

Integrated report of Stress Impact:  
On the impact of changing social structures on stress and quality  
of life: Individual and social perspectives



**HPSE-CT-2002-00110**

**Work Package 8**  
**Integrated report**

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## Preface

This report describes the main findings of the Stress Impact project. Stress Impact is the Acronym for the EU funded project entitled: *The impact of changing social structures on stress and quality of life: Individual and social perspectives*, (project code: HPSE-CT-2002-00110). From December 2002 – March 2006.

The project has been the joint effort of a team of researchers from 6 European Countries (Austria, Finland, Ireland, Italy, The Netherlands, and United Kingdom), and would never have been completed without intensive co-operation of the team members.

Teams are seldom constant entities in these large projects, so, was the case with this international project. Different people have contributed at various stages of the project and to various work packages. Below is a list of people who have contributed to this project. I had the honour to play the role of the General Project Manager of this project, and it makes me feel humble when I think of what my actual contribution to the project was, because this project was teamwork. On the other hand I am proud to see how this team has worked together and what it has achieved over this period. This report testifies of that achievement.

This project also demonstrated that working in a large international team can be great fun. Therefore I thank all project members for their contribution to this project.

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# Chapter 1 The Stress Impact Project

## 1.1 Introduction

Long term sickness absence has become a key issue in many European countries. Of particular concern has been the increase of the proportion of mental disorders in long term absences. Stress and burnout are a major cause of absenteeism from work. Across Europe it appears that stress and burnout are amongst the most frequently mentioned work related health complaints (Paoli, 1997; Merlié & Paoli, 2001; Weiler, 2004). However, the prevalence of mental disorders in the entire population has not increased (e.g. Singleton, Bumpstead, O'Brien, Lee, & Meltzer, 2000); this suggests that the increase in mental disorders as a reason for absence and disability is related to work.

It is generally acknowledged that our society has changed considerably over the past decades. In particular changes on a structural level, such as changing social and working contexts and the introduction of new technology, are believed to have a significant impact. In 2005 the European Agency for Safety and Health at Work recently prioritised topics regarding Occupational Safety and Health (OHS) in the EU

([http://agency.osha.eu.int/data/products/oshinfo\\_231/view?searchterm=main%20priorities](http://agency.osha.eu.int/data/products/oshinfo_231/view?searchterm=main%20priorities)).

This Agency considers work stress and mental health as emerging. One of the first issues they prioritize mainly as a 'psychosocial risk' is 'the changing world of work' and its influence on safety and health at work. This issue is associated with 'emerging risks' and the sub topic mentioned here is 'work-life balance'. Regarding interventions as a second specific issue the Agency identifies as one of the risk groups the workers who develop chronic health complaints. This group is prone to drop out of work for a considerable time due to health problems.

Societal factors play a major role in the background contributing to the stress process, in the sense that these factors often constitute demands that exceed people's capacities to cope. The pressures on people and levels of stress have increased considerably.

In 2001 the World Health Organization (WHO) predicted that by 2020, mental illness will be world-wide the second most important cause for work-disability after heart disease. Studies published by ILO (2000) on mental health policies and programs affecting the workforces of Finland, Germany, Poland, UK and USA showed that the incidence of mental health problems is increasing. It reported that as many as one in 10 workers suffer from depression, anxiety, stress or burnout, with problems leading to absenteeism, unemployment and even in hospitalisation in some cases. Currently many people are not taking part in society as they are out of the work process. This is both at high individual (social isolation) and societal-/economic costs.

In October 2005 the European Union also produced a 'green paper' on the improvement of mental health in the population

([http://ec.europa.eu/health/ph\\_determinants/life\\_style/mental\\_health\\_en.htm](http://ec.europa.eu/health/ph_determinants/life_style/mental_health_en.htm)).

The Green paper aims to launch a public consultation on how better to tackle mental illness and promote mental well-being in the EU, in line with the mandate for action at Community level. The 'working population' is a 'subset' of their arena. One of their main target groups is, however, workers who dropped out of work more or less temporarily. Concern was thus expressed towards both work resumption of those who were long term absent because of mental health problems, as well as the group that became unemployed either because they could not get a job, were made redundant or were not eligible to receive benefits after a period of long term sickness absence.

Governments are currently looking for ways to maximize long term absentees' chances for returning to work as well. This research project aims to contribute to this objective by providing information on this particular group of employees that can help to develop interventions to help employees to return to work. What is lacking is a theory of action to assist in guiding interventions to reduce long-term absence from work as a result of stress related breakdown in (mental)health and well-being. This makes it necessary to know what factors facilitate or inhibit return to work. However, little is known about the absence process in relation to stress, and what is known is not based on the experience of people on stress related long-term absence. Studies that have come up with figures concerning sickness absence, and estimates of the (economic) impact of stress and stress related absence have been conducted by examining employers reports, documents and records, et cetera (e.g. Davies and Teasdale, 1994). However, the people concerned (the absentees) have hardly ever been questioned and surveyed with respect to their situation.

The initiatives as presented above already lead to the development of a new Commission proposal for an EU-strategy on mental health in late 2006 (Call FP6-2005-SSP-5-A), which aims at developing guidelines for employers, employees, professionals and policy makers on how to better tackle the risk factors for mental illness and mental well being in the workplace. The present project may provide a lot of basic information to be used in this new call.

This project's main focus is on employees who are long term absent from their work because of stress related mental health complaints, and explicitly intends to present the absentees' views and experiences. Long term absentees have been surveyed and interviewed with respect to their present situation and experiences.

## 1.2 Key research questions

Key questions for the 'Stress Impact' project are: What factors contribute to an increased risk of sickness absence? What is currently done to help long-term absentees reintegrate in their work situation again?

It is clear that specific information on people who are on long term sickness leave is scarce. Therefore an important practical aim for the Stress Impact project is to fill the gap of the knowledge base with respect to this group. In particular descriptive information on people with stress-related absence (i.e. demographic and psychological characteristics) is lacking, but also the extent to which people with mental health problems differ from those with physical health complaints, or those with both physical and mental health complaints (co-morbidity).

A second and related aim is to explore what the *impact* is of being long-term absent from work. This means exploring what the consequences are in social and economic sense.

Finding out what factors influence (and their relative weight in this process) employees' decision to pass the threshold of reporting absent, and also resuming work again. This evidently includes looking into work-related factors and personal circumstances, and also into what kind of interventions have taken place.

However, as surveying a large group of employees will only result in a momentary picture, a second wave of measurement was introduced with which it was aimed to answer the following key questions:

- 1) Whether the employees' situation has changed over the time interval.

- 2) Whether employees have resumed work, yes/no, and what factors may have contributed to either outcome.

In sum, the key question to be answered in the Stress Impact project actually translates into ‘who are the employees with stress-related mental health complaints’?

### **1.3 Outline of the Stress Impact study**

The main aim of this project is to collect information on what factors hinder and facilitate the return to work of people who are on long term sickness leave. In order to achieve this goal the project consists of two parts:

- 1) Review of relevant information. This includes reviewing the scientific literature on this topic, and reviewing the national systems and policies of participating countries.
- 2) An empirical part in which information has been collected. In this part information was collected from long-term absentees and professionals dealing with long-term absentees, by means of surveys and interviews.

This way both the absentees’ views and experiences have been obtained, and the professionals’ view on this problem. This allows detecting discrepancies between both perspectives.

As far as the relevant scientific literature on this area is concerned, four domains were identified as relevant for this project:

1. determinants of work stress and mental health; reviewing the literature dealing with the extent to which work causes stress;
2. determinants of absence, and absence indicators (e.g. frequency, duration, percentage);
3. determinants of vocational rehabilitation and work resumption after a period of sickness absence, with special attention to absence as related to work stress, psychological problems and mental health;
4. effectiveness of work stress interventions.

The empirical part of the project consisted of three interrelated studies in the six participating European countries. Study 1 is a longitudinal survey of approximately 400 long-term absentees in each participating country, covering their present situation, family situation, financial situation, work-related aspects, and future perspectives with respect to work resumption. A second wave of data collection followed approximately 6 months later (exact study design will be reported later).

Study 2 is a ‘family’ study: sub-samples of approximately 50 absentees and a ‘significant other’ when available (spouse, partner, or parent) have been interviewed concerning their experiences of being absent, to provide detailed information on family situation and social network, and main factors influencing decisions concerning being absent from work, or resume work again.

Study 3 was a ‘professional’ study: in which interviews have been conducted with approximately 40 professionals focussing on their experiences and views with respect to long-term absenteeism, and diagnostic processes, and procedural flaws and congestions in the administrative and legal system.

The national studies have been reported in national reports. This report aims to highlight and relate the findings from the various studies.

## **1.4 The Structure of this report**

In this report the main findings of the Stress Impact project will be reported. This includes a summary of each of the relevant work packages: literature review, review of national systems and policies, and the three studies. The full reports of each work package are available on the project's website. ([www.Surrey.ac.uk/Psychology/stressimpact](http://www.Surrey.ac.uk/Psychology/stressimpact) ).

Subsequently an integrated discussion of the project findings will be presented, followed by practical recommendations.



## Chapter 2 Summary literature reviews.

The four literature reviews focussed on the various moments or action levels in the process of sickness absence and return to work. It was decided that the review would cover the last 10 years (1992 – 2002), and both psycho(socio-)logical and medical sources were tapped upon ('psychinfo' and 'medline'), and often occupational health research was included as well (oshrom). National literature was also included if it was considered to be a relevant study, and if it provided useful information. Of course, personal archives of the researchers (e.g. important older studies) were included as well when considered relevant.

### 2.1 Occupational stress

The first domain reviewed is the literature on occupational stress. The aim was to identify the main determinants of occupational stress and mental health outcomes. The literature spanning the period between 1990- 2002 was scanned, and the idea was to focus on prospective (longitudinal) studies, since these are believed to have the highest explanatory power. However, it turned out that very few longitudinal studies have been published in this domain; the vast majority of studies are cross-sectional studies. These are rather weak in their methodology and do not allow any causal inferences to be made.

Since the area of occupational stress has been extensively reviewed (Kahn & Boysiere, 1992; Sonnentag & Frese, 2003) and we didn't want to copy this studies, we have adopted for this particular literature review a method that has not been used in this area before, and which is developed in the area of qualitative research: Exploratory Analysis of the articles. Hereto a technique is used that is based on analysing the content of the abstracts accompanying each article or chapter, and try to observe if there are certain trends noticeable in topics that are discussed in the literature. This technique checks whether in specific periods of time particular concepts, or keywords, etc. have been used significantly more (or less) frequent than in other periods. In this way specific trends in the literature can be identified. A special technique, called Correspondence Analyses, is used that helps to quantify the observed tendencies (for an extensive description see; D'Amato & Zijlstra, 2003).

While reviewing the literature on occupational stress it appeared that the concept of (work) stress is rather ambiguous, and often used as an 'umbrella-concept', indicating a field of research where many different topics have been included: e.g. (work) stressors (or rather 'work demands') and their effects on physiological and psychological responses (stress), job satisfaction, well-being, mental disorders, sexual problems, absence, violence, accidents and several kinds of morbidity (e.g. musculoskeletal problems, cardiovascular problems) and even mortality (e.g. cardiovascular, cancer, all cause mortality).

Historically, four main approaches in the area of stress research have been distinguished:

1. Stress as a *stimulus*, i.e. an external load or demand originating from an event or situation that affects the individual and is potentially harmful;
2. Stress as a psychological or physiological *response* of the organism to external stimuli (i.e. threats);
3. The interaction approach, which describes stress as a *process* where the organism responds to particular situations or events (i.e. stressors) by developing strain reactions;
4. The cognitive appraisal approach, which defines stress as the response when people appraise a situation and *perceive* an imbalance between the demands imposed upon them and the resources they have available to meet those demands (Moore, Cooper, 1998; Buunk et al., 1998).

In the first approach 'stress' is conceived as an 'input' (a stimulus), while the other three approaches to stress are more 'output' oriented (the third approach conceives stress as a process).

The models that are currently most prominent were developed under the last theoretical framework, and therefore a widely accepted definition of psychological stress is:

*"A relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984; p.21).*

This has evolved into a working definition: *"Stress is the adverse reaction people have to excessive pressure or other types of demands placed upon them"*. This definition is also used as a basis for the definition used by the British Health and Safety Executive (HSE) (<http://www.hse.gov.uk/stress>).

The content analysis of the relevant literature revealed that some trends can be observed in the literature. In the first few years of the decade (up to 1995) many studies were published that primarily tried to identify and describe various kinds of occupational stressors and to highlight factors correlated with poor psychological health or mental well-being. In this period it seems as if it is generally acknowledged that there is a relation between detrimental working conditions and mental ill health.

In the second half of the decade most studies used one of the theoretical frameworks as a starting point to guide and to direct the study. One of the most frequent used frameworks appeared to be the Job-Demand control Model (Karasek, 1979; Karasek & Theorell, 1990). This framework centres on the notion that when people have sufficient skills and mastery over their work, and are free to make relevant decisions concerning their work, they have the means to withstand potentially harmful situations and demands. Stressful jobs should therefore be redesigned in such a way that the worker's level of control is enhanced and the job demands are reduced, while support by colleagues and supervisor should be stimulated.

Another important framework that emerged in this period is the Effort-Reward Imbalance model (ERI) by Siegrist, 1996. According to this framework workers are at high risk for developing burnout when they perceive a structural imbalance between the (high) efforts that they invest in work and the (low) rewards. In particular when there are no 'intrinsic' rewards (as opposed to material rewards, such as pay).

The ERI model also introduces 'over-commitment' as a personal characteristic that may moderate this compensatory mechanism.

A third relevant framework that needs to be mentioned is the Effort-Recovery model (Meijman & Mulder, 1998). Although specifically focussing on aspects related to workload this model is the only model that stresses explicitly the fact that people need to recover from their efforts. And if recovery is lacking or insufficient than irreversible health effects may result (<http://www.uni-duesseldorf.de/MedicalSociology/index-eri.htm>).

The importance of this framework is that it coincides with increased interest in finding a balance between working life and private life in the last couple of years.

In this period there also appeared to be a great interest in comparing specific professional groups with the general population. In particular teachers and nurses have been studied, and found to be particularly vulnerable for burnout. People in these professions are dealing with

other people (students, patients) and do not always feel that their help and support is appreciated by the recipients.

### 2.1.1 Trends

The review indicated furthermore that the majority of the literature in this domain could be described along three factors. The first one can be labelled *development*, while it shows a change in focus from the individual to an organisational perspective in the stress/strain research over the last decade. The second factor refers to *'third' variables*, and is primarily concerned with coping strategies, and work and non-work issues which moderate, mediate or influence the relation between stressors and (negative) outcomes more directly. The third factor can be labelled *'organizational change'*, and encompasses studies in which keywords like managerial power, turnover, absence and compensation against lack of power, are central issues as a result of organizational change. In these studies the effects of organizational change on people are studied in terms of job insecurity, (lack of) promotion, physical symptoms, and external locus of control.

It should be noted that in the '90's many organizations went through a process of change, due to increased economic competition. In particular removing the 'economic borders' in 1992 in the European Union has led to fierce economic competition. Organizations have tried to become as lean as possible, and tried to make optimal use of information technology. This has led to increased pressures on staff in many organizations.

### 2.1.2 Methodology

While reviewing the literature on occupational stress it becomes evident that there are some gaps in the literature. These are primarily related to methodological aspects. The gaps that have been identified in the literature are related to:

- the need for longitudinal data, since most studies are cross-sectional in nature. Cross-sectional studies do not allow making causal inferences; they only indicate a certain level of association between the observed phenomena. For some relationships (e.g. work stress risks and <self reported> back pain) a considerable amount of literature is available (see e.g. Hoogendoorn et al, 2000), whereas for other outcomes there are much less studies available (see also De Lange et al, 2003).
- the fact that in a most studies only self-reported measures were used, which introduces the risk of falling into the 'triviality trap'. Only in a few studies objective measures have been used (e.g. registered absence, cardiovascular mortality). These studies offer some reference with respect to the question whether feelings of stress or perceived stress indeed can be associated with absence and ill-health. And can thus provide an indication of how serious the stress problem is.

A lot of risks and moderator or mediator variables of work stress (outcomes) have been studied. The heterogeneity of the instruments and methods used, and models tested, makes it difficult to come to conclusions as to causal effects of work stress risks.

Summarizing, there is evidence that, despite imperfections in research methods, particular job characteristics constitute an increased risk for mental health problems. In particular lack of control (influence) over one's work (in terms of working method, work pace, etc.) has irrefutably been associated with feelings of depression, and low levels of self-efficacy.

While lack of support moderates this relationship.

Furthermore, when people are confronted with a high level of demand at work, this means they are expected to work hard and put in substantial effort to get the work done. High level

of effort is clearly associated with fatigue. When people perceive a structural imbalance between their effort and rewards in the sense that they always have to invest considerable effort and find that these efforts are not adequately rewarded (and this is not about material rewards), they are highly susceptible for burnout (emotional exhaustion and feelings of depression).

### *2.1.3 Job characteristics and stress*

The literature supports the relationship between several working characteristics (such as aspects of demands, control and support) and work stress and mental health outcomes. Demands refer to a certain weight that is placed upon people; this can be a particular level of responsibility, or inconvenient working hours. The concept of 'control' refers to the amount of say people have over their work, i.e. when they can decide themselves on when to take a break, what method of working they would like to use. Support refers to the level of help and understanding people receive from their supervisor(s) and colleagues when they encounter particular problems.

The various job characteristics are related to different health outcomes. Whereas for example, demands may be predictive for emotional exhaustion and fatigue, aspects of control and reward may be more predictive for depression, absence as well as other kinds of health outcomes like cardiovascular problems.

It is clear that work stress is a multifaceted concept; therefore it is often difficult to find an undifferentiated cause for stress. Causes are often clustered, so that there are 'poor' jobs, and 'good' jobs.

Evidently there also are more interpersonal and organisational aspects that have an impact on stress: recently aspects of bullying and harassment have come in the spotlight. But also apart from support from supervisors, a more overarching concept plays a role: managerial style or issues of leadership. Moreover factors from the organisational context, such as economical aspects have an impact, because it may affect workers' job security.

## **2.2 Determinants of sickness absence**

Sickness absence has received considerable attention in recent years in many countries and from many different perspectives (Alexanderson, 1998). It has been viewed as an indicator of health, as a path to exclusion, and as a cost to companies and society. It has been studied within e.g. medical, sociological, political, economical and psychological disciplines. All these modes of research have discovered factors that are associated with sickness absence. However, despite the increasing knowledge of the correlates of sickness absence, it has proven to be difficult to form holistic theories and subsequent intervention strategies that could incorporate all aspects of the phenomenon.

Most relevant parameters concerning sickness absence are: frequency of absence, length of absence, and, of course, cumulative duration of various spells of absence.

Furthermore a distinction has to be made between 'granted absence' (certified by doctor's note), and 'non-granted absence' (absence that is not officially sanctioned = also 'grey' absence – which is not necessarily illegal absence).

Sickness absence is a complex phenomenon combining physical, psychological and social aspects. It is often difficult to assess which of these aspects has the heaviest weight. Usually it is believed that sickness absence is for those cases where people are physically unfit to work, and not for situations in which people feel that they are psychologically not fit to confront the demands of work. The various parameters of absence are believed to be associated with

different aspects of absenteeism: absence frequency is often believed to have a larger psychological component (i.e. medical urgency is less compelling), whereas absence duration is often associated with medical necessity of an illness or injury. Therefore it is believed that long spells of absence are better indicators of ill-health.

### *2.2.1 Incidence of absence*

In the Third European survey on working conditions (Paoli & Merllie, 2000) it was reported that absence due to work-related health problems ranged from 18 % in Finland to 4 % in Portugal in the European Union, with an EU-average of 9 %. Work-related stress, depression or anxiety has been estimated based on self-reports to affect 563 000 people in Great Britain, with an estimated 13.5 million working days lost due to these work related conditions in 2001, i.e. 29 working days lost per year per affected case (SWI01/2).

According to workforce studies there has been a steep increase in long-term sickness absences in some European countries in the past few years (Bergendorff et al., 2002). In the Netherlands, Sweden and Norway the number of people who had been on a sick leave of over a week has risen to over 4 % of the workforce. Other European countries have more moderate and stable figures and the EU-average has been around 2% for about 15 years. Because of the steep increase of sickness absence in Sweden, a number of projects assessing sickness absence has been initiated (Nyman et al. 2002). Special attention has been given to long-term absences and especially psychological problems, because the percentage of long-term absentees due to psychological problems has increased from 14 % in the early 1990's to 25 % in 2001(Riksförsekringsverket, 2002).

Cross-country comparisons with respect to sickness absence have always been very difficult, also meta-analyses on data from different studies on sickness absence are extremely difficult due to large dissimilarities in studies originating from various countries. Sickness absence registration systems vary greatly between countries (or are sometimes even lacking). Moreover, economic and other social welfare factors are different per country and do have a large effect on sickness absence.

### *2.2.2 Factors influencing absence*

The literature review on determinants of absence indicators showed that previous ill health (and absences), chronic disease, low social economic class (SEC) and Low-grade jobs were strong predictors for current absence. Factors like psychological distress, health behaviours, job dissatisfaction, low justice and bullying that are known to be strongly related to health outcomes were found to be moderate predictors of absence. Work characteristics such as high job demands, low levels of control and low levels of social support (from colleagues or supervisor) were found to have a small predictive effect on absence.

However, some comments have to be made concerning these finding and the studies on which they were based. Health appears to be an important determinant of sickness absence as such. However, large increases in sickness absence in some countries were probably mainly caused by societal factors like the economic situation, (changes in) compensation policies, (changing) attitudes and norms regarding absence. The different absence indicators also tell different things, e.g. absence frequency may tell something about the need for recovery, and is not related to health problems per se. The absence duration is much more related to ill health. Mental disorders tend to have longer absence duration as compared to other diagnoses. An abundant number of interactions have been reported in the studies reviewed. This means that one must be careful in interpreting simple (uni-variate) predictor effects on sickness absence.

In the context of this project are those issues important that can be influenced. Economic and labour market figures, as well as factors on the national or sector level are hard to influence from the organisational or individual perspective. Nonetheless these factors have a strong effect on sickness absence.

Factors at the organisational level, such as health promotion, absence policies, and organisational changes as related to climate development, redesign of tasks and management issues are found to be very important in dealing with sickness absence and may be easier to influence.

Farrel & Stam (1988) found in their meta-analysis that organizational factors were better predictors of absence than psychological and demographic correlates.

As far as demographic variables are concerned, it appeared that job level or level of education have some effect. Higher levels of education usually coincide with better jobs, have lower sickness absence rates. The so-called 'white-collar jobs' have significantly less absence than 'blue – collar jobs' (i.e. manual workers), whereas psychological complaints are more frequently found amongst white collar workers and blue collar workers have more often physical complaints.

For all employees it appeared that in particular bullying (harassment) and low organizational fairness were predictors of absence. This means that the psychological climate in the organization is quite important. This is confirmed by the fact that employees who evaluate the atmosphere at work to be poor and unsupportive showed a significant higher incidence of absenteeism. Work atmosphere can be seen as the primary responsibility of management and is dependent on managerial style and leadership style. In general the importance of these issues seems to be underestimated.

Some general patterns could be identified: psychiatric illnesses have the longest spells of absence, which could also be read as if these types of illness have the worst prognosis in terms of recovery. Secondly, there are many ways to influence sickness absence, both on an organizational level as well as on community level: with general health promotion programs, and within the organization by investing in the organizational climate.

### **2.3 Stress management**

In most reviews on work stress interventions, even the very recent ones (e.g. Semmer, 2003) it is concluded that the majority of the research on the effectiveness of work stress interventions focuses on individually directed interventions, which mainly aim at adapting individuals to their environment. Reasons behind this orientation are:

1. Management itself often has the opinion that work stress problems are based on individual factors, particularly on the inability of certain individuals to cope with the work demands imposed upon them.
2. It is also in their interest not to change the organisation too much in response to the problems discovered.
3. It is much easier to study the effect of interventions in an experimentally proper way when an individual, rather than an organisation, or even a part of it, is the target of the intervention study. Issues like randomisation, follow-up of a control group, restricting the intervention only to the experimental group, and avoiding other changes than just the experimental ones are much easier at the level of individuals than at the level of (parts of) the organisation. Some prominent researchers even consider a randomised clinical trial

invalid when it focuses on the complex organisational level (e.g. Griffiths, 1999; Kristensen, 2000).

When considering the outcomes of the studies presented by Van den Bossche et al. (2003), the studies targeting individuals not only showed more consistent and positive results than those dealing with organisations, they were also -in general- of better quality. The latter finding especially may be due to the fact that it has generally been found too difficult to set up a well controlled randomised intervention study at the organisational level. This is well illustrated for example by the review by Landsbergis et al (1999) which refers to the large amount of 'grey' documentation on the effectiveness of organisational interventions. It has also become a kind of accepted trend to present and publish well documented case studies (e.g. Karasek, 1992; Kompier & Cooper, 1999; Kompier et al., 2000 a & b). Several researchers even see this as a better way to evaluate the implementation of organisational measures, since it is only by a combination of quantitative and qualitative (process) perspectives that one can determine if 'the patient really took the pill', and 'the active ingredient was present' (e.g. Griffiths, 1999; Kompier & Kristensen, 2001). Major arguments for not considering the 'RCT' as the gold standard for these type of interventions clearly have to do with the fact that at the organisational level it is often not advisable to choose any single organisation as a control, since organisations that are principally opposed to such interventions differ a great deal from the experimental ones in terms of 'attitude & motive' (and probably several other relevant issues as well).

In spite of this, many of the reviews promote the merits of organisational interventions, and use the following arguments:

1. to prevent is better than to cure;
2. When primary prevention is considered, the causes can best be tackled at the organisational level. When done exclusively at the individual level there are problems related to stigmatisation and marginalisation, and neither the worker nor the manager may be in a position to deal with the issue in a successful way. On the other hand, if the work is really stressful, even the stronger employees will fail to perform and instead will report absent, which certainly will make proper handling of the problem at the organisational level even more time-consuming and difficult.

