



Supporting occupational health
and wellbeing professionals

Evaluating and supporting **Neurodifferences*** at work



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March 2022

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ISBN 978-1-3999-2138-1

*Typically includes ADHD, Autism, Dyslexia, Dyspraxia and Tourette's Syndrome. Also known as Neurodevelopmental Disorders, Specific Learning Disabilities, Neurominorities, Neurodiversity Neurodivergence/diversity – see glossary of terms in the appendix.

Who is this guide for?

Occupational health (OH) practitioners, Human Resources professionals and employers, who are considering referring their staff for a diagnostic assessment of or services to support ADHD, Autism, Dyslexia, Dyspraxia, Tourette's Syndrome and/or similar.

The document will outline what you could look out for in staff, different options available for support and legal duties of employers. We present recommendations informed by research evidence, the latest guidance from regulatory bodies, current practice, and case law. The document is not a literature review or SOM guidance.

1. WHAT SHOULD OH ADVISE MANAGERS REGARDING NEURODIVERSITY?

Between 15 and 20% of the workforce is estimated to be in a “neurominority”¹ who are people whose thinking skills and behaviours are not like the neurotypical norm. The cognitive hallmark of a neurodifference is often an inconsistency in performance, known as the ‘spiky profile’. This is when an employee excels at some aspects of their work, but struggles in others, or can work brilliantly for a time, but who has persistent periods of productivity loss. There are other hidden disabilities that may cause this, such as Multiple Sclerosis, Chronic Fatigue and more recently, Long COVID as well as mental ill health such as anxiety or bipolar disorder.

Either way, it is a flag for an employer that an individual may have a health or neurodevelopmental condition and may prompt a referral to occupational health (OH) for support recommendations. Some employers have tended to see inconsistent performance as an attitude or motivational issue. It is recommended to explore genuine reasons, as well as training and sufficient role resourcing, before assuming that the behaviour is wilful and proceeding with some sort of performance management or punitive process.

More specifically, the following areas of difficulty are typical for neurodifferent employees²⁻⁴:

- Memory/concentration (>90% of neurodifferent (ND) employees experience this)
- Organisation and time management (>75% of ND employees)
- Managing stress (>65%)
- Communicating (>65%) which can include:
 - » Written communication accuracy
 - » Written communication speed
 - » Verbal communication difficulties
 - » Managing intense emotions

It is easy to see how these are mistaken for incompetence or a negative attitude, but taking time to give the benefit of the doubt is in line with the Equality Act 2010, which cites persistent, chronic difficulties in memory, learning and communicating as part of the definition of disability⁵.

It's important to state that neurominorities also have strengths to balance the struggles. That's why it is sometimes considered a diversity rather than an impairment, and why the language has evolved to be neutral. Below are some of the strengths associated with various neurodifferences. Please note that there are relatively fewer published studies on Dyspraxia and Tourette's Syndrome. This does not mean that these neurotypes confer less strengths; rather, that there is less research directed to these conditions (by 50:1 when compared to Autism research, despite similar population prevalence)⁶.

OH professionals can draw on the above evidence to focus on the talent conversation when liaising with employers and employees. Neurodifferent employees can bring exceptional abilities, particular specialisms and creativity to their work. We can help flip the narrative from duty of care to opportunity and potential for advancement. The role of any OH intervention in this area is to facilitate the employee to work at their best and bring their strengths to their role.

Neurotype	Strengths
Dyslexia	Entrepreneurialism ⁷ Creativity and cognitive control ⁸ Visual reasoning ⁹ Practical skills, visual-spatial skills and story-telling ability ¹⁰
Dyspraxia	High verbal comprehension ability ¹¹
ADHD	Authenticity ¹² Creative thinking ¹³ Visual spatial reasoning ability ¹¹ Hyper-focus, passion and courage ¹⁴
Autism	Memory ability, and other 'specialist individual skills' including: Reading, drawing, music and computation ¹⁵ Innovative thinking and detail observation ¹⁴
Tourette's Syndrome	Ability to 'hyper-focus' ¹⁶ Verbal ability ¹⁷

2. HOW SHOULD OH TREAT A MANAGEMENT REFERRAL IF THERE IS A NEURODIFFERENCE SUSPECTED?

Imagine now that you are an OH professional to whom an employee has been referred because there have been performance difficulties such as persistent missed deadlines, and management have asked you for further insight, assessment and potential onward referral. It can be difficult to broach this subject with an employee who is struggling. You will need to consider what the employer can offer as support as well as how open the individual is to a conversation. For example, when an employer has a comprehensive process for providing adjustments, you could start there:

- “Are you aware that your employer often provides reasonable adjustments for colleagues who are neurodifferent? For example...”

