership with Personal Advisors

Condition Management: The Pathway to Success

- Shift perceptions, attitudes and beliefs
- Modulate expectations, exploit values and build confidence
- Recognise and address the social contexts of health, disadvantage and economic inactivity
- Promote emotional/physical well-being
- Engender clear work focus and vocational goals
- Encourage behaviour change
- Living with fatigue/pain

PATHWAYS TO WORK

- 6-800 new job entries each month in existing *Pathways* areas
- Doubling of claimants entering work
- Take-up around 5 times that expected from previous RTW interventions
- Exceeds threshold for cost-effectiveness
- Welfare Reform :extending provision across country by 2010

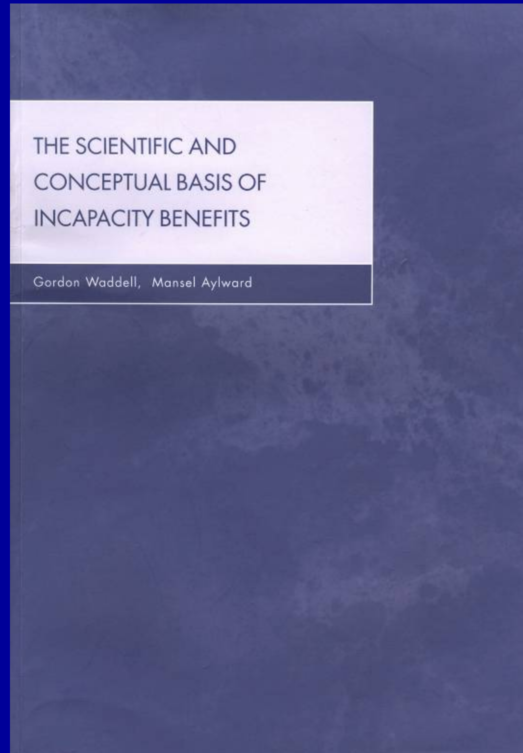
  :Reducing by 1 million the number on Incapacity Benefits

  :employment rate = 80% working population

A Strategy for Success

- Abandon the forlorn pursuit for objectivity
- Moderate sole reliance on the bio-medical model
- Embrace the bio-psycho-social paradigm shift
- Identify and address obstacles to recovery and to (return to) work
- Widen the pathways to work, health, happiness and well-being

The Scientific and Conceptual Basis of Incapacity Benefits



Gordon Waddell and Mansel Aylward

The Power of Belief

Peter Halligan and Mansel Aylward

Professor Mansel Aylward CB

Contact:

Email: **AylwardM@Cardiff.ac.uk**

Website: **http://www.cf.ac.uk/psych/cpdr/index.html**

http://www.wch.wales.nhs.uk