So, in the end, the approach to reduce risks at their source appears most attractive for all.

Yet there is, at present, little research on the effectiveness of organisational interventions, and the research results that we present tend to be quite inconclusive. Semmer (2003) does indicate their effectiveness when methodological problems like restricting the evaluation to only those who 'took the pill' are taken into account. A recent example of such a study is the one by Randall, Griffiths and Cox (2005), in which this is nicely described in a quantitative way in two case studies.

Regarding the effectiveness of *individual* interventions, a lot of new information is available. This is partly the result of the Dutch Research Programme on 'Fatigue at Work' (NWO-PVA). A meta-analysis was first conducted within the framework of this programme, which aimed to identify the most effective intervention. The cognitive therapy approach appeared to be most effective on the basis of the studies performed thus far (Van der Klink et al., 2001). All of the intervention studies performed within this research programme started out from a very practical and to some extent even unique 'Dutch' situation. The intervention studies conducted as part of this research program found that only occupational health physician actions using this cognitive behavioural approach were effective. An additional aspect to the approach applied in these studies was the notion accepted in policy and professional

guidelines about the importance of *early* work resumption and the ways professionals (Occupational Health Physicians and Psychologists) should support return to work. A recent study tested the effectiveness of two interventions on self-employed persons with a stress related disorder. Results showed that a highly significant reduction in days absent was obtained by the combined approach, whereas cognitive behavioural therapy alone was no more effective than the 'usual care' option over a 10-month period (Blonk & Lagerveld, 2003). Comparable effects but with somewhat smaller differences were obtained in a study on employees (Klink et al, 2003).

## **2.4 Return to work practices**

The World Health Organization predicts that by 2020 mental illness will be the second leading cause of disability worldwide, after heart disease. Studies released by the International Labour Organization (ILO, 2000) indicate that 10 % of workers in Finland, Germany, Poland, United Kingdom, and United States suffer from anxiety, stress, burnout and depressive feelings. Because mental illnesses are seen as a major source for work disability in the near future, the challenge will be to deal with this problem. Disability Management is one way of dealing with this problem.

Disability Management is a worksite based approach to early intervention and covers the range of interventions that are implemented from the point of injury or onset of disability, through job retention interventions that ensure that the worker has been properly accommodated and that future lost time and work disability will be minimized. Another term for 'disability management' is 'occupational rehabilitation'. The goals of disability management include prevention of chronic and progressive disabilities, effective return-to-work outcomes and employment retention of workers with disabilities. It is believed that early intervention and timely return to work is critical to achieving successful outcomes for the worker and employer.

From the perspective of disability management the management of mental illnesses in the workplace is seen as the major challenge for the coming years, as mental illness is increasingly seen as one of the major sources of occupational disabilities.

Other workplace responses to sickness absence are: case management, return to work programmes, vocational rehabilitation. Return to work programmes are primarily centred on procedures that serve as a guidance to the worker and other members in the organization concerning return to work of an absentee. The process aims to begin as early as possible after the onset of an injury or disability and end when a worker has made a safe return to work and is able to safely perform sustained and productive work activity.

Return to work after long-term disability has primarily been studied in terms of clinical factors, treatment factors such as pain management. Therefore they are mostly related to particular types of diseases (i.e. heart diseases, back pain, etc.). In general the environmental or worksite variables have been given very little attention (Shaw et al, 2002).

A few studies have looked at the influence that psychological conditions have on the probability of returning to work. Gard et al (1998) suggested that 'pre-injury' job satisfaction, relationship with supervisors and colleagues and financial pressures were factors that affected the worker's successful return to work.

According to Shaw et al. (2002) the key factors that were important to understand return to work from the individual perspective were: the personal relevance of work and the personal



meaning of disability. The more important work is for the person, the greater the likelihood of return to work. Personal meaning of disability refers to the person's perceptions and beliefs concerning the impact of his/her disability.

Supervisors appear to play an important role in the return to work process; they are usually the daily contact of the worker, and are in a position to serve as a change agent. Nevertheless, very little has been published on their attitudes and reactions towards return to work of the injured worker. It is important that supervisors have adequate knowledge and understanding of the medical and psychosocial aspects of rehabilitation.

A study that examined supervisors of people that were in a process of returning to work, learned that supervisors believed that they contributed significantly to the successful occupational rehabilitation of people. However, many of the supervisors considered such employees to be problematic, because their occupational functioning is often impaired and they require special attention and support (Talma, 2002). Gard (1997) found that when relationships with supervisors were perceived as poor it acted as a de-motivating factor for return to work and that self-confidence of the worker was an important factor.

As far as the role of professionals in Return to work is concerned, various studies have shown that the communication and coordination between professionals is quite poor, and negatively impacts on employee's chances to return to work (Anema, et al., 2002; Houtman, 2002). Talma (2002) found that occupational physicians have a significant contribution to employee's return to work. This group has a systematic and appropriate knowledge about the workplace characteristics and the employee's health problems. However, Talma's study concentrated on people with coronary related illnesses.

When looking at ineffective disability management by doctors it was found that occupational physicians regarded the clinical waiting period, duration of treatment and view of the treating GP's as obstacles for return to work (Anema, et al., 2002). In less than 20 % of the cases there was contact between OP and GP. One of the problems for return to work is to be able to assess the physical and psychosocial demands of jobs, and relate these to the work potential of the employee in order to decide what accommodations would be required to promote safe and timely return to work.

A few studies addressed the topic of rehabilitation of people with psychiatric disabilities, and this concerns working in sheltered workplaces. Work is primarily considered as a therapeutic intervention, and has not much relevance for stress induced mental health problems (burnout, depressive feelings, etc.).

Very few studies have addressed specifically stress-related absence and return to work. One study from Australia has been reported (Dollard, et al., 1999) which investigated compensation claims of people absent because of stress related problems. The study explored the factors that supported or inhibited an early return to work after a claim had been lodged. The study findings showed that stress claimants had taken twice as many days of sick leave as the organizational average in the year preceding their claim. The nature of the stress related injury precipitating the stress claim could be divided into three types with 19% experiencing a critical incident only; 37% experiencing a critical incident on top of chronic work stressors and 44% experiencing chronic work stressors only. Chronic work stressors included high workload, unmet needs for training, conflict with fellow workers or management, escalating grievances, job dissatisfaction through lack of recognition and promotion opportunities, the violent nature of the work environment, high demands and very high responsibility, redeployment failure (lack of suitable work), lack of support in ones' position, chronic turnover of managers and job uncertainty. A clear relationship was found between type of

stress precipitant and length of stress-related leave, suggesting that the organisational response to specific stressful incidents was much more effective than its response to chronic work stressors. The role of non-work stressors was not seen by the workers as critical in the development of strain.

Half of the work stress claimants rated their manager's or supervisor's response to their problem as 'bad' and a quarter as 'average'. The way in which supervisors, in particular, and co-workers responded to the worker's open expression of distress was cited as a critical factor in the long-term resolution of the claim. In this study, the majority of evaluations of supervisors were negative. With many respondents perceiving management as totally unresponsive, unresponsive, untrustworthy, untrained and lacking in all human/communication skills

It was mentioned in several studies that there is a significant social stigma surrounding depression and similar conditions. Employees fear the consequences, whether perceived or actual, of being identified as suffering from a mental health disorder. Their fear often leads them to hide the true cause of their disability from their employees, and as a consequence employers are not getting an accurate picture of the impact of mental health disorders on their employees.

Also employees seem to be concerned to use their employee benefits to obtain treatment for mental illness out of fear that their boss and colleagues will learn about their problem and use this against them.

Overall it can be concluded that there is very little literature available dealing specifically with the issue of re-integration into the workplace of people with stress related illness or mental health problems. Most of the literature relating to RTW comes from the area of physical illness or injury.

One aspect stood out in the various publications: the role of the supervisor/manager of the employee. This person has a fundamental role in managing relations with the returning worker both when absent and also when returning to work and also in managing the perceptions and expectations of co-workers.

## **2.5 Summary**

The review of literature indicated that there is clear evidence suggesting that people in poorly designed jobs (high demands, and low level of control over their work) are at higher risk for physical and mental health problems. In particular low levels of control over work are associated with mental health problems (i.e. depressive feelings).

The literature on sickness absence made clear that international comparison on sickness absence is severely hindered by differences in economic and social welfare systems. A general conclusion is that people in low-grade jobs have a higher incidence of sickness absence. Furthermore organizational factors, such as climate in the organization and managerial style have a considerable influence on sickness absence, in particular on mental health complaints of people in the organization. Managerial style refers to how people are treated and also relates to how much influence people have over their own work and work environment. These are factors that can be dealt with at the organizational level.

Stress management interventions seem to be primarily focussed on individuals rather than on structural factors in organizations. Managers still seem to think that stress and mental health problems are a sign of 'weakness' of the individual rather than that something in the organization needs to change.

Disability management is still a relatively new field, and has not yet explored the issue of reintegration into the workplace of people with mental health problems. In relation to this an important aspect is the distinction between 'general mental health' and 'stress-related mental health'. This aspect will be dealt with in the next section.

### **Chapter 3 Defining Stress and Mental Health.**

The Stress Impact project focuses on people who are long term absent for stress-related health problems. However, 'stress' is a rather vague and indistinctive concept (see "occupational stress" above), and used as an 'umbrella concept'. It is now more or less generally agreed that 'stress' refers to a particular condition which can be characterized by physiological and psychological parameters, and it therefore has a physical health component (i.e. cardiovascular problems) and a mental health component (i.e. depressive feelings, feelings of fatigue or exhaustion, feeling vulnerable). For this reason it is useful to clarify the distinction between 'stress' and 'mental health'.

'Mental health problems' refer to psychological problems of a clinical nature (more or less severe), and includes a much wider group of 'patients' than has been targeted for this Stress Impact project. The problems that people with mental health problems have are not necessarily stress-related, and may be dispositional, or resulting from a trauma.

On the other side of the spectrum are the mental health problems related to stress and burnout. Stress and burnout are closely related constructs and the distinction between them is somewhat unclear. Nevertheless, they both relate to situations in which people have been over-stretched for a long period without sufficient opportunities to recover from the strains that have been put upon them. The demands then exceed a person's capacity to cope with these problems and rises the level of anxiety. This results in a dysphoric and dysfunctional state in individuals often without major psychopathology (Bril, 1984; Schaufeli & Enzmann, 1998). Typical characteristics include high levels of (emotional or psychological) exhaustion, and feelings of reduced personal competence, or self-efficacy, accompanied by depressive feelings. This prevents people from functioning adequately in their job, and from using appropriate coping strategies, thus causing a negative spiral. Where levels of demand are high and chronic, longer term health breakdowns may result. Typically people suffering from stress would have (some of) the following symptoms: feeling exhausted, depressive feelings, reduced self-efficacy, and psychosomatic complaints. People are at risk when they perceive a chronic imbalance between their input (effort, time) and the output (material and immaterial rewards) in their work (Siegrist, 1996, Schaufeli, et al., 1993) and usually do not recover from this situation without outside help or environmental rearrangement (Brill, 1984).

Burnout is a stress-related disorder. Although originally 'burnout' was seen as a rather specific form of 'work-related stress' (i.e. a 'sub-set' of stress reserved for people in jobs where they are working with people: teachers, nurses, etc.). This idea has now more or less been abandoned; people in all kind of jobs can suffer from burnout. The core is that people who have invested quite a lot of themselves in their job and have been very committed to their job (some speak of 'over-commitment'), and at some point in time, for any particular reason, perceive that it hasn't exactly been worthwhile, or that their efforts are not valued, might feel emotionally 'drained', or 'exhausted'. The exact definition of burnout depends on the theoretical framework that one prefers to use: MBI – framework (Maslach, 1984), or Effort-Reward Imbalance (ERI) framework (Siegrist, 1996). The common denominator, however, is that people have been exposed to high levels of demands over a longer period and, as a consequence, they are suffering from reduced levels of well-being, and are not capable to function adequately. The specific symptoms include: feelings of (emotional) exhaustion, feelings of disengagement from the object of work, and feelings of reduced competency.

Therefore, when speaking about 'stress-related mental health problems' one should particularly look at people with the following psychological complaints: 'depressive feelings',

and 'feelings of exhaustion' or 'fatigue'. It is also quite likely that this person will experience a reduction of self-efficacy, as (s)he cannot really 'get to things' or 'get things done'.

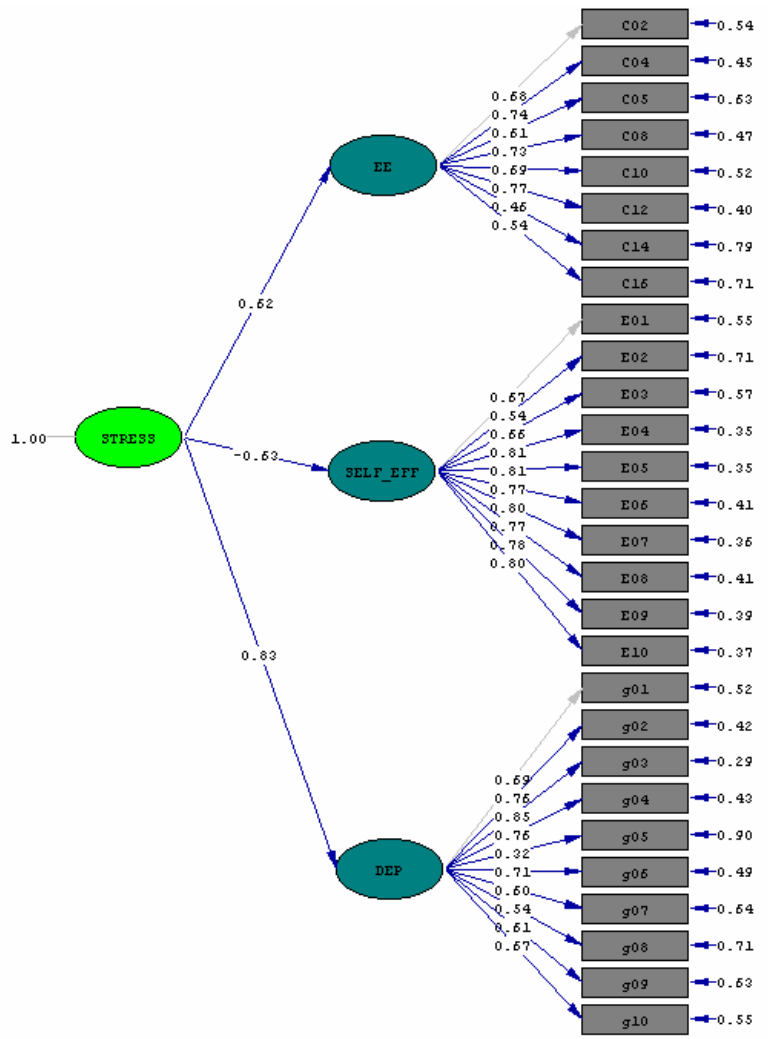
### **3.2. Measuring stress**

Various instruments have been published in the literature to measure stress (see D'Amato & Zijlstra, 2003). However, given the earlier mentioned lack of conceptual clarity of stress, it is for most of these instruments not entirely clear what they actually refer to. Some of the instruments include items that relate to the amount of work and are conceptually related to the demands of work, or the effects of those demands (i.e. workload), while others include items pointing towards psycho-physiological symptoms, whereas again others seem to measure primarily the level of anxiety. But most importantly all these instruments have in common that they are one-dimensional, while the stress concepts can be assumed to be multi-dimensional (see above).

Depressive feelings and fatigue have been acknowledged as symptoms of stress (see D'Amato & Zijlstra, 2003). However, only a few studies have included self-efficacy as part of the stress concept. Self-efficacy refers to the individual's believe that one has the ability to produce desirable outcomes (Bandura, 1977). It has been demonstrated that this concept has a significant effect in active coping strategies and work-stress models (Gerin, Litt, Deich & Pickering, 1995). This actually means that like the corresponding 'burnout' concept, also stress should be conceived as consisting of three dimensions.

For that reason we included a stress concept that includes the three elements that have been referred to above: feelings of exhaustion: feelings of depression, and perceptions of reduced self-efficacy. These three scales have been included in a confirmatory factor analyses in order to have a statistical check on the viability of such a three dimensional concept.

With Confirmatory Factor Analysis (CFA) (Jöreskog & Sorbom, 1993) it was tried to verify whether these three scales would together indicate a latent variable, which we will refer to as 'stress' (See Figure below). For this analyses we used the entire sample of the present study (total available sample N= 1994 – Austria = 364; Finland = 492, Ireland = 366, The Netherlands = 405; UK = 367).



Chi-Square=2379.82, df=347, P-value=0.00000, RMSEA=0.058

The goodness of fit statistics (as they are presented below) suggest a good fit of the model to the data.

$\chi^2/df = 2379.82/347$

**RMSEA** = 0.058

**RMR** = 0.036

**SRMR** = 0.047

**GFI** = 0.91

**AGFI** = 0.90

**CFI** = 0.92

**NNFI** = 0.91

**CN** = 320.42

The model appears to fit the data, as well in the combined sample as well as in the various national samples. Therefore it can be argued that these three variables – depression, exhaustion and self-efficacy – can be seen as part of a common latent factor: stress. This measure is used in the analysis where there is referred to ‘stress’.

## **Chapter 4 Towards a conceptual framework for the Stress Impact study**

In their review chapter on sickness absence Allegro & Veerman (1998) referred to sickness absence as the outcome of a decision making process. When people feel not well and stay at home this can be seen as the outcome of a decision, rather than an inevitable consequence of peoples' health status. Evidently there are gradations in health status, varying from completely incapacitated to more or less capable, or being hospitalized or being at home. In principle in all these situations people have to make a decision concerning going to work or not. It is evident that in some cases the health status leaves not much choice; however, there are many instances in which there actually is a choice. Some people even manage to go to work when they have broken a leg. Evidently there are many factors affecting such a decision, such as the work situation itself (how important the person thinks his/her presence is, how easy is it to get there, etc). In the example of a broken leg there should be a volunteer to bring this person. The factors influencing such a decision can be grouped under: Work-related aspects (i.e. type of work, work environmental aspects, organizational climate), Personal aspects (i.e. age, health status, commitment to work), private or Non-work aspects (family situation, distance to work, resources and social pressures, etc.), and Contextual factors (financial implications, administrative process of reporting ill, etc.).

In sum, when people decide to stay at home they have to make an active decision to do so, in fact they are changing a daily routine or 'habit' of going to work, This can be conceived as if they are crossing a threshold. Some of the above mentioned factors will 'push' people towards the threshold, while other factors might 'pull' people across the threshold. For instance, a job of poor quality will push people towards absenteeism, while a lack of administrative process (or checks upon actually being absent) will pull people across the threshold. The Figure below presents a graphical representation, and contains thresholds and 'push' and 'pull' factors. It has to be noted that in daily practice it may not always be possible to decide what has acted as a 'push' or 'pull' factor. This distinction is primarily made to clarify the conceptual model.

Similarly one can argue that return to work can be seen as a decision making process, people need to cross a threshold when they decide to go back to work. They need to break again with an 'old' routine and develop a 'new' routine. So, again they need to pass a threshold. And yet again there are various factors that can affect the decision, or the threshold. And again various factors will act as 'push' and/or 'pull' factors. For example, financial incentives, or social contacts with colleagues may 'pull' people towards work; while social pressures from the environment may act as 'push' factors to go to work again.

This model has been used as a conceptual framework to guide the Stress Impact study.

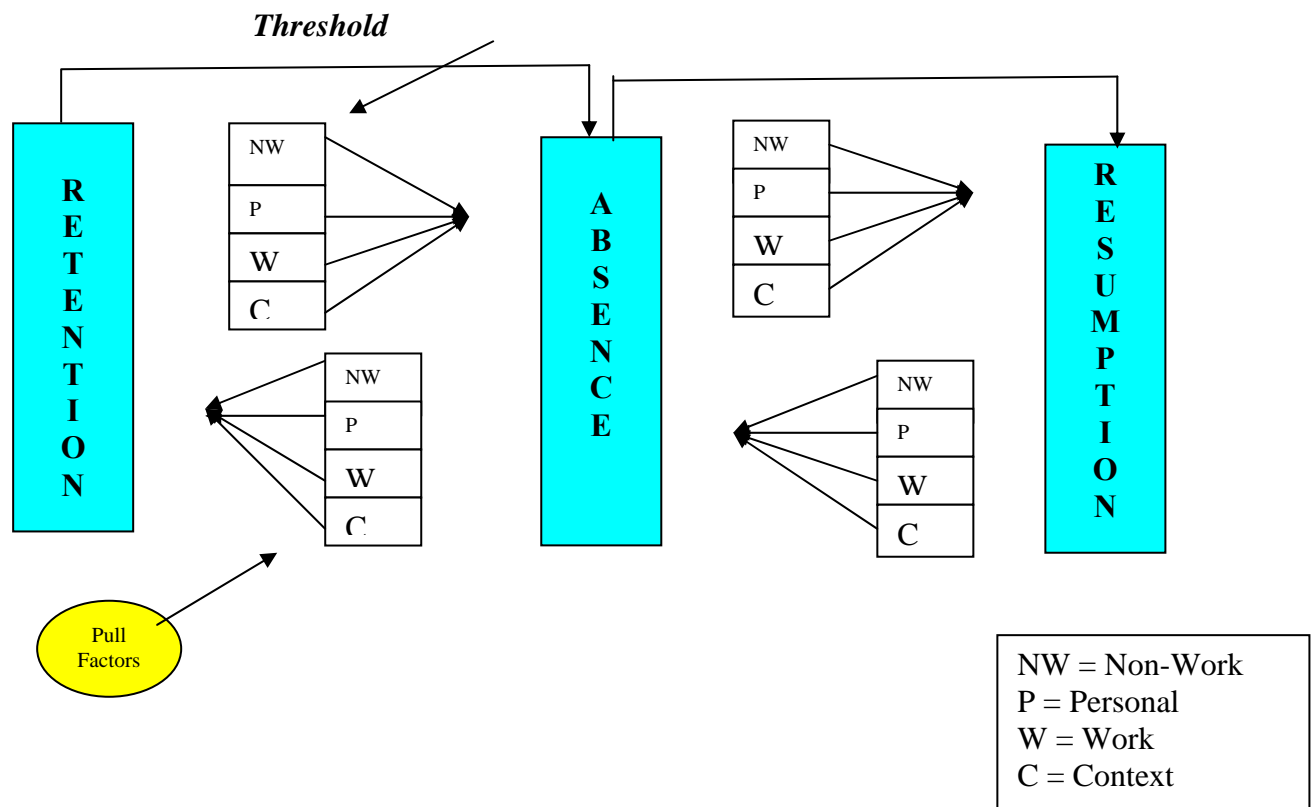


Figure 4.1: Conceptual Model for the Stress Impact study.

In addition Figure 4.2 specifies what kind of factors should be included in the various categories (Work, Non-work, Personal, and Contextual factors). These factors have been included in the survey as described in the methodology section.



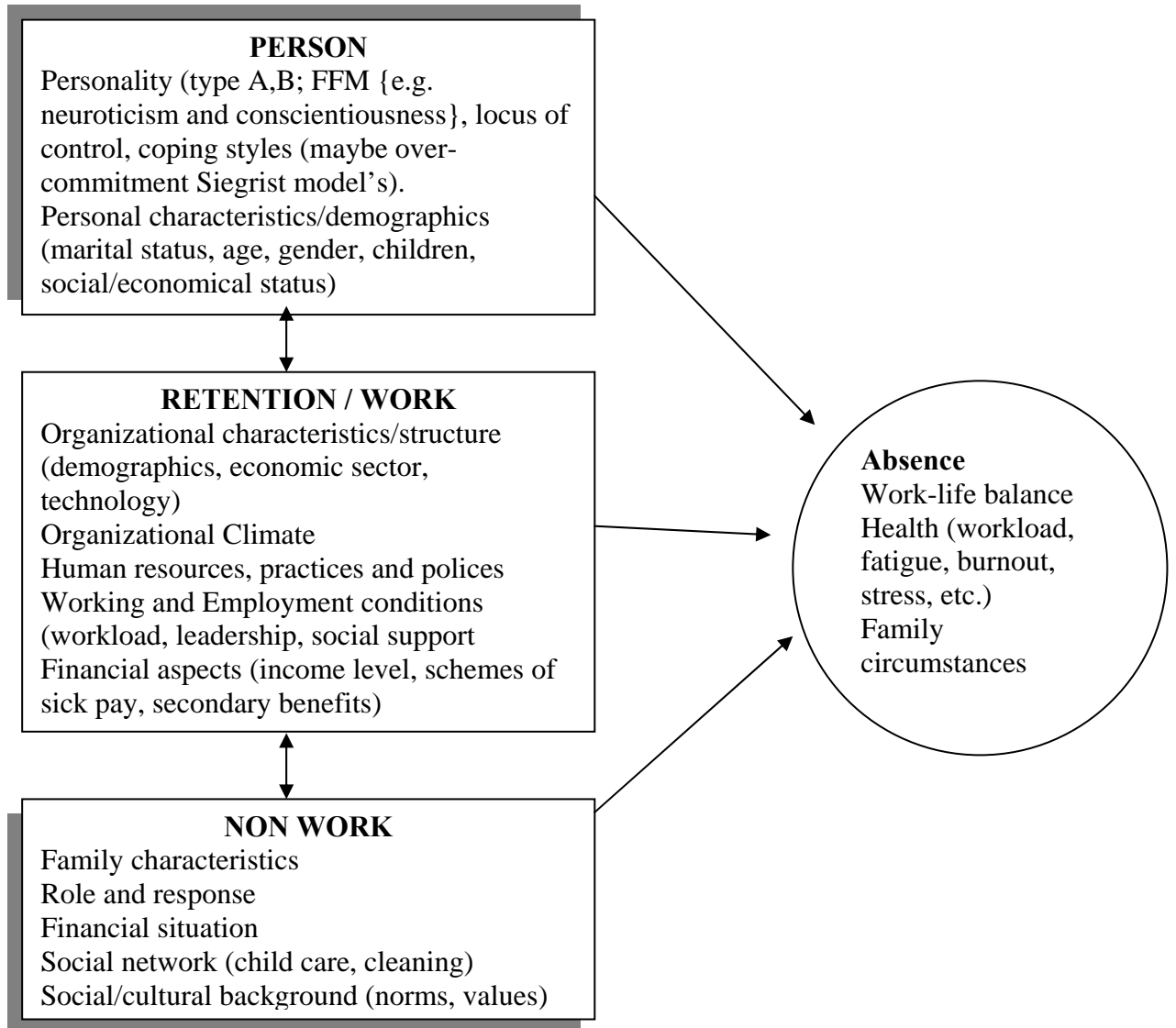


Figure 4.2: Overview of variables

## 4.1 Conclusion

The issue of mental health problems in relation to work is generally seen as an emerging theme, and is dominating the political agenda in many European countries (see also section 5). However, it has not received much scientific attention thus far.