You might think that it isn't appropriate to suggest that the person is neurodifferent. There is no need to have a label to provide recommendations. For example:

- “When I've seen employees with this type of specific difficulty before, we've tried XXXX strategy which seems to work well. Would you like to explore this?”

The following adjustments are supported by evaluative evidence³:

- **Assistive technology** such as voice/text software or dual monitors, with training on how to implement.
- **Flexible hours and remote working** options (to reduce sensory overwhelm of commuting or shared office spaces).
- **Environmental flexibility** (e.g. a dedicated desk in a quiet space or using quiet spaces for focused tasks such as booking a meeting room for report writing).
- **Coaching** to devise specific strategies for managing executive functions and psychosocial issues.

You can recommend these without a formal diagnosis. A diagnosis is not the only route to help. There are also several online, free screening tools which you might want to use with the employee, and you can recommend adjustments while waiting to see if more specialist advice is required, if the situation isn't urgent.

If you judge that a diagnosis is the right avenue for the situation, OH practitioners could broach the subject like this:

- “I notice that you excel at XYZ, but often struggle with ABC. This sometimes indicates neurodifferences, would you like support to explore that further?”

It is important to note that only management can make the initial decision as to whether they feel your recommendations for adjustments are reasonable.

A final decision on reasonableness can only be made in a court of law. However, if there is a legal dispute, your recommendations are likely to be evaluated and assessed in a tribunal hearing and therefore it is recommended that you seek referral to a specialist if you feel out of your depth.

3. WHEN SHOULD OH RECOMMEND A DIAGNOSTIC ASSESSMENT?

In many organisations, formal diagnosis is required before any adjustments are made (a 'gatekeeping' approach). However, diagnosis is expensive and may take a few weeks/months, meanwhile performance and relationships suffer. For day-to-day performance issues, a 'stepped approach' is recommended, as follows:

1. Upon identification of need or informal self-diagnosis, an initial screening conversation to ascertain if there are any adjustment strategy options already available, such as remote working, technology and coaching. This could be done using an online screening tool or checklist, with a manager, HR, or with a generalist OH professional interview.
2. If this is insufficient to improve performance, escalate to a specialist review, which can be done remotely.
3. If this is insufficient, escalate to a workplace needs assessment, in situ, so that the environment can be assessed as well as the individual. These should include interviews with both employee and employer.
4. If this is insufficient and a diagnosis has not been formally made, then a diagnosis would be recommended at this point, to find out if there are any other underlying conditions contributing.

The irony of the gatekeeping approach is that the adjustment costs could be less than the cost of the assessment! However, you should skip straight to the workplace needs or diagnostic assessment if there is imminent risk of job loss or if under performance is risking safety in any way: a stepped approach should not be used to delay or avoid meeting the needs of disabled employees. The OH role here is to assess the urgency and severity, and to be empowered to make simple adjustment recommendations within remit, rather than to feel no action can be taken until further specialised assessment is complete.

The most important thing to remember is that you do not need a diagnosis for the Equality Act to apply, only evidence that the individual's difficulties are chronic and substantial (affecting normal day-to-day activities) and long-term (difficulties spanning a period of 12 months or more). There are links to Case Law examples provided at the end of this document, which show how difficult it is to assert that an individual has no right to Equality Act protection without a diagnosis. Beyond diagnosis, there is reasonable consistency suggesting that neurominorities are likely to sufficiently justify Equality Act protection as disabilities. Therefore, it is also reasonable to assume that a suspected neurominority will require reasonable adjustments until proven otherwise.

Neurominorities experience typical everyday difficulties in memory, communication (written or verbal) and learning; these are likely to be the basis for asserting disability as a protected characteristic. OH should never report categorically that an employee is or is not disabled within the Equality Act definition, since that is a legal not a medical question, but should advise the employer with consent whether the employee has an impairment which is long term and has a substantial adverse effect on normal day to day activities. It is acceptable to report that it is likely/unlikely that they are disabled.