## 4.2 Study questions

To summarize, the key questions to be answered in this survey are:

- 1) what are the demographic characteristics of long-term absentees,
- 2) what are the psychological characteristics of long-term absentees,
- 3) to what extent can people, who are absent for stress-related reasons (mental health problems), be differentiated from other long-term absentees. This differentiation should also include other than demographic factors, i.e. life style, general health, job characteristics, psychological aspects, etc.
- 4) which factors (including availability and use of services, etc.) contribute to predicting peoples' absenteeism, and or work resumption.

## Chapter 5 Summary of National systems and policies related to stress and absence from work

Work package 2 of the project undertook a set of 6 national analyses of policies and systems related to stress and absence from work. These analyses provide great detail on the rates of absence from work, the structure and operation of national welfare (social insurance) and other responses to absence from work. In addition, they investigated the current debates within the 6 participating countries with regard to stress, absence from work and possible future directions in legislation and regulation.

### 5.1. Types of welfare systems

As might be imagined, national social insurance and welfare systems are complex, often ad hoc in their design and construction, different in terms of their underlying philosophies and organisation. In addition, they vary in relation to the role of the public, private and semi-state sectors, the source and level of funding of the systems, the nature and types of service delivery mechanisms and the professionals involved and a wide range of other parameters. It is beyond the scope of this document to compare systems along all of these dimensions. However, some of the more relevant elements of national systems are compared in the Table below.

**Table 5.1. Major comparative elements of national systems**

System element	Ireland	United Kingdom	Italy	Netherlands	Finland	Austria
Type	Welfare based	Welfare based				
Philosophy	Income replacement	Income replacement and RTW	Income replacement	Income replacement, return to work	Income replacement return to work	Income replacement return to work
System delivery	Mix of public, semi-state and private sector provision	Mix of public and private sector provision				
Legislative backing	Strong legislation, no collective agreements	Strong legislation, no collective agreements		Strong legislation, strong collective agreements	Strong legislation, strong collective agreements	Strong legislation, strong collective agreements
Funding levels	Low levels of benefits, General funding base	Low levels of benefits, General funding base				
Levels of claims	Low	Moderate	Moderate	High	High	Moderate

National systems have been set up and organised according to different principles. At a fundamental level, there are differences between what might be termed welfare based systems

and social insurance based systems. The important distinction here relates to how the system is funded and how money (benefits) is paid out. In welfare based systems, funding is raised through general taxation and/or some form of tax which might be labelled social or national insurance. The money raised in this way goes into the general taxation pool within a country, and all state benefits are paid from general taxation. The UK and Ireland provide examples of such systems. In contrast, social insurance based systems collect social insurance contributions, but disburse them in a hypothecated way, i.e. contributions to the social insurance fund are protected from the general taxation pool and the fund is expected to perform in a financially neutral manner. These systems are more common in Continental Europe and variations on them can be seen in Finland, Austria and the Netherlands.

The important distinction between these systems is that insurance based systems tend to have a stronger *bonus malus* element built into them – there is greater incentive to control both insurance premia and payouts. Welfare based systems on the other hand, tend to separate the income raising and benefit payment functions.

Another distinction between these systems relates to the level of benefits paid out (at least in relation to the systems under review in this study). Social insurance systems have broadly arisen from social solidarity models, where a high emphasis has been placed on agreements between the different strata of society. In this context payments are seen as entitlements, rather than as benefits (it is common for the word pension rather than benefit to be used within these systems). In contrast, welfare systems have arisen from movements relating to the relief of poverty (hence the word benefit). In this study there is a marked difference in benefit levels between these two systems with larger percentages of pay being paid out under the social insurance models of the Netherlands, Austria and Finland than is the case in Ireland and the UK. (This difference is also related to the types of economic policy practiced in these countries). Though not much difference is seen in relation to short term sickness benefits, where differences with pre-absence pay and benefits are generally made up by top-ups from the employer (by agreement in the Netherlands, voluntarily in Ireland and the UK), the differences between the systems are especially marked in relation to longer term sickness benefits (generally payable after about 12 months absence). Here, social insurance systems will payout some percentage of pre absence-pay, whereas welfare based systems will usually pay a flat rate of benefits.

## **5.2 The treatment of stress in legislation and practice**

The issue of stress and its treatment in legislation is a recent phenomenon and there are marked differences between the countries within the study in this regards. Of particular interest in the current context is how stress is treated in relation to health and safety legislation and social welfare legislation, since these two are pivotal in relation to the actions taken at workplace level to combat stress on the one hand, and to the entitlements of stressed individuals to access benefits payments on the other. The table below summarises the treatment of these issues in the 6 participating countries.

In general terms stress is well recognised as an occupational health hazard by all of the participating countries, even if this is more explicit in some countries. However, Finland is the only country to have undertaken an investigation of whether occupational stress should be viewed as an occupational disease. Here the conclusion was that difficulties of definition and attribution of case meant that it could not be so treated. On the other hand, the Netherlands is

the only country in the study to have recognised burnout as a legitimate work related illness and as being allowable in the context of benefits payments.

It should be noted that a peculiarity of the UK and Irish legal systems relates to the need to establish fault in cases of occupational stress. This feature of the system means that such cases often end up in court and that the courts have been used to establish precedent in dealing with such cases, thereby establishing legal norms for practice.

The Tables below provides a summary of the adequacy of national provisions in relation to stress at work, levels of awareness about the issue and future plans in the area. Though all countries recognise occupational stress as a hazard, there is considerable difference in approach to the issue, both in terms of the emphasis placed upon it and the strategies employed to deal with it. A relatively clear pattern emerges though, with the Netherlands and Finland (and to a lesser extent, Austria) in one group, the UK and Ireland in another and Italy apparently adopting a third approach.

**Table 5.2. Adequacy of provisions for stress and long term absence**

Country	Provisions for stress
Ireland	Irish legislative provisions on absence, return to work and stress are at best fragmentary, with a large number of un-coordinated Acts in existence. Court judgements set precedent in the area of occupational stress. Health and safety legislation recognises stress as a hazard and provides some guidance on prevention. However, accessing appropriate treatment services is difficult and often is not covered by insurance of any form.
United Kingdom	Provisions for stress related absence are the same as those from any other cause. Assessments of incapacity include assessment of ability to work. ICD-10 and DSM-IV are used, but these leave no explicit provision for stress related problems. GPs are not trained in occupational health and this may lead to weaknesses in the system. There are no obligations on employers to make provisions for return to work. A weak OSH system means that specialist services for work related stress are at best intermittently available.
Netherlands	Stress is recognised as a hazard in the workplace and burnout is recognised as a legitimate cause of absence. Professionals (OHP's and Psychologists) have adopted guidelines for the management of work-related mental health problems. The government also issued a guideline using input from all stakeholders on employer, employee and professional responsibilities and principles in RTW of employees who are long term absent with (work-related) mental health problems (Donner committees).
Italy	Legislative provisions in relation to stress are weak and un-coordinated. Return to work services are seen as being experimental. However, future changes may see more emphasis on psychosocial issues and on reintegration.
Finland	Recent reviews of the major legislation in the area have led to more emphasis on psychosocial and psychological issues. In addition, there has been increased focus on rehabilitation and collaboration between the major service providers.
Austria	The provisions for dealing with stress are the same as those for dealing with absence from any other cause. A social insurance based system provides schemes for stress prevention and rehabilitation. Recent legislation allows for the employment of psychologists as part of the prevention activities which take place, thereby improving the focus of occupational stress.

In the first group (SF, NL, A; see section 6 on Project Methodology) there is widespread recognition of the issue of occupational stress amongst most if not all stakeholders. Legislative provisions tend to be relatively strong (if complex) while services to both employers and employees, though present, may not be optimally effective. In contrast, the UK

and Ireland (which share a legal history and approach to social service provision), legislative provisions are less adequate and service provisions are less available.

However, there are problems common to all of the systems. Chief among these is the availability of services and the payment for these services. While all systems appear to have appropriate treatment services available, they may not be generally available, easily accessible or publicly funded. In addition, there may be co-ordination problems between services providers in most countries, and it is not clear in most that returning people to work is a major priority.

**Table 5.3. Level of awareness and debate**

Country	
Ireland	Responsibility for stress is a key issue in the debate, with employers seeking to reduce liability in this regard. However, debate is quite active, with issues concerning mental health, prevention of work stress and increasingly, return to work becoming live issues.
United Kingdom	A high level of debate takes place in the UK, with significant contributions coming from the Department of Work and Pensions, the Health and Safety Executive and NGOs such as the CBI and CIPD. Despite official and high level debate, there is still a lot of confusion over the meaning of the term stress.
Netherlands	There is a high level of awareness of the issue of both stress and stress as a cause for absence. The work of the Donner committees has provided a focus for this debate and other relevant issues under debate include the role of the OSH services, improving the emphasis on prevention and reintegration and making improvements in legislation and social insurance.
Italy	A review of the health system may take a more favourable approach to the issue of stress and absence.
Finland	The level of debate is both high and generalised with the issue of occupational stress and well-being at work long being recognised by the major players. As evidence, there are many agreements between the Social partners and projects and programmes in the area.
Austria	Levels of awareness are reasonably high.

There is a marked contrast between countries with regard to the level of and sophistication of the debate on stress related absenteeism. Much of this is related to the baseline of legislation in the area, but there also appears to qualitative differences between countries with regard to the focus of the debate. In some countries, the issues of stress prevention, treatment and return to work are linked, but in others, the level of debate is confined to stress prevention at work. Treatment would appear to be confined to a public health agenda while return to work features only in countries such as the Netherlands and Finland.

Despite current limitations in relation to legislation and existing services, there are prospects for change in a number of countries. In some cases these prospects are quite specific, for example, Ireland is undertaking a review of health and safety policy in order to develop a national workplace well-being strategy, while the UK is actively addressing the return to work issue in a number of ways – the main ones being the development of a number of return to work pilots under two programmes. Other countries such as Italy are depending upon a less focused debate on health service reform to deliver change in relation to how occupational stress is dealt with. However, even if the issues relating to stress at work, mental health and absence are not yet on the national agenda in a linked way, it is likely that they will be in the future, as in almost all countries the levels of absence due to mental health problems are increasing.

**Table 5.4. Future directions**

<b>Country</b>	
Ireland	A major review of policy on occupational health is currently taking place, which seeks to develop a more 'well-being' oriented approach. However, recent amendments to health and safety law did not strengthen provisions in the area. A recent review of social protection measures does indicate a move towards more active measures.
United Kingdom	There is support for an approved code of practice in the area. There is an investigation into the possibility of setting quantitative targets for occupational stress. Guidance on return to work strategies will be developed and
Netherlands	Recent legislative changes need to be monitored. The effects of provisions for changing the responsibility for sickness absence in relation to stress are clear, in the sense that they are the responsibility of the employer and the employee. How the new social security benefit system will work out for those with work-related mental health problems remains to be seen.
Italy	A review of health legislation is underway.
Finland	There have been recent changes in legislation on rehabilitation and employee health and this may be extended to changes in sickness benefits. The implementation of these changes in practices remains an issue, especially in relation to collaboration between the services involved.
Austria	Sickness absence due to mental health problems is increasing.

# Chapter 6 Project Methodology

The Stress Impact project consisted of three related studies:

- a) A longitudinal Survey: ‘the survey’ (WP-5);
- b) Interviews with professionals working in this field: ‘the professional’s study’ (WP-6);
- c) Interviews with a sub-sample of the respondents of the survey, and their ‘significant others’: ‘the family study’ (WP-7).

## 6.1 Survey

A survey questionnaire was developed that was administered in all participating countries to a sample of Long Term Absentees (LTA). For each country the objective was to collect information from a national representative sample of approximately 400 LTA’s. A longitudinal study design was used with two measurements. The general procedure that used included that potential respondents would first receive a letter stating the objective of the study and asking their co-operation. If participants agreed they were requested to return a ‘screener’ that was included (to assess whether the participants met the inclusion criteria for the study) and the informed consent statement. In the various countries some small deviations from this general procedure were required due to the local situation (see national reports on WP 5).

Due to differences in national registration systems it was impossible to fully synchronize the data collection in all countries. The length of absenteeism for potential respondents differed per country (see Work package 2). Therefore the countries were assigned to either an early group (length of absence of respondents between 12 and 20 weeks) or a late group (28-36 weeks). The time interval between the two measurement waves was set at six months. This means that when the early and late samples are combined a period of one year can be covered. The timeframe of a year is critical in some countries with respect to legislation concerning sickness absence. People often move on from sickness absence to Incapacity Benefit within this time-frame. This might affect the ‘Return to work’ decision of respondents.

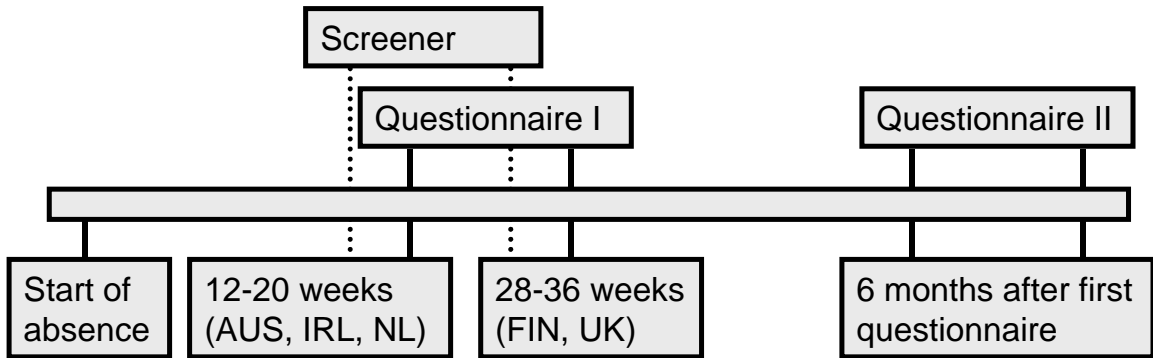


Figure 6.1: Stress Impact study design.

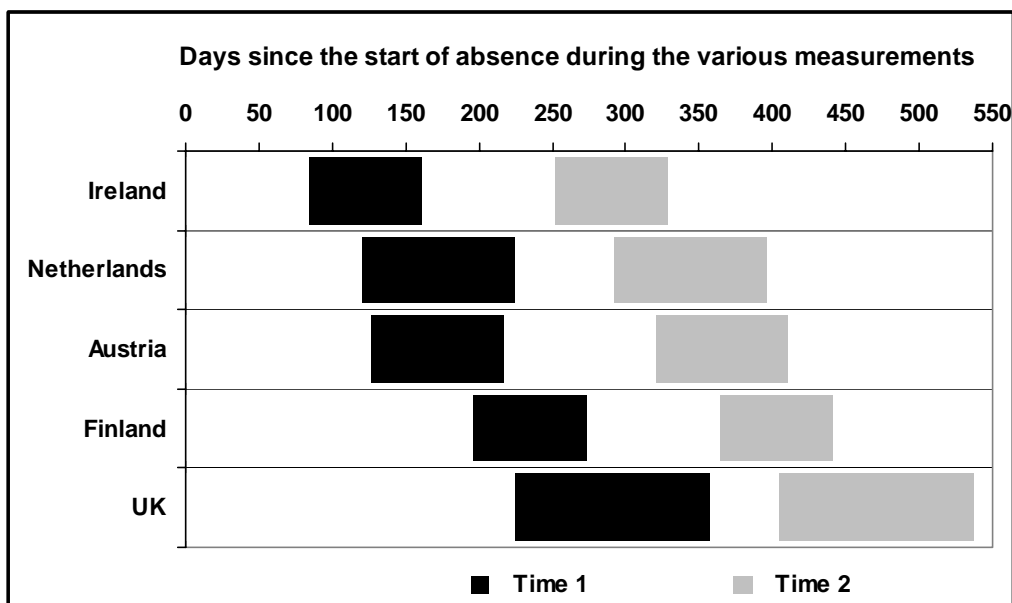


Figure 6.2: Sampling timeframe in participating countries

## 6.2 Questionnaire

A questionnaire was designed for this study. The questionnaire consists of several nationally and internationally validated scales and several newly developed scales and items, covering the factors that might influence the return to work process. First an English questionnaire was constructed. Then this questionnaire was translated into the different languages and cross-checked by several researchers. As much as possible original translations of the validated scales were used in each country. The total list of all items and scales used in the questionnaire can be found in appendix A.

## 6.3 Sample

In each participating country a sample of approximately 400 Long Term Absentees were recruited. The total sample size was 2002 respondents. The exact details for each sample are presented in each national report.

Due to various problems the Italian sample could not be included in the total data file.

A more detailed overview of the total and national samples and a comparison of the various samples is presented in Section 7.

## 6.4 Analyses

In first instance descriptive analyses have been performed. These are reported in the National Reports (Work package 5 reports). Subsequently logistic regression analyses have been performed on all national data sets (if possible). These are reported in the national reports.

In this report analyses on the total sample are reported.

Multivariate logistic regression was used to look at predictors of return to work at time 2. The outcome variable in the logistic regression model was work resumption asked in the time 2 questionnaire, i.e. whether the absentees had 1) returned to work completely 2) returned to work partially or on a therapeutic basis or 3) not returned. For the regression models full resumption and partial resumption were grouped together. In the logistic models the comparison therefore is between those who have not resumed work at all and those who have resumed work either fully or partially.

The logistic models are constructed so that four different models are analyzed first. These models represent different domains in life: personal variables, work related variables, family



related variables and contextual variables. The domain specific variables are predetermined on a theoretical basis. These variables are first looked at within the domain specific model and then the most relevant variables from each model are selected into a fifth model. This overall model includes the most relevant variables relating to work resumption.

### *Interaction analyses*

In order to examine the effects of some of the most profound variables and the systemic effects between different countries a set of interaction models were constructed for five different breakdowns: reason for absence, workability, stress measure, cohort timeframe and social system. In the interaction models all variables in the final overall model were included and their interaction with a breakdown variable. A separate model was constructed for each breakdown.

## **6.5 Variables**

There are three different types of variables used in logistic regression, firstly, there are nominal categories (e.g. gender); secondly, yes/no dichotomies (e.g. do you have children under 18 living in the household) are included, and thirdly trichotomies (low, medium, high), which were made for the scales and other continuous variables (e.g. depression) based on tertiles of the total sample population of five countries.

In the interaction analyses the effect of five variables was examined. In the first distinction the respondents were asked whether the main reason for their absence was a physical illness, a mental illness or a combination of a physical illness and mental illness. This distinction was validated against the physician diagnoses the respondents indicated they had from a list of medical diagnoses. In the analyses the group which indicated they had both physical and mental reasons for their absence was dropped out.

Second, a stress measure or general psychological morbidity was constructed on the basis of three factors of mental functioning i.e. emotional exhaustion, depression, and general self-efficacy (see section 3). Third, the respondents were asked to rate their current workability on a scale of 1 to 10. This variable was transformed into a dichotomy (low<4, high>=4). The distinction between a low and high workability group was done to in some take into account large differences in the severity of the health problem that incapacitated the employee. Fourth, the participating countries were grouped according to how long their sample had been absent from work. Austria, The Netherlands and Ireland were grouped together in the early group their samples being absent for 25 weeks on average. In the other group were Finland and UK, whose samples were 34 weeks absent on average. Fifth, a distinction was made based on which type of social system the country has. UK and Ireland were grouped together, representing a welfare type system. On the other hand Finland and the Netherlands were grouped together representing an integrated model of services and benefits. Austria was dropped from these 'system' analyses because its system was not classifiable to either group.

In the models the figures are odds ratios where one of the variable levels (e.g. 'low stress') is set as a reference (odds ratio of 1) and the other variable levels are contrasted against this reference group. Odds ratio higher than 1 mean a higher chance of returning to work in the employees at this variable level compared to the reference level and odds ratio lower than 1 mean a lower chance of returning to work compared to the reference level. The significant interactions are also described in pictures.

## Chapter 7 Results from the quantitative cohort study

### 7.1 Sample Characteristics

The objective for this study was to obtain information on Long Term Absentees (LTA's) in various countries from the European Community. A power analysis revealed that a sample of approximately 400 LTA's per country could be representative in each country. In some countries (i.e. NL, FIN) there are national registration systems for sickness absence available, however in other countries this is not the case (see WP 2 & 5 reports). In these situations other sources have been consulted (i.e. social insurance companies, database of Incapacity Benefit recipients). From these sources samples have been obtained. In this section the various samples will be briefly described. Although an identical sampling strategy was agreed for all countries, the fact that different organizations had to be worked with for the data collection in the various countries has caused some differences between the various samples. The individual samples are described in the National Reports (WP 5), an overview of main sample characteristics is presented in Table 7.1. Subsequently the samples are compared on main characteristics.

At first instance 2002 valid questionnaires have been received (Time 1) and subsequently 1557 at Time 2.

**Table 7.1. LTA's characteristics for the total sample (N = 2002).**

VARIABLE	CATEGORY	PERCENTAGES
<b>GENDER</b>	Male	48,9
	Female	51,1
<b>EDUCATION</b>	Up to lower professional education	32,6
	Intermediate general and professional education	32,2
	Completed highschool	10,4
	Higher professional education	17,5
	Academic education and higher	7,3
<b>MARITAL STATUS</b>	Married	59,4
	Cohabiting	9,3
	Single	15,1
	Divorced	13,9
	Widowed	2,3
<b>CHILDREN (&gt;18)</b>	YES	30,7
	NO	69,3
<b>WORK SECTOR</b>	Private	65,0
	Public	28,1
	Non-profit	6,9

<b>WORK SECTOR</b>	Agriculture	2,5
	Manufacturing	16,8
	Building	10,5
	Trade	13,4
	Hotels & restaurants	6,1
	Transport	9,7
	Banking	4,4
	Public administration	6,5
	Education	7,3
	Health	14,4
	Other community	6,5
	Recreational	2,0
	<b>JOB TENURE</b>	0 to 5
6 to 10		7,4
11 to 20		20,7
21 to 30		27,7
31 and higher		38,7
<b>JOB TYPE</b>	Permanent	87,9
	Temporary	12,1

As far as level of education is concerned, the majority of the sample had a low or intermediate level of education; most respondents were married, worked in the private sector, were employed on a permanent basis, with, on average, high job tenure.

In Table 7.2 the distribution of the sub-samples is represented.

**Table 7.2. Demographic characteristics and sample distribution.**

	AUSTRIA	FINLAND	IRELAND	NETHERLANDS	UK
<b>GENDER</b>					
Male	198	204	158	204	207
Female	166	282	207	199	159
<b>Total</b>	364	486	365	403	366
<b>EDUCATION</b>					
Up To Lower Professional Education	86	194	152	117	97
Intermediate General And Professional Education	160	107	77	124	170
Completed Highschool	37	48	26	33	63
Higher Professional Education	61	96	65	97	28
Academic Education And Higher	20	41	43	32	9
	364	486	363	403	367
<b>MARITAL STATUS</b>					
Married	220	284	232	274	167
Cohabiting	29	60	21	36	39

Single	51	50	70	52	76
Divorced	60	73	33	35	74
Widowed	4	19	8	5	9
	364	486	364	402	365
<b>JOB TYPE</b>					
Permanent	262	444	295	373	248
Temporary	75	29	54	26	39
Self-Employed	3	4	11	0	72
Other	10	1	4	0	6
Total	350	478	364	399	365
<b>PRIVATE/ PUBLIC</b>					
Private	242	281	252	157	259
Public	67	189	72	121	65
Non-Profit	9	12	19	72	14
Total	318	482	343	350	338
<b>SECTOR</b>					
Agriculture	13	8	9	8	11
Manufacturing	58	101	67	53	46
Building	41	37	36	38	50
Trade	73	43	61	30	52
Hotels & Restaurants	27	25	29	8	28
Transport	17	58	26	38	48
Banking	8	5	26	37	9
Public Administration	14	35	9	52	15
Education	5	25	8	80	23
Health	38	93	55	54	38
Other Community	49	38	17	0	21
Recreational	3	13	5	6	12
	346	481	348	404	353
<b>JOB TENURE</b>					
0 To 2	4	3	3	5	13
3 To 5	13	14	26	17	11
6 To 10	17	17	39	41	28
11 To 20	64	62	99	100	74
21 To 30	100	141	97	115	81
31 And Higher	141	250	96	117	143
	339	487	360	395	350

When the various samples are compared, it is obvious that there are considerable differences with respect to the various samples. As far as the gender distribution is concerned it is clear that in Finland and Ireland the majority of respondents was female (58 %, resp. 56,7 %), and in the Netherlands the distribution is fairly equal. In Austria and the UK the sample consists in majority of male respondents.

As far as level of education is concerned in all samples the lower bands of education are well-represented, and the UK sample contains the lowest amount of higher educated people.

The UK sample also contains the highest percentage of self-employed (about 20 %). Although the aim was to concentrate only on people who were employed, the UK database didn't provide the option to exclude self-employed on forehand. And although respondents received an 'opt-in letter' with a screener before the questionnaire, still a considerable number of people responded as if they were employed. In other countries this figure is much lower.

Also interesting to note is the fact that both the Finnish and the Dutch sample have a considerable higher percentage of respondents from the public sector (39 % respectively 30 %), versus approximately 18 – 20 % for the other samples.

As far as the sector is concerned the Dutch sample has the lowest percentage from the hotels & restaurants sector and has the highest percentage from the education sector. While the Irish sample has very few respondents from the Public Administrative sector.

The samples are clearly not identical. Given these differences it is clear that extreme caution needs to be taken when performing statistical analyses on the total sample. However, the comparison doesn't show any structural biases with respect to one sample or the other. Countries differ in their trades, and jobs available on the labour market will thus differ between countries as well. On the other hand, it must also be clear that given the reservations mentioned above, this sample is unique. Such a sample of long term absentees has never before been surveyed.

A second objective for this study was to look at the distribution of percentages of respondents who were absent for physical and mental health problems. Table 7.3 presents an overview.

**Table 7.3. Main reason for absence and sample distribution.**

MAIN REASON FOR ABSENCE		AUSTRIA	FINLAND	IRELAND	NETHERLANDS	UK
Physical health	Count	233	305	242	171	<b>222</b>
Mental health	Count	31	69	60	81	<b>75</b>
Co-morbid	Count	76	94	47	115	<b>60</b>

**Tab. 7.4. Return to work and sample distribution.**

<u>RTW</u>		Austria	Finland	Ireland	Netherlands	UK	Total
Yes, completely	Count	66	76	81	218	23	464
Yes, partially	Count	22	31	19	55	22	149
No, still ill	Count	174	329	139	71	218	931
<u>TOTAL</u>		262	436	239	344	263	1544

The aim of this study was to look at factors that facilitate or inhibit return to work. For that reason it was also checked how the samples compare on this aspect. Table 7.4 presents an overview of the number of people that have returned to work (fully, partially/therapeutic, or not). Significant differences were found between the various countries. From Table 7.4 it is clear that in the Dutch sample most people have returned to work (54 %), while the UK sample contains the lowest number (6 %). In Austria (18 %), Finland (15.6 %), and Ireland (22.2 %) the percentages are in the same intermediate range. The high percentage of people that have returned to work in The Netherlands can be explained by the fact that the Dutch system is highly geared towards 'return to work'. The Dutch social security system has been reformed during the last decade in order to control/reduce the number of Incapacity Benefit recipients. Much is currently done to facilitate 'return to work' of LTA's (see Dutch WP 2 report), and the figures show that it pays off.

When tested, it appeared that there were no significant differences with regard to return to work for respondents with physical or mental health problems.

## 7.2 Factors associated with absence (Time 1 profile)

A profile of some sample characteristics and return to work performance is presented in Table 7.5. The figures are based on a randomised replacement sample of 1,881 long-term absent workers in 5 countries including Austria, Finland, Ireland, the Netherlands and the UK. The table presents the average of the participating Member States and the range of performance from highest to lowest. The overall picture is one of substantial diversity and disparity. In viewing the figures it is important to note that the samples in each of the countries were obtained at different stages of the absence process in terms of duration. Specifically, the greater proportion of the Dutch, Irish and Austrian respondents were sampled between the 12<sup>th</sup> and 25<sup>th</sup> week of absence while the majority of Finnish and UK respondents had been absent for over 25 weeks before being surveyed. System factors were responsible for this discrepancy as it was just not feasible in some countries to identify absent workers until after 6 months of absence. Consequently, 'length of absence is effectively nested within jurisdiction. However, delaying sampling in order to ensure comparability between countries would have meant not obtaining data from those at an early stage of absence. Respondents were asked to complete a second questionnaire 6 months later.

The average full time return to work performance for all countries was 30%. However, there was a significant discrepancy in performance between the best performer - the Netherlands at 70% and the lowest return to work performance – UK at 9%. Ireland had the greatest number of younger workers claiming disability benefit, 48% compared to a European average of 38% and a lowest rate of 18% in Finland. The sample in Ireland also contained the largest number of people who were out of work for less than 24 weeks, 88% compared to a 33% average for the other Member States. Over 95% of Finnish respondents were out of work for over 24 weeks. It is also important to note that 56% of the Dutch sample considered themselves to be in good health compared to a European average of 32% and a low of 17% in Finland. In addition, over 40% of the sample indicated that their jobs were being held open for more than six months. This ranged from a high of 61% in Finland to a low of 16% in the UK. On average 50% of respondents indicated that they could see the long term absence coming before it actually happened. The range was from 60% in Finland to 42% in Austria.

There was a general perception that stress and mental health difficulties can complicate the return to work process. Almost a third of the respondents reported high stress. The range was 46% reporting high stress in the UK and 15% of respondents in the Netherlands. On average across all participating countries 58% of respondents worked for small companies (1-50 employees). The range was 76% working for small companies in Finland to 31% in the Netherlands. The most common contact for people in the Irish sample was the GP (96%). The lowest GP contact was reported in Finland (70%). Austrian respondents reported the lowest contact with occupational health physician, 15% compared to a 43% average and an 84% contact rate in the Netherlands. Contact with a return to work co-ordinator was reported by 35% of respondents with a high of 65% in the Netherlands and a low of 26% in Finland. The Irish sample reported the lowest amount of contact with rehabilitation professionals, 13% in comparison to an average of 32% and a high in Finland of 52%. With reference to mental health services, 15% of the Irish sample reported contact in comparison to an average of 25% and a high of 35% in Finland.

**Table 7.5. Return to Work Profile for Long-term Absent Workers; In 5 EU Member States (N=1881)**

Profile	Average	Highest	Lowest
Return to Work Full	30%	NL 63%	UK 9%
Return to Work Partial	10%	NL 16%	Fin 7%
Same/Different Job	32%/68%	UK 73%/27%	NL 9%/91%
Age Less than 45 years/Over 45 years	38% 62%	Irl 48%/52%	Fin 18%/82%
Length of Absence Less than 24 week/35 weeks plus	33%/31%	Irl 88%/10%	Fin 5%/44%
Currently in Good Health	32%	NL 56%	Fin 17%
Job held open for more than 6 months	41%	Fin 61%	UK 16%
Could see it coming	50%	Fin 60%	Aus 42%
High Stress	32%	UK 46%	NL 15%
Size of Company 1-50/50 plus	58%/42%	Fin 76%/24%	NL 31%/69%
Contacts: GP	87%	IRL/UK 96%	Fin 70%
Contacts: Occupational Health Physician	43%	NL 84%	Aus 11%
Contacts: Return to Work Coordinator	35%	NL 65%	Fin 26%
Contacts: Rehabilitation Professional	32%	Fin 52%	Irl/NL 13%
Contacts: Mental Health Services	25%	Fin 35%	Irl 15%

### 7.3 Return to work: comparison of various groups at Time 2

#### 7.3.1 Overall analyses on predicting return to work

The results of the overall analyses are presented in table 7.6. They indicate that overall a higher chance of full or partial return to work was obtained when workers:

- were female
- have a higher education
- have a higher personal monthly income
- have a better general health
- have higher work ability
- worked in a country with an integrated social system

A lower chance of full or partial return to work was obtained when workers:

- were more than 55 years of age
- have a medium or high depression score
- have a high job insecurity
- were part of the late cohort timeframe

From the above description we can see that the main predictors of return to work appear to be mainly personal characteristics like gender, age, education, personal monthly income, and health (including depression and workability), and context variables like job insecurity. Also presence of a return-to work policy results in an increased chance of RTW when social system and the cohort timeframe are taken into account. The work and non-work variables appeared to be of less importance, this is at least what these overall analyses appear to indicate. It should, however be noted that the analyses at country level (see also the WP5 reports) do find predictive power in the variables indicating work characteristics and sometimes also family characteristics, but these appear to be rather different for the different countries. In the overall analyses these effects appear to have been partialled out.

In table 7.7 the main results from the national analyses are presented to indicate that in the different countries some, but different working conditions in particular significantly contributed to the explanation of full or partial return to work.

When the divisional variables like work ability scores of returnees and non-returnees groups are compared for T 1 and T 2 (6 months later), it becomes clear that people who have returned to work rated their work ability significantly higher at T 2 (5.3 versus 7.1), while those who had not returned remained more or less at the same level (3.3 versus 3.4). Also level of depressive feelings decreased significantly for the returnees. These are indications that improvement of health conditions is a prerequisite before considering return to work.

Since the reason for absence (mental or physical), indicating high or low stress, high or low workability, or the two system variables (early or late cohort timeframe, and integrated or welfare system) did show main effects and significant interactions with the main determinants or return to work, particularly these interactions will be discussed below.

Table 7.6 Overall results of the multiple regression analyses on the total sample

Final models	Basic model	Basic model§	
	N=1365 Cox & Snell r <sup>2</sup> =.254	N=1365 Cox & Snell r <sup>2</sup> =.309	
Gender	Male	1	
	Female	1,30	1,39 *
Age	<=35	1	
	36-45	0,97	0,96
	46-55	0,70	0,75
	>55	0,30 ***	0,40 ***
Education	Basic	1	
	Intermediate	1,10	1,23
	Highschool	1,44	1,79 *
	Professional	1,70 **	1,84 **
	Academic	2,06 **	2,60 ***
Personal monthly income	Less than 899 €	1	
	900 - 1799 €	2,16 ***	1,60 **
	1800 € or more	3,36 ***	2,10 **
General health	Poor	1	
	Good	3,04 ***	2,34 ***
Depression	Low	1	
	Medium	0,63 **	0,69 *
	High	0,50 ***	0,53 ***
Job control	Low	1	
	Medium	1,28	1,18
	High	1,35	1,24



Cognitive demands	Low	1	
	Medium	0,74	0,89
	High	0,64 **	0,76
Job satisfaction	Low	1	
	Medium	1,57 **	1,25
	High	0,87	0,76
Over-commitment	Low	1	
	Medium	0,75	0,86
	High	0,87	0,93
Work-family balance	Low	1	
	Medium	1,11	0,98
	High	1,02	1,06
Job insecurity	Low	1	
	High	0,60 ***	0,51 ***
Return to work- policy	No	1	
	Yes	1,41 *	0,97
Contact with supervisor during absence	No	1	
	Yes	1,25	0,96
<b>Divisional variables main effects added separately</b>			
Reason for absence	Physical	1	1
	Mental	1,23	1,04
Workability	Low	1	1
	High	3,15 ***	3,68 ***
Stress measure	Low	1	1
	High	0,63 *	0,70
Cohort timeframe	Early (M=25 weeks)	1	
	Late (M=34 weeks)	0,37 ***	
Social system	Welfare	1	
	Integrated	1,83 ***	

Note. \*p<.05, \*\*p<.01, \*\*\*p<.001, § adjusted for country

Table 7.7 Summary of results of the multivariate analyses by country

Country	High RTW chance	Low RTW chance
Austria	<ul style="list-style-type: none"> <li>• Work ability ↑</li> <li>• Size company ↑</li> <li>• Cohabiting (yes)</li> </ul>	<ul style="list-style-type: none"> <li>• Age ↑</li> <li>• Job insecurity ↑</li> <li>• RTW coordinator ↑</li> </ul>
Ireland	<ul style="list-style-type: none"> <li>• Work ability ↑</li> </ul>	<ul style="list-style-type: none"> <li>• Exercise ↔</li> <li>• Able to make a living without RTW (yes)</li> </ul>
Netherlands	<ul style="list-style-type: none"> <li>• Early contact with OHS (yes)</li> </ul>	<ul style="list-style-type: none"> <li>• Age ↑</li> <li>• Depression ↑</li> <li>• Family-work balance ↑</li> </ul>
Finland	<ul style="list-style-type: none"> <li>• Work ability ↑</li> <li>• Co-worker support ↑</li> <li>• Age ↔</li> </ul>	<ul style="list-style-type: none"> <li>• Work ability ↑</li> <li>• Income ↑</li> </ul>
United Kingdom	<ul style="list-style-type: none"> <li>• Cognitive demands ↑</li> <li>• Work centrality ↑</li> <li>• Able to make a living without RTW (yes)</li> </ul>	<ul style="list-style-type: none"> <li>• Education ↓</li> <li>• Age ↑</li> </ul>

In the paragraphs below we will only discuss those interactions that are significant for that particular dimension that appears specific to the overall analyses across the national data bases.

### 7.3.2 Mental versus physical health problems

This section reports on which factors interact with, and thus add to explaining the chances to return to work after a period of sickness absence of respondents with mental or physical health problems.

The main significant interaction effect resulting from analysing the relation between predictors and full or partial return to work as opposed no return to work is related to education (see figure 7.1)

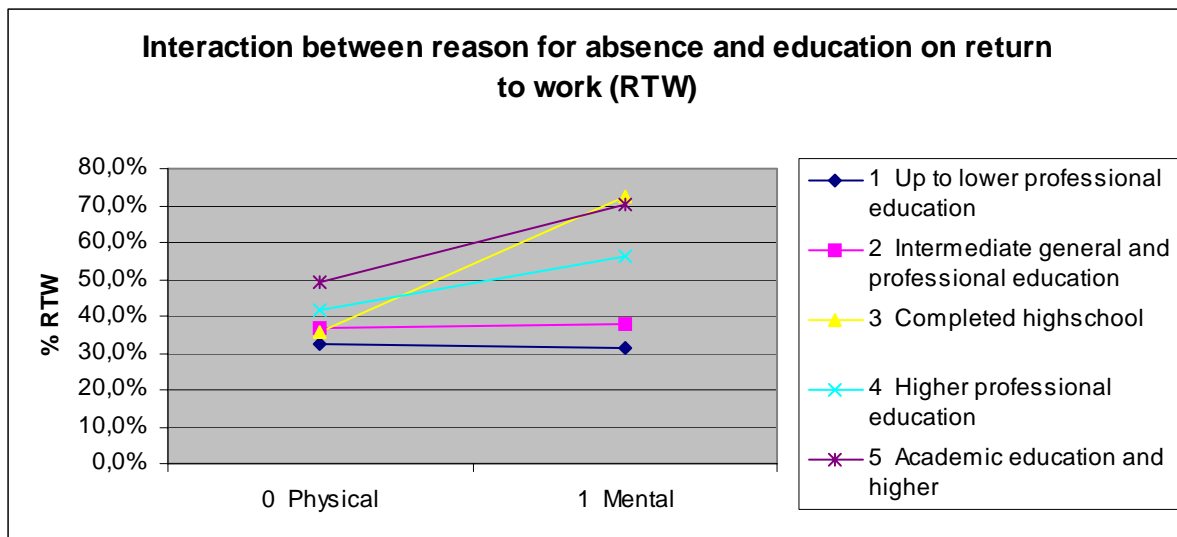


Figure 7.1 *The interaction between education and the type of health problem (physical or mental) in relation to chance of return to work*

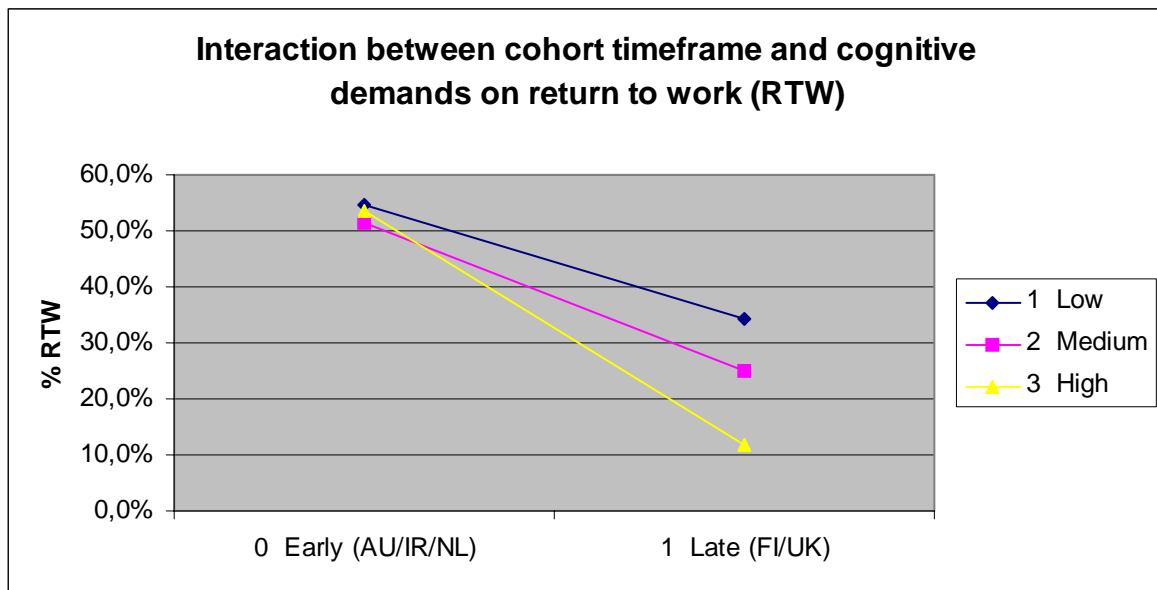
Overall, the lower educated are less likely to return than the higher educated. For the two lowest grades there is no difference between physical and mental health groups, but for the two highest grades there is a clear difference between respondents with physical complaints and mental health complaints. Higher educated with mental health complaints have a higher chance to return to work than respondents with physical health complaints. This effect is most manifest for the ‘middle’ group (i.e. those that have completed high school, but no higher professional education). From this group about 35 % more people return to work from the group with mental health complaints than from the group with physical health complaints. Apparently physical health complaints make return to work more difficult, in particular when the job is primarily physically demanding; highly educated with physical health complaints return most frequently, their jobs are probably less physically demanding. The ‘middle’ and ‘lower’ educated group are more likely to consist of two groups: a group with primarily physically demanding jobs and a group with jobs that are primarily mentally demanding. Also it may be easier to start working on a part time basis in mentally demanding jobs.

### 7.3.3 *Early versus Late Sampling*

To understand the influence of early and late sampling, the sample has been split in two groups, relating to the length of absence at the time of data collection. This resulted in two groups: an ‘early group’ (Austria, Ireland and The Netherlands) and a ‘late group’ (Finland and United Kingdom). In the ‘early’ group respondents were approached when they were between 12 and 20 weeks absent, and in the ‘late’ group respondents were absent for 28 – 36 weeks.

In the multilevel logistic regression analyses it appeared that cognitive demands of the job resulted in a significant interaction effect. The percentage of returnees in the early sample is substantially higher than in the late sample (approx. 53 % versus 28 %; see figure 7.2).

Figure 7.2: *The interaction between cognitive demands at work and the cohort time frame in relation to chance of return to work*



This effect is more prominent for the people with high cognitive demands in their work. From the literature on sickness absence it is well-known that the length of absenteeism has an effect on the likelihood to return to work: the longer the absenteeism the smaller the chances that the person will return to work. This finding confirms this notion, but it also makes clear that the characteristics of the job play a role. The higher the cognitive demands of the job before absenteeism, the more difficult it seems to return to work. In this case return to another job could be considered as an option.

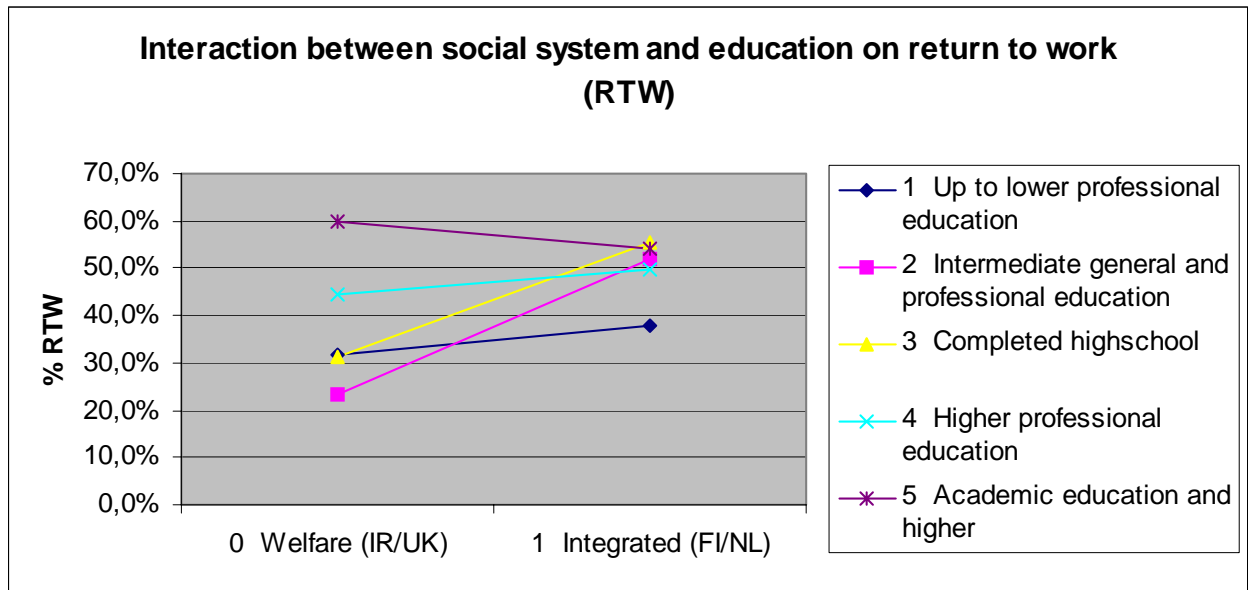
#### 7.3.4 *Welfare versus integrated systems*

The review of national systems and policies (Work package 2) indicated that a distinction could be made between two principles for the social security systems: this distinction was labelled: a system based upon ‘welfare’ (welfare based system) in which people receive financial support in case no other means of income is available. The other system, labelled ‘integrated’ is much more focused on helping people to get back to work; providing financial support is not the only or main goal of the system. In our sample the Irish and UK systems are examples of the ‘welfare’ principle, while the Dutch and Finnish systems are examples of the ‘integrated’ systems.

Two representatives of each system were compared: NL and Finnish versus Ireland and UK.

A general finding is that in the integrated system generally a higher percentage of respondents return to work (either full time or part time) than in the ‘welfare based system’. Between these countries the Netherlands has the highest percentages of returnees.

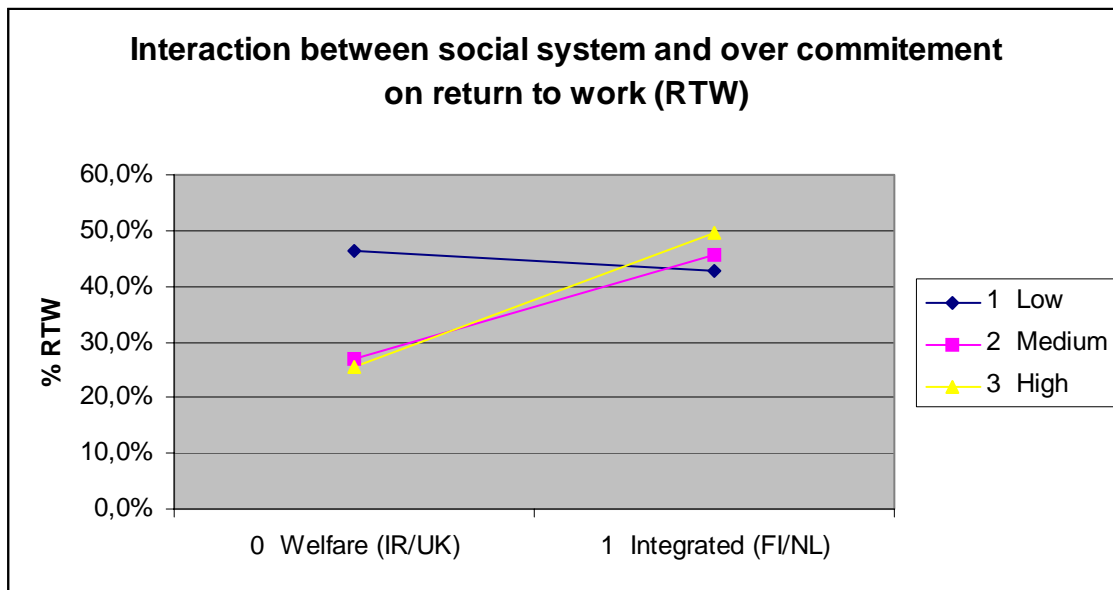
Figure 7.3: *The interaction between education and the social system in relation to chance of return to work*



Multilevel logistic regression analyses revealed a significant interaction between the type of system and the level of education of the absentees (Figure 7.3). It appeared that the integrated system was particularly beneficial for the groups with lower levels of education, while for the higher educated groups there was not much difference between both systems. The effect was strongest for the ‘intermediate’ educated group; the group that has completed high school, but has no further (professional) education. As said before, the integrated system implies an active orientation towards return to work. This means that the system not only stimulates, but also offers support (reintegration services, etc.) to help people back to work. Apparently the group of higher educated people (Higher professional education and Academic education) need less help to find their way back to work.

Another statistical significant finding concerned the (over)commitment to work of the respondents: respondents with medium and high level of commitment significantly returned more frequently to work in the ‘integrated system’ compared to the welfare based system (Figure 7.4). For the groups with low level of (over)commitment no difference was found between the two systems. So, apparently commitment of the absentee towards work is a prerequisite and the system apparently may facilitate these people.