If funds are limited, it may be better to avoid a formal diagnosis and accept self-diagnosis and performance difficulties at face value. Instead, you can conduct or request a specialist workplace need assessment (WPNA). A WPNA cross references the particular aspects of performance difficulty (as presented by employee and employer) with potential adjustments (such as technology, flexible hours, coaching) and makes recommendations. The Equality Act requires us to do due diligence in exploring all possible, affordable adjustments before determining that the individual cannot deliver the job role; this is how “reasonable” is defined. There is obviously less expectation on smaller businesses with smaller budgets, so use your discretion to consider whether you can make recommendations yourself or whether you need to bring in more expertise.

With neurominorities, change and transitions can take longer to bed in, so be sure to give any new adjustments time to work, before deciding whether they were adequate. Four to 12 weeks is recommended as best practice, depending on context, though this has not been legally or academically challenged. So, again, management discretion will apply here.

Also be very careful about interpreting management reports of performance. If reports are based on subjective, single manager assessments it can be open to abuse and discrimination. It is easy to discriminate against people who communicate differently, and to make assumptions about them. This is a major legal risk. If you are unsure about this, a viable recommendation is co-coaching, where both manager and employee are coached at the same time, or team training to build awareness.

However, If the assessment and adjustment process is genuine, thorough, and includes referral to appropriate specialists, it is likely to be considered sufficient in any legal dispute. Outplacement counselling (a process to help employees find their next role when they exit) or offering alternative roles can be considered if the adjustments process does not result in performance improvement.

4. HOW SHOULD OH RECOMMEND COMMISSIONING A SERVICE FROM A SPECIALIST?

- 1. REGULATION.** You need to ensure that a diagnostic professional is appropriately registered with the HCPC, the GMC or PATOSS. Both the BPS and SASC provide regular updates on conducting assessments for neurominorities, these can be checked and referred to if you are not sure¹⁸. Approach the same way you would for any other commission – check insurance, GDPR, ICO registration etc. Anyone providing must be appropriately trained and certified in using the testing equipment, for example Psychologists must be on the [Register of Qualified Test Users](#) for using psychometric tools and have undertaken additional training for specialist assessment tools such as those for ADHD/Autism. Psychiatrists are needed to recommend medication for ADHD, this cannot be done by a psychologist or teacher. Psychologists, OH and teachers should also be referring to appropriate medical/clinical support when conditions such as Bipolar Disorder, brain injury or trauma are suspected or disclosed.
- 2. UNREGULATED PROVIDERS.** There are no guidelines or limits on who can provide workplace needs assessments, coaching and awareness training, but OH professionals are advised to apply caution when referring to suppliers here. For example, those who assert coaching expertise without coaching qualifications may not provide an adequate service and there is no recourse to complaint for unregistered operatives. Question the governance, experience and training of anyone you are recommending. Check how they present the effectiveness of their services, whether they rely on anecdotal reports only or have a more rigorous method of quality assurance. When recommending assistive technology trainers, the [British Assistive Technology Association](#) keeps a list of possible suppliers. Should specialist referral recommendations ever be reviewed in a court setting, would they stand up to scrutiny? The courts use the ‘man on the Clapham omnibus’ test to determine if a person was an appropriate expert – i.e. does the specialist you are taking advice from have enough credibility that an ordinary person on a bus would recognise them as such?

- 3. CREDIBILITY.** The specialist/specialist company need to have appropriate workplace experience. If you, as an employer or employer's representative, are commissioning a report/service, will it be adult appropriate? Will it be workplace contextualised rather than purely educational or clinical? Consider if those offering HR consulting and awareness training have management or HR credentials, such as being a member of the Chartered Institute of Personnel and Development, and can offer legally contextualised advice on adjustments and policy. Ensure that the professional has appropriate training in and/or experience of the OH and human resources implications for their analysis, enough to understand the employment implications of the diagnosis and make appropriate signposting.
- 4. PSYCHOLOGICAL SAFETY.** When an employer is requiring an assessment or coaching, the individual can feel obliged to submit to scrutiny to retain their job. It's very important that the professional knows how to tread the line with client confidentiality and supporting vulnerable people during an identity changing process. Like any consumer process, remember you can ask to "try before you buy" and review an example assessment report. You can arrange a "chemistry session" for the employee and their assessor if they are nervous, to ensure a positive experience. You can ask for explanations and changes if you need more detail or an explanation of terms. For example, Psychologists should be available to ask questions that come up in preparation or follow up to a diagnosis; the assessment and report are not single events, they are part of process. Coaches should be providing notes for employees and can be asked to summarise reports to employers, with permission from employees. Records are important in coaching for disability support in case there is a need to evaluate the employer's adjustment provision in a Court of Law.
- 5. PAYMENT.** There is no fixed guidance on who should pay for the report, if disability eligibility is disputed. However, given that Case Law is reasonably consistent that Equality Act provision applies to neurominorities, it is advisable that an employer should pay to minimise the risk of later being found in breach of duty and show that they have operated in good faith towards the employee. However, as above, the cost of most reasonable adjustments is low, so it is potentially better to direct employers with limited funds to solving the problem rather than naming it.