Figure 7.4 *The interaction between over commitment and the social system in relation to chance of return to work*



## 7.4 Conclusion

From this chapter it can be concluded that the chances of full or part time return to work (RTW) after a longer period (three to six months) of absence are higher when one is a women, has a higher education, has a higher monthly income, has a better health in general, and has a higher self-perceived work ability, and chances are lower when one is older than 55 years of age, when one has a high depression score, or low job insecurity. Next to these personal and context variables, system differences and sampling effects appeared to be important as well. Employees in countries with an integrated system, like in Finland and in the Netherlands, the chances were also higher of full or part time RTW as compared to countries with a welfare based system. The risk of full or part time RTW was less in countries where the sample could be taken in the late timeframe. Surprisingly, working conditions were not a significant predictor of RTW in the total sample, but they were in the country samples. However, in the different countries different working conditions mattered when predicting RTW, which may be the main reason why specific working conditions were not powerful enough to predict RTW in the total sample.

In the total sample some interactions appeared to significantly predict RTW. The higher educated employee was more likely to fully or partially return to work when they had mental health problems, but not when they had physical health problems. Regarding the welfare - versus- the integrated systems, it appeared to particularly the low and intermediately educated who had lower chances of RTW in the welfare systems, whereas the higher educated had about the same chances of RTW in both systems. Another interaction that appeared to be related to the system was the effect of over commitment. It were particularly the medium and highly over-committed employees who appeared to have lower chances of RTW. Again the integrated system appeared to better able to provide high chances of RTW irrespective of the degree of over-commitment.

Despite the fact that RTW was less in the case of being part of the late sample, this was particularly the case when the cognitive demands were high. When cognitive demands were low, the differences between the chances of full and partial RTW were much smaller.

The more qualitative in-depth studies on perceptions of and experiences by the absent employees and their family partner, as well as from the professionals involved in the RTW process are described in the next two chapters, Followed by conclusions and guidelines.

## **Chapter 8: Opinions from the long term absentees and their family partner**

The Family Study forms the third main aspect and study of the Stress Impact project and it was undertaken in five countries – Austria, Finland, Ireland, The Netherlands and the UK. This study undertook interviews with a sub sample of respondents who took part in the main study – a longitudinal study about their experiences during long-term absence (WP5). A total of 128 long-term absentees (LTA's) participated and 93 spouses / partners in the study.

Family studies in the area of work absence are relatively unknown to date. The family perspective is considered important as family members typically support their members and are directly affected by their actions. The family study is exploratory in nature and was formulated from the idea that families might play a significant role in either supporting the return to work of the absent worker, or else in maintaining their absence.

The aim of this study was to investigate the experience of absence in more detail and focus on the impact that absence may have on the family and the individual. It was anticipated that long-term absence would have both positive and negative impacts on families, relationships between members, the division of labour and various other aspects of family life. This study also looks in greater depth at the process of becoming absent, absentees opinions about factors that might have prevented their absence, the return to work process and absentees opinions about factors that might contribute to their return to work. It also looked more generally at respondents' perceptions of the changes in work and society and the effect this has on quality of working life and absenteeism in workplaces.

The five countries involved in the study differ greatly in the management of long term absence from work with regard to payment while on absence leave and systems to return absent workers to the workplace. Ireland and the UK operate under a welfare system, where long term absentees are put onto incapacity benefit which is generally at a fixed rate that is greatly below the LTA's take home pay. In these countries there is no obligation on employers to provide occupational health services or return to work programmes and by and large it is only very large employers or multi-nationals that engage in these practices. In Austria there are a large number of social insurers involved in the support of LTA's and the provision of income during absence and services for absentees is unsystematic and varies widely depending on the insurer. Finland and The Netherlands, on the other hand, have a legal obligation to provide occupational health services, replacement incomes / percentage of income (for varying duration) to absentees and return to work programmes.

Findings from this qualitative study showed that the experience of absence differs widely between LTA's depending on the reason for and consequences of the absence. However, there are no great national differences in the absence process or the reasons for becoming absent. The people involved in the decision to become absent varied depending on the provision of services. In countries with lower incomes during absence, LTA's tended to remain in the workplace while sick for longer periods with consequent negative impacts on the duration of absence. Also the impacts on families are very similar across the five countries. Again, the only impact that was noticeably different was the financial impact on families. In the welfare operated systems (UK and Ireland) the impact of finances was very dramatic and was reported by almost every respondent, whereas in the other countries only a few respondents mentioned this aspect of absence. When it comes to the process of returning absent workers to the workplace the countries differ widely according to how formally return to work is organised.



As might be expected, findings indicate sickness absence and the process of work resumption to be a multi-faceted phenomenon.

## **8.1 The Absence Threshold**

The main reason for LTA's to take leave of absence from work was that their health condition did not allow them to work: they had become incapable of working. As might be expected, the reasons and process of becoming absent was related to the nature of the illness. Two main types of absence threshold were experienced. Low absence threshold describes absence leave that was immediate/spontaneous. In these cases, health complaints usually had a sudden and unexpected onset (e.g. accident, heart attack, brain haemorrhage) and most frequently referred to physical health complaints. High absence threshold describes absence leave that people have been contemplating for a period of time. In this study the timeframe ranged from a few weeks to, in a few of cases, even a number of years. Absence from work was premeditated where the individuals' health problem was bearable or tolerable and/or because there were financial, work or family pressures on the individual to remain at work. Other examples of why LTA remained at work when very ill included 'did not wish to be seen as malingering/hypochondriac by colleagues', responsible for staff, specialist role in company, getting treatment e.g. chemo and able to work while ill. Individuals who had mental health problems most frequently reported having deliberated their absence. There were also many examples of individuals with on-going chronic physical health problems (e.g. arthritis, skin conditions etc.) who continued to work through tolerable pain levels that ultimately became unbearable. Often in cases of contemplated absence, a significant event on top of their other problems (e.g. death of family member, breakdown of relationship, incident at work) triggered the LTA's absence.

Problems experienced before taking absence leave from work were different between people absent due to physical health reasons and those absent due to mental/co-morbid health reasons. People who were absent due to a physical problem generally only reported the related physical problems they experienced before becoming absent (e.g. muscular-skeletal, cancer, cardiovascular problems, eye problems, skin problems etc.).

In general, mental health problems were more complex and people had greater difficulty in describing their problems. The majority of those interviewed with mental health problems attributed their difficulties to work-related issues such as work overload, issues with management / their supervisor, stress in the workplace or bullying, mobbing and harassment. However, in many cases interviews exposed multiple reasons for mental health problems e.g. illness specific reasons (depression, stress, anxiety etc.), personal reasons (family problems, personal problems, relationship difficulties, bereavement) as well as work-related reasons.

In the majority of cases, those absent due to co-morbid health problems initially experienced physical health problems made worse either by poor work conditions or a triggering event with subsequent mental health difficulties. In a few cases people with co-morbid health problems disclosed that they had a mental health difficulty which they could not admit to their employer and claimed that they had a physical health problem when seeking leave of absence.

For all illness categories, findings from the interviews showed that delays in seeking absence from work can lead to deteriorating health conditions before the onset of the absence period and consequently a negative impact on recovery time.

Respondents identified a wide range of symptoms that they experienced prior to becoming absent from work. In the case of physical health problems the main symptoms experienced were pain, discomfort, sleep difficulties and symptoms typically associated with their illnesses such as sweating, breathlessness associated with some cardio-vascular diseases. People with mental health or co-morbid health problems experienced a range of symptoms including behavioural problems e.g. overeating, excessive drinking / substance taking, sleeplessness, crying, loss of appetite; physical problems e.g. severe pain, fatigue, nausea and psychological problems e.g. panic attacks, depression, anxiety, obscure dreams and stress.

#### *Recommendation*

Employers need to be made more aware of the impact of work on health. They need to be aware of the signs and symptoms of different illnesses, particularly mental health issues that are more complex and difficult to determine. Employees need to be more aware of their health problems and of the negative impact of a delay in seeking help.

## **8.2 Decision- making / support around taking absence leave**

The number of LTA's who consulted with others when deciding whether or not to take sick leave varied according to countries. Whether there are cultural or country specific reasons for this is not clear from the responses. At one end of the spectrum, in Finland, almost all LTA's consulted someone before taking leave at the other extreme in The Netherlands almost half of respondents reported that they did not consult anyone before taking leave. Consultations were most frequently with people outside of the workplace. In the social network, partners/spouses, siblings, parents and children were the people most frequently consulted followed by friends. Among professionals, GPs were the main professional group consulted in 3 of the 5 countries (Ireland, UK, and Austria). Other professionals consulted include mental health professionals and other medical specialists. Surprisingly, in Finland and The Netherlands, where occupational health services are formally organised, very few respondents said that occupational health practitioners were the main professionals consulted and LTA's in these countries often consulted line managers and colleagues instead. In other countries, where LTA's reported consulting with people in the workplace, it was usually with colleagues, followed by supervisors and lastly with managers. However, some commented that they did not wish to discuss their problem with work colleagues because they feared consequences such as being made redundant.

The type of support received in the workplace from colleagues, supervisors and line managers was practical, advisory or emotional. Practical support was offered in relation to assisting the ill person with their work-related tasks. Advice, helpful suggestions and referrals to services were offered by colleagues and this often prompted the ill person seek help or take action. Many LTA's referred to having someone to talk to, being listened to and empathy as very important in the lead up to their absence.

#### *Recommendation*

These findings show the importance of training of occupational health care professionals, GPs and other professionals in how to deal with work absence and also their role in the return to work process. Within the workplace the main support prior to absence came from colleagues, supervisors, and managers. The many examples of positive support contributing to the LTA seeking help suggests that employee awareness of illness as well as management and supervisor awareness of the indicators of illness are important.

### **8.3 Prevention of absence**

Findings from the survey show that strategies aimed at preventing absence in the workplace are clearly lacking and that in most cases, prior to their absence, LTA's were unaware of strategies they could have adopted themselves. When prompted to provide opinions on actions that might have prevented their absence, few absentees answered the question. Of those that did, the majority of LTA's with physical health problems reported nothing could have been done to prevent their absence from work, mainly because of the sudden onset of their health problems. However, a number of those who experienced on-going, chronic physical illnesses felt that workplace actions such as reducing their workload / working time, providing support at work and providing information on hazards and or personal actions such as lifestyle improvements, recognising their symptoms earlier or changing their work-related behaviour (e.g. slowing down the pace of work, not lifting heavy items and asking for help) may have prevented their absence.

People absent for mental health related and co-morbid reasons reported actions that could have been undertaken to prevent their absence more frequently. Many of the strategies mentioned concerned work procedures (e.g. job rotation, working different hours, reduced workload) and strategies by management (e.g. take reports about overwork, bullying seriously and deal with them, proper management of work / workload, reduce stress, training). Others concerned actions the individual could take (e.g. get a different job, learn to say 'no', be assertive, pay attention to the symptoms and seek help earlier).

It should be noted that in a few cases LTA's reported not asking the employer for these actions, or even informing them about their health problems. So, the employer did not have knowledge about the wishes of the employee and therefore they lacked opportunities to undertake any actions to prevent the absence. Others mentioned that their absence might have been avoidable if they had been consulted about workplace changes, listened to and respected.

#### *Recommendation*

These findings indicate that some work absence could be prevented by better communication and action in the workplace to address work-related issues that play a part in employee absence.

### **8.4 The effect of long term absence on mental health**

Long term absence had both a positive and a negative impact on the mental health of the LTA's. Several interviewees absent due to physical health problems and who did not report mental health problems initially reported that they were experiencing psychological distress after periods of absence. The main symptom reported in these cases was depression. Many also reported feelings of loneliness, isolation, guilt and lowered self-esteem. Of those who classified themselves as absent due to co-morbid illnesses, many reported that their physical illness came first and was followed by the stress, anxiety, depression and other mental health problems after a period of absence. On the other hand, some of the respondents absent for mental health reasons, particularly stress and anxiety, reported feeling much better mentally when they stopped working. They felt that dealing with one less situation (work) reduced the pressure on them, provided a sense of relief and gave them time to become well.

From the interviews, it was apparent that accepting being on sick leave and adjusting to it often took quite a while. For some LTA's admitting oneself being incapable of work and being ill was difficult and time consuming. This process made the initial period of absence difficult and may have set back their recovery. But once the LTA's adjusted to the idea of being ill and the necessity of absence, they often started to feel better. So, adapting to sick leave can be seen as the first step in being rehabilitated.

#### *Recommendation*

More support should be made available to absentees to address mental health issues.

## **8.5 Impact of absence on families**

Being long term absent from work for health related reasons impacted on many people. It impacts directly on the LTA's immediate social network, i.e. their spouse/partner, their children and other dependents and also (in)directly on colleagues. The focus of this study was to examine the impact of long-term absence on the LTA and his / her immediate family.

Most LTA's mentioned both positive and negative impacts of their absence on their household and their family. Having more time around the home contributed to many positive outcomes including improvements in relationships with spouse/partner, more time to spend with children and getting involved in or taking over a greater part of the domestic work. On a personal level, many LTA's reported that during their absence they had a sense of relief; they could relax, reassess work and life issues, learned more about themselves and had time to see things in a different perspective. Some respondents mentioned that they have taken up new hobbies, have more time to spend with extended family (parents, grandchildren).

The main negative impacts of absence on both the individual and families were financial, personal, emotional, and practical. Negative emotional impacts on the household were mainly experienced as increased tension due to illness or due to household and family routines being changed by the LTA. Also, some spouses/partners mentioned that they lacked the understanding of their partner's illness and did not know how to handle them. This was particularly true of partners of LTA's with mental health problems. Negative practical aspects included situations where the LTA could no longer do the things he or she used to do and as a consequence other family members had a greater share of household work. At a personal level LTA's had to cope with a range of issues: feelings of being useless, loss of self-esteem, loss of social contacts (work), having too much time on their hands, altered daily routines, boredom, frustration, feelings of guilt about not contributing to the family finances, future fears concerning their own health, job and financial situation and depressive feelings. Some mentioned being preoccupied with their illness to such an extent that it had a detrimental effect on family life. Their partners mentioned that it was difficult to get used to having the LTA at home all day, difficult to see their partner so frustrated and upset.

The single biggest negative impact mentioned by respondents in all countries to a greater or lesser extent was the dramatic financial effect that absence had on families. In Ireland, UK and Austria, LTA's level of income was highly reduced during the period of their absence. This had a major impact on family lifestyle and in some cases was reported as the reason why the LTA delayed taking absence leave for so long. In many cases LTA's reported that children did not really notice the financial impacts, however, in others children found this difficult. It is interesting that in Finland, where financial support is at full-pay for 300 days, negative financial effects were still mentioned by a number of respondents, presumably by

those absent for more than 300 days. In the Netherlands long-term absentees were on 70% of full pay during their absence and finances were seldom mentioned as an issue. On a system level it seems that the level of financial support received is not related to return to work.

The majority of LTA's mentioned that the impact of their absence on their children was primarily positive due to the time they had available to spend with them and the children benefited because they did not have to attend childcare. However, many respondents, particularly those with mental health problems, reported that there were difficulties with children because it was not obvious to them why their father/mother was sick and at home and they lacked the understanding of the problem. Others with very young children mentioned that the children were upset because when their parents were in hospital and because they could not do some of the things they used to do with the children.

#### *Recommendation*

The positive outcomes of absenteeism suggest that in some cases, there is a need for more work-life balance, more family-friendly work practices and more flexibility in the workplaces.

## **8.6 Return to work**

From the LTA's perspective there are many factors that prompt them to return to work. For the majority of LTA's the main reason for their return to work was an improvement in their health status. Other reasons given were the need / desire to work, the LTA was fed up with being at home, feared losing his/her job, needed something to do, needed structure in his/her life, needed to go back and face bully, needed to go back to preserve their mental health or went back because the company needed them. Often it was a combination of several of these factors. There were some country differences in the reasons given for returning to work. In Ireland and the UK, one of the reasons for returning to work was financial pressure. This was also given as a reason to a lesser extent in Austria and in a couple of cases in Finland. It was seldom as a reason in The Netherlands mainly due to the financial compensation system prevalent in this country.

A number of respondents in The Netherlands reported that they did so because they were advised to return by OHS. In some cases people felt that they had been pushed back when they were not ready to resume work duties.

*It should be kept in mind that work ability consists of both capacity (being able to work) and motivation (wanting to/having to work). Therefore, it should be considered what factors promote the sense of work ability of the employees and attempts should be made to improve these factors.*

A range of professionals and family members were involved in the LTA's decision to return to work. In Ireland, UK and Austria, GPs, physiotherapists, psychotherapists and other medical were the main professionals involved. On the other hand, in The Netherlands OHS, OHP and managers were mentioned as important in the decision to return to work. Although it is obligatory in the Netherlands to develop a return to work plan, in more than half of the cases no return to work plan was available. This is a remarkable finding. When a return to work plan was available, most LTA's found this plan useful. The return to work plan generally included advice on gradually increasing activity and building up the amount of

working hours and adjustments required. Some respondents felt that when drawing up return to work plans OHS did not look at the merits of their case and simply followed the rules regarding returning employees to work. They felt they were put under pressure to return when they did not feel ready to.

While many returnees had few or no problems on their return to work, some faced a number of difficulties. These included work-related issues (e.g. workload, learning new tasks, learning about changes in workplace, physical limitations – unable to do specific tasks, lack of accommodations), personal issues (e.g. getting a proper sleep routine, exhaustion, getting back into the work routine,) and interpersonal issues (e.g. managing relationship with manager, colleagues not knowing what to expect of returnee and how to treat him/her, lack of support).

Most LTA's reported that they had support at workplace when returning to work. Colleagues and supervisors were the main source of that support. The type of support offered was practical help with tasks, advice and looking out / warning returnee not to over do it. Many returnees mentioned that managers and supervisors could have done more to help settle them back to work such as practical solutions, adjustments to tasks, alternative work arrangements. Others felt that managers and supervisors should have rectified negative work problems that pushed them into absence (e.g. stress, bullying, and work overload) and that they should communicate better with returnees and address issues through discussion prior to their return.

#### *Recommendations*

Findings from the survey indicate that on-going contact with LTA's is important. It demonstrates that the organisation cares about their well-being and it stimulates the LTA's enthusiasm to return to work.

Work adjustments / interventions (gradual return, part-time work, flexible arrangements)

Prior to return to work, meetings between supervisor's management, LTA's and other relevant persons (e.g. occupational health personnel) to discuss the LTA's return and organise any special requirements.

Another aspect mentioned as important in return to work is support from supervisors and management in the early stages of RTW.

## **8.7 Non-returnees**

The main reason LTA's gave for not returning to work was continued ill health. This included symptoms like depression, anxiety and lack of concentration and or the illness that made them absent. Some were not working because they had taken retirement or their employment was terminated. Others wished to find alternative employment or to return to work under different conditions e.g. part-time or gradual return and these options were not available to them. In a few cases people with mental health problems gave other reasons, such as that they felt unable to return as they were concerned about the stigma of their MH problem and their history being known or following them to new employment, that they had negative thoughts about work and the lacked confidence to return to work.

When asked what might prompt them to return to work. LTA's mentioned a variety of factors: Evidently the most important was getting better and feeling well enough to return. Other factors were "if alternative work would be available", "if work adjustments or alternative work arrangements were available" (e.g. easier tasks, flexible hours, gradual return to work,

working fewer hours the first few weeks, moving to a more suitable job). Many LTA's mentioned better contact with the company (i.e. genuine concern about LTA's health rather than simply contact to gain medical and other information would make them feel valued and needed); the assignment of a competent case manager. When asked to describe how they thought contact should be, LTA's mentioned: more frequent contact, more sincere contact, and regular contact with advice on services available to assist RTW.

In this study the LTA's in Finland had the most contact with their workplace via phone or visits to the workplace. When they visited they met both colleagues and supervisors and had the opportunity to discuss practical issues around absence, share information and show interest. Some LTA's wished to have no contact with their workplace, usually these were people in conflict situations e.g. with a court case pending, redundancy or bullying issues or other negative experiences of their workplace. In a few cases LTA's described contact from employers as harassment. Interviewees reported that employers often lacked a coherent RTW process. Also, in many cases the role of professionals in this process was unclear.

#### *Final Recommendation*

- For RTW the importance of work adjustments can not be underestimated. Before RTW, it is a good idea to arrange a meeting between the LTA and management, supervisor, representative of HR department and representative of occupational health services. The range of options and interventions to return the absentee to the workplace should be discussed when appropriate.
- Work adjustments and alternative interventions need to be widely understood by employers so that they can support LTA's to make the best RTW choices
- Design guidelines on RTW process in many workplaces.
- The provision of rehabilitation programmes and services varied greatly across countries, with low level of participation in all countries and very little in Ireland, Austria and the UK.
- In all countries, except the Netherlands, LTA's were mostly unaware of the availability of rehabilitation services and how to access them. In the Netherlands, only half of respondents were offered a rehabilitation programme as part of their RTW. Where rehabilitation programmes were made available to LTA's, many commented that they were not comprehensive or intense enough; their provision was inconsistent and was not well organised or integrated. LTA's felt there should be more awareness of what is available and how to access it, more support from the workplace and more counselling as well as reintegration at the right pace. The types of rehabilitation available were physiotherapy, psychotherapy, counselling, peer support/ group support, relaxation methods alternative therapies.

Overall, findings from the survey show that the family had a significant role in the LTA becoming absent and resuming work. The main factor was support in their decision. Therefore families of LTA have to be provided with information on the health problems of the absentee and the different factors and issues concerning absence and return to work.

## **Chapter 9 Opinions from professionals on work resumption**

The professional study explored the views of those involved in identifying and providing interventions to workers experiencing stress. Apart from the General Practitioner (GP), the 'gate keeper' in many countries, and main professional when it comes to referrals to others, the Occupational Health Physician (OHP) is central to the absent worker in some countries as well. Next to this, we can discriminate 'work-based' professionals, Health and Safety (HSO), Human Resources (HRM) Professionals and (general) Managers, as opposed to professionals who are more health or behaviour oriented and may mediate between the person and the workplace (as the OHP may do as well), mental health professionals (MHP), and Return to Work Coordinators (RTW).

The study set out to provide an insight into respondents' experiences of dealing with long term stress related absence and their opinions and attitudes towards 'stress' and work resumption. Respondents were also asked to specify any current policies for dealing with stress related long term absence and to identify interventions used to support people back into the workplace.

Additionally some case studies were highlighted on successful and unsuccessful return to work.

The key focus of the study was upon the commonalities and discrepancies in views and practice between, and within professional groupings about stress related sickness absence and work resumption across the six participating countries (Austria, Finland, Ireland, Italy, the Netherlands, and the UK).

### **9.1 The Methodology**

The methodology used a combination of in-depth and telephone semi-structured interviews based around stress recognition/diagnosis (where relevant), experience of the respondent, factors relating to stress, interventions, referrals and the return to work process.

A set of interviews were designed, one for each professional, one for each professional designation. Pilot interviews were conducted with each of these professional categories prior to the main study and revisions were made in line with the comments made by those interviewed.

Participants were recruited through a number of channels including professional associations, National Stakeholder Network, Employer Organisations and cold calls to professionals whose names were located on the Internet or in the telephone book. The target for each country was 5 respondents in each professional category. As it transpired some countries had difficulty in identifying professionals in all categories.

All the interviews were tape recorded with the consent of the respondent and were transcribed at a later stage. The data was analysed using a Reporting Framework that was devised to highlight common themes and which was amenable to a key word search. A report was produced by each country. The main concepts and themes arising from each of these reports were summarised in cross country and cross professional category tables. These were re-circulated to the national researchers who were requested to validate the content on the basis of the original data and reporting framework.



An overview of the respondents by professional category and country is presented in Table 8.1. It is clear that not all professionals are present in all countries. Also specific professionals may not have the same role, tasks or duties in the six participating countries. One of the most salient differences between countries is that in all countries but the Netherlands the GP has to sign a 'sick note' for the employee to allow this employee be paid out his salary during the period of sickness absence. Particularly the explicit role of the professionals in RTW -if they have one- appears to be very different.

Table 8.1. Overview of the respondents by professional category and country.

Professional category	Austria	Finland	Ireland	Italy	The Netherlands	UK
General practitioner	7	8	5	7	5	7
Occupational Health Physician	-		5	6	8	7
Reintegration counselor/specialist	6	4	5		5	7
Labour Expert					5	
Mental health professional	8	7	5	11	5	5
Manager	7	7	5	9	5	7
HRM	7	7	5	7	5	7
Health & Safety Manager	6	7	4	-	-	-

## 9.2 Description of themes and topics

### 9.2.1 Incidence of stress:

There was a general consensus across the majority of professionals and jurisdictions that the incidence of stress was on the increase. However, estimates of the incidence of stress ranged from 0-80%. There was no discernible pattern in the estimates that might reflect professional or jurisdictional influences.

### *Diagnosis*

Medical professionals were evenly split with regard to the issue of diagnosis. Finnish, Dutch and UK based GPs expressed doubts while Austrian, Italian and Irish GPs did not. Occupational health physicians in most countries expressed some reservations. Reservations were not consistent across countries or professional designations. One of the key reservations expressed was that stress is not an accepted or primary diagnosis. The clinical profile associated with stress is variable and it is difficult to make a differential diagnosis between stress and depression. It was a 'trendy' topic and that it provided a 'quick fix'.

Another reservation was that stress is purely descriptive and lacks objective criteria. In fact, Finnish Occupational Health Physicians and GPs expressed the view that that stress is normal.

Another concern was that clients often don't understand the term and find it difficult to accept.

### ***Level of Knowledge about stress***

When asked did they have sufficient knowledge about stress, the majority of professionals in most countries indicated that they did. Medical professionals (GP, OHP) consistently indicated that they had sufficient knowledge about stress, as did the majority of mental health professionals. Work based professionals were likely to say that they could never have enough or that they needed more knowledge. Given the extent to which respondents believed that they had sufficient knowledge about stress, the degree of variation between and within professional groups in terms of their perceptions of the causes of stress and responses to stress related absence is quite surprising.

### ***9.2.2 Causes of stress***

The causes of stress specified by respondents were diverse and lacked consistency within countries or professional categories. Nevertheless, overall responses provide a fairly comprehensive picture of the causes of stress. Responses can be categorised into 5 domains: job factors, relationships, home life, specific events, personal factors and circumstances.

#### ***Job related factors***

Job related factors were more often specified by Finnish, Dutch and UK professionals. Managers specified job related factors more often than any other professional grouping. The most frequently specified work place factor was *workload*. Other job related factors included:  
Job fit,  
Long hours,  
Work place change, reorganisation, redeployment, job insecurity, short-term contracts or downsizing,  
Non-stimulating work, job dissatisfaction, negative organisational atmosphere,  
Work conflict or loss of control  
Supervisory and management pressure, high unrealistic tasks,  
Lack of appreciation at work and absence of coaching.

Finally, work-life balance was specified primarily by Finnish and UK professionals and commuting was specified only by UK human resource professionals.

#### ***Relationships***

Relationship problems were referred to most often by Austrian, Finnish, Irish and UK professionals. Relationships at work were frequently referred to by Finnish and UK professionals. Relationships with a partner were specified by Finnish and Irish professionals.

#### ***Home Life***

Home life issues and in particular family concerns were most often referred to by Austrian professionals. The issue of caring was raised by at least one professional in every jurisdiction apart from Italy.

#### ***Specific Events***

Traumatic stress as a result of bereavement or a divorce was referred to relatively infrequently by Mental Health professionals, Return to Work coordinators or managers.

### ***Personal Factors and Circumstances***

Across countries mental health professionals most frequently referred to personal factors in their descriptions of the causes of stress. Ill health was most frequently referred to by Austrian and Finnish professionals. Sleep disruption was consistently referred to by all groups of professionals in Finland. Other personal factors such as lack of insight, fatigue, loneliness, ageing, addiction, poor time management and personality were infrequently referred to by professionals across Member States. Italian professionals referred less frequently to personal factors. The main circumstance referred to was financial difficulties. This was most often referred to by UK professionals. From a professional perspective, GPs in most countries apart from Austria and Finland indicated financial difficulties as a source of stress.

### 9.2.3 Models of stress

When asked to describe the model of stress that they favoured, respondents produced most of the concepts that have been posited by researchers into work-related stress. However, there was little or no congruence between the views of professionals within jurisdictions or within professional groupings.

#### ***Positive versus Negative Stress***

The need to distinguish between positive and negative stress was raised by GPs in Austria and Finland and Occupational Health Physicians in Finland.

#### ***Inability to Cope***

Inability to cope was most often referred to by Dutch and UK professionals.

#### ***Demands versus Capacity***

References to demands versus capacity or resources were scattered across most jurisdictions. Respondents referred to adverse pressure, reaction to external conditions or customers, excessive pressure (time versus work), overload and too much to do in a timeframe. Human resource managers most often referred to demands versus capacity as a model of stress.

#### ***Physical and Psychological Strain***

Physical and psychological symptoms such as sleeplessness, lack of concentration and disorganisation were most often referred to by Finnish medical professionals and managers. Extended psychological strain was specified by Austrian, and Italian Mental Health professionals and Dutch Occupational Health and Work-based professionals. Physical and mental overload such as psychological/physical burnout or biophysical response were most often referred to by mental health professionals. A negative state of mind, a cognitive problem and anxiety were also referred to.

#### ***Work Relationships and Reward***

Poor work relationships and lack of acknowledgement were referred to by Italian managers and human resource professionals.

#### ***Environmental Factors***

Environmental factors were referred to by Irish HR professionals.

#### ***Work-Life Balance***

Work-life balance was referred to only by two groups of managers from Finland and the Netherlands.

#### 9.2.4 *Reasons for the increase in stress*

Professionals were also asked to explain why there had been such an increase in the incidence of stress in recent years. This probe elicited responses that were similar to those offered as causes of stress. Once again workplace factors, organisational change and personal characteristics were referred to. In addition, economic and demographic factors were specified. A number of professionals particularly in Ireland, the Netherlands and the UK, indicated that the reason for the increase in the incidence of stress is a greater awareness and recognition of the problem.

##### ***Workplace Factors***

The most frequently specified workplace factor was the *increase in demands and pace of work*. This was most often referred to by GPs and mental health professionals and in Finland, Italy and the Netherlands. Other references to workplace factors included:

Organisational management culture (Dutch and UK OHPs and Finnish RTWs and GMs),  
New technology (Irish and UK GMs),  
Job uncertainty (Austrian HRMs and Finnish MHPs),  
Lack of resources (Finnish GMs)

##### ***Organisational Change***

Organisational change factors such as mergers and acquisitions, downsizing and reorganisation were most often referred to by Dutch and UK professionals.

##### ***Economic factors***

Economic factors such as recession, weak economy, globalisation, increased competitiveness and high unemployment were most often referred to by Austrian and Dutch professionals.

##### ***Socio-cultural factors***

Societal factors such as lifestyle, culture, materialism, performance orientation, pace of life and values conflict were referred to most often by Irish professionals.

##### ***Ageing***

Ageing was referred to by Italian mental health professionals and human resource professionals.

##### ***Non-work relationships***

Family issues were referred to by GPs in Ireland, Italy and the Netherlands. Demands and social care were referred to by Finnish medical professionals and UK managers. Personal relationships were referred to by GPs in Austria and the Netherlands and managers in Italy.

##### ***Financial Pressures***

Financial concerns were referred to by GPs in Finland, the Netherlands and the UK and OHPs in Finland.

##### ***Work-life balance***

Work-life balance was most often referred to by work-based professional and in particularly Finnish Human Resource Managers and General Managers from Ireland, the Netherlands and the UK. Commuting was specified by Irish Health & Safety officers.

### ***Drive to Succeed***

High expectations, achievement orientation ((Austrian RTWs and UK OHPs and MHPs)The drive to succeed was only specified by UK medical professionals.

### ***9.2.5 Perceptions of stress***

Work based professionals were asked to indicate how they recognised that a worker was experiencing stress. Responses covered a wide range of indicators including:

#### ***Somatic Indicators***

Somatic indicators such as fatigue, lack of energy, tiredness, migraines, high blood pressure, stomach trouble, insomnia and body language. These were most often referred to by Austrian and Dutch professionals.

#### ***Emotional and Behavioural Indicators***

These included emotional reactivity, anger, temper, crying, disengagement or shutting off from others, irritability such as complaining, conflictual behaviour, being disruptive, resistance and frustration. Emotional and behavioural indicators were most often referred to by Finnish managers. Other indicators including negative feelings such as lack of joy, inadequacy, overestimation of self and persecution were referred to by Finnish and Italian managers and human resource professionals.

#### ***Work Indicators***

Poor decision making was referred to by Irish work based professionals. Being involved in a disciplinary process was specified by UK human resource managers. Reduced productivity, undone work and reduced quality were referred to by Austrian, Finnish, Italian and UK professionals. A negative attitude to work and disinterest or low motivation was mainly indicated by Finnish and Irish professionals. Communication difficulties were specified by UK managers and Italian human resource professionals.

### ***9.2.6 Return to work factors***

Professionals were requested to indicate their views about which factors were most likely to facilitate return to work of employees who were absent as a result of stress. Professionals over all jurisdictions produced a wide range of possible return to work enablers including workplace factors, personal factors, social factors, individual interventions, and professional practice.

#### ***Workplace facilitators***

Return to work facilitators indicated by respondents included work conditions, work organisation, organisational support, communications, workplace interventions and organisational culture. Austrian professionals, apart from Occupational Health professionals, consistently specified changes to the work environment and work organisation and reduced hours. Responses across other jurisdictions and professional groupings lacked this consistency. Responses of Finnish work based professionals tended to be the most elaborated. Factors specified included changes to work conditions, work organisation, increased organisational support, improved employer worker contact and phased return to work. Professionals in the UK and the Netherlands most often referred to organisational support

factors. Italian work-based professionals referred to new, friendly work environments. Dutch professionals also indicated communication factors and workplace intervention factors.

### ***Personal facilitators***

Personal factors included psychological/physical factors, personal strategies and personal circumstances. These were referred to infrequently and inconsistently across jurisdictions and professional groupings apart from the responses of Austrian professionals who indicated that financial circumstances and active coping were important coping factors in return to work.

### ***Social Facilitators***

Social factors such as family support, friends, partners, recognition of the complaint, building a social network and a stable private life were mainly referred to by Austrian, Irish and Dutch professionals.

### ***Individual Interventions***

The individual interventions specified as being important factors in the return to work process for people on stress related absence varied widely. Austrian professionals were consistent in their views that medical and therapeutic interventions were important factors. These perceptions were not shared consistently across other jurisdictions or other professional groupings although Finnish professionals also frequently referred to medical and therapeutic interventions. Dutch professionals, on the other hand, referred to these types of interventions less frequently. Allied health and person development interventions were most often referred to by UK professionals. Complementary interventions such as massage and sports were most often referred to by Austrian professionals.

### ***Professional Practice***

Professional practice was most often referred to in the Netherlands and the UK. The most often referred to aspects of professional practice were *early recognition and intervention* and *an agreed return to work plan*. Other elements of professional practice included occupational health support (Finland, Ireland and the Netherlands), co-operation with the employer (the Netherlands), understanding the patient (Austria and the UK), a good client relationship and empowering the client (the Netherlands and the UK), motivate and support the client (Ireland, the Netherlands and the UK), multi-disciplinary care (the UK), match the solution to the problem (Italy), mediation (the Netherlands and the UK), and timely return to work (Finland).

#### ***9.2.7 Factors obstructing return to work***

Professionals in Finland, Ireland, the Netherlands and the UK were asked what factors might inhibit the return to work of a person on stress-related absence. Responses were diverse and inconsistent across both jurisdictions and professional groupings. Nevertheless, a wide range of potential barriers to return to work were identified within the workplace, related to personal factors, process factors, professional factors and social factors.

### ***Workplace inhibitors***

Finnish, Dutch and UK professionals referred most often to workplace factors including lack of support/co-operation, lack of compromise, lack of understanding of the problem on the part of the manager or Occupational Health Physician, not acknowledging the employee's complaint, the offer of unsuitable work, a lack of work adjustment, a lack of appreciation of the employee, stress being endemic within the team or organisation, negative relationships

with a colleague, work climate or negative attitudes and stigma. Workplace factors were least often referred to by Irish professionals.

### ***Personal inhibitors***

Personal factors included return to work motivation, health, personal circumstances, traits and behaviour.

Motivational factors:

Return to work motivational factors included boredom, dissatisfaction with the job or the organisation, the provision of low level work, job ambiguity or job person fit.

Health factors:

These were most often referred to by Finnish mental health professionals and included co morbidity with mental or physical illness, a lack of fitness, relapse, addiction, and a poor response to treatment.

Coping Strategies:

Poor coping strategies were referred to by Finnish managers and UK mental health professionals.

Personal Circumstances, Traits and Behaviour:

Personal circumstances such as mourning or getting a high financial reward were referred to by professionals in the Netherlands and the UK. Personal traits such as lack of introspection, selfishness, denial, lack of motivation, personality problems or negative attitudes were referred to by some professional groupings in each of the jurisdictions that responded. However, no pattern was discernible. Aspects of the person's behaviour referred to included lack of compromise, rejection of alternatives, lack of co-operation and lack of compliance.

### ***Process inhibitors***

Process factors included incident-related stress, such as bullying, a legal case, a disciplinary procedure or a traumatic event, and poor communications arising from irresolvable differences or a lack of trust.

### ***Professional inhibitors***

Professional factors specified included inappropriate diagnosis, late referral, too early return to work or too long a period off work, not dealing with the underlying causes and unsupervised time off.

### ***Social inhibitors***

Finnish and Dutch Mental Health professionals, Finnish Return to work coordinators and General Managers and Irish GPs referred to social factors including lack of family support.

#### ***9.2.8 Return to work role***

Professionals were also asked to indicate their perceptions of the role of their own profession within the return to work process. Once again, there was no consistent pattern of responses, either within jurisdictions or within professional groupings.

### General Practitioners

GPs in Austria, Finland and Ireland indicated that their role was to investigate the absence, Italian and Dutch GPs indicated that they had no role in return to work and GPs in the UK indicated that they would liaise with the employer and take an active return to work role depending on the time available.

### Occupational Health Professionals

Occupational health professionals, in all jurisdictions except Austria, indicated an active return to work role in terms of problem identification, developing a return to work plan and providing return to work support.

### Mental Health Professionals

Mental health professionals in all jurisdictions apart from Ireland indicated some active role in the return to work process including providing return to work support, advising the employer or the worker and proposing a reorganisation of the workplace or facilitating work-life balance. Other roles specified less frequently by mental health professionals included individual interventions in relation to medication or psychotherapy and maintaining communications with GPs and employers.

### Return to Work Professionals

Surprisingly, return to work professionals were not consistent in how they perceived their role in the return to work process. Finnish return to work professionals specified motivating the worker and providing timely treatment as being part of their role as well as networking with specialists and providing case management and co-ordination. Irish return to work professionals referred to motivating the worker, mediating between the worker and the employer, problem identification, developing a return to work plan and reorganising the workplace as part of their role. Dutch return to work co-ordinators indicated onward referral to a psychologist, occupational health professional or a labour market specialist as being part of their role as well as providing timely treatment and taking an unspecified active return to work role. In the UK, the main role of a return to work co-ordinator specified was restoring a worker fit for work, motivating the worker, providing timely treatment, maintaining communications, problem identification and resolution and reorganisation of the workplace.

### General Managers

Managers in Italy, the Netherlands and the UK were most elaborated in their responses to this question. They saw themselves as having an onward referral role particularly to a psychologist or occupational health physician, maintaining communications particularly with the GP, providing time out and actively engaging in the return to work process through problem identification, problem resolution and the reorganisation of the workplace.

### Human Resource Professionals

Human resource professionals mainly saw themselves involved in actively returning a worker to their job through providing return to work support, reorganising the workplace and creating a positive return to work climate.

### Health and Safety Officers

Health and safety officers were less clear about their role in the return to work process although Irish health and safety officers specified a role in onward referral, providing timely treatment, maintaining communications and reorganising the workplace.



## The Family

Respondents were also asked to indicate whether or not the family should be involved in the return to work process. Once again there was little agreement across professional groupings or jurisdictions about the role of the family.

## Contact with the employer

When asked whether or not contact with the employer was an important part of their role in the return to work process, occupational health physicians were consistent in their views that this was part of their role. Most return to work professionals also indicated this. The views of GPs and mental health professionals were inconsistent in this regard.

## Social Insurance Role

Finally, medical professionals in Finland, Ireland and the UK all indicated that social insurance had a role in the return to work process.

### *9.2.9 Return to work interventions*

Respondents were asked to indicate what types of interventions they prescribed in the return to work process for employees on stress related absence. They were also asked in a separate question to indicate which interventions they believed to be most effective in achieving a positive return to work outcome. Work based professionals were most consistent in that they tended to prescribe interventions that they believed to be most effective. Medical professionals and mediating professionals were less consistent.

### ***Medical Professionals***

GPs and occupational health professionals responded most frequently in terms of mental health, medical and allied health interventions. Only infrequently did they refer to other types of interventions such as complementary medicine, vocational training, problem resolution, temporary absence or discussion of support. The most often specified mental health interventions were counselling, psychotherapy and psychological interventions.

### GPs

Austrian GPs considered these interventions to be most effective but indicated that they generally prescribed medication or allied health interventions. Conversely, Finnish GPs indicated that they prescribed these interventions but believed that medication was most effective. Irish GPs prescribed counselling and believed it to be most effective. However, they also indicated prescribing psychotherapy, which they did not believe to be 'most effective'. In addition, they believed medication to be effective but did not normally prescribe it. Italian GPs considered psychiatric and medical interventions to be most effective and these were the ones they indicated prescribing. Dutch GPs were equally consistent in that they indicated psychotherapy, psychiatric interventions and medication as being the most prescribed and the most effective. UK GPs believed that counselling and medication were the most effective and these were the ones prescribed although they also prescribed psychotherapy.

### Occupational Health Physicians

Occupational Health professionals in Finland prescribed mental health interventions but considered discussion and support to be most effective. Irish Occupational Health physicians believed cognitive behavioural interventions to be the most effective and also prescribed this. Medication was also indicated as being most effective but not often prescribed. Italian occupational health professionals prescribed psychological interventions, which they believed

to be the most effective, but also prescribed psychiatric, medical and allied health interventions, which they did not consider to be particularly effective. Dutch Occupational Health physicians considered cognitive behavioural interventions and medication to be most effective and prescribed both. Psycho-education was prescribed but not considered to be particularly effective. In the UK, cognitive behavioural techniques were considered to be most effective and were most often prescribed. Medication was considered to be also most effective but not prescribed.

### ***Mediating Professionals***

Similar inconsistencies were identified in the return to work and mental health professional groups. While a wide range of mental health, medical and allied health interventions were referred to, there was little congruence between those interventions considered to be most effective and those that generally prescribed. The most frequently specified interventions were Counselling, Psychotherapy and Medication. Only mental health professionals in Finland and the UK and return to work professionals in Finland and the Netherlands specified Work Interventions.

#### **Mental Health Professionals**

The patterns and responses of mental health professionals in Austria and Finland mirrored those of GPs in that those interventions prescribed were not considered to be most effective. In particular, Austrian mental health professionals believed mental health interventions to be most effective but prescribed medication and allied health interventions, whereas Finnish mental health professionals prescribed mental health interventions but believed medication to be most effective. Although mental health professionals in all jurisdictions indicated mental health interventions as being frequently prescribed in the return to work process, they did not always rate them as being most effective. Mental health professionals in the Netherlands and the UK did not consider prescribing medication nor did they consider them to be the most effective.

#### **Return to Work Professionals**

Return to work professionals were most diverse in their responses in terms of interventions. They indicated the use of or a preference for mental health interventions, medical interventions, allied health interventions, complementary interventions (such as relaxation, acupuncture, etc.), personal development activities, communication strategies (such as conflict management and problem resolution). The only work interventions specified employer consultation and discussion and support (Finland and the Netherlands). Once again those interventions prescribed were not always considered to be most effective.

### ***Work-based Professionals***

Not surprisingly the responses of workplace professionals were most likely to focus upon work interventions. Most work-based professionals in most jurisdictions apart from Finland, the Netherlands, and the UK specified *work reorganisation* as a key intervention in the return to work process. Only Finnish, Italian and UK managers and Finnish and Italian HR professionals referred to interventions other than work based interventions. These included complementary interventions and rehabilitation (Finland), Medical Interventions (Finland and Italy) and Stress Management Training (UK). All work-based professionals in Austria, Irish managers and health and safety officers and Italian human resource managers specified redeployment to another position within the company as an important intervention.

#### **General Managers**

General managers were most elaborated of all the work-based professionals in their responses. In addition to work reorganisation, general managers specified reducing the workload, technical aids and appliances and providing incentives and workplace support as being important. Other responses included flexible deadlines, temporary absence, promoting organisational change, quick return to work, discussion and support as being useful interventions.

### ***Human Resource Professionals***

All HR professionals, apart from those in Finland specified work reorganisation as the most often used and preferred RTW intervention. Relatively few other interventions were mentioned. HR professionals in one or two jurisdictions also referred to ergonomics, technical aids and appliances, risk assessment, assessing worker motivation, discussion and support.

### **Health and Safety Officers**

Once again work reorganisation was consistently referred by those professionals who participated in the study. Finish professionals also referred to work rotation, temporary absence and risk assessment. Austrian and Irish professional specified discussion and support.

### ***9.2.10 Referral patterns***

In addition being asked to indicate the interventions that they would prescribe or recommend in the return to work process, respondents were also asked to indicate where they would refer an individual who was absent from work as a result of stress. Both medical and work based professionals were asked to specify their preferred onward referral routes to professionals or other services. The mediating professionals (mental health professionals and return to work co-ordinators) were asked to indicate the main sources of their referrals.

### **GPs**

GPs across all jurisdictions indicated referrals to either mental health services or specialist medical facilities. Dutch GPs mentioned a more diverse range of referral pathways including to occupational health nurses, allied health services, sports clubs and social services.

### **Occupational Health Professionals**

Occupational health physicians in most jurisdictions also referred to mental health services such as psychologists and psychiatrists and medical services including GPs. Other referral routes were to physiotherapy (Italy), company welfare officers (the Netherlands) and human resource managers (UK).

### **Work-based professionals**

The referral patterns indicated by work based professionals tended to cluster around external referrals to medical and occupational health services and internal referrals to the human resource function, the company welfare officer, the employee assistance programme or the supervisor/line manager. Work based professionals only infrequently mentioned referring to mental health services such as psychologists and counsellors. Only Dutch human resource managers and Austrian health and safety officers indicated that they referred to return to work support measures such as mentoring/job coaching or mediation.

Mental health professionals and return to work co-ordinators were asked to indicate the sources of their referrals. Only mental health professionals in the UK and return to work co-ordinators in Ireland indicated that they received referrals directly from employers. Mental

health professionals mainly specified referrals from other mental health professionals or medical specialists and GPs. In Austria and Finland referrals were also received from the social insurance institutes. Return to work co-ordinators in Austria and Finland received direct referrals from mental health, medical and occupational health services. Referrals were also received from social insurance institutes. Only in Ireland did referrals come to return to work co-ordinators from private insurance companies. Self referral was specified by mental health professionals in Austria and Ireland and return to work co-ordinators in Austria. Finnish return to work co-ordinators also specified receiving referrals from the employment office.

### **9.3 Summary and Conclusions**

The most striking characteristic of the responses of professionals across the six jurisdictions that participated in Work package 6 was the lack of congruence or coherence in views and beliefs. The heterogeneity of responses of respondents within the same professional group across jurisdictional boundaries and the lack of congruence between professionals within the same jurisdiction make it difficult to come to any strong and unconditional conclusions. The variability in beliefs and conceptions must be contrasted with the level of self-assessed knowledge about stress. Apart from Finnish professionals, most other respondents were satisfied with their knowledge of stress. Nevertheless, a number of general conclusions can be drawn.

- There was a general consensus that the incidence of stress had increased in recent years although estimates of the incidence of stress related conditions varied widely.
- There were qualitative differences between the responses of work-based professionals and those external to the workplace.
- The primary causal factors in stress were considered to be the job, relationships and personal factors.
- The main reasons cited for the increase in the incidence of stress were enhanced awareness of the problem, workplace factors and economic and social circumstances.
- The predominant model for occupational health and human resource professionals was one of physical and mental overload, particularly in the Netherlands and Italy.
- The main barriers to return to work were considered to arise within the workplace itself.
- The main return to work facilitators specified were work conditions, organisational support and professional practice.
- Professionals that indicated the most active return to work roles were occupational health and mental health professionals. Human resource professionals, general managers and the return to work co-ordinators were less often actively involved in return to work processes. GPs and health and safety officers were infrequently involved.
- The GP is one of the most important health professionals, because he always is at the start of the chain. However, the GP's adopt a very different role in different countries - probably dependent upon the system. Their role in RTW is not clear and not explicit in many countries, which should be a matter of dispute.
- There was a lack of consensus as to whether or not the family had a role in the return to work process.
- There was a strong emphasis on contact with the employer during the return to work process.

- There was only weak support for a role for social insurance in the return to work process.
- Work-based professionals preferred work-based interventions and medical professionals preferred mental health interventions.
- Most often used interventions were workplace interventions, mental health and medical interventions. Most effective interventions included both the workplace and (mental) health. Treating only (mental) health complaints was considered ineffective.
- Return to work co-ordinators received most of their referrals from external agencies rather than other professionals.
- Mental health professionals or return to work co-ordinators rarely cited employers as sources of referrals.

### 9.3.1 *Conclusions*

There is little evidence in the responses of professionals during Work package 6 that any clear message is getting across to professionals in the field. Professionals are just not aware that they lack sufficient knowledge to respond to stress related absence and are consequently not concerned about the issue. There is a need for cross disciplinary discourse about the nature of stress, its role in the absence process and the most appropriate ways to intervene in the return to work process. In this regard it is necessary to begin to build the capacity of medical professionals to respond in more flexible and holistic ways to the issues arising from stress related absence. In particular it would be important to increase the knowledge base of medical professionals of the range of psychosocial and work-based supports and interventions available.

It is critical that employers get linked directly to mediating services such as return to work and mental health services, not only to enhance the return to work process but also in terms of referral paths where stress has been identified at as early stage as possible. Work-based factors were cited as most important both as a cause of stress related absence and as a key facilitator of return to work. Nevertheless, these views were more strongly held by work-based professionals and a cross-disciplinary consensus on the role of the workplace needs to be established.

There is no indication that a purely medical diagnostic code for stress will be agreed in the medium term. Nor was there any consideration that such an approach to stress would be appropriate. Consequently an alternative strategy is required to respond to the acknowledged increase in stress related absence. Thus, there is a need to extend the construal of stress as being a physical and mental overload to a more flexible bio-psychosocial model of the stress process.

References to work life balance as either a cause of stress related absence or as a barrier or facilitator to return to work were identified infrequently. This lack of awareness needs to be redressed.

From a public health perspective, stress and its impact on mental health require a clearer conceptualisation, a simpler message and a more forceful awareness campaign to emphasise the bio-psychosocial dimensions of stress. The importance of communications between work-based and external professionals during the return to work process needs to be emphasised both within national labour force policies, disability policies and social protection policies.

European Associations of professionals need to be encouraged to engage in constructive discourse with a view to producing coherent professional practice guidelines for responding to people on stress related absence.

By moving the emphasis from work-related stress to stress that can arise from work and non work factors, employers can engage more proactively with the issues without the fear of opening themselves up to liability for substantial legal claims. By adopting an active Disability Management policy, employers can utilise mental health promotion, risk management, early identification and intervention and case management to reduce the impact of stress related absence upon their workers and upon the profitability of their companies.