5. DATA AND CONSENT

Seeking an expert report is no different to any other medical referral in that an employee must provide consent and the Data Protection Act applies. The employee must give consent (common law) to be examined by the expert and for the report to be disclosed to OH. Consent should ideally be written for reasons of evidence, though oral consent is valid if properly recorded and documented by the practitioner. Good governance is essential for any specialist provider; for example, check that they are registered with the Information Commissioner's Office and have sound policies on data, confidentiality, complaints, and quality assurance accreditation such as the British Standards Institute for technology or quality management.

Once the referral is made, the specialist assessor will be beholden to their own standards around data and consent, which may mean they are unable to share full results with OH. In most cases, OH and the specialist will share some details as part of the OH care being provided; however, this does not extend to employers. OH need consent under common law and the Data Protection Act 2018 to report to the employer (health professionals also have an ethical duty of confidence). Psychologists are also bound by their professional practice guidance, and regulated by the Health and Care Professionals Council.

Summary reports, following Caldicott principles¹⁹, are recommended which state that information should only be shared with who 'needs to know'. For example, an assessor should give the client first sight of the report and talking it through if needs be, before sending an abridged version to you. You don't need their raw scores or IQ scores any more than you would need to review an MRI scan in detail if a medical practitioner told you someone had a tumour or receive detailed notes on traumatic experiences if a mental health professional confirmed a diagnosis of PTSD.

Restrictions on report details is recommended best practice from the British Psychological Society in assessment of adults^{20,21}. The BPS guidelines are clear that an end user is the 'client', irrespective of who is funding the assessment. As such, consent can be withdrawn on the part of the employee at any time, so it is important to establish good relationships as above. An employee may not wish for their employer to be informed of their diagnosis; this is also within the boundaries of their rights. However, you can still provide useful recommendations on adjustments, which may alleviate performance concerns.

6. FURTHER RESOURCES

[ADHD Foundation](#)

[National Autistic Society](#)

[British Dyslexia Association](#)

[Dyspraxia Foundation](#)

[Tourette's Action](#)

[Find a Psychologist](#)

[Find a specialist teacher](#)

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APPENDIX 1: GLOSSARY

The following glossary of terms in current use is subject to the caveat that terms evolve and change as part of the developing biopsychosocial understanding of neurodiversity. Neurominorities bear the hallmark of a human rights movement, and as with similar movements such as the Deaf community and LGBTQIA2S+, they assert the right to define their nomenclature. Just as we expect to maintain awareness and educate ourselves on the preferred terms of other protected conditions, we need to with neurodiversity. And, just as some women select the term Lesbian, Gay woman or Queer woman, there is disagreement within the Neurodiversity community as to which terms are best. OH practitioners are advised to enquire as to language preferences where appropriate, defer to individual choice and caveat written documents as we have done here. OH practitioners are also advised to listen for and learn updated language preferences and new terms as they emerge. If you use a term that someone doesn't like, just with any other protected condition, it is appropriate to apologise, correct your speech and move on. Feeling nervous about getting it wrong is natural, but an honest attempt and a quick pivot where needed should facilitate positive conversations in most interactions.