## Chapter 10 - Policy recommendations:

The Stress Impact study has undertaken perhaps the most comprehensive investigation ever undertaken into absence from work due to stress related illness. In doing so, it has also addressed absence from work due to all health causes. It has done so in a longitudinal manner in the main part of the study (the survey of sickness absence claimants) and it has also investigated the impacts of absence in a qualitative manner in the Families study. In addition, it has investigated the attitudes and beliefs of professionals involved in the absence process through the Professionals study.

The study therefore provides a rich and multi-stranded information set about the processes which impinge on the individual who becomes absent. This information set provides the basis for the generation of the policy recommendations from the study.

The findings from the three main elements of the study are complex and detailed, to the extent that not all of the findings are capable of being reflected in policy recommendations. However, the study also provides a number of broader scale findings which can be transformed into policy recommendations and can advance the state of policy in the area. These broader findings provide the main basis of the policy recommendations made below.

### 10.1 What policies are appropriate in this context?

The target groups for the stress impact project (people on short term illness benefits due to stress related or other illness) are at an interesting point where a number of policy areas intersect. These policy areas at EU level include:

- Health and safety and occupational health – Health and safety and occupational health policy have an important role to play in relation to the prevention of absence and in the development of effective return to work plans. The results from the study have particular significance in relation to these areas, for example in relation to prevention of risks and also in relation to the reintegration of people who have become absent.
- Employment policy<sup>1</sup> – absence from work due to health problems has relevance for health policy in a number of ways. Firstly, it relates to the Barcelona and Stockholm targets in relation to older workers. People who are absent from work (in particular the group who were the subject of the study) are at risk of becoming long-term absent from work, i.e. moving on to long-term disability benefits. They are therefore at risk of becoming permanently inactive in the labour force and of becoming socially excluded. This process runs contrary to meeting the targets of having more older workers in the labour force and of raising the effective retirement age of the labour force. In addition, the findings of the study have relevance to employment policy in terms of the National Action Plans on employment. In particular, the goal of

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<sup>1</sup> The main policy documents here are: Annual Employment Guidelines, (DG Employment), National Action Plans on Employment (DG Employment); the Joint Report on Social Exclusion (2002) (DG Employment); the Barcelona Council Agreement (Presidency conclusions, 2002); Employment Guideline on active ageing (DG Employment, 2001); the Stockholm Summit Conclusions (Presidency Conclusions, 2001); and the annual series of Employment in Europe reports (DG Employment).

improving the employability of workers depends in part on maintaining their health and on improving return to work practices.

- Social inclusion policy<sup>2</sup> – the findings from the Stress Impact study relate to social inclusion policy as they throw light on the processes whereby people become inactive in the labour market and, if this inactivity persists, on the process of how people become socially excluded. The demographic profile of people within the main survey study of the SIP project (older, lower skilled, lower educational level, ill or injured) indicates a group with multiple risks of social exclusion, some of whom are in the process of becoming socially excluded. The study findings, therefore, are of considerable relevance to social exclusion policy and to the kinds of interventions that may be appropriate to retard or prevent this process.
- Disability policy<sup>3</sup> – Most people with a disability acquire their disability at some point during their working lives. The causes of disability may vary from injury to illness and may be work related or otherwise, but for those in the work at the time the impairment occurs, the process of becoming disabled begins with the individual becoming short term absent from work before moving on to long term disability benefits. The data from the SIP study, especially the longitudinal nature of it, throws considerable light on how the process of becoming disabled proceeds.
- Public health policy<sup>4</sup> – EU public health policy has two major elements for which the SIP findings have relevance. Firstly, public health policy on the determinants of disease recognises the role that work can play in producing disease. Secondly, this element of public health policy also recognises the workplace as a setting for undertaking workplace health promotion. The SIP findings have particular relevance for identifying issues which relate to both of these elements of public health policy.

In addressing these areas of policy relevance, the SIP study also fulfils a crucial role in linking these policy areas. In particular, because of the longitudinal nature of the findings and the fact that they relate to a process whereby the individual moves from being in active employment to becoming absent and may then progress to becoming disabled, the results from the study can help address the links (or lack of links) between policy areas. It can thus contribute to the development of ‘joined-up’ policy and to the development of a more dynamic approach to the problems of absence from work.

In addition to these areas of EU policy, the project results have implications for national policy over which the EU has no or limited competence. Chief among these areas is social welfare/social insurance policy, but other relevant areas include employment policy, rehabilitation and the regulation of the major service providers. While these areas are not the subject of detailed recommendations from the study, as the specifics of national policy in these areas vary considerably from country to country, the results from the study nonetheless have considerable relevance for these areas and their implications should be addressed at national level.

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2 The main policy document here is: the Joint Report on Social Exclusion (2002) (DG Employment);

3 The main policy documents here are: Annual Employment Guidelines, (DG Employment), National Action Plans on Employment (DG Employment); Council Resolution 2003/C 175/01; the Lisbon Council Agreement (Presidency conclusions 2000).

4 The main policy documents here are: European Council decision 1786 (2002); Social protection in Europe report (2001);



## 10.2 The main findings from the study

The SIP study has provided a wide range of detailed and complex findings from the three study elements. Not all of these findings are addressed at the level of recommendations, as it is not always the case that these carry policy implications. However, many of the findings have major relevance for policy and the principal findings of this type, broken down by the study element from which they came, are detailed below. It should be noted that the findings from the study do not relate solely to stress as a cause of absence, but to all causes of absence. Accordingly, findings which relate to other major issues in the absence process are also addressed.

### Survey of benefits claimants

- The range of causes of absence – the survey participants reported a wide range of causes of absence (both mental and physical problems) and in many cases there was significant evidence of co-morbidity, i.e. the presence of multiple symptomatology. Though each individual had a diagnosis which was the official cause of absence, this often did not do justice to the full range of health problems experienced by the individual.
- The role of self assessment of fitness to work – the absentees' own assessment of their workability proved to be the single most powerful predictor of return to work.
- The role of work stress in causing absence – work stress played a moderate role in explaining absence from work. Health status, job insecurity, age, education and a range of other non-workplace based factors were also important.
- Premeditating absence – one of the more striking findings from the survey and from the qualitative study was the fact that individuals contemplate going absent from work for period before they do so (in situations where sudden onset of injury or illness does not occur). This period varies, but in some cases, often where there are mental health difficulties, it can last for periods of months.
- Return to work rates – there were significant differences between the participating countries in relation to return to work rates. Even allowing for the differing lengths of absence due to sampling constraints, by far the highest rates of return to work were seen in the Netherlands, where the rate was more than twice that of the lowest countries.
- National differences – there are significant differences between the countries on terms of the factors which explain absence from work and return to work. While some of these are presumably due to differences between the national systems, others appear to be due to a combination of workplace and situational factors. This finding means that recommendations that are transposed to national level need to be tailored to take account of these differences.
- Co-morbidity – there was a considerable level of co-morbidity reported by respondents to the survey. People with chronic illness often had mental health systems, while the development of mental health symptoms coincided with becoming absent for many.

### Professionals survey

- Absence career and the disability process – the process whereby a person becomes ill, then becomes absent and is then in contact with treatment and return to work services before either returning to work or staying absent is a dynamic process from the perspective of the individual, but from the perspective of the various other stakeholders involved, tends to be an unlinked series of separate actions.

- Differing definitions of stress used by professionals and others involved in absence management – though it is hardly surprising that definitions vary between professionals and non-professionals, this finding has may have serious consequences for how the problem of stress related absence is treated.
- The gap between diagnosis and treatment – the professionals showed a fairly high level for agreement about what the appropriate treatment for stress related problems should be (psychological interventions). However, they also showed a high level of agreement that clients did not receive the appropriate treatment.
- The role of diagnosis – the assignment of a diagnosis in the case of stress related problems differed between the countries. In some countries stress could appear on the medical certificates of absentees (even though it is not an officially recognised diagnosis), in others stress would not be used, either because it is not an official diagnosis or because of cultural reasons, while in others the diagnosis of burnout was allowed.

### Qualitative study

- The evolution of symptomatology and health status – the health status of the individual was not static during the period of absence. People with physical causes of absence tended to develop mental symptomatology during the absence period.
- Absentees tend to contemplate absence prior to becoming absent, often for a long time, especially in the case of mental causes of absence.
- Becoming absent from work was often viewed as a positive phenomenon or relief for individuals, at least in the initial stages, especially those with mental health causes of absence.
- The frequency, type and intensity of contact between the individual and the range of treatment and return to work services was often inadequate. People with mental health problems often had real difficulties accessing appropriate treatment services in all countries.
- Contacts between the workplace and the employee were often viewed in a negative light. In addition, the interaction between the employer and employee upon return to work was often less than optimal, being characterised by an absence of appropriate work adjustments, poor communications, and a failure to understand the situation of the returnee.
- The level of communication between employers and services (as reported by the absentee) was often minimal or non-existent.

### National systems

- Complexity of systems – all of the national systems reviewed (with the possible exception of the Dutch system) were complex to understand and access from the perspective of the absentee. This makes it difficult to access appropriate services in a timely manner.
- Systems differences – there are significant differences between the national systems as they relate to the issue of absence from work (See section XXX for details). These may usefully be summarised as being integrated social insurance based systems (the Netherlands, Finland and to a lesser extent, Austria) and welfare based less integrated systems (Ireland and the UK). There are also structural differences between the systems in terms of the nature, type and funding of agencies involved and in the overall level of resources devoted to these system elements. In addition, there are significant differences in relation to the amount and type of services to support return to work.

- The orientation towards return to work – the national systems reviewed were generally designed in a piecemeal manner which has evolved over long periods of time and which faced multiple and sometimes competing design objectives. For example, the objectives of income replacement and return to work are incorporated into all systems, but high benefits levels may generate disincentives towards returning to work. For many elements of systems, return to work may not be an explicit goal (e.g. the public health system). However, national systems differ in this regard, where the Dutch system in particular, has placed a high priority on return to work and this is reflected in successive redesigns of system elements in order to promote return to work.
- Level of integration of systems – If systems have not been explicitly designed to promote return to work, then the level of integration between system elements, especially with regard to collaboration between service suppliers tends to be poor. This lack of integration has serious consequences for the absentee, as they have major difficulty in accessing appropriate services in a timely manner, thereby prolonging the period of absence.
- All national systems would appear to have a shortage of mental health treatment services, especially with regard to psychological interventions.

### **10.3 The structure of the policy recommendations**

The recommendations are targeted at three groups:

- Policy makers in social insurance, health, rehabilitation and the labour market;
- Service providers in these areas;
- Employers.

These represent the main actors in return to work and are best placed to improve on current policies and practices.

### **10.4 Recommendations for policy makers**

These recommendations are at the intersection of employment, health, disability, active ageing and social protection policy. It is unlikely that absence from work be it due to stress related causes or otherwise, can be adequately covered in any one policy strand. Integrated and coordinated policy initiatives must acknowledge the contributions each area can make to an effective solution.

National Action Plans for employment and inclusion can be part of the strategy and the health agenda can promote early intervention in health maintenance and the need to prevent job loss as a result of illness. Public health policy could incorporate early interventions and rehabilitation as important contributors to a improving return to work rates and ultimately to improving a nation's health. Active ageing policies can incorporate retention and reintegration to reduce exit from work for older workers who become absent.

Whatever the approach to achieve an integrated policy response to the problem, it must include a number of critical strategic elements.

1. **Raise awareness of the issue** – Policy makers need to be aware that the problem of stress

related illness is growing and that many people who suffering from such illnesses (especially mental health problems) may ultimately face social exclusion.

2. **Introduce more proactive policies** – All relevant policy makers need to move from passive towards more active policies for short-term absent workers, assigning rights and responsibilities clearly and ensuring that accountability exists and is transparent. Policy needs to support action rather than inaction on the part of the major stakeholders. Adopting disability management as a system paradigm linking the workplace and external interventions to proactive reintegration strategies could assist in producing a system blueprint.
3. **Streamline policy towards return to work** – Current policies in many member states rarely target reintegration. This may be for historical reasons, where for example, income maintenance policies are solely for that purpose. Equally, reintegration is not always the goal of such policies because of different strands of policy and provision. Policy makers should place return to work at the centre of their approach if strategies are to become effective.
4. **Change expectation norms from welfare to work** – Many national systems do not have a consistent reintegration agenda. Policy makers should consider changing perceptions of what should happen when someone becomes absent so that the norm is that people return to work, rather than survive on welfare payments.
5. **Consider ways to reduce complexity in the system** – Most national systems are characterised by complexity in terms of their legal basis, administrative procedures and the range and role of service providers. This complexity militates against a smooth return to work process for both employee and employer.
6. **Introduce *bonus-malus* elements to return to work** – Systems should contain financial reintegration incentives for individuals, workplaces and service providers.
7. **Specify stakeholders' roles and responsibilities in the return to work process** – Service provider collaboration is a problem in many countries with major gaps in service provision occurring. Policy makers need to specify the roles of service provider agencies to eliminate gaps and provide collaboration incentives. In particular, links between health and rehabilitation agencies and return to work agencies need to be strengthened.
8. **Strengthen links between workplace, absent employees and service suppliers** – Reintegration failures are largely due to weak links between the stakeholders. Services and entitlements are often complex, inadequate and difficult to comprehend for individual and employer. The links between the employee and the workplace are often weak as are those between service providers and the workplace. These links need to be strengthened to facilitate a successful return to work.
9. **Improve data collection and analysis on absence.** Not enough is known about how many people become absent through stress related illness nor is it known early enough to enable useful interventions to be developed (in the UK, not data is collected before 6 months absence). In addition, the short-term illness registers should not be considered the sole source of information. Ways to incorporate data from the public health system into existing data sets should be considered.

10. **Strengthen the role of occupational health services and policy** – In many countries the role of OSH policy and practice does not extend to absence management. This responsibility needs to be clearly assigned, and OSH services can play a pivotal role, since they occupy a position between the employer and the public health services.

11. **Establish a Taskforce on Job Retention and Reintegration** with these responsibilities:

- Prepare statistics on the scale of the problem and associated costs with monitoring mechanisms;
- Advocate a higher priority for the issue in national policy and social partnership fora;
- Promote greater understanding among those who confront the problem and those with responsibility for action;
- Develop and implement flagship projects to test policy initiatives;
- Advocate system-wide change particularly for resources, responsibilities, entitlements, incentives and supports;
- Review and amend legislation and policy.

## 10.5 Recommendations for service providers

Service providers have a major role in supporting a person long-term absent from work as a result of a health condition. More flexible, responsive interventions emphasising workplace-based solutions, can significantly improve reintegration. This may require re-engineering existing service models and convincing funding agencies and employers of the benefit of these new approaches.

A substantial challenge for service providers is to create proactive reintegration measures rather than traditional services, requiring changes in the way providers deal with employers, with services to solve the employers' problems as well as the rehabilitation of the ill or injured worker.

A number of strategies can help to modernise current provision and promote more effective outcomes.

1. **Encourage collaboration between service suppliers** – A major problem is system complexity, which, *inter alia*, causes poor collaboration between service suppliers, especially those from different parts of the system. Effective, flexible collaboration between service suppliers, based on a return to work philosophy is essential for successful reintegration.
2. **Apply the disability management model to service suppliers** – Service suppliers could benefit from a Disability Management model. This would involve proactive management of claimants or clients, liaison with other stakeholders and managing the relationship between the individual, the workplace and service suppliers.
3. **Enhance and upgrade professionals' skills** – To support Disability Management for employers and absent workers, professionals need a wide range of skills and knowledge. They must also have appropriate attitudes to promote DM among their customers. Continuing professional development and accreditation will enhance the skill base of service providers.

4. **Strengthen services for mental health treatment** - It is clear from the survey that there is a shortage of appropriate psychological interventions available to absentees in need. Appropriate services need to be made available and made widely accessible. In some countries there is also an issue concerning the funding of such services, where the public insurance system does not cover the costs of treatments such as psychotherapy. This situation needs to be addressed if absentees are to receive appropriate treatment.
5. **Provide services for the employer** – Employers rarely have services targeted at them during the absence and return to work process. At minimum, information should be provided on the progress of the absentee, which is currently rarely done. In addition, employers may need informational and other support during the return to work process and after the return to work, where monitoring of the returnee may be needed.
6. **Consider developing a single point of contact service for absentees** – absentees have difficulty in navigating their way through the range of services they may need in order to be treated, rehabilitated and returned to work. The lack of collaboration between service providers often means that individual service providers have limited knowledge of the availability and/or appropriateness of the services the absentee may need. A single point of contact service with responsibility for directing and arranging service appropriate to the absentee is therefore needed.
7. **Investigate return to work and mental health problems** – There is need for greater knowledge to ensure reintegration of employees with mental health problems. Little is known about the prognosis of various mental health problems, appropriate early intervention nor how these problems reduce working capacity. Research is needed to clarify these issues and provide appropriate reintegration services.
8. **Introduce local redeployment pools for SMEs and micro-enterprises** – where returnees need to be redeployed from their old jobs due to their impairments, it is often difficult for to redeploy them to suitable alternatives. This may happen even within large employers, but is an especially acute problem for smaller employers. There is a need to develop local alternative redeployment arrangements, whereby people can move between employers to more suitable jobs.
9. **Re-orient services towards the absence process** – the individual who becomes absent is travelling through a process whereby they have become ill, they have taken absence from work and they are seeking to improve their health so that a return to work is possible. A range of services are appropriate for the individual at each point of this process. However, most services deal with only single points of this process with the result that ensuring less than optimal service provision occurs. Service providers need to re-orient their activities so that services are provided at the optimum time for the individual absentee and that relationships between service providers and employers function efficiently and effectively.

## 10.6 Recommendations for employers

Employers have a central role in promoting more effective reintegration for employees who experience reduced work capacity as a result of a health condition. Such problems first

manifest themselves in the workplace and thus early intervention is difficult without the proactive, vigilant role of the line manager or supervisor.

Effective reintegration strategies make good business sense. Even where social insurance or the exchequer carries the burden of sick pay or disability benefits, the employer incurs direct costs in overtime and replacement costs and indirectly in higher personnel turnover, reduced productivity, low staff morale, loss of experience and higher insurance premia.

1. **Workplaces should adopt a disability management approach** – This involves adopting workplace health management interventions ranging from targeted risk management and health promotion to an early intervention and case management approach for employees who become absent. In this way, access to appropriate policies and services can be arranged.
2. **Develop policies early** - It is inappropriate to introduce return to work after the individual has developed a health condition and become absent. At this stage, interventions, strategies or incentives can appear to victimise the individual by forcing a return to work. Reintegration policy should be made clear to all workers during their induction phase to a company so it is clear from the outset what will happen if they absent due to illness or injury.
3. **Flexible return to work solutions** – Organisations should make available a range of return to work options (e.g. adapted work, part-time working, redeployment, retraining) for people who become absent. These should be flexible, especially for staff with mental ill health, where full recovery is less easy to predict.
4. **Assign clear responsibilities for return to work** – Specific staff should be responsible for reintegration of employees with reduced work capacity. They should have developed the appropriate policies and resources needed to implement the policies. There should also be clear responsibilities and accountabilities assigned.
5. **Introduce monitoring systems in the pre-absence period** – Workers with chronic or slowly emerging health impairments often contemplate absence from work for a long period before crossing the absence threshold. Current health and other monitoring systems where they exist do not seem to identify employees at most risk of becoming absent.
6. **Stress awareness programmes** – Introduce stress awareness and prevention programmes in workplaces. These should have the function of preventing occupational stress where possible, and of explaining the process of reintegration of workers with stress related problems.
7. **Develop an effective reintegration policy** – employers need to develop an effective policy which promotes the reintegration of workers who have become absent for health reasons. This policy will need to integrate elements of human resource management policy, reintegration management policy, occupational health and safety policy and equality policy. The overall aim of this policy is to ensure that there is a clear statement that early return to work is the norm within the organisation and to ensure that there are the necessary infrastructures, skills and practices in place to realise this aim. This policy should specify the roles and responsibilities of the stakeholders within the enterprise who

are to be involved, the ways they should interact, the activities they should undertake, the resources available to them and the types of outcomes they should achieve.

8. **Strengthen occupational health and safety policy and practice** – this can play a major role in the reintegration process through monitoring of the returnees health and wellbeing, through assessing the risks associated with the job which the returnee is working at and through communicating to management and co-workers the capabilities of the returning worker. Policy on occupational health and safety needs to be altered to reflect this expanded role.
9. **Human resource management policy** - The Human Resource Management function is the best place to locate responsibility for the reintegration process as it is responsible for many of the processes and personnel that should be involved in the reintegration process. Critical elements of HRM policy which contribute to the positive reintegration process include employment contracts, remuneration, job design, work organisation, liaison with external agencies, job placement and redeployment, reintegration management, joint labour-management agreements, occupational health services, training and development, safe and early intervention and transitional work. In addition, the HRM department is responsible for the communication of reintegration management policy throughout the organisation.
10. **Introduce and/or develop equality policy** - The new developments at legislative level in relation to equality policy need to be reflected at enterprise level. These developments provide the opportunity and the obligation to incorporate improved treatment of workers who are returning to work following illness or injury. At minimum, equality policy at company level should state the commitment of the company to provide equal opportunities for returning workers to have access to suitable employment.
11. **Provide adequate infrastructure and resources** - In order to ensure an efficient reintegration process, adequate resources and infrastructure need to be provided by the employer. Appropriate resources include budget, training of staff in the reintegration methods, having a designated reintegration management function, developing joint management-labour support for the reintegration policy and implementing a management information system that tracks absence, causes of absence, interventions and progress towards reintegration and progress following reintegration.

## 10.7 Recommendations for professionals

The survey of professionals involved in dealing with absence revealed many notable findings, both in relation to their knowledge of and procedures for dealing with stress related absence and also their general approach to dealing with absence and reintegration to work. The recommendations below are based on these findings and they relate to the main developmental needs of professionals in the context of improving their practice in relation to the reintegration of people who are absent from work for stress related or other reasons.

Important system elements of the absence and reintegration thresholds are the quality and effectiveness of services and professionals with whom absent workers have contact. Within the SI threshold model such professionals are characterised as an essential part of the mediating mechanisms that operate between the person and the system in the stress,



absence/reintegration processes. For this reason, the Stress Impact study incorporated in-depth semi-structured interviews with a range of professionals including work-based professionals such as managers, human resource professionals and health & safety officers; medical professionals including GPs and occupational health physicians; and mediating professionals specifically mental health professionals and return to work co-ordinators.

The aim of these interviews was to throw some light on the commonalities and distinctions that might exist between professional designations and across jurisdictions in relation to the stress, absence/reintegration processes. The purpose of this section is to draw some broad conclusions about stress, absence and reintegration from the perspective of those professionals who are most likely to be in daily contact with people who are 'stressed-out', at risk of being so and are contemplating absence or return to work.

On the basis of interviews with over 180 professionals across six jurisdictions and seven professional disciplines, it would be difficult to refute the argument that there is no consistency or consensus on the issues of stress, absence and re-integration. Many professionals rated their understanding of stress as being adequate. Nevertheless, they differed radically when it came to defining stress, identifying incidences of stress, estimating the level of stress-related conditions and proposing options and responses. This effectively means that a person who is enmeshed in the stress, absence/reintegration processes takes part in a 'lottery' when it comes to getting appropriate and timely supports and interventions.

There was little consensus between professionals in the workplace or within the health sector as to what constituted stress or how to treat it. If any conclusion can be drawn, it is that workplace professionals tend to respond to stress as a medical/health problem and the most predominant referral path is from work to a medical professional and in many cases self-referral to a GP. Many GPs, however, did not consider themselves as having a specific role in the reintegration process. Thus, the overriding conclusion of the Stress Impact professional study is that there is a need for a more consistent, coherent and co-ordinated approach by work-based, mediating and health professionals to people engaged in the stress, absence/reintegration processes.

A starting point for building consistency in the way that stress is understood and responded to by professionals is the establishment of a clear and unambiguous description of how stress impacts on the absence/reintegration process for employees. Many of the current theories are useful in describing how stressful conditions can be caused and created, particularly within the workplace. In order to develop a more coherent approach to stress and absence, however, it is essential to go beyond this descriptive approach to try to capture the dynamic, work and non-work, biopsychosocial processes that operate when an individual crosses the absence or reintegration thresholds.

Significant advances have been made in characterising and specifying the policies and strategies required to assist people to re-integrate into work and to retain their jobs. In particular, a Disability Management (DM) approach (Wynn & McAnaney 2004; NIDMAR, xxxx; Shrey, 2000) provides a continuum of responses, supports and interventions that can respond to any health condition that reduces work functioning and which places a person at risk of restricted participation in the labour market. The main challenge for researchers and professionals is to find a way to make the DM model, which has been developed primarily to respond to work place acquired physical impairments, more compatible with stress related conditions. This requires a clear specification of the role of stress in the absence/reintegration processes.

The SI threshold model captures all these elements in a dynamic relationship. Within the model, professionals and services fulfil an essential 'mediating' role between the person, their work and non-work environments and system-level factors. In an ideal threshold model,

professionals and services would be in a position to modulate environmental factors, provide supports and build functional capacity and coping strategies at each stage of the absence/reintegration trajectory. In the event, the response of professionals did not provide any basis to conclude that this is the case in any of the jurisdictions surveyed. On the contrary, perceptions of, and responses to, stress, absence and reintegration were one-dimensional, inconsistent and, generally speaking, fragmented.

What was of particular concern was the view of many medical professionals and in particular GPs that they had little or no role in the reintegration process. In some cases even occupational health physicians considered their role in the reintegration process as being relatively weak. Additionally, work-based professionals tended to favour referrals out to medical professionals rather than engaging in workplace mediation or return to work programmes. In fact, return to work coordinators were mainly approached by private insurers or the workers themselves.