Term	Rationale
Condition first language (i.e. disabled people rather than people with disabilities)	Though the person-first language, developed in the 80s and 90s was designed to draw attention to the humanity of disabled people, it is no longer in vogue. The current preference elicits the social model, in that people are disabled by their environment, rather than a disability being something you have at the individual level.
Condition or difference	As opposed to Disorder. Though many experience their difference as disorder, we should avoid making assumptions of deficit and distress, mindful that our position as professional will be pivotal in framing the experience of those with whom we work. When we frame in the negative, this can be self-fulfilling for those who are in our care.
Autism/Autistic/Autist	As opposed to Autistic Spectrum Disorder, Asperger's, on the spectrum or any other variation, this phrase is preferred though many people still identify as Asperger's or Aspie.
Dyslexic, Dyspraxic, Dyscalculic, Dysgraphic	As opposed to "person with dys*": The term Developmental Coordination Disorder (or DCD) is referred to as an alternative to Dypraxia, however Dyspraxic people prefer the term Dyspraxia.
ADHDer/Touretter	These conditions are not easy to take out of person-first language, however some people with lived experience use these adaptations, others may continue to use person with ADHD/Tourette's.

Term	Rationale
Neurodiversity	A feature of the whole species and not a synonym for disability. ²²
Neurominority/ neurodifferences	An umbrella term. These are more frequently chosen in place of Specific Learning Disabilities (SpLD) or Neurodevelopmental Disorders for the same reason as the use of condition vs disorder, i.e. to infer neutrality and create space for a balanced narrative. Additionally, unpublished research conducted by the British Psychological Society's (BPS) Neurodiversity Working Group in 2015 and 2019 found that the older terms were preferred by less than 10% of those with lived experience (2015, N=115; 2019, N=267). This survey is currently being repeated and will be published, so you can stay up to date on evolving language by research and checking with professional bodies and charities.
Neurodiverse (/ neurodifferent)	To refer to an individual, referring to the diversity at the individual level within the spiky profile. This term is not favoured by all, in particular the BPS survey indicated that Autistic people and those from USA/Australia do not identify with this term.
Neurodivergent (/neurodifferent)	To refer to an individual, noting the divergence from neurotypicality. This term is also sometimes contentious, potentially favoured by ADHD/ Dyslexic communities.
Person with learning disabilities	In learning disability communities those with lived experience still prefer the person-first language.
Low/High/Additional needs	Used instead of high/low functioning, a phrase has been used to separate Autistic people in to two categories, typically those with or without cooccurring Learning Disability. The phrase has been widely criticised for framing "functioning" from the neuronormative position and minimising the human value of those with lower IQs. Additionally, it does not take into account the distress experienced by Autistics with high IQ who "mask" in order to pass for "functioning" and experience high rates of mental ill health and suicide. Use of the word "need" centres the individual rather than the role they play and is therefore more respectful.
Capitalisation	Similarly to the Deaf community and Black community, where the capitalisation denotes respect and acknowledgement of a group identity that has been marginalised, the capitalisation of Autism, Dyslexia etc. serves to reinforce the autonomy and formal assertion of culture.

APPENDIX 2: CASE LAW EXAMPLES

The following accounts relate to employment tribunal (appeal) cases where the claimant has made an appeal against an employer as a consequence of disability discrimination. The full report of these judgements can be found on the government website (please follow the links).

1. Employment Tribunal Decisions: Disability Discrimination

Cases 1-3 are employment tribunals. It is important to note that these are not precedents but examples which may or may not be upheld.

Case 1

Mr. P McQueen v General Optical Council

- Mr McQueen disclosed his neurodifferences when appointed with General Optical Council and adjustments were put in place for some of these such as his dyslexia.
- However, the appeal found General Optical Council failed to make reasonable adjustments for Mr McQueen's Asperger's Syndrome, or even whether he did have Asperger's Syndrome.
- They could not 'get to grips with' the assertion that Mr McQueen had Asperger's as a reason for his conduct at work, or for raging when asked to do a task. This appeal was upheld as Mr McQueen's managers and then HR failed in their duty.

<https://www.gov.uk/employment-tribunal-decisions/mr-p-mcqueen-v-general-optical-council-2200667-2019>

Case 2

Mr R Pearce Thomas v Pembrokeshire County Council

- This case considers whether a claimant has a disability as described under the Equality Act 2010.
- Mr Pearce ticked a box on application for his job, stating that he did not have a disability and did not declare his disabilities. He also told his employers that his difficulties were 'mild'.

- Mr Pearce had previous diagnoses of dyspraxia/DCD alongside autism, which had been assessed during his childhood. Mr Pearce experienced stress and anxiety soon after starting his job.
- The respondent therefore felt that Mr Pearce did not have a disability under the Equality Act as they felt his difficulties were not long term or significant and that his stress and anxiety were not a consequence of any underlying difficulties/disorders.
- The tribunal concluded this was a consequence of his disability as described under the Act. This was seen as regardless of the diagnoses.

<https://www.gov.uk/employment-tribunal-decisions/mr-r-pearce-thomas-v-pembrokeshire-county-council-1600642-slash-2020>

Case 3

Mr T Cox v Lancashire County Council

- Mr Cox had been employed by the respondent for over 10 years before a formal diagnosis of Asperger's Syndrome was made. During this time, he had been subject to many complaints, warnings and delayed hearings which caused him much stress.
- Mr Cox finally agreed to an assessment for autism as his son had undergone some assessments for ASD. His employers appeared aware of these issues but had failed to put in place support for these difficulties.
- The tribunal found that the respondent that was content to 'stick its head in the sand' about a disability that had been apparent for many years and Mr Cox had to seek a diagnosis at considerable personal expense. Only then did the respondent pay any attention to this issue and seemed extremely reluctant to properly assess Mr Cox's needs and failed to make any reasonable adjustments.

https://assets.publishing.service.gov.uk/media/6102874ed3bf7f044c5159e1/Mr_T_Cox_v_Lancashire_County_Council_-_2402124_2019_2404795_2019.pdf

2. Employment Tribunal Appeals

Cases 4-6 are illustrations of Employment Tribunal Appeals (ETA) which can be used as precedents in law.

Case 4

Elliott v Dorset County Council

- This ETA was based on the ET that the claimant – Mr Elliott – did not experience a disability under the Equality Act, despite his diagnosis on the autistic spectrum, as the panel deemed his difficulties did not have a “substantial” adverse impact on his ability to carry out day-to-day activities.
- ET erred in law by not sufficiently identifying the day-to-day activities that Mr Elliot could not do, or could only do with difficulty, to find a proper analysis; further, the ET excessively focused on coping strategies which Mr Elliott made for himself, without considering whether any coping strategies might break down in certain circumstances.
- The ET excessively relied upon comparison of Mr Elliott with the general population. They therefore did not apply the statutory definition of “substantial” as more than minor or trivial and the case was referred for fresh ET for a full reconsideration.

http://www.bailii.org/uk/cases/UKCAT/2021/0197_20_0904.html

Case 5

British Telecommunications plc v Meier

- This appeal by BT was dismissed by the ETA; It agreed with the original decision of the ET that BT discriminated against a man who applied for a graduate post by failing to make reasonable adjustments for his disability.
- Mr Meier had to sit a Situational Strength Test (SST) as part of the application for a post and was not allowed any adjustments for this process, and the recruiter failed to have a conversation with Mr Meier until after the test.

- The Tribunal further held that BT did not take any steps to consider whether any information in the monitoring form was relevant to its commitment to plan for and make reasonable adjustments to the assessment and interview process and said that BT knew or ought reasonably to have known that the claimant was disabled and that his disability was placing him at a substantial disadvantage.

<https://www.bailii.org/nie/cases/NICA/2019/43.html>

Case 6

Government Legal Service v Brookes

- Ms Brookes applied for a training contract with Government Legal Services (GLS). She has Asperger's syndrome. The first stage of the GLS recruitment process involves a Situational Judgement Test (SJT).
- Despite informing the recruiter about her condition, GLS failed to allow Ms Brookes adjustments for this test, although they allowed extra time. Ms Brookes asked if she could provide short written answers to questions, but GLS refused. Consequently, Ms Brookes failed the pass mark of the SJT by 2 points.
- The ETA found that Ms Brookes Asperger's would place her under additional difficulty due to the multiple-choice format of the SJT.
- Ms Brookes brought claims of indirect disability discrimination, failure to make reasonable adjustments and disability-related discrimination. A tribunal upheld all her claims and recommended that the GLS should say sorry (in writing) and review its procedures in relation to people with a disability. GLS appealed - unsuccessfully.

http://www.bailii.org/uk/cases/UKCAT/2017/0302_16_2803.html



Supporting occupational health
and wellbeing professionals

ISBN 978-1-3999-2138-1

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Charity Commission No: 1184142 • Scottish Charity No: SC049793 • VAT No: 927 0030 57