What is required at this stage is the development of a cross-disciplinary consensus on the nature of the stress/health/absence/reintegration processes, their interaction and a set of straight-forward guidelines for professionals to follow in a case where it becomes clear, for whatever reason, that a person is experiencing stress and is contemplating absence or where a person on sick-leave as a result of stress is beginning to consider to return to work. The production of such guidelines is easier said than done and requires a substantial and sustained discourse within the field. It is particularly important to acknowledge, in the development of any guidelines for professionals, that most work-based professionals are not professionally qualified to deal with the medical aspects of stress related conditions. This is crucial given that work-based professionals play a crucial role in the stress, absence/reintegration processes. It is essential that those who are pivotal, i.e. human resource managers, supervisors and health and safety officers, are provided with clear guidelines on the kinds of things they can do within their job role and what other professionals could do to assist them. The complexity of the Stress Impact data precludes a comprehensive and definitive solution to these requirements. Nevertheless, it is possible to point to some of the issues that would need to be addressed in such guidelines and some of the possible approaches that could be adopted in response to these issues.

## **10.8 Issues and Challenges:**

### **1. A consistent and applied medical/diagnostic perspective on stress is required.**

There was little or no support for the proposal to alter the ICD10 to include a separate diagnosis for 'stress'. Survey data illustrated that high stress could occur alongside both physical and mental health conditions. It was not clear in how many cases high stress was the result of ill health and absence rather than the cause. Professionals and services need to be vigilant when someone presents with any health condition or symptom that stress may also be a factor. Treatment options, supports and interventions should be adjusted accordingly when high stress is identified as a concomitant condition.

### **2. Most current models of stress work equally well in the non-work as in the work environment.**

A demands control support model of stress can just as easily be used to describe the circumstances of someone at home caring for an elderly relative or children as it can be for a production-line worker. It is possible to extrapolate other models of stress including

personal environment fit and effort reward models to the non-work environment. By generalising stress models outside the workplace, it is possible to begin to design a continuum of responses in terms of retention and reintegration. However, it is important to note that, while there are many assessment tools to measure 'work' stress, there are very few that are targeted at 'non-work' environments specifically. This creates a major challenge for guiding practice and for evaluating programmes. Given the generalisability of the models, it should be possible to adapt current work based stress tools. This requires a concerted effort on the part of researchers working in multi-disciplinary teams that include work based professionals, mediating professionals and medical professionals.

**3. Respite has an important role to play in managing stress situations.**

It is not unusual for people in stressful caring situations to be offered periodic relief through respite. People who are stressed out at work often use work withdrawal as a coping mechanism. Such absences can be certified or uncertified sick-leave or taken from holiday entitlements. In some cases, the frequency of absence may reduce the possibility of a longer-term absence or a total work withdrawal. Human resources professionals and managers would do well to consider the use of non-medical absence periods as part of an overall stress-management strategy for an individual.

**4. Redeployment has a particularly strong role to play in managing the stress and absence/reintegration processes.**

Many of those surveyed had not returned to the same job or even to the same employer. From a job retention point of view, the temporary redeployment from a current job role or position could provide the respite required to assist in managing the stress/absence process. The use of redeployment in the reintegration process could have equal benefits. Redeployment should be considered as a way of providing respite on a temporary basis to a current employee, a transitional option for those returning to work and a permanent solution where it is clear that there are toxic elements in the environment for a particular worker.

**5. Responsibility for managing the stress and absence/reintegration processes must be clear.**

This clarity was not evident in the responses of the professionals who participated in the Stress Impact project. Whether it is a workplace professional e.g. the human resource professional or supervisor, or an occupational health advisor, at each stage of the process it must be clear to the person, their family and the workplace who is taking the lead in co-ordinating the retention or reintegration processes.

**6. Those responsible for managing the stress and absence/reintegration processes need to be properly prepared for the responsibility.**

Whether it be a work-based or health professional or return to work co-ordinator, it is essential that the person co-ordinating the process be aware of the issues and challenges facing somebody who is experiencing heightened stress and the possible responses and supports available at each stage of the absence/re-integration process.

**7. Issues and responses can be described along a continuum that encapsulates**

## **organisation-wide policies and procedures and individual interventions.**

Approaches to managing stress and absence/reintegration processes can be implemented at any point in the stress/absence/reintegration continuum. Policies and procedures designed for the whole work force such as sickness absence and risk management policies or workplace health promotion initiatives can be adapted to incorporate stress as an issue. Well-being initiatives such as work-life balance policies can target stress reduction as a key performance indicator. Support structures such as employee assistance programmes, early identification mechanisms and targeted and customised interventions for at-risk groups (e.g. high stress jobs and/or older workers) can assist in creating a more positive psychosocial ecology. Individually focused retention/reintegration strategies such as capacity building, respite, support and/or redeployment can assist individual employees to continue working or to return to productive work.. Responsibility needs to shift seamlessly and transparently from one professional to another across this continuum. At all costs this responsibility needs to be made clear and explicit to both the employer and the absent worker.

### **8. Work-based professionals should consider non-medical strategies, supports and interventions initially.**

Work-based professionals should consider referring workers who are experiencing high stress directly to disability management or mediating professionals rather than automatically taking a medical route.

### **9. GPs, as the most frequent point of contact for absent workers, need to reconsider their roles in the absence/reintegration process.**

The lack of effective communication between medical professionals and the workplace can create an insurmountable challenge for many absent workers. GPs need to be more aware of the possibility that stress is an underlying factor when someone presents with another condition and take it into account in prescribing interventions. The role of the GP in making contact with the workplace or in onward referral to a return to work professional needs to be highlighted.

### **10. In dealing with the stress and absence/reintegration processes, psychological realities, perceptions and misconceptions are as important as evidence and facts.**

Very often the issue is not whether a person is rewarded, fits a job role or has sufficient support but whether he or she perceives this to be the case. An important task of the mediating professional in the reintegration process is the negotiation of a consensual position between worker and supervisor about, not only the terms of the return to work programme, but also the events that precipitated the stress-related absence in the first place. A lack of congruence between the worker's goals and perceptions and those of the immediate supervisor is a strong indicator that redeployment to another position or employer is required.

### **11. Multiple approaches should be utilised in identifying stress issues in the absence/reintegration process.**

There are many different ways to identify a worker who is experiencing stress and

contemplating absence. Worker behaviour, reduced productivity or work quality can all indicate a negative stress reaction. Self-report is a fairly reliable indicator that something is amiss. The use of stress inventories and questionnaires can also identify organisational 'hotspots'. Presenting symptomatology and frequency of unexplained absences can also be indicative. Organisations need to be systematic in the way in which they scan for stress related issues in the absence/reintegration process.

## **12. Where stress is identified, an environmental scan should always be carried out.**

When there are indications that stress is a factor for a person in the absence/reintegration process, it is essential to assist that person to evaluate his or her work and non-work contexts for potential stressors or aggravating factors. Identified factors will need to be addressed in any job retention or reintegration plan.

## **13. Absence leave without any other interventions is unlikely to result in a sustainable impact.**

There is little evidence that absence leave will have anything other than a temporary impact in terms of sustainable reintegration if environmental issues have not been addressed. Specific stressors or aggravating factors in the workplace or at home need to be adjusted, the capacity of the person needs to be built and personal development goals must be achieved for a successful and sustainable reintegration to be achieved.

## **14. The processes and factors involved in assisting someone to avoid absence are fundamentally different to those required to assist somebody in the reintegration process.**

The job retention process involves workplace health promotion; health scanning; awareness raising amongst staff and management; HR policies including work-life balance and diversity policies; supports including employee-assistance programmes and occupational health services; and individual actions such as mediation, counselling, cognitive behavioural therapy, temporary redeployment, part-time working, compassionate leave, and training and development.

The reintegration process, on the other hand, involves early monitoring and maintaining contact with the absent worker, mediation between the worker and the workplace, involvement of the GP and family, adaptations to work organisation and conditions, transitional work opportunities, multi-disciplinary inputs as required e.g. psychological inputs, capacity building, personal development support, temporary or permanent redeployment, re-training and skill building, a negotiated return to work plan with times and milestones, case management and co-ordination.

## **15. Dealing with concomitant conditions.**

While stress can in certain circumstances be seen as the primary cause of a deteriorated health condition, it also occurs alongside other physical and mental health conditions. It is essential that these be treated appropriately while at the same time providing the individual with the support and development opportunities required to cope with, or reduce, perceived stressors within the environment.

## **16. Reasonable accommodations for stress-related conditions.**

When it comes to providing reasonable accommodations under equality and non-discrimination legislation for people with physical impairments, the issues generally relate to physical access, the ergonomic adaptation of a workplace or the provision of a technical aid or device. In the case of mental health difficulties, or where an individual is experiencing high stress, it is less clear as to what would constitute a reasonable accommodation. Nevertheless, employers could consider adaptations and accommodations to work conditions and work organisation where this might be appropriate. For example, temporary redeployment to another position might be considered a reasonable accommodation where continued working in the current environment might increase stress levels. Allowing for reduced hours or a change of responsibilities might also be considered. Providing a worker with access to counselling support during working hours might well be considered to be a reasonable adjustment. The key criterion for judging whether or not a reasonable accommodation is required in the case of a stress related absence or reintegration objective can be determined on the basis that, if an employer is aware that a worker has experienced high stress previously in their current position and the employer takes no ameliorative action to redress the situation, the employer is likely to be found legally culpable under most equality and health and safety legislation. However, legal redress after the fact is no substitution for proactive action to ensure that employees experiencing stress are provided with opportunities to prolong a productive working career.

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## References

- Alexanderson, K. Sickness absence: a review of performed studies with focused on levels of exposure and theories utilized. *Scandinavian Journal of Social Medicine*, 1998; 26: 241-249.
- Allegro, J.T. & Veerman, T.J. Sickness Absence. In: Drenth, P. J. D., Henk, T. & de Wolff, C. J.(eds). *Handbook of Work and Organisational Psychology 2<sup>nd</sup> edition*, part 2: Work Psychology, Psychology Press, Hove, 1998
- Anema, J.R., van der Giezen, A.M, Buis, P.C. and van Mechelen, W. Ineffective disability management by doctors is an obstacle for return-to-work: a cohort study on low back pain patients sick listed for 3-4 months. *Occup Environ Med*, 2002; 59: 729-733-
- Bandura, A. Self-efficacy: toward a unifying theory of behavioral change. *Psychological Review*, 1977; 84: 191-215.
- Bergendorff, S., Berggren, S., Cohen Birman, M., Nyberg, K., Palmer, E., Skogman Thoursie, P. & Söderberg, J. *Svensk sjukfrånvaro i ett europeiskt perspektiv*. RFV Analyserar 2002:11. Riksförsäkringsverket. Stockholm, 2002. [in Swedish].
- Bossche, S. van den & Houtman, I.L.D. (2003). Work stress interventions and their effectiveness: a literature review. Hoofddorp: TNO Work and Employment, november 2003.
- Blonk, RWB & Lagerveld, S,E. (2003). Preventie Psychische Arbeidsongeschiktheid bij Zelfstandig ondernemers (PPAZ); resultaten van een gecontroleerd effectonderzoek, Hoofddorp: TNO Arbeid, 2003.
- Brill, P.L., The need for an operational definition of burnout. *Family and Community Health*, 1984; 6 (4): 12-24.
- Buunk, B.P., Jonge J. de, Ybema J.F., Wolff C.J. Psychosocial aspects of Occupational Stress. In Drenth, P. J. D., Henk, T. & de Wolff, C. J.(eds). *Handbook of Work and Organisational Psychology 2<sup>nd</sup> edition*, part 2: Work Psychology, Psychology Press, Hove, 1998.
- D'Amato, A., & Zijlstra, F.R.H., Occupational stress: A Review of the literature relating to mental health. Report to the EU commission. University of Surrey, 2003.
- Davies, N. and Teasdale, P. The Costs to the British Economy of Work Accidents and Work related ill Health. Sudbury: HSE books, 1994
- Dollard, M.F., Winefield, H.R. and Winefield, A.H. Predicting Work Stress Compensation Claims and Return to Work in Welfare Workers. *Journal of Occupational Health Psychology*, 1999; 3:279-287
- Farrel, D. & Stam, C. L. Meta-analysis of the correlates of employee attendance. *Human Relations*, 1988; 41: 211-227.
- Gard, G. & Sandberg, A. C. Motivating factors for return to work. *Physiotherapy Research International*. 1998; 3 (2):100-108.

- Gerin, W., Litt, M., Deich, J., & Pickering, T., Self-efficacy as a moderator of perceived control effects on cardiovascular reactivity: Is enhanced control always beneficial? *Psychosomatic Medicine*, 1995; 57: 390-397.
- Griffiths, A. Organizational interventions facing the limits of the natural science paradigm. *Scand J Work Environmental Health*, 1999; 25:589-596.
- Hoogendoorn, W.E., Poppel, M.N.M. van, Bongers, P.M., Koes, B.M., Bouter, L.M. Systematic review of psychosocial factors at work and private life as risk factors for back pain. *Spine*, 2003;25:2114-2125.
- Houtman, I.L.D., Schoemaker, C.G., Blatter, B.M., Vroome, E.M.M. de, Berg, R. van den & Bijl, R.V. Psychological complaints, interventions and rehabilitation to work; the prognostic study of INVENT. (in Dutch). Hoofddorp: TNO Work & Employment, 2002.
- International Labour Organization. *Mental Health and Work: Impact, Issues and Good Practices*. The World Health Organization and International Labour Organization, 2000 ([www.wfmh.org](http://www.wfmh.org))
- Kahn, R.L., & Boyers, P., (1992). *Stress in Organizations*. In: Dunnette, M.D., & Hough, L. (Eds.), *Handbook of industrial and organizational psychology* (2nd ed.) pp. 571-650. California: consulting psychologists Press.
- Karasek, R. A. Job demands, job decision latitude and mental strain: implications for job redesign. *Administrative Science Quarterly*, 1979; 24: 285-307.
- Karasek, R. Stress prevention through work reorganization: a summary of 19 international case studies. In: *Conditions of Work Digest; Preventing Stress at Work*. Geneva: ILO, 1992; 11 (2): 23-42
- Karasek, R.A., and Theorell, T. *Healthy Work: Stress, productivity and the reconstruction of working life*. New York: Basic Books, 1990.
- Klink, J.J.L. van der, Blonk, R.W.B., Schene, A.H. & Van Dijk, F.J.H. (2001). The benefits of interventions for work related stress. *American Journal of Public Health*, 91:270-6.
- Klink, J.J. van der, Blonk R.W., Schene AH, Dijk, F.J. van. (2003). Reducing long term sickness absence by an activating intervention in adjustment disorders: a cluster randomised controlled design. *Occupational and Environmental Medicine*, 60, 429-437.
- Kompier, M.A, Aust, B, Berg, A.M. van den & Siegrist, J. (2000). Stress prevention in bus drivers: evaluation of 13 natural experiments. *Journal of Occupational Health Psychology*; 5:11-31.
- Kompier, M. & Cooper, C. (1999). *Preventing stress, improving productivity; European case studies in the workplace*. London: Routledge, 1999.
- Kompier, M.A.J. & Kristensen, T.S. (2001). Organizational work stress interventions in a theoretical, methodological and practical context. In: Dunham J. (Ed). *Stress in the Workplace: Past, present and future*. London: Whurr Publishers, 2001: 164-190.



Kristensen, T.S. Workplace Intervention Studies. (2000). *Occupational Medicine*, 2000;15(1):293-305.

Landsbergis, P.A., Cahill, J., Schnall, P. The impact of lean production and related new systems of work organization on worker health. *Journal of Occupational Health Psychology*, 1999; 4: 108-130.

Lange, A.H., de, Taris, T.W., Kompier M.A.J., Houtman, I.L.D., Bongers, P.M. "The Very Best of the Millennium": Longitudinal Research and the Demand-Control-(Support) Model. *Journal of Occupational Health Psychology*, 2003; 8(4): 282-305.

Lazarus, R.S., Folkman S. *Stress, Appraisal, Coping*. New-York: Springer Publishing Company, 1984.

Meijman, T.F. & Mulder, G. Psychological Aspects of Workload. In P.J.D Drenth, H. Thierry & C.J. deWolff (Eds.). *Handbook of Work and Organisational Psychology* (2<sup>nd</sup>Ed.). *Work Psychology* (Vol. 2., pp. 5-33). Sussex: Psychology Press, 1998.

Merllié, D. & Paoli, P. *Third European Survey on Working Conditions*. Dublin: European Foundation for the improvement of living and working conditions. Dublin: EFILWC, 2001.

Moore, K.A., Cooper, C.L. Theories of Stress among Mental Health professionals. In Hardy, S., Carson, J., Thomas, B. (Eds.) *Occupational stress: personal and professional approaches*. Cheltenham: Stanley Thornes, 1998.

Nyman, K., Palmer, E. & Bergendorff, S. *Den Svenska Sjukan, 2002* Retrieved from: [http://finans.regeringen.se/eso/PDF/ds2002\\_49.pdf](http://finans.regeringen.se/eso/PDF/ds2002_49.pdf) [ in Swedish].

Paoli, P. *Second Survey on Working Conditions*. Dublin: European Foundation for the improvement of living and working conditions, Dublin: EFILWC, 1997.

Randall, R. Griffiths, A. & Cox, C. Evaluating organizational stress-management interventions using adapted study designs. *European Journal of Work and Organizational Psychology*, 2005; 14(1): 23-41.

Riksförsäkringsverket. *Långtidssjukskrivningar för psykisk sjukdom och utbrändhet*. RFV Analyserar 2002:4. Riksförsäkringsverket. Stockholm, 2002. [in Swedish].

Schaufeli, W.B., Maslach, C., & Marek, T., (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 53-69). Washington: Taylor & Francis, 1993.

Schaufeli, W.B. & Enzmann, D. *The Burnout Companion to Study & Practice. A Critical Analysis*. London: Taylor & Francis, 1998.

Semmer, N.K. (2003). Job stress interventions and organization of work. In: Quick, J.C., Tetrick, L.E. (Eds.). *Handbook of Occupational Health Psychology*. Washington: American Psychological Association.

Shaw, L., Segal, R., Polatajko, H. & Harburn, K. Understanding return to work behaviours: promoting the importance of individual perceptions in the study of return to work. *Disability and rehabilitation (England)* , Mar 10 2002; 24 (4): 185-95]

Siegrist, J. Adverse health effects on high-effort/low-reward conditions. *Journal of Occupational Health Psychology*,; 1996:1, 27-41.

Singleton, N., Bumpstead, R., O'Brien, M., Lee, A., & Meltzer, H., The prevalence of Psychiatric morbidity among adults living in private households, 2000. The Stationary Office London, 2000.

Sonnentag, S. & Frese, M. (2003). Stress in organizations. In W. C. Borman, D. R. Ilgen, & R. J. Klimoski (Eds.), *Comprehensive handbook of psychology, Volume 12: Industrial and organizational psychology* (pp. 453-491). Hoboken: Wiley.

Talma, K.; Orit; L. et al. Supervisors' attitudes toward return to work after myocardial infarction or coronary artery bypass graft. *Journal of occupational and environmental medicine / American College of Occupational and Environmental Medicine (United States)*, 2002; 44, (4): 331-7.

World Health Organization (WHO). *The World Health Report. Mental Health: New understanding, New hope.* WHO, 2002.

## Appendix A List of variables and scales used in the questionnaire

Time 1 Variable	Reference	Reliability ( $\alpha$ )
<b>Demographics</b>		
Gender		
Age		
Education		
Marital status		
Number of adults in household		
Number of children in household		
Number of people working in household		
Care for elderly/disabled		
Personal monthly income		
Household monthly income		
Ability to make living without returning to work		
 <i>Job characteristics</i>		
Job title		
Job tenure		
Job contract type		
Private/public sector		
Work sector specification		
Size of workplace		
Availability of sick pay/health insurance/pension at workplace		
Contract work hours		
Actual work hours		
 <b>Psychosocial work characteristics</b>		
JCQ-Job Content Questionnaire (modified version)	Karasek et al, 1998	
– Job Control: 7 items		0.79
– Psychological Job Demands: 5 items		0.77
– Supervisor Social Support: 4 items		0.90
– Coworker Social Support: 4 items		0.77
– Physical Job Demand: 3 items		0.84
ERI-Effort Reward Imbalance Scale (modified version)	Siegrist, 1996	
– Reward: 8 items		0.71
– Overcommitment: 6 items		0.85
COPSOQ-Copenhagen Psychosocial Questionnaire (modified version)	Kristensen, 2002	
– Emotional demands: 4 items		0.78
– Cognitive Demands: 3 items (using 2 items from COPSOQ & 1 item from JCQ)	Kristensen, 2002 Karasek et al, 1998	0.84
MOSI-Masterson Overall Satisfaction Index	Masterson et al, 2000	
– Job satisfaction: 2 items		0.83
Work-family balance scale (modified version)	Marmot et al, 1991; Hammer et al, 2004	
– Work-family interference: 3 items		0.73
– Family-work interference: 2 items		0.80
QPSN-Nordic-General Questionnaire for Psychological and Social factors at work (modified version)	Linström et al, 2000	
– Work Centrality index: 2 items		0.61
 <b>Availability of H&amp;S policies, guidelines and health schemes at work</b>		
Policies & guidelines: 7 items		
Health schemes: 6 items		
 <i>Lifestyle</i>		
Amount of exercise before absence: 3 items		
Amount of exercise after absence: 3 items		
PSQI-Pittsburgh Sleep Quality Index: 11 items (modified version)	Buysee et al, 2000	
– Sleeping problems: 4 items		0.67
Life-style changes: 9 items (eating, smoking, drinking, exercising)		
 <b>Personality &amp; health characteristics</b>		
OLBI-Oldenburg Burnout Inventory (full version)	Demerouti et al, 2003	
– Exhaustion: 8 items		0.86
		0.74

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- Disengagement: 8 items		
GSE-Generalized Self-Efficacy scale: 10 items (full version)	Schwarzer & Jerusalem, 1995	0.92
CESD-Depression scale: 10 items (short version)	Radloff, 1977	0.88
	Andresen et al, 1994	
Stressfull life-events: 11 items		
General health status: 1 item		
Work ability index (modified version)	Tuomi et al, 1998	
- Medical condition (diagnosis): 16 items		
- Condition work related: 1 item		
- General work ability: 1 item		
- Physical work ability: 1 item		
- Mental work ability: 1 item		
Number of previous absences		
Length of previous absences		
Reason for previous absence		
Length of current absence		
Main reason for current absence		
(coded) Diagnosis for absence		
Absence: particular event or gradual process		
Absence: Unexpected event		

### *Absence & return to work*

Main sources household income during absence		
Experience of absence	Kivistö & Joensuu, 2001	
- Detached from: 5 items		0.75
- Attached to work: 4 items		0.67
Have you returned to work		
When did you return		
What job after return to work		
When do you expect to return to work		
To what job do you expect to return		
Likelihood of future labour market position		

### *Contact with (health) services and professionals*

Contact with services & helpfulness: 11 items  
 Contact with professionals & helpfulness: 13 items  
 Contact between professionals  
 Contact manager and professionals  
 Contact with work organisation/OHS in first month: 4 items  
 Contact with work organisation/OHS after first month: 4 items  
 Return to work co-ordinator  
 Job position held open  
 How long job position open

### *Interventions*

Medical interventions & helpfulness: 7 items  
 Interventions offered by employer before absence: 11 items  
 Interventions offered by employer after absence: 11 items  
 Were offered interventions helpful: 11 items  
 Which interventions would help: 11 items

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## *Time 2*

### **Demographics**

Marital status  
 Number of adults in household  
 Number of children in household  
 Number of people working in household  
 Personal monthly income  
 Household monthly income

### ***Main sources of household income***

### ***Job characteristics (for people that have resumed only)***

#### ***Job title***

#### ***Current job same as before absence***

Job type  
 Private/public sector  
 Work sector specification  
 Size of workplace

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**Return to work (for people that have resumed only)**

Have you returned to work (for all respondents)  
How many hours do you work  
How many weeks since you have returned  
What date did you return  
Relapse to absence  
Factors that influenced return to work  
Arrangements offered by employer: 5 items

***Return to work (for people who are still absent)***

When do you expect to return to work  
To what job do you expect to return  
Factors preventing your return to work  
Contact with work organisation/OHS in past 3 months: 4 items  
Arrangements offered by employer & helpfulness: 5 items  
Ability to make living without returning to work  
Likelihood of future labour market position

**Psychosocial work characteristics**

QPSNordic-General Questionnaire for Psychological and Social factors at work (modified version) Lindström et al, 2000  
– Work Centrality index: 2 items 0.77

***Lifestyle***

Amount of exercise last month: 3 items  
PSQI-Pittsburgh Sleep Quality Index: 11 items (modified version) Buysee et al, 2000 0.68  
– Sleeping problems: 4 items

Life-style changes: 9 items (eating, smoking, drinking, exercising)

**Personality & health characteristics**

Stressful life-events: 11 items  
GSE-Generalized Self-Efficacy scale: 10 items (full version) Schwarzer & Jerusalem, 1995 0.92  
Hopkins Symptoms Checklist: 26 items (modified version)  
– Somatization: 12 items **Derogatis et al, 1974** 0.87  
– Anxiety: 6 items 0.89  
– Obsessive compulsive: 8 items 0.92  
General health status: 1 item  
CESD-Depression scale: 10 items (short version) Radloff, 1977 0.87  
Andresen et al, 1994  
Tuomi et al, 1998  
Work ability index (modified version)  
– Medical condition (diagnosis): 16 items  
– General work ability: 1 item  
– Physical work ability: 1 item  
– Mental work ability: 1 item

***Stress-definition: 1 item***

Health change

Elo et al, 2003

***Contact with (health) services and professionals***

Contact with services & helpfulness: 11 items  
Contact with professionals & helpfulness: 12 items  
Contact between professionals  
Contact manager and professionals

***Interventions & absence experience***

Medical/vocational interventions & helpfulness: 6 items  
Experience of absence Kivistö & Joensuu, 2001  
– Detached from: 5 items 0.81  
– Attached to work: 4 items 0.73